Medicare Advantage Attestation of Benefit Plan
HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007
Date: 09/25/2020

I attest that I have examined the Plan Benefit Packages (PBPs) identified below and that the benefits identified in the PBPs are those that the above-stated organization will make available to eligible beneficiaries in the approved service area during program year 2021. I further attest that we have reviewed the bid pricing tools (BPTs) with the certifying actuary and have determined them to be consistent with the PBPs being attested to here.

I attest that I have examined the employer/union-only group waiver (""800 series"") PBPs identified below and that these PBPs are those that the above-stated organization will make available only to eligible employer/union-sponsored group plan beneficiaries in the approved service area during program year 2021. I further attest we have reviewed any MA bid pricing tools (BPTs) associated with these PBPs (no Part D bids are required for 2021 "800 series" PBPs) with the certifying actuary and have determined them to be consistent with any MA PBPs being attested to here.

I attest that our MA plan(s) are implementing Part B step therapy under the direction of its P&T committee consistent with CMS regulatory and sub-regulatory guidance.

I further attest that these benefits will be offered in accordance with all applicable Medicare program authorizing statutes and regulations and program guidance that CMS has issued to date and will issue during the remainder of 2020 and 2021, including but not limited to, the 2021 Solicitations for New Contract Applicants, the Medicare Prescription Drug Benefit Manual, the Medicare Managed Care Manual, and the CMS memoranda issued through the Health Plan Management System (HPMS).

Plan ID	Segment ID	Version	Plan Name	Plan Type	Transaction Type	MA Premium	Part D Premium	CMS Approval Date	Effective Date
012	0	6	Humana Gold Plus H4007-012 (HMO)	HMO	Renewal	0.00	0.00	09/03/2020	01/01/2021
013	0	6	Humana Gold Plus H4007-013 (HMO)	HMO	Renewal	0.00	0.00	09/03/2020	01/01/2021
016	0	6	Humana Gold Plus SNP-DE H4007-016 (HMO D-SNP)	HMO	Renewal	0.00	0.00	09/03/2020	01/01/2021
018	0	5	Humana Gold Plus SNP-DE H4007-018 (HMO D-SNP)	HMO	Plan Correction	0.00	0.00	09/18/2020	01/01/2021
019	0	6	Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)	HMO	Renewal	0.00	0.00	09/03/2020	01/01/2021
020	0	2	Humana Gold Plus H4007-020 (HMO)	HMO	Renewal	0.00	0.00	09/03/2020	01/01/2021
021	0	5	Humana Gold Plus H4007-021 (HMO)	HMO	Renewal	0.00	0.00	09/03/2020	01/01/2021
022	0	3	Humana Gold Plus SNP-DE H4007-022 (HMO D-SNP)	HMO	Plan Correction	0.00	0.00	09/18/2020	01/01/2021
023	0	4	Humana Gold Plus SNP-DE H4007-023 (HMO D-SNP)	HMO	Renewal	0.00	0.00	09/03/2020	01/01/2021
801	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	0.00	33.10	09/03/2020	01/01/2021
802	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	0.00	N/A	09/03/2020	01/01/2021
811	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	0.00	33.10	09/03/2020	01/01/2021
812	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	0.00	N/A	09/03/2020	01/01/2021
813	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	0.00	33.10	09/03/2020	01/01/2021
814	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	0.00	N/A	09/03/2020	01/01/2021
815	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	0.00	33.10	09/03/2020	01/01/2021
816	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	0.00	N/A	09/03/2020	01/01/2021

BRIAN KANE
Contracting Official Name

8/27/2020 2:21:28 PM
Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131
Address

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H4007

CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)

CONTRACT (H4007)

Between

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

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, 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' authorized representative through December 31, 2021, 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. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, 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 (hereafter the "Part D Addendum"). For MA Organizations offering MA-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
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR §422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) 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 or policies implementing or interpreting such statutory provisions.

C. 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. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2020 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 2020 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2020 or prior year contracts.

E. 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.

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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 §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. 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 §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. 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.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMS-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. 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. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

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

(3.a) Each 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. To meet this requirement the MA Organization must—

(3.a.i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(3.a.ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(3.a.iii) Ensure that the enrollee does not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to the enrollee by an MA contracting individual or entity on the preclusion list, as defined and described in 42 CFR § 422.2 and 422.222. [422.504(g)(1))iv)]

(3.b) The MA Organization must provide for continuation of enrollee health care benefits-

(3.b.i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(3.b.ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(3.c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA

Organization may use—

(3.c.i) Contractual arrangements;

(3.c.ii) Insurance acceptable to CMS;

(3.c.iii) Financial reserves acceptable to CMS; or

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

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements 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 & 422.224. **[422.504(a)(6)]**

2. The MA Organization agrees to ensure that the plan's provider agreement contains a provision stating that after the expiration of the 60-day period specified in 42 CFR §422.222:

(2.a) The provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per 42 CFR §422.504(g)(1)(iv); and

(2.b) The provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider will have already received notification of the preclusion. [422.504(g)(1)(v)]

3. Prompt Payment.

(3.a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(2.a.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.

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

(3.b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(3.c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(2.c.i) For direct payment of the sums owed to providers; and

(2.c.ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

4. Agreements with Federally Qualified Health Centers (FQHC)

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

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

(4.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]

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. The MA Organization agrees to develop and operate a chronic care improvement program in accordance with the requirements of 42 CFR §422.152(c).

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152 & 422.162(c)]**

4. Utilization Review:

(4.a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(4.b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(5.a) The MA Organization must:

(5.a.i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(5.a.ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(5.a.iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization by:

(7.a) Addressing and resolving complaints in the CMS complaint tracking system; and

(7.b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.**[422.504(a)(15)]**

F. COMPLIANCE PLAN

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

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.165, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

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 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. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V, consistent with guidance provided in the Medicare Communication and Marketing Guidelines. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

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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. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

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 attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.
(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, 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 attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, 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 attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also *attest to (based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(l)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, 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 attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(l)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. 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. **[422.504(i)(1)]**

B. The MA Organization agrees to require all first tier, downstream, and related entities to agree that—

1. 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' 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 B (1) of this Article directly from any first tier, downstream, or related entity;

3. For records subject to review under paragraph B(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; and

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. **[422.504(l)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with first tier, downstream, and related entities shall contain the following elements:

1. Enrollee protection provisions that provide—

(1.a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(1.b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a first tier, downstream, or related entity in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, and related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations.**[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(4.a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(4.b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. 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. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

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 that-

(1.a) Are sufficient to do the following:

(1.a.i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(1.a.ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(1.a.iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(1.a.iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(1.a.v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(1.a.vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(1.b) Include at least records of the following:

(1.b.i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(1.b.ii) Financial statements for the current contract period and ten prior periods.
(1.b.iii) Federal income tax or informational returns for the current contract period and ten prior periods.
(1.b.iv) Asset acquisition, lease, sale, or other action.
(1.b.v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.
(1.b.vi) Franchise, marketing, and management agreements.
(1.b.vii) Schedules of charges for the MA Organization's fee-for-service patients.
(1.b.viii) Matters pertaining to costs of operations.
(1.b.ix) Amounts of income received, by source and payment.
(1.b.x) Cash flow statements.
(1.b.xi) Any financial reports filed with other Federal programs or State authorities.**[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(2.a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means

(2.a.i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(2.a.ii) Compliance with CMS requirements for maintaining the privacy and security of protected health information and other personally identifiable information of Medicare enrollees;

(2.a.iii) The facilities of the MA Organization; and

(2.a.iv) The enrollment and disenrollment records for the current contract period and ten prior periods.

(2.b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(2.c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require.

(2.d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(2.d.i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(2.d.ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(2.d.iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(2.a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(2.a.i) The cost of its operations;

(2.a.ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(2.a.iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(2.a.iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(2.a.iv.aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(2.a.iv.bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(2.a.v) Requirements for combined financial statements.

(2.a.v.aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(2.a.v.bb) Inter-entity transactions must be eliminated in the consolidated column.

(2.a.v.cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(2.a.v.dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(2.a.vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(2.b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(2.c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(3.a) The benefits covered under the MA plan;

(3.b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(3.c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(3.d) Plan quality and performance indicators for the benefits under the plan including —

(3.d.i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(3.d.ii) Information on Medicare enrollee satisfaction;

(3.d.iii) The patterns of utilization of plan services;

(3.d.iv) The availability, accessibility, and acceptability of the plan's services;

(3.d.v) Information on health outcomes and other performance measures required by CMS;

(3.d.vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(3.d.vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(3.d.viii) Information about beneficiary appeals and their disposition;

(3.d.ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(3.d.x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's, request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(5.a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(5.b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

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

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. 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:

(8.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);

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

(8.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.

9. The MA Organization agrees that it must subject information collected pursuant to 42 CFR §422.516(a) to a yearly independent audit to determine their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS. [422.516(g)]

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; **[422.506(a)]**

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

3. CMS informs the MA Organization that it authorizes a renewal.

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 time frames for doing so set forth in this subparagraph.

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

(2.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

(2.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 and must receive CMS approval prior to issuance.

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

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

(3.b) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph 1(b)(ii) of this paragraph; and

(3.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, CMS may deny an application for a new contract or a service area expansion from the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(4), also served as covered persons for the non-renewed 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.[422.506(a) & 422.508(c)]

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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.

(1.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 time frames specified by CMS. **[422.508(a)(2)]**

(1.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. **[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.**[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. **[422.508(c)]**

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

1. Termination by CMS.

(1.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)]

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

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

(1.a.iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(1.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.

(1.c) Notice. If CMS decides to terminate a contract , it will give notice of the termination as follows: [42 CFR §422.510(b)(1)] (1.c.i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(1.c.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.

(1.c.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.

(1.c.iv) In the event that CMS issues a termination notice to an 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.

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

(1.d.i) For terminations based on violations prescribed in 42 CFR §422.510(a)(4)(i) 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.

(1.d.ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan 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.

(1.d.iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' 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.

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

(1.e.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 an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(1.e.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.

(1.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. **[422.510(d)]**

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

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

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

(2.b.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.

(2.b.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, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(2.b.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.

(2.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.

(2.d) CMS' liability. CMS' 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.

(2.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 two 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. **[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. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.**[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 related entities, contractors, or subcontractors. **[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.

E. 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 §92.5.

Article X
Severability

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

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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 an MA organization is out of compliance with a Part C requirement when the organization fails to meet performance standards articulated in the Part C statutes, regulations, or guidance. If CMS has not already articulated a measure for determining noncompliance, CMS may determine that an MA organization is out of compliance when its performance in fulfilling Part C requirements represents and outlier relative to the performance of other MA organizations. **[422.504(m)]**

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

ATTACHMENT A

ATTESTATION OF ENROLLMENT
INFORMATION RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING
TO CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/27/2020 2:21:28 PM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/18/2020 3:51:31 PM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
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H4007

MEDICARE MARK LICENSE AGREEMENT

THIS AGREEMENT is made and entered into 8/27/2020 2:21:28 PM

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd.,Baltimore, MD 21244

and

HUMANA HEALTH PLANS OF PUERTO RICO, INC. (hereinafter "Licensee"),
with offices located at 383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

CMS Contract ID: H4007

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning October 15, 2020.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2021, concurrent with the execution of the Part D contract (or Part D addendum to a Medicare Managed Care contract). This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2021, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Medicare Managed Care contract).
7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their duly authorized officers as of the date first set forth above.

This document has been electronically signed by:

FOR THE LICENSEE

BRIAN KANE

Contracting Official Name

8/27/2020 2:21:28 PM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

FOR THE LICENSOR

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

9/18/2020 3:51:31 PM

Date

ADMINISTRACION DE SEGUROS DE SALUD
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H4007

DATA USE ATTESTATION

The sponsor shall restrict its use and disclosure of Medicare data obtained from CMS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare managed care and/or outpatient prescription drug benefits for which it has contracted with the Centers for Medicare & Medicaid Services (CMS) to administer. The sponsor shall only maintain data obtained from CMS information systems that are needed to administer the Medicare managed care and/or outpatient prescription drug benefits that it has contracted with CMS to administer. The sponsor (or its subcontractors or other related entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system, to support any line of business other than the Medicare managed care and/or outpatient prescription drug benefit for which the sponsor contracted with CMS.

The sponsor further attests that it shall limit the use of information it obtains from its Medicare plan members to those purposes directly related to the administration of such plan. The sponsor acknowledges two exceptions to this limitation. First, the sponsor may provide its Medicare members information about non-health related services after obtaining consent from the members. Second, the sponsor may provide information about health-related services without obtaining prior member consent, as long as the sponsor affords the member an opportunity to elect not to receive such information.

CMS may terminate the sponsor's access to the CMS data systems immediately upon determining that the sponsor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare members beyond the scope for which CMS has authorized under this agreement. A termination of this data use agreement may result in CMS terminating the sponsor's Medicare contract(s) on the basis that it is no longer qualified as a Medicare sponsor. This agreement shall remain in effect as long as the sponsor remains a Medicare managed care organization and/or outpatient prescription drug benefit sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS makes available to the general public on our website.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

This document has been electronically signed by:

BRIAN KANE

Contracting Official Name

8/27/2020 2:21:28 PM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

H4007

EMPLOYER/UNION-ONLY GROUP PART C ADDENDUM TO CONTRACT WITH APPROVED ENTITY PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare Advantage Organization (hereinafter referred to as the "MA Organization") agree to amend the contract H4007 governing the MA Organization's operation of a Medicare Advantage plan described in §1851(a)(2)(A) or §1851(a)(2)(C) of the Social Security Act (hereinafter referred to as "the Act"), including all attachments, addenda, and amendments thereto, to include the provisions contained in this Addendum (collectively hereinafter referred to as the "contract"), under which the MA Organization shall offer Employer/Union-Only Group MA-Only Plans (hereinafter referred to as "employer/union-only group health plans") in accordance with the waivers granted by CMS under §1857(i) of the Act. The terms of this Addendum shall only apply to MA-only health plans offered by the MA Organization exclusively to eligible individuals enrolled in employment-based health coverage under a contract between the MA Organization and the employer/union sponsor of the employment-based health coverage.

This Addendum is made pursuant to Subpart K of 42 CFR Part 422.

Article I

Employer/Union-Only Group Medicare Advantage Health Plan

A. MA Organization agrees to operate one or more employer/union-only group health plans in accordance with the Medicare Advantage contract (as modified by this Addendum), which incorporates in its entirety the *2021 Part C-Medicare Advantage and 1876 Cost Plan Expansion Application* (released on January 8, 2020) and any employer/union-only group waiver guidance, including, but not limited to those requirements contained in Chapter 9 of the Medicare Managed Care Manual).

B. This Addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract, and any regulations and policies implementing or interpreting such statutory provisions.

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

D. This Addendum is in no way intended to supersede or modify 42 CFR Part 422 or §§1851 through 1859 of the Act, except as specifically provided in applicable employer/union-only group waiver guidance and/or in this Addendum. Failure to reference a statutory or regulatory requirement in this Addendum does not affect the applicability of such requirement to the MA Organization and CMS.

E. The provisions of this Addendum apply to all employer/union-only group health plans offered by MA Organization under this contract number. In the event of any conflict between the provisions of this Addendum and any other provision of the contract, the terms of this Addendum shall control.

Article II

Functions to be Performed by the Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. MA Organization agrees to provide enrollees in each of its employer/union-only group health plans the basic benefits (hereinafter referred to as "basic benefits") as required under 42 CFR §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.

2. 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 2021 Rate Announcement issued on April 6, 2020.

3. 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 plan are waived for employer/union-only group health plan enrollees who are not entitled to Medicare Part A.

4. For employer/union-only group health plans offering non-calendar year coverage, MA Organization may determine basic and supplemental benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

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

(4.b) CMS payments will be determined on a calendar year basis.

5. For employer/union-only group MA-only plans that have a monthly beneficiary rebate described in 42 CFR §422.266:

(5.a) 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 MA Organization offers the plan benefit package; and

(5.b) 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 in accordance with the requirements of 42 CFR §422.504(e).

B. ENROLLMENT REQUIREMENTS

1. MA Organization agrees to restrict enrollment in an employer/union-only group health plan to those individuals eligible for the employer's/union's employment-based group coverage.

2. MA Organization will not be subject to the requirement to offer the employer/union-only group health plan to all eligible beneficiaries residing in the plan's service area as set forth in 42 CFR §422.50.

3. If an employer/union elects to enroll eligible individuals eligible for its employer/union-only group health plan through a group enrollment process, MA Organization will not be subject to the individual enrollment requirements set forth in 42 CFR §422.60. MA Organization agrees that it will comply with all the requirements for group enrollment contained in CMS guidance, including those requirements contained in Chapter 2 of the Medicare Managed Care Manual.

C. BENEFICIARY PROTECTIONS

1. Except as provided in subparagraph 2 of this paragraph, CMS agrees that with respect to any employer/union-only group health plans, MA Organization will not be subject to the prior review and approval of marketing materials and election forms requirements set forth in 42 CFR Part 422 Subpart V. MA Organization will be subject to all other disclosure requirements contained in 42 CFR §422.111 and that are conditions on any waivers for EGWPs provided in CMS guidance in Chapter 9 of the Medicare Managed Care Manual.

2. (2.a) CMS agrees that the disclosure requirements set forth in 42 CFR §422.111 will not apply with respect to any employer/union-only group health plan when the employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. As a condition of this waiver, MA Organization must:

(2.a.i) Provide summary plan descriptions and all other beneficiary communications required by the alternative disclosure requirements on a timely basis;

(2.a.ii) Provide these materials to CMS, upon request, in the event of beneficiary complaints, or for any other reason CMS requests, so that CMS may ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

(2.a.iii) Retain these dissemination materials and provide access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

(2.b) MA Organization agrees to comply with the requirements for this waiver contained in employer/union-only group waiver guidance, including those requirements contained in Chapter 9 of the Medicare Managed Care Manual.

D. SERVICE AREA

1. CMS agrees that local employer/union-only group health plans that provide coverage to individuals in any part of a State may offer coverage to individuals eligible for the employer/union-only group throughout that State provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service areas in CMS's Health Plan Management System (HPMS) as including those areas outside of its individual service area(s) to allow for enrollment of these beneficiaries in CMS enrollment systems.

2. Notwithstanding 42 CFR § 422.50(a)(3), CMS agrees that those Local Coordinated Care Health MA-PDs that provide coverage to individuals in any part of a State can offer coverage to beneficiaries eligible for the employer/union-only group plan that reside outside of the State provided it meets the requirements designated in the Medicare Managed Care Manual.

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/27/2020 2:21:28 PM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
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FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/18/2020 3:51:31 PM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
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H4007

ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare managed care organization (hereinafter referred to as MA-PD Sponsor) agree to amend the contract H4007 governing MA-PD Sponsor's operation of a Part C plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") or a Medicare cost plan to include this addendum under which MA-PD Sponsor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

This addendum is made pursuant to Subpart L of 42 CFR Part 417 (in the case of cost plan sponsors offering a Part D benefit) and Subpart K of 42 CFR Part 422 (in the case of an MA-PD Sponsor offering a Part C plan).

NOTE: For purposes of this addendum, unless otherwise noted, reference to an "MA-PD Sponsor" or "MA-PD Plan" is deemed to include a cost plan sponsor or a MA private fee-for-service contractor offering a Part D benefit.

Article I
Voluntary Medicare Prescription Drug Plan

A. MA-PD Sponsor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *Solicitation for Applications for Medicare Prescription Drug Plan 2021 Contracts*, released on January 8, 2020 (hereinafter collectively referred to as "the addendum"). MA-PD Sponsor also agrees to operate in accordance with the regulations at 42 CFR Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to MA-PD Sponsor consistent with the regulations at 42 CFR Part423 (with the exception of Subparts Q, R, and S), §§1860D- 1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 CFR Part 423 that impose new, significant regulatory requirements on MA-PD Sponsor. This provision does not apply to new requirements mandated by statute.

D. If MA-PD Sponsor had an MA-PD Addendum with CMS for Contract Year 2020 under the contract ID number designated above, this document is considered a renewal of the existing addendum. While the terms of this document supersede the terms of the 2020 addendum, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2020 or prior year addendums.

E. This addendum is in no way intended to supersede or modify 42 CFR, Parts 417, 422 or 423. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to MA-PD Sponsor and CMS.

Article II
Functions to be Performed by MA-PD Sponsor

A. ENROLLMENT

1. MA-PD Sponsor agrees to enroll in its MA-PD plan only Part D-eligible beneficiaries as they are defined in 42 CFR §423.30(a) and who have elected to enroll in MA-PD Sponsor's Part C or §1876 benefit.

2. If MA-PD Sponsor is a cost plan sponsor, MA-PD Sponsor acknowledges that its §1876 plan enrollees are not required to elect enrollment in its Part D plan.

B. PRESCRIPTION DRUG BENEFIT

1. MA-PD Sponsor agrees to provide the required prescription drug coverage as defined under 42 CFR §423.100 and, to the extent applicable, supplemental benefits as defined in 42 CFR §423.100 and in accordance with Subpart C of 42 CFR Part 423. MA-PD Sponsor also agrees to provide Part D benefits as described in MA-PD Sponsor's Part D bid(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. MA-PD Sponsor agrees to calculate and collect beneficiary Part D premiums in accordance with 42 CFR §§423.286 and 423.293.

3. If MA-PD Sponsor is a cost plan sponsor, it acknowledges that its Part D benefit is offered as an optional supplemental service in accordance with 42 CFR §417.440(b)(2)(ii).

4. MA-PD Sponsor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, communication, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 CFR §423.505(b)(25).

5. MA-PD Sponsor agrees to provide applicable beneficiaries applicable discounts on applicable drugs in accordance with the requirements of 42 CFR Part 423 Subpart W.

C. DISSEMINATION OF PLAN INFORMATION

1. MA-PD Sponsor agrees to provide the information required in 42 CFR §423.48.

2. MA-PD Sponsor acknowledges that CMS releases to the public the following data, consistent with 42 CFR Part 423, Subpart K:

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

(b) Part D Medical Loss Ratio data for the contract year, as described at 42 CFR §423.2490.

3. MA-PD Sponsor agrees to disclose information related to Part D benefits to beneficiaries in the manner and the form specified by CMS under 42 CFR §§423.128 and 423 Subpart V, consistent with the guidance provided in the Medicare Communication and Marketing Guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. MA-PD Sponsor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 CFR Part 423.

2. MA-PD Sponsor agrees to address complaints received by CMS against the Part D sponsor as required in 42 CFR §423.505(b)(22) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

3. MA-PD Sponsor agrees to maintain a Part D summary plan rating score of at least 3 stars as required by 42 CFR §423.505(b)(26).

4. MA-PD Sponsor agrees to pass an essential operations test prior to the start of the benefit year. This provision only applies to new sponsors that have not previously entered into a Part D contract with CMS and neither it, nor another subsidiary of the applicant's parent organization, is offering Part D benefits during the current year. 42 CFR §423.505(b)(27).

E. APPEALS AND GRIEVANCES

MA-PD Sponsor agrees to comply with all requirements in Subpart M of 42 CFR Part 423 governing coverage determinations, grievances and appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. MA-PD Sponsor acknowledges that these requirements are separate and distinct from the appeals and grievances requirements applicable to MA-PD Sponsor through the operation of its Part C or cost plan benefits.

F. PAYMENT TO MA-PD SPONSOR

MA-PD Sponsor and CMS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 CFR Part 423.

G. BID SUBMISSION AND REVIEW

If MA-PD Sponsor intends to participate in the Part D program for the next program year, MA-PD Sponsor agrees to submit the next year's Part D bid, including all required information on premiums, benefits, and cost-sharing, by the applicable due date, as provided in Subpart F of 42 CFR Part 423 so that CMS and MA-PD Sponsor may conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan renewal. MA-PD Sponsor acknowledges that failure to submit a timely bid under this section may affect the sponsor's ability to offer a Part C plan, pursuant to the provisions of 42 CFR §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. MA-PD Sponsor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 CFR Part 423.

2. MA-PD Sponsor agrees to comply with Medicare Secondary Payer procedures as stated in 42 CFR §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. MA-PD Sponsor agrees to provide Part D benefits in the service area for which it has been approved by CMS to offer Part C or cost plan benefits utilizing a pharmacy network and formulary approved by CMS that meet the requirements of 42 CFR §423.120.

2. MA-PD Sponsor agrees to provide Part D benefits through out-of-network pharmacies according to 42 CFR §423.124.

3. MA-PD Sponsor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 CFR §423.100), and long-term care pharmacies (as defined in 42 CFR §423.100) according to 42 CFR §423.505(b)(17).

4. MA-PD Sponsor agrees to contract with any pharmacy that meets MA-PD Sponsor's reasonable and relevant standard terms and conditions according to 42 CFR §423.505(b)(18), including making standard contracts available on request in accordance with the timelines specified in the regulation.

(a) If MA-PD Sponsor has demonstrated that it historically fills 98% or more of its enrollees' prescriptions at pharmacies owned and operated by MA-PD Sponsor (or presents compelling circumstances that prevent the sponsor from meeting the 98% standard or demonstrates that its Part D plan design will enable the sponsor to meet the 98% standard during the contract year), this provision does not apply to MA-PD Sponsor's plan. 42 CFR§423.120(a)(7)(i)

(b) The provisions of 42 CFR §423.120(a) concerning the retail pharmacy access standard do not apply to MA-PD Sponsor if the Sponsor has demonstrated to CMS that it historically fills more than 50% of its enrollees' prescriptions at pharmacies owned and operated by MA-PD Sponsor. MA-PD Sponsors excused from meeting the standard are required to demonstrate retail pharmacy access that meets the requirements of 42 CFR §422.112 for a Part C contractor and 42 CFR §417.416(e) for a cost plan contractor. 42 CFR§423.120(a)(7)(i)

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

MA-PD Sponsor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 CFR §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

MA-PD Sponsor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 CFR Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

MA-PD Sponsor agrees to afford its enrollees protection from liability for payment of fees that are the obligation of MA-PD Sponsor in accordance with 42 CFR §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. MA-PD Sponsor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum. 42 CFR §423.503(i).

2. MA-PD Sponsor shall ensure that any contracts or agreements with first tier, downstream, and related entities performing functions on MA-PD Sponsor's behalf related to the operation of the Part D benefit are in compliance with 42 CFR §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

MA-PD Sponsor must provide certifications in accordance with 42 CFR §423.505(k).

O. MA-PD SPONSOR REIMBURSEMENT TO PHARMACIES (42 CFR §§ 423.505(b)(21), 423.520)

1. If MA-PD Sponsor uses a standard for reimbursement of pharmacies based on the cost of a drug, MA-PD Sponsor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. If the source for any prescription drug pricing standard is not publicly available, MA-PD Sponsor will disclose all individual drug prices to be updated to the applicable pharmacies in advance for their use for the reimbursement of claims.

3. MA-PD Sponsor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

4. MA-PD Sponsor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to MA-PD Sponsor for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

MA-PD Sponsor agrees to maintain records and provide access in accordance with 42 CFR §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

MA-PD Sponsor agrees to submit information to CMS according to 42 CFR §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements."

C. CMS LICENSE FOR USE OF PLAN FORMULARY

MA-PD Sponsor agrees to submit to CMS each plan's formulary information, including any changes to its formularies, and hereby grants to the Government and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. MA-PD Sponsor agrees to comply with the confidentiality and enrollee record accuracy requirements specified in 42 CFR §423.136.

B. MA-PD Sponsor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of- pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2021. This addendum shall be renewable for successive one-year periods thereafter according to 42 CFR §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 CFR §423.507, MA-PD Sponsor will be determined qualified to renew this addendum annually only if MA-PD Sponsor has not provided CMS with a notice of intention not to renew in accordance with Article VII of this addendum.

2. Although MA-PD Sponsor may be determined qualified to renew its addendum under this Article, if MA-PD Sponsor and CMS cannot reach agreement on the Part D bid under Subpart F of 42 CFR Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 CFR Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VI
Nonrenewal of Addendum by MA-PD Sponsor

A. MA-PD Sponsor may non-renew this addendum in accordance with 42 CFR 423.507(a).

B. If MA-PD Sponsor non-renews this addendum under this Article, CMS cannot enter into a Part D addendum with the organization or with an organization whose covered persons, as defined in 42 CFR §423.507(a)(4), also served as covered persons for the nonrenewing sponsor for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS.

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 CFR 423.508. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 CFR 423.509. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article IX
Termination of Addendum by MA-PD Sponsor

A. MA-PD Sponsor may terminate this addendum only in accordance with 42 CFR 423.510.

B. CMS will not enter into a Part D addendum with an MA-PD Sponsor that has terminated its addendum or with an organization whose covered persons, as defined in 42 CFR §423.508(f), also served as covered persons for the terminating sponsor within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS.

C. If the addendum is terminated under section A of this Article, MA-PD Sponsor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article X
Relationship between Addendum and Part C Contract or 1876 Cost Contract

A. MA-PD Sponsor acknowledges that, if it is a Medicare Part C contractor, the termination or nonrenewal of this addendum by either party may require CMS to terminate or non-renew the Sponsor's Part C contract in the event that such non-renewal or termination prevents MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c), in which case the Sponsor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 CFR Part 422. MA-PD Sponsor also acknowledges that Article IX.B. of this addendum may prevent the sponsor from entering into a Part C contract for two years following an addendum termination or non-renewal where such non-renewal or termination prevents MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c).

B. The termination of this addendum by either party shall not, by itself, relieve the parties from their obligations under the Part C or cost plan contracts to which this document is an addendum.

C. In the event that MA-PD Sponsor's Part C or cost plan contract (as applicable) is terminated or nonrenewed by either party, the provisions of this addendum shall also terminate. In such an event, MA-PD Sponsor and CMS shall provide notice to enrollees and the public as described in this contract as well as 42 CFR Part 422, Subpart K or 42 CFR Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 CFR Part 423, MA-PD Sponsor shall be subject to sanctions and civil money penalties.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 CFR §423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 CFR Part 423 or, as applicable, 42 CFR Part 422 or Part 417.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

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

C. ADDITIONAL CONTRACT TERMS

MA-PD Sponsor agrees to include in this addendum other terms and conditions in accordance with 42 CFR §423.505(j).

D. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), MA-PD Sponsor 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.

E. MA-PD sponsor 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 §423.505(b)(23).

F. **Business Continuity:** MA-PD Sponsor agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR §423.505(p).

G. The MA-PD sponsor 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-PD sponsor's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.5.

In witness whereof, the parties hereby execute this contract. This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/27/2020 2:21:28 PM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

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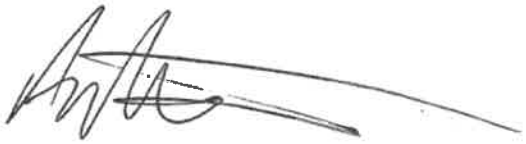
FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES



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Date

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

H4007

ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO SECTIONS 1851 THROUGH 1859 AND 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF

AN EMPLOYER GROUP ONLY A MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare Advantage Organization (hereinafter referred to as the "MA Organization") agree to amend the contract H4007 governing the MA Organization's operation of a Medicare Advantage plan described in § 1851(a)(2)(A) or § 1851(a)(2)(C) of the Social Security Act (hereinafter referred to as "the Act"), including all attachments, addenda, and amendments thereto, to include the provisions contained in this addendum (collectively hereinafter referred to as the "contract"), under which the MA Organization shall offer Employer/Union-Only Group MA-PD Plans (hereinafter referred to as "employer/union-only group MA-PDs") in accordance with the waivers granted by CMS under section 1857(i) of the Act. The terms of this Addendum shall only apply to MA-PD plans offered exclusively to Medicare Advantage-eligible individuals enrolled in employment-based health coverage under a contract between the MA Organization and the employer/union sponsor of the employment-based health coverage, pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

This addendum is made pursuant to Subpart K of 42 CFR Parts 422 and 423.

ARTICLE I

EMPLOYER/UNION-ONLY GROUP MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

A. MA Organization agrees to operate one or more employer/union-only group MA-PDs in accordance with the Medicare Advantage contract (as modified by this addendum), which incorporates in its entirety the *Solicitation for Applications for Medicare Prescription Drug Plan 2021 Contracts and 2021 Part C – Medicare Advantage and 1876 Cost Plan Expansion Application* (both released on January 8, 2020) and any employer/union-only group waiver guidance issued by CMS, including, but not limited to, those requirements set forth in Chapter 12 of the Medicare Prescription Drug Benefit Manual and Chapter 9 of the Medicare Managed Care Manual (hereinafter referred to as "employer/union group waiver guidance"). This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

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

C. This Addendum is in no way intended to supersede or modify 42 CFR Parts 422 and 423 or sections 1851 through 1859 and 1860D-1 through D-43 of the Act, except as specifically provided in applicable employer/union-only group waiver guidance and/or in this Addendum. Failure to reference a statutory or regulatory requirement in this Addendum does not affect the applicability of such requirement to the MA Organization and CMS.

D. The provisions of this Addendum apply to all employer/union-only group MA-PDs offered by MA Organization under this contract number. In the event of any conflict between the provisions of this Addendum and any other provision of the contract, the terms of this Addendum shall control.

ARTICLE II

FUNCTIONS TO BE PERFORMED BY THE MEDICARE ADVANTAGE ORGANIZATION

A. PROVISION OF MA BENEFITS

1. MA Organization agrees to provide enrollees in each of its employer/union-only group MA-PDs the basic benefits (hereinafter referred to as "basic benefits") as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit as approved by CMS.

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

3. For employer/union-only group MA-PDs offering non-calendar year coverage, MA Organization may determine basic and supplemental benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

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

(3.b) CMS payments will be determined on a calendar year basis.

4. For employer/union-only group MA-PDs that have a monthly beneficiary rebate described in 42 CFR §422.266:

(4.a) 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 MA Organization offers the plan benefit package and

(4.b) 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 for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR 422.503(d) and (e).

5. 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 II.A.5(a) through (c). 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)

(5.a) The employer/union can subsidize different amounts for different classes of enrollees in the employer group health 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).

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

(5.c) The employer/union cannot charge an enrollee for coverage provided under the employer group health 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 (i.e., all Medicare-covered benefits, except hospice services) and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part C benefits (if any). 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).

B. PROVISION OF PRESCRIPTION DRUG BENEFIT

1. Except as provided in this subsection, MA Organization agrees to provide basic prescription drug coverage, as defined under 42 CFR §423.100, under any employer/union-only group MA-PD, in accordance with Subpart C of 42 CFR Part 423.

(1.a) CMS agrees that MA Organization will not be subject to the actuarial equivalence requirement set forth in 42 CFR §423.104(e)(5) with respect to any employer/union-only group MA-PD and may provide less than the defined standard coverage between the deductible and initial coverage limit. MA Organization agrees that its basic prescription drug coverage under any employer/union-only group MA-PD will satisfy all of the other actuarial equivalence standards set forth in 42 CFR §423.104, including but not limited to the requirement set forth in 42 CFR §423.104(e)(3) that the plan has a total or gross value that is at least equal to the total or gross value of defined standard coverage.

2. CMS agrees that nothing in this Addendum prevents MA Organization from offering prescription drug benefits in addition to basic prescription drug coverage to employers/unions. Such additional benefits offered pursuant to private agreements between MA Organization and employers/unions will be considered non-Medicare Part D benefits ("non-Medicare Part D benefits"). MA Organization agrees that such additional benefits may not reduce the value of basic prescription drug coverage (e.g., additional benefits cannot impose a cap that would preclude enrollees from realizing the full value of such basic prescription drug coverage).

3. MA Organization agrees that enrollees of employer/union-only group MA-PDs shall not be charged more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). MA

Organization must pass through the direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of an eligible spouse or dependent, the amount the subscriber or participant pays).

4. MA Organization agrees that any additional non-Medicare Part D benefits offered to an employer/union will always pay primary to the subsidies provided by CMS to low-income individuals under Subpart P of 42 CFR Part 423 (the "Low-Income Subsidy").

5. MA Organization agrees enrollees of employer/union-only group MA-PDs will not be permitted to make payment of premiums under 42 CFR §423.293(a) through withholding from the enrollee's Social Security, Railroad Retirement Board, or Office of Personnel Management benefit payment.

6. 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 D monthly beneficiary premium it will subsidize, subject to the restrictions set forth in this subsection. MA Organization agrees to retain these written agreements with employers/unions, including any written agreements related to items (d) through (f) of this subsection, and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR §§423.504(d) and 423.505(d) and (e).

(6.a) The employer/union can subsidize different amounts for different classes of enrollees in the employer/union-only group MA-PD 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). Different classes cannot be based on eligibility for the Low Income Subsidy.

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

(6.c) The employer/union cannot charge an enrollee for prescription drug coverage provided under the plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). The employer/union must pass through direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of an eligible spouse or dependent, the amount the subscriber or participant pays).

(6.d) For all enrollees eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce any portion of the MA-PD monthly beneficiary premium paid by the enrollee (or in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a low-income eligible spouse or dependent, the amount the subscriber or participant pays), with any remaining portion of the premium subsidy amount then applied toward any portion of the MA-PD monthly beneficiary premium (including any MA premium) paid by the employer/union. However, if the sum of the enrollee's MA-PD monthly premium (or the subscriber's/participant's MA-PD monthly premium, if applicable) and the employer's/union's MA-PD monthly premiums (i.e., total monthly premium) are less than the monthly low-income premium subsidy amount, any portion of the low-income subsidy premium amount above the total MA-PD monthly premium must be returned directly to CMS. Similarly, if there is no MA-PD monthly premium charged the beneficiary (or subscriber/participant, if applicable) or employer/union, the entire low-income premium subsidy amount must be returned directly to CMS and cannot be retained by the MA Organization, the employer/union, or the beneficiary (or the subscriber/participant, if applicable).

(6.e) If the Part D sponsor does not or cannot directly bill an employer group's beneficiaries, CMS will permit the Part D sponsor to directly refund the amount of the low-income premium subsidy to the LIS beneficiary. This refund must meet the above requirements concerning beneficiary premium contributions; specifically, that the amount of the refund not exceed the amount of the monthly premium contribution by the enrollee and/or the employer. In addition, the sponsor must refund these amounts to the beneficiary within a reasonable time period. However, under no circumstances may this time period exceed forty five (45) days from the date that the Part D sponsor receives the low-income premium subsidy amount payment for that beneficiary from CMS.

(6.f) The MA Organization and the employer/union may agree that the employer/union will be responsible for reducing up-front the MA-PD premium contribution required for enrollees eligible for the Low Income Subsidy. In those instances where the employer/union is not able to reduce up-front the MA-PD premiums paid by the enrollee (or, the subscriber/participant, if applicable), the MA Organization and the employer/union may agree that the employer/union shall directly refund to the enrollee (or subscriber/participant, if applicable) the amount of the low-income premium subsidy up to the MA-PD monthly premium contribution previously collected from the enrollee (or subscriber/participant, if applicable). The employer/union is required to complete the refund on behalf of the MA Organization within forty-five (45) days of the date the MA Organization receives from CMS the low-income premium subsidy amount payment for the low-income subsidy eligible enrollee.

(6.g) If the low income premium subsidy amount for which an enrollee is eligible is less than the portion of the Part D monthly beneficiary premium paid by the enrollee (or subscriber/participant, if applicable), then the employer/union should communicate to the enrollee (or subscriber/participant) the financial consequences of the low-income subsidy eligible individual enrolling in the employer/union-only group MA-PD as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

7. For non-calendar year employer/union-only group MA-PDs, MA Organization may determine benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

(7.a) Applications, formularies, bids and other submissions to CMS must be submitted on a calendar year basis;

(7.b) The prescription drug coverage under the employer/union-only group MA-PD must be at least actuarially equivalent to defined standard coverage for the portion of its plan year that falls in a given calendar year. An employer/union-only group MA-PD will meet this standard if its prescription drug coverage is at least actuarially equivalent for the calendar year in which the plan year starts and no design change is made for the remainder of the plan year. In no event can MA Organization increase during the plan year the annual out-of-pocket threshold;

(7.c) After an enrollee's incurred costs exceed the annual out-of-pocket threshold, the employer/union-only group MA-PD must provide prescription drug coverage that is at least actuarially equivalent to that provided under standard prescription drug coverage; eligibility for such coverage can be determined on a plan year basis.

8. 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 assurance activities related to the delivery of Part D services as required by 42 CFR §423.505(b)(25).

9. MA Organization agrees to provide applicable beneficiaries applicable discounts on applicable drugs in accordance with the requirements of 42 CFR Part 423 Subpart W.

10. MA Organization agrees to pass an essential operations test prior to the start of the benefit year. This provision only applies to new sponsors that have not previously entered into a Part D contract with CMS and neither it, nor another subsidiary of the applicant's parent organization, is offering Part D benefits during the current year. 42 CFR §423.505(b)(27).

C. CMS ENROLLMENT REQUIREMENTS

1. MA Organization agrees to restrict enrollment in an employer/union-only group MA-PD to those individuals eligible for the employer's/union's employment- based group coverage.

2. MA Organization will not be subject to the requirement to offer the employer/union-only group MA-PD to all Medicare eligible beneficiaries residing in its service area as set forth in 42 CFR §422.50.

3. If an employer/union elects to enroll eligible individuals eligible for its employer/union-only group MA-PDs through a group enrollment process, MA Organization will not be subject to the individual enrollment requirements set forth in 42 CFR §422.60. MA Organization agrees that it will comply with all the requirements for group enrollment contained in CMS guidance, including those requirements contained in Chapter 2 of the Medicare Managed Care Manual.

D. BENEFICIARY PROTECTIONS

1. Except as provided in II.D.2., CMS agrees that, with respect to any employer/union-only group MA-PDs, MA Organization will not be subject to the information requirements set forth in 42 CFR §423.48 and the prior review and approval of marketing materials and election forms requirements set forth in 42 CFR Part 422, subpart V and Part 423, subpart V. MA Organization will be subject to all other disclosure and dissemination requirements contained in 42 CFR §422.111, §423.128 and that are conditions on any waivers for EGWPs provided in CMS guidance in Chapter 9 of the Medicare Managed Care Manual.

2. (a) CMS agrees that the disclosure requirements set forth in 42 CFR §422.111 will not apply with respect to any employer/union-only group health plan when the employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. As a condition of this waiver, MA Organization must:

(2.a.i) Provide summary plan descriptions and all other beneficiary communications required by the alternative disclosure requirements on a timely basis;

(2.a.ii) Provide these materials to CMS, upon request, in the even ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

(2.a.iii) Retain these dissemination materials and provide access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

(b) MA Organization agrees to comply with the requirements for this waiver contained in employer/union-only group waiver guidance in Chapter 9 of the Medicare Managed Care Manual.

E. SERVICE AREA, FORMULARIES AND PHARMACY ACCESS

1. CMS agrees that Local employer/union-only group MA-PDs that provide coverage to individuals in any part of a State may offer coverage to retirees eligible for the employer/union-only group MA-PD throughout that State provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service areas in CMS's Health Plan Management System (HPMS) as including those areas outside of its individual service area(s) to allow for enrollment of these beneficiaries in CMS enrollment systems. CMS also agrees that employer/union-only group Regional MA-PDs that provide coverage to individuals in any part of a Region can offer coverage to retirees eligible for the employer/union-only group MA-PD throughout that Region.

2. Notwithstanding 42 CFR § 422.50(a)(3), CMS agrees that those Local Coordinated Care Health MA-PDs that provide coverage to individuals in any part of a State can offer coverage to beneficiaries eligible for the employer/union-only group plan that reside outside of the State provided it meets the requirements designated in the Medicare Managed Care Manual.

3. CMS agrees that Private Fee-for-Service employer/union-only group MA-PDs may offer coverage beyond their designated individual service areas to all enrollees of a particular employer/union-only group plan, regardless of where they reside in the nation, provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service area in CMS' HPMS as including areas outside of its individual plan service area(s) to allow for the enrollment of these beneficiaries in CMS enrollment systems.

4. MA Organization agrees to utilize, as the formulary for any employer/union-only group MA-PD, a base formulary that has received approval from CMS, in accordance with CMS formulary guidance, for use in a non-group MA-PD offered by MA Organization. Except as set forth in 42 CFR §423.120(b) and sub-regulatory guidance, MA Organization may not modify the approved base formulary used for any employer/union-only group MA-PD by removing drugs, adding additional utilization management restrictions, or increasing the cost-sharing status of a drug from the base formulary. Enhancements that are permitted to the base formulary include adding additional drugs, removing utilization management restrictions, and improving the cost-sharing status of drugs.

5. For any employer/union-only group MA-PD, MA Organization agrees to provide Part D benefits in the plan's service area utilizing a pharmacy network and formulary that meets the requirements of 42 CFR §423.120, with the following exception: CMS agrees that the retail pharmacy access requirements set forth in 42 CFR §423.120(a)(1) will not apply when the employer/union-only group MA-PD's pharmacy network is sufficient to meet the needs of its enrollees throughout the employer/union-only group MA-PD's service area, as determined by CMS. CMS may periodically review the adequacy of the employer/union-only group MA-PD's pharmacy network and require the employer/union-only group MA-PD to expand access if CMS determines that such expansion is necessary in order to ensure that the employer/union-only group MA-PD's network is sufficient to meet the needs of its enrollees.

F. PAYMENT TO MA ORGANIZATION

1. MA Organization is not required to submit a Part C bid pricing tool; 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 2021 Rate Announcement issued on April 6, 2020. Except as provided in this subsection, payment under this Addendum will be governed by the rules of Subparts G and J of 42 CFR Part 423.

(1.a) MA Organization acknowledges that the risk sharing, plan entry and retention bonus provisions of section 1858 of the Act and 42 CFR §422.458 shall not apply to any employer/union-only group Regional MA-PDs.

(1.b) MA Organization acknowledges that the risk-sharing payment adjustment described in 42 CFR §423.336 is not applicable for any employer/union-only group MA-PD enrollee.

(1.c) MA Organization is not required to submit a Part D bid and will receive a monthly direct subsidy under 42 CFR Subpart G for each employer/union-only group MA-PD enrollee equal to the amount of the national average monthly bid amount (not its approved standardized bid), adjusted for health status (as determined under 42 CFR §423.329(b)(1)) and reduced by the base beneficiary premium for the employer/union-only group MA-PD, as adjusted under 42 CFR §423.286(d)(3), if applicable. The further adjustments to the base beneficiary premium contained in 42 CFR §423.286(d)(1) and (2) will not apply.

(1.d) MA Organization will not receive monthly reinsurance payment or low-income cost-sharing subsidy amounts in the manner set forth in 42 CFR §423.329(c)(2)(i) and 42 CFR §423.329(d)(2)(i) for any employer/union-only group MA-PD enrollee, but instead will receive the full reinsurance and low-income cost-sharing subsidy payments following the end of year reconciliation as described in 42 CFR §423.329(c)(2)(ii) and 42 CFR §423.329(d)(2)(ii) respectively.

2. For non-calendar year plans:

(2.a) CMS payments will be determined on a calendar year basis;

(2.b) Low income subsidy payments and reconciliations will be determined based on the calendar year for which the payments are made; and (2.c) MA Organization acknowledges that it will not receive reinsurance payments under 42 CFR §423.329(c).

G. MA ORGANIZATION REIMBURSEMENT TO PHARMACIES(42 CFR §§ 423.505(b)(21), 423.520)

1. If an MA Organization uses a standard for reimbursement of pharmacies based on the cost of a drug, MA Organization will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. If the source for any prescription drug pricing standard is not publicly available, MA Organization will disclose all individual drug prices to be updated to the applicable pharmacies in advance for their use for the reimbursement of claims.

3. MA Organization will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

4. MA Organization must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to MA Organization for reimbursement.

H. PUBLIC HEALTH SERVICE ACT

Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), 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.

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/27/2020 2:21:28 PM

Date

ADMINISTRACION DE SEGUROS DE SALUD
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H4007

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
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FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/18/2020 3:51:31 PM

Date

Amy Larrick Chavez-Valdez
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ADMINISTRACION DE SEGUROS DE SALUD
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H4007

ADDENDUM TO CONTRACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN FOR PARTICIPATION IN THE PART D SENIOR SAVINGS MODEL (the "Addendum")

The Centers for Medicare & Medicaid Services ("CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare Part D Prescription Drug Plan Sponsor("**Part D Sponsor**") agree to amend the contract H4007, including all attachments, addenda, and amendments thereto (the "Underlying Contract"), governing the Part D Sponsor's operation of a Voluntary Medicare Prescription Drug Plan pursuant to §§ 1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Social Security Act ("**Act**"), to include this addendum to provide for the Part D Sponsor's participation in the Part D Senior Savings Model ("**Model**").

This voluntary Model, conducted pursuant to Section 1115A of the Act, is intended to exist for five plan years of the Part D Program commencing with plan year 2021. The purpose of this Model is to test a change to the Manufacturer Coverage Gap Discount Program to allow Part D sponsors, through eligible enhanced alternative plans, to offer a Part D benefit design that includes predictable, stable copays in the deductible, initial coverage, and coverage gap phases by offering supplemental benefits that apply, in the coverage gap, after manufacturers provide a discounted price for applicable drugs included in the Model without regard for the Special Rule for Supplemental Benefits.

The parties hereby amend the Underlying Contract by adding the following:

Article I
Model Term and Part D Sponsor Participation

A. This Addendum becomes effective on the date it is signed by CMS ("Effective Date") and will remain in effect through December 31, 2021, unless sooner terminated in accordance with Articles 6 or 8 of this Addendum. This Addendum covers Plan Year 2021 for the Part D Senior Savings Model, which will start on January 1, 2021 ("Start Date"). If Part D Sponsor wishes to participate in the Model during a subsequent Plan Year, it must timely submit for CMS review a Model application for the relevant Plan Year in addition to its annual Part D bid submission and enter into a contract addendum for participation in the Model for that plan year.

B. Part D Sponsor may participate in the Model only with the eligible plan benefit packages (PBPs) providing Enhanced Alternative Coverage that are identified in the Approved Proposal (each a "Model PBP").

C. The following plan types and programs are not eligible plan benefit packages and may not participate in the Model: PBPs for dual-eligible special needs plans (D-SNPs); Private Fee-For-Service (PFFS) Plans; Employer Group Waiver Plans (EGWPs); cost plans offered under section 1876 of the Act; Health Care Prepayment Plans (HCCP) offered under section 1833 of the Act; Programs of All-Inclusive Care for the Elderly (PACE);Medicare-Medicaid Plans (MMP) and other demonstration plans; and Religious Fraternal Benefit (RFB) plans.

Article II
Definitions

"Approved Proposal" means the Part D Sponsor's final approved application including, if applicable, any Part D RI Programs, allowing for the Part D Sponsor's participation in the Model in plan year 2021 and all corresponding bid submissions as finalized

"Diabetes " has the meaning set forth in 42 CFR § 410.18(a).

"Enhanced Alternative Coverage" has the meaning set forth in 42 CFR § 423.100.

"Model Beneficiary" means an applicable beneficiary as defined in 42 CFR § 423.100 enrolled in a Model PBP.

"Model Guidance" refers to documentation provided by CMS outlining requirements related to participation in the Model, including guidance on Model monitoring and necessary data submissions, and guidance on marketing and other communications for Part D sponsors participating in the Model.

"Model Drug" means an applicable drug as defined in 42 CFR § 423.100 that is, or contains, a drug classified as insulin in American Hospital Formulary Service (AHFS) Drug Information or the DRUGDEX Information System compendia, and is marketed by and available from a Model-participating manufacturer.CMS lists Model Drugs on the Model website.

"Model PBP" stands for Model plan benefit package and has the meaning set forth in Paragraph B of Article 1.

"Model-Specific Supplemental Benefits " means supplemental benefits that conform to the Model requirements in Paragraph C of Article 3.

"PDP" stands for prescription drug plan and has the meaning set forth in 42 C.F.R. § 423.4.

"Part D RI Program" stands for Part D Rewards and Incentives Program and means a program, as identified in the Part D Sponsor's Approved Proposal, that offers certain rewards and incentives that are connected to the Part D Prescription Drug Benefit.

"Plan Selected Model Drug" means a Model Drug identified in the Part D Sponsor's Approved Proposal for which Part D Sponsor offers Model-Specific Supplemental Benefits.

"Pre-diabetes" has the meaning set forth in 42 CFR § 410.18(a).

"Special Rule for Supplemental Benefits" means § 1860D-14A(c)(2) of the Act.

"Targeted Enrollee" means a Medicare beneficiary who is enrolled in one of the Part D Sponsor's Model PBPs and who is targeted by the Part D Sponsor to receive rewards and incentives in the Part D Sponsor's RI program based on the Approved Proposal.

ADMINISTRACION DE SEGUROS DE SALUD
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Article III
Functions to be Performed by Part D Sponsor

A. PART D BID AND BENEFIT PACKAGE SUBMISSION AND REVIEW.

Part D Sponsor certifies that its annual benefit and bid submission for each Model PBP is consistent with the Approved Proposal (unless otherwise authorized in writing by CMS) and in accordance with all program and bid instructions issued by CMS for applicants to the Model.

B. MODEL IMPLEMENTATION REQUIREMENTS

1. Part D Sponsor shall comply with all applicable laws governing its operation and offering of qualified prescription drug coverage, except as specifically waived in writing in accordance with section 1115A of the Act.

2. Part D Sponsor shall implement the Model in each Model PBP on the Start Date and in accordance with the Approved Proposal and this Addendum, including without limitation Appendix 2.

3. Part D Sponsor shall:

(3.a) Carry out this Addendum in a manner that is consistent with the efficient and effective implementation of 42 C.F.R. Part 423 (as applicable) and Section 1115A of the Act;

(3.b) Comply with the Model Guidance, including, without limitation, requirements regarding the timely submission of data to facilitate Model monitoring

(3.c) Not take any action that threatens the health or safety of an enrollee; and

(3.d) Ensure Part D Sponsor's participation in the Model does not result in lower quality of care or other adverse outcomes for enrollees

C. MODEL-SPECIFIC SUPPLEMENTAL BENEFITS

1. Part D Sponsor shall comply with all applicable laws, regulations, and guidance regarding formulary design, except as expressly modified by this Addendum.

2. For each Model PBP, Part D Sponsor shall furnish Model-Specific Supplemental Benefits for Plan Selected Model Drugs in accordance with the Approved Proposal and the following requirements:

(2.a) Copayment. Part D Sponsor's Part D benefit will specify a copayment of no more than thirty five dollars ($35) for a month's supply of any Plan Selected Model Drug in the deductible, initial coverage, and coverage gap phases. If Part D Sponsor covers a Plan Selected Model Drug in larger increments than a month's supply, such as 2 or 3 month's supply, the copayment on such increment must be equal to or less than the multiple of the month's supply copayment (i.e., 2 times for 2 months and 3 times for 3 months) consistent with current CMS requirements.

(2.b) Drug Type. Plan Selected Model Drugs must include at least one Model Drug of each the following types of insulins: rapid-acting, short-acting, intermediate-acting, and long-acting.

(2.c) Dosage Form. Plan Selected Model Drugs must include both the vial dosage form and pen dosage form for all Plan Selected Model Drugs, unless a Plan Selected Model Drug is not manufactured in both dosage forms.

(2.d) Supply Duration. The Part D Sponsor shall determine a month's supply of any Plan Selected Model Drug in a manner consistent with how it determines month's supplies of other Part D drugs.

(2.e) Pharmacy Type. The Part D Sponsor shall provide Model-Specific Supplemental Benefits for Plan Selected Model Drugs without regard to pharmacy type. Part D Sponsor may continue to offer a lower copay for a Plan Selected Model Drug at preferred or mail-order pharmacies in accordance with Part D program guidelines.

3. Nothing in this section prevents a Part D Sponsor from offering supplemental benefits for Model Drugs that are not Plan Selected Model Drugs

D. PART D REWARDS AND INCENTIVES PROGRAMS

1. Part D Sponsor shall implement any Part D RI Program under this Addendum only in the Model PBPs for which the Approved Proposal includes a Part D RI Program. Part D Sponsor shall implement any Part D RI Program on the Start Date and in a manner that is consistent with the Approved Proposal and this Addendum, including without limitation Appendix 2.

2. The methodologies and criteria used by the Part D Sponsor to implement any Part D RI Program must be specified in the Approved Proposal and able to be replicated by CMS, applied uniformly to all enrollees who meet the defined criteria, be evidence-based, and be expected to materially impact the health of the targeted population. The targeted population for the Part D RI Program must be limited to enrollees in a Model PBP with Diabetes or Pre-diabetes.

3. Part D Sponsor shall identify the Targeted Enrollees who will receive rewards and incentives under the Part D RI Program based on the Part D Sponsor's Approved Proposal and information known to Part D Sponsor.

4. Part D Sponsor shall submit to CMS all targeting and engagement data used in the Part D RI Program (e.g., data regarding outreach to Targeted Enrollees) in a form, manner, and on the timeline specified by CMS in this Addendum or the Model Guidance.

5. Part D Rewards and Incentives are not benefits and may not be listed in the Evidence of Coverage or Annual Notice of Change (ANOC).In any marketing materials regarding Part D RI Programs, the Part D Sponsor shall include: (1) the intended goal of the reward and incentive program(s); (2) what must be done to receive the rewards and incentives; (3) the per unit value of the reward and incentive; (4) the total value that an enrollee can receive; and (5) how to ask questions or receive help on understanding the rewards and incentives program.

6. Because eligibility for a particular reward or incentive under any Part D RI Program is not assured or cannot be determined before a plan year for a specific enrollee or enrollees, the Part D Sponsor shall provide a disclaimer on all materials describing the reward, incentive, or Part D RI Program. Such disclaimer must clearly state that eligibility for the Part D reward or incentive under the Model is not assured and will be determined by the Part D Sponsor after enrollment based on relevant criteria (e.g., clinical diagnosis of Pre-diabetes or Diabetes, participation in a disease state management program).

E. COMPLIANCE WITH MODEL GUIDANCE.

1. In addition to the requirements in the Underlying Contract and this Addendum, Part D Sponsor shall comply with any Model Guidance, including for monitoring, communication and marketing, issued by CMS and available on the Model website at https://innovation.cms.gov/innovation-models/part-d-savings-model. Changes in the URL for the Model's dedicated website will be communicated to Part D Sponsor by CMS.

2. As applicable, Part D Sponsor shall submit any Model-related enrollee communications materials to CMS under the Health Plan Management System code or codes as specified by CMS.

3. In the event of a conflict between the marketing requirements in the Underlying Contract and the Model Guidance such that Part D Sponsor cannot comply with both, Part D Sponsor must comply with any Model Guidance..

F. NOTICE OF CHANGES

The Part D Sponsor shall not make any changes to the Approved Proposal, without prior, written CMS approval, except that Part D Sponsor may make formulary changes and provide notice (when required) in accordance with existing Part D requirements. In addition, the Part D Sponsor agrees to provide CMS written notice of any change in circumstances that would constitute a material change to a fact or representation made in Part D Sponsor's Approved Proposal, including not implementing a Part D RI Program or not providing Model-Specific Supplemental Benefits.

G. RELEASE OF INFORMATION

1. Part D Sponsor shall obtain prior approval from CMS during the term of this Addendum and for six months thereafter for the publication or release of any press release, external report or statistical/analytical material or other similar material that references Part D Sponsor's participation in the Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. When reviewing these materials, CMS intends to disapprove only those materials containing material misstatements of fact or conclusions based on improper methodology or inaccurate data, or that are inconsistent with the implementation of the Model or other applicable laws, regulations, or CMS instructions. CMS will make reasonable efforts to complete its review expeditiously. Any material submitted to CMS for prior approval that is not disapproved in writing by CMS, or where CMS has requested additional time to review, within 30 calendar days after receipt by CMS will be deemed approved.

2. Part D Sponsor agrees to include the following statement on the first page of all external reports and statistical/analytical material that are subject to this Section: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

H. NON-DISCRIMINATION

Part D Sponsor shall not discriminate against enrollees in any Model PBP.

Article IV
Optional Narrowing of First Risk Corridor Threshold

A. APPLICABILITY OF ARTICLE

This Article 4 applies only if the Part D Sponsor's Approved Proposal indicates, at the PBP level, election of a narrowed first risk corridor threshold.

B. OPTIONAL NARROWED FIRST RISK CORRIDOR THRESHOLD

For a Model PBP for which the narrowed first risk corridor has been elected, if the Model PBP's aggregate proportion of insulin-dependent diabetic enrollees is one standard deviation or greater above the average for all Model-eligible enhanced PBPs of the Model PBP's plan type, calculated as described in Paragraph C of this Article 4, CMS will apply a narrowed risk corridor for that Model PBP. Under the narrowed risk corridor, the government will bear or retain 50 percent of the difference between 2.5 percent and 10 percent of the target amount, as defined in Section 1860D-15(e)(3)(B) the Act.

C. DETERMINATION OF ELIGIBILITY FOR NARROWED FIRST RISK CORRIDOR THRESHOLD.

All calculations determining the application of the optional narrowed first risk corridor threshold will be performed using the data available to CMS following reconciliation under 42 C.F.R. Part 423 for the plan year CMS shall determine whether the narrowed first risk corridor applies to a Model PBP using the following methodology:

1. Determine average proportion of beneficiaries that utilize a Model Drug for each of the eligible model plan types. CMS will determine for each of the following plan types the average proportion of beneficiaries for that plan type that utilize a Model Drug: (i) eligible standalone PDPs; (ii) eligible MA-PDs; (iii) Chronic Condition Special Needs Plans (C-SNPs); and (iv) Institutional Special Needs Plans (I-SNPs). For each of the types of plans above, CMS determines the number of enrollees in the plan type with at least one Prescription Drug Event (PDE) for any Model Drug in the plan year reported to CMS by June 30 following a plan year. CMS divides that number by the total number of enrollees in the plan type as of December of the plan year. This will yield the proportion of beneficiaries that have at least one Model Drug PDE for the plan year in each plan type (i.e., eligible standalone PDPs, eligible MA-PDs, C-SNPs, and I-SNPs).
2. Calculate the standard deviation for each plan type (i.e., eligible standalone PDPs, eligible MA-PDs, C-SNPs, and I-SNPs).
3. Calculate the statistical significance threshold for each plan type by adding the standard deviation determined in step 2 of this Paragraph Cto the average proportion determined in step 1 of this Paragraph C for each plan type. The statistical significance threshold will be calculated at two decimal places.
4. Calculate the proportion of enrollees in the Model PBP that used a Model Drug in the plan year. CMS determines the number of enrollees in the Model PBP with at least one PDE for a Model Drug in the plan year, as reported to CMS by June 30following the plan year and divides this number by the Model PBP's total number of enrollees in the plan type as of December of the plan year. The Model PBP's proportion will be calculated at two decimal places.

5. Determine eligibility for the narrowed first threshold risk corridor. For each Model PBP for which the narrowed first risk corridor has been elected, if the Model PBP's proportion, as calculated in step 4 of this Paragraph C, is greater than or equal to the statistical significance threshold, as determined in step 3 of this Paragraph C, CMS applies the narrowed risk corridor as described in Paragraph D of this Article 4. Otherwise, CMS applies the risk corridors as specified in section 1860D-15(e) and 42 C.F.R. § 423.336.

D. APPLICATION OF NARROWED RISK CORRIDOR FOR ELIGIBLE MODEL PBPS.

For each Model PBP that meets the eligibility requirements for the narrowed risk corridor as described in Paragraph C of this Article 4, CMS calculates the portion of total payments subject to risk consistent with 42 C.F.R. § 423.336, except that CMS substitutes 2.5 percent for 5 percent for purposes of 42 C.F.R. §423.336(a)(2)(ii)(A)(3). Except as specified in this Paragraph D, all other Part D requirements with respect to the calculation and application of risk corridors apply.

Article V
Additional Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS.

1. Part D Sponsor shall maintain records relating to the Model for 10 years. The Part D Sponsor shall provide access to such records in accordance with the record retention provisions of the Underlying Contract.

B. DATA REPORTING & COOPERATION WITH MONITORING AND EVALUATION.

1. Part D Sponsor shall cooperate with CMS's efforts to evaluate the effectiveness of the Model and shall participate in all Model-related monitoring, auditing, evaluation, and learning and diffusion activities. The obligation to cooperate in Model-related monitoring, auditing, and evaluation shall survive termination of the Part D Sponsor's participation in the Model.

2. The Part D Sponsor shall submit to CMS, in a form, manner, frequency, and by a deadline specified by CMS data to monitor the real-time impact of the Model and to perform the requisite Model evaluation. Part D Sponsor shall comply with any instructions regarding the collection and submission of data regarding the Part D Sponsor's participation in Model, including without limitation the data outlined in Appendix 2. CMS will make a reasonable effort to limit data submission from Part D Sponsors to data that is not readily available to CMS, such as any implementation of Part D RI Programs.

Article VI
Termination of Addendum or Model PBP Participation by CMS

A. CMS may terminate this Addendum, or terminate one or more particular PBP(s) from the Model at any time, with or without advance notice if:

1. CMS terminates the Model pursuant to Section 1115A(b)(3)(B) of the Act or otherwise

2. CMS determines that Part D Sponsor or a particular PDP, MA-PD, or its subcontractor or downstream entity (as defined at 42 C.F.R. § 423.4):

(2.a) Has failed to comply with any term of this Addendum or documents incorporated herein;

(2.b) Has carried out this Addendum in a manner that is inconsistent with the efficient and effective implementation of 42 C.F.R. Part 423 or Section 1115A of the Act;

(2.c) Has failed to continually meet the applicable eligibility conditions, or does not have an exception to one or more eligibility conditions, of the Model;

(2.d) Has failed to implement or fully comply with the terms of a corrective action plan or other intermediate sanction;

(2.e) Has taken an action that threatens the health or safety of an enrollee, or Part D Sponsor's participation in the Model is resulting in lower quality of care or any other adverse outcomes for enrollees;

(2.f) Has submitted false data or made false representations, warranties, attestations or certifications in connection with any aspect of the Model;

(2.g) Is subject to sanctions or other enforcement or correction actions of an accrediting organization or federal, state, or local government agency;

(2.h) Is subject to investigation or action by HHS (including HHS-OIG and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct,including being subject to the filing of a complaint, filing of a criminal charge, eing subject to an indictment, or being named as a defendant in a False Claims Act qui tam matter in which the government has intervened or similar action;

(2.i) Assigned or purported to assign any of the rights or obligations under the Underlying Contract or this Addendum voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS;

(2.j) 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;

(2.k) Has committed any act that would be cause for termination of the Underlying Contract or imposition of any penalty or sanction thereunder, regardless of whether such termination, penalty or sanction is actually imposed by CMS; or

(2.l) Has engaged in prohibited discrimination against a Medicare beneficiary.

B. Prior to terminating the Addendum or a particular Model PBP's participation in the Model pursuant to this Article 6, CMS may afford the Part D Sponsor an opportunity develop and implement a corrective action plan to correct deficiencies in accordance with the procedures of 42 C.F.R. Section 423.509(c)(1). In addition to any sanction or penalty authorized under 42 C.F.R. 423.750, CMS may rescind or make inapplicable on a prospective basis one or more waivers provided to Part D Sponsor, or limit the benefits or Part D RI Programs that may be offered by Part D Sponsor if CMS determines that an event identified in Paragraph A.2 of this Article has occurred.

Article VII
Modifications of Addendum

A. This Addendum may be modified at any time by written mutual consent

B. CMS may modify this Addendum without the consent of the Part D Sponsor for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, or accreditation standards. To the extent practicable, CMS shall provide the Part D Sponsor with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date. If the Part D Sponsor does not wish to be bound by the unilateral amendment, it may terminate this Addendum by providing CMS with 30 days advance written notice.

Article VIII
Procedure upon Termination and Surviving Obligations

A. As the term of this Addendum is from the Start Date through the 2021 plan year, if Part D Sponsor does not wish for its Model PBPs to continue participating in the Model for the upcoming plan year, it must notify CMS in writing by the first Monday in June that precedes the start of the upcoming plan year.

B. If the Plan Sponsor does not wish to continue participation in the Model, the Part D Sponsor must notify enrollees in the Model PBP by including a notification in the ANOC for the PBP. Such notice must comply with Part D communications and marketing requirements, including without limitation any Model Guidance.

C. Part D Sponsor shall ensure timely transfer of any data or files to CMS necessary for monitoring, assessment, transition or close-out of Part D Sponsor's Model-related activities and shall comply with all other CMS-specified close-out procedures.

D. Termination of this Addendum by either party shall not affect the rights and obligations of the parties accrued prior to the effective date of the termination or expiration of this Addendum. The termination of this Addendum does not relieve either party of any claims against it that arise under this Addendum before this Addendum is terminated.

E. Upon any termination of this Addendum (other than pursuant to Article 6), Part D Sponsor shall continue to provide coverage for items and services consistent with applicable law and the Underlying Contract as if this Addendum had never been executed. CMS may require Part D Sponsors to make appropriate adjustments in its bid submission for a plan year to account for the absence of benefits that were offered under the Model.

Article IX
Order of Precedence & Relationship to Other Agreements

A. This Addendum does not supersede or modify Sections 1860D-1 through 1860D-43 of the Act, or 42 C.F.R. Part 423, except as specifically waived in Appendix 1 of this Addendum for purposes of carrying out this Model.

B. This Addendum specifies additional rights and obligations of the parties with respect to the Model only, and does not relieve the parties from, or modify their rights and obligations with respect to, the operation of a prescription drug plan in general or pursuant to the Underlying Contract.

C. If Part D Sponsor is also participating in the Part D Enhanced Medication Therapy Management Model (Enhanced MTM Model), the Medicare Advantage Value-Based Insurance Design Model (MA-VBID) or the Part D Payment Modernization Model (PDPM Model) and has proposed to offer rewards and incentives associated with the Part D benefit under such model, the Part D Sponsor may not conduct a Part D RI Program under this Model. Accordingly, this Addendum does not supersede or modify the Underlying Contract or other addenda as they relate to rewards and incentives in the Enhanced MTM Model, MA-VBID Model, or the PDPM Model.

D. In the event of any conflict among the documents or other requirements that govern the conduct of CMS and Part D Sponsor in their administration of or participation in the Model, the order of priority to interpret the obligations of the parties shall be as follows:

1. This Addendum;

2. The Underlying Contract to which this Addendum is attached, and other addenda;

3. Any Model Guidance, including, without limitation, guidance on marketing, data collection and determination of eligibility for risk corridor payments and liability for risk corridor recoveries; and

4. Part D Sponsor's Approved Proposal.

E. The termination of this Addendum by either party shall not, by itself, relieve the parties from their obligations under the Underlying Contract and its other addenda, if any.

Article X
Attestation of Compliance

Part D Sponsor hereby attests that:

A. The Part D Sponsor will implement their Approved Proposal;

B. Each Model PBP's bid pricing tool (BPT) has been completed in a manner consistent with all CMS guidelines and Model Guidance; and

C. Part D Sponsor has not made changes to the Model PBP's benefit structure, formulary, network, or otherwise that discriminate against enrollees in any Model PBP.

Article XI
Limitation on Review

A. Limitations on Review. There is no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:

1. The selection of Part D sponsors to participate in the Model, including the decision by CMS to terminate this Addendum or to direct the termination of any Model PBPs;

2. The selection of manufacturers to participate in the Model, including the decision by CMS to terminate a manufacturer's participation in the Model;

3. The elements, parameters, scope, and duration of the Model;

4. Determinations regarding budget neutrality under section 1115A(b)(3);

5. The termination or modification of the design and implementation of a Model under section 1115A(b)(3)(B);

6. Decisions about expansion of the duration and scope of a model under subsection 1115A(c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection; or

7. The determination of a Model PBP's eligibility for the optional first risk corridor.

Article XII
Severability

In the event that one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Addendum, but this Addendum shall be construed as if such invalid, illegal or unenforceable provisions had never been contained herein, unless the deletion of such provision or provisions would result in such a material change so as to cause completion of the transactions contemplated herein to be unreasonable.

Article XII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this Addendum shall have the meaning given such terms in the Underlying Contract, or 42 C.F.R. Part 423, as applicable.

B. NOTIFICATIONS

All notifications to CMS required under this Addendum shall be submitted by the Part D Sponsor to CMS by electronic mail to PartDSavingsModel@cms.hhs.gov. All notifications to the Part D Sponsor required under this Addendum shall be submitted by CMS to Part D Sponsor by electronic mail either to the person(s) designated in the Approved Proposal or the Health Plan Management System as the Part D Sponsor's primary point of contact, or via a Health Plan Management System broadcast email.

C. COMPLIANCE WITH LAWS

1. The Part D Sponsor shall comply with the applicable terms of this Addendum, the Underlying Contract and all applicable statutes, regulations, and guidance, including without limitation (a) federal criminal laws; (b) the federal False Claims Act (31 U.S.C. § 3729 et seq.); (c) the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the federal civil monetary penalties law (42 U.S.C. § 1320a-7a); (e) the federal physician self-referral law (42 U.S.C. § 1395nn), and (f) applicable State laws.

2. This Addendum does not provide any waivers of the fraud and abuse laws. The Part D Sponsor must comply with all applicable fraud and abuse laws, except as such laws may be waived pursuant to section 1115A(d)(1) of the Act specifically for the Model.

D. EXECUTION IN COUNTERPART.

This Addendum and any amendments hereto may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement. In the event that any signature is delivered by facsimile transmission or by e-mail delivery of a ".pdf" format data file, such signature shall create a valid and binding obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such facsimile or ".pdf" signature page were an original thereof.

In witness whereof, the parties hereby execute this Addendum. This document has been electronically signed by:

FOR THE PART D SPONSOR

BRIAN KANE

Contracting Official Name

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8/27/2020 2:21:28 PM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/18/2020 3:51:31 PM

Date

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

9/18/2020 3:51:31 PM

Date

Amy Bassano
Deputy Director
Center for Medicare and
Medicaid Innovation

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21 - 0 0 4

Attachments:
Appendix 1 (Waivers of Part D Program Requirements)
Appendix 2 (Part D Rewards and Incentives Programs)

Appendix 1:
Waivers of Part D Program Requirements

A. Pursuant to Section 1115A(d)(1) of the Act, in its sole discretion, CMS waives the Medicare Part D statutory and regulatory requirements enumerated in this Appendix 1 for purposes of the Model. These waivers are granted only to the extent necessary to implement the Model. CMS may modify or rescind any or all of these waivers at any time, in its sole discretion.

B. Waivers for Part D Sponsors that are Model Participants. The waivers identified in this paragraph B are for Part D sponsors participating in the Model. Each waiver in this paragraph B is (1) each contingent on compliance with the terms and conditions of this Addendum, the Approved Proposal, and documents incorporated therein; (2) is granted to the Part D Plan Sponsor only as to the Model PBPs and only to the extent necessary to implement the Model in accordance with the Addendum and documents incorporated therein; and (3) is granted only for the term of this Addendum

1. Special Rule for Supplemental Benefits. The following requirement of section 1860D-14A(c)(2) of the Act and 42 C.F.R. § 423.2325(e): "where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug." This will allow supplemental benefits to apply to the discounted price after the manufacturer coverage gap discount is applied a Model Drug;

2. Reduction of First Threshold Risk Percentage. Section 1860D-15(e)(3)(C)(i)(III) of the Act and 42 C.F.R. § 423.336(a)(2)(ii)(A)(3) to allow for the first threshold risk percentage to be narrowed to 2.5 percent rather than 5 percent for a Model PBP that has elected the narrowed risk corridor and that has a proportion of insulin-dependent enrollees that is at least one standard deviation greater than the average proportion of insulin-dependent enrollees in all Model-eligible enhanced alternative PBPs of the same plan type (i.e, standalone PDP, MA-PD, C-SNP, or I-SNPs);

3. Low Income Cost Sharing Subsidy Calculation. 42 C.F.R. § 423.329(d)(1) to the extent necessary calculate the low income cost-sharing subsidy for a Model Drug based on the cost sharing of the formulary tier(s) for the Model Drug without regard to any Model-Specific Supplemental Benefits for such drug.

4. Tiering Exceptions. 42 C.F.R. §423.578(a) to the extent necessary to permit Part D sponsors to exclude from their tiering exceptions process for Model PBPs any requests to apply Model-Specific Supplemental Benefits to any applicable drug that is, or contains, a drug classified as insulin in American Hospital Formulary Service (AHFS) Drug Information or the DRUGDEX Information System compendia.

5. Prohibition on Mid-year Benefit Enhancements. Requirements under § 1860D-11, to the extent necessary solely to permit Part D sponsors to add Plan Selected Model Drugs at any time during the plan year, consistent with existing Part D formulary requirements.

C. Waiver for Part D sponsors. The waivers identified in this paragraph C are for Part D sponsors, inclusive of Part D Sponsors not participating in the Model and is granted only for the duration of the Model.

1. Star Ratings for Part D plans. 42 C.F.R. § 423.186 to the extent necessary to mitigate any statistically significant impacts to the Part C or D Star Ratings that are directly attributable to the Model.

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2. Part D Bid and Payment Data. Section 1860D-15(f) of the Act is waived to the extent necessary to permit CMS to use Part D bid and payment data for purposes of conducting and evaluating the Model.

Appendix 2:
Part D Rewards and Incentives Programs

The Part D Sponsor may, subject to certain conditions and CMS approval, implement a Part D RI Program. The Part D Sponsor shall implement any Part D RI Program under the Part D Senior Savings Model during the term of the Addendum only in accordance with the terms of this Addendum, including this Appendix 2, and the Approved Proposal.

1. Part D Rewards and Incentives Programs Structure and Content

A. If the Part D Sponsor is implementing a Part D RI Program under the Model, the parties acknowledge that Part D Sponsor has submitted as part of its application for participation in the Part D Senior Savings Model, a proposal to offer one or more Part D RI Programs.

B. Part D Sponsor shall identify Targeted Enrollees for each Part D RI Program without discrimination and using objective criteria that comply with the terms of the Addendum, including this Appendix 2, and are specified in the Approved Proposal or are otherwise approved in writing by CMS. Such objective criteria must identify the subset of enrollees who would receive the greatest health care value from receiving the benefits or participating in the activities associated with the particular reward or incentive in the Part D RI Program and must include that the enrollee have Diabetes or Pre-diabetes.

C. The Part D Sponsor acknowledges that for each Part D RI Program the Approved Proposal contains the following:

1. The goals of the Part D RI Program;

2. The list of Model PBPs in which the Part D RI Program will be implemented;

3. The nature and scope of the Part D RI Program, including the criteria for identifying Targeted Enrollees and the beneficiary engagement methodology;

4. The eligibility criteria that must be met for an individual targeted enrollee to qualify to receive the reward or incentive, including the associated healthcare activity that must be completed for the reward or incentive to be available, and, if eligibility includes an adherence metric, the specific criteria for measuring adherence and the evidence base to support the clinical appropriateness of the adherence criteria;

5. The type and per unit value of each reward or incentive and the method for providing the reward or incentive to eligible Targeted Enrollees;

6. The maximum number and frequency of the rewards and incentives that may be obtained by an eligible Targeted Enrollee per year; and

7. The evidence base and theory of change used to develop the reward or incentive and the expected outcomes of the Part D RI Program.

D. The Part D Sponsor shall:

1. Provide the rewards and incentives only to eligible Targeted Enrollees and only in accordance with the Approved Proposal and this Addendum;

2. Not provide any individual reward or incentive the value of which exceeds the value of the expected impact on enrollee behavior or benefit of the healthcare activity on which receipt of the reward or incentive is based, but notwithstanding, the Rewards and Incentives provisions in the Medicare Managed Care Manual Ch. 4 § 100, may provide an individual reward or incentive the value of which exceeds the cost of the health-related service or activity itself;

3. Limit the provision of rewards and incentives to each enrollee to a maximum annual aggregate amount of $600.00 for all rewards and incentives in this Model; and

4. Comply with the Rewards and Incentives provisions in the Medicare Managed Care Manual Ch. 4 § 100 issued and effective April 22, 2016 at available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf except as waived or otherwise modified by the Addendum, including Appendix 1 or this Appendix 2

E. Part D Sponsor shall ensure that any rewards and incentives in its Part D RI Programs are furnished in accordance with the goals of the program set forth in the Approved Proposal, which must reward or incentivize one or more of the following:

1. Participation of Targeted Enrollees with Pre-diabetes or Diabetes in a disease state management programs specifically for individuals with Pre-diabetes or Diabetes.

2. Participation in a Part D Sponsor's medication therapy management (MTM) program that include a review of all of the Targeted Enrollee's medications and a focus on a Pre-diabetes or Diabetes.

3. Receipt by the Targeted Enrollee with Pre-Diabetes or Diabetes of preventative health services, such as receiving Part D covered vaccines.

4. Participation in educational activities designed to enable Targeted Enrollees with Pre-diabetes or Diabetes to better understand their Part D plan benefit, costs, and clinically-appropriate coverage alternatives, including biosimilars and generics.

F. In offering any reward or incentive for participation in an MTM program, the Part D Sponsor shall comply with existing CMS requirements for MTM programs, as set forth in 42 C.F.R. § 423.153.

G. In implementing and operating its Part D RI Program, the Part D Sponsor shall not:

1. Provide a reward or incentive to a Medicare beneficiary who is not enrolled in a Model PBP

2. Provide a reward or incentive to an enrollee in a Model PBP who does not have a Diabetes or Pre-diabetes.

3. Structure a Part D RI Program to discourage clinically-indicated medication use.

4. Use a Part D RI Program to largely market a PBP or encourage Model Beneficiaries to remain with a specific plan based on a reward and incentive. Use a Part D RI Program to, in any way, choose or solicit healthier enrollees over enrollees who the sponsors believe may be less healthy.

5. Create a Part D RI Program that discriminates against enrollees based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty status, health status, or other prohibited basis

6. Incentivize enrollees to use mail service pharmacies, preferred pharmacies, or any other specific network providers.

7. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a drug manufacturer. This includes, but is not limited to, the use of personnel affiliated with a drug manufacturer, or manufacturer-financed coupons or discounts provided to a beneficiary.

8. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a pharmacy or entity that owns or operates pharmacies. This includes use of personnel affiliated with a pharmacy, or pharmacy-financed coupons or other discounts provided to a beneficiary.

2. Record Retention

A. In accordance with Article 5 of this Addendum, the Part D Sponsor shall maintain the following records regarding each Part D RI Program:

1. The identity of each enrollee who received a reward and incentive, including enrollees identified with Diabetes or Pre-diabetes;

2. The Part D RI Program pursuant to which the enrollee received the reward or incentive;

3. The nature and date(s) of the activities or other conduct engaged in by the enrollee to qualify for the reward or incentive;

4. The nature and amount of the reward or incentive received by the enrollee; and

5. The value of the expected impact on enrollee behavior and the value of the benefit of the healthcare activity on which receipt of the reward or incentive is based.

B. The Part D Sponsor shall submit reports to CMS, in a form and manner and by a deadline specified by CMS, regarding its implementation of each Part D RI Program. The Part D Sponsor shall provide CMS with supplemental information upon request regarding its implementation of any Part D RI Program.

3. Compliance and Enforcement

A. Part D Sponsor shall have in place a protocol for monitoring the implementation and administration of each Part D RI Program. Part D Sponsor shall make this protocol available to CMS upon request.

B. CMS may terminate or suspend the Part D Sponsor's implementation of any Part D RI Program, or take other remedial action in accordance with Article 6 of the

Addendum, including without limitation if –

1. The Part D Sponsor fails to comply with the terms and conditions of the Addendum or this Appendix 2; or

2. CMS determines that the Part D Sponsor's implementation of such a program might compromise the integrity of the Model.

C. Without limiting the foregoing, the parties agree that if CMS determines that the Part D Sponsor has failed to comply with the terms of Article 3 of this Addendum or this Appendix 2, CMS may prohibit the Part D Sponsor from offering Part D RI Programs in one or more future plan years, regardless of whether the Part D Sponsor has corrected or otherwise resolved the noncompliance.

SIGNATURE ATTESTATION

Contract ID: H4007
Contract Name: HUMANA HEALTH PLANS OF PUERTO RICO, INC.

I understand that by signing and dating this form, I am acknowledging that I am an authorized representative of the above named organization and that I am the contracting official associated with the user ID used to log on to the Health Plan Management System (HPMS) to sign the 2021 Medicare contracting documents. I also acknowledge that in accordance with the HPMS Rule of Behavior, sharing user IDs is strictly prohibited.

This document has been electronically signed by:

BRIAN KANE

Contracting Official Name

8/27/2020 2:21:28 PM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

ADDENDUM TO MEDICAREMANAGED CARE CONTRACT FOR PARTICIPATION IN THE MEDICARE ADVANTAGE VALUE-BASED INSURANCE DESIGN VBID MODEL

The Centers for Medicare & Medicaid Services ("CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare Advantage organization("**MA Organization**") agree to amend the contract H4007, including all attachments, addenda, and amendments thereto (the "Underlying Contract"), governing MA Organization's operation of a Part C plan described in § 1851(a)(2)(A) of the Social Security Act ("**Act**"), and, if applicable, a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act to include this Addendum to provide for MA Organization's participation in the Medicare Advantage Value-Based Insurance Design Model ("**VBID Model**" or "**Model**").

For purposes of this Addendum, unless otherwise noted, reference to an "MA Organization" or "MA Plan" is deemed to include "MA-PD Sponsor" or "MA-PD Plan" to the extent the MA Organization is offering a Part D benefit.

The VBID Model, conducted under the authority of Section 1115A of the Act, is an opportunity for CMS to test the impact on Medicare program costs and the quality of care of services furnished by Medicare Advantage organizations that agree to offer a Wellness and Health Care Planning Component and at least one of the following:

i. additional supplemental benefits, such as reduced cost sharing for Targeted Enrollees, based on the chronic condition and/or socioeconomic status criteria proposed by the MA Organization and approved by CMS;

ii. additional rewards and incentives to enrollees, including in the Part D benefit;

iii. cash or monetary rebates as a mandatory supplemental benefit for all enrollees in any VBID PBP that is approved by CMS for participation in the VBID Component for Cash or Monetary Rebates ("Cash or Monetary Rebates Component");

iv. new and innovative technologies for Targeted Enrollees for an FDA approved medical device or new technology that has a Medicare coverage determination (either national or local) where the MA plan seeks to cover it for an indication that differs from the Medicare coverage determination and the MA plan demonstrates the device is medically reasonable and necessary, as well as for new technologies that do not fit into an existing benefit category. and

v. the Medicare hospice benefit (referred to herein as the "Hospice Benefit Component"). The Parties hereby amend the Underlying Contract as follows:

Article I
Term and MA Plan Participation

A. This Addendum becomes effective on the date it is signed by CMS ("Effective Date") and will remain in effect through December 31, 2021, unless sooner terminated in accordance with Articles 5 or 6 of this Addendum. This contract covers Plan Year 2021 for the VBID Model, which will start on January 1, 2021 ("Start Date"). If MA Organization wishes to participate in the Model during a subsequent Plan Year, it must timely submit for CMS review a Model application for the relevant Plan Year in addition to its annual MA bid submission.

B. The MA Organization must not include any of its plans of the following types in its participation in the VBID model: Medicare-Medicaid Plan (MMP) or other demonstration plans; Employer Group Waiver Plan (EGWP); Medical Savings Account Plan (MSA); Private Fee-For-Service (PFFS) Plan; cost plan offered under section 1876 of the Act; or a Program of All-Inclusive Care for the Elderly (PACE).

Article II
Definitions

"Approved Proposal" means the MA Organization's final approved application that reflects and is consistent with the MA Organization's final approved bid and VBID Model benefit pacakage(s), as may be modified by the final corresponding bid submission approved by CMS. This includes all updates based on CMS guidance, and all corresponding bid submissions, allowing participation in the VBID Model in Plan Year 2021 for the VBID Components for which the MA Organization is participating.

"Cash or Monetary Rebate" means the mandatory supplemental benefit provided in the form of cash or monetary rebates by the MA Organization to all enrollees in a VBID PBP that is approved by CMS for participation in the VBID Cash or Monetary Rebates Component.

"Hospice Benefit Component" means the part of the VBID Model permitting the MA Organization to cover the Medicare Part A hospice benefit, Palliative Care strategy, Transitional Concurrent Care strategy, and any optional hospice supplemental benefits offered by the MA Organization.

"Model Communications and Marketing Guidance" means the supplemental document provided by CMS outlining the required communications and marketing for all enrollees in a VBID PBP.

"Model Monitoring Guidance" means the supplemental document, provided by CMS, outlining the required monitoring for MA Organizations participating in the VBID Model.

"Part C RI Program" means Part C Rewards and Incentives Program and means a program that offers certain rewards and incentives that are connected to the Part C program.

"Part D RI Program" stands for Part D Rewards and Incentives Program and means a program that offers certain rewards and incentives that are connected to the Part D Prescription Drug Benefit.

"PBP" stands for Plan Benefit Package and has the meaning set forth at 42 CFR § 422.162.

"Plan Year" has the same meaning as set for at 42 CFR § 422.2274.

"Rewards and Incentives Program" means a Part C RI Program, a Part D RI Program, or both.

"Targeted Enrollee" means a Medicare beneficiary who is enrolled in one of the MA Organization's VBID PBPs participating in the Model and targeted by the MA Organization to receive one or more VBID Components, except for Cash or Monetary and the Hospice Benefit Components. The standards and criteria used by the MA Organization to identify Targeted Enrollees may vary depending on the VBID Component, and must be identified in the Approved Proposal.

"VBID Component" means one or more of the following components of the VBID Model offered by the MA Organization pursuant to its participation in the VBID Model: (i) required WHP Services; (ii) additional supplemental benefits furnished pursuant to Article 3.D in the form of certain reduced cost-sharing obligations and certain additional services; (iii) additional supplemental benefits furnished pursuant to Article 3.F in the form of Cash or Monetary Rebates and new and innovative technologies; (iv) Hospice Benefit Component; and (v) a Rewards and Incentives Program.

"VBID PBP" has the meaning set forth in Article 3.B.1.

"WHP Services" stands for Wellness and Health Care Planning Services and means advance care planning services and other services identified in the Approved Proposal for the WHP Services VBID Component.

A list of definitions specific to the Hospice Benefit Component is included in Appendix 3 (Hospice Benefit Component) of this Addendum.

Article III
Functions to be Performed by MA Organization

A. BID AND BENEFIT PACKAGE SUBMISSION AND REVIEW

MA Organization certifies that its annual benefit and price bid proposal for Parts C and D bids are consistent with the Approved Proposal (unless otherwise authorized in writing by CMS) and in accordance with supplemental bid instructions issued by CMS for participants in the VBID Model.

B. IMPLEMENTATION OF VBID COMPONENTS

1. MA Organization shall implement the VBID Components in accordance with the Approved Proposal. and this Addendum (including all applicable Appendices). MA Organization may participate in the VBID Model only with the MA PBPs that CMS has approved for participation in the VBID Model and which are identified in the Approved Proposal(each, a"**VBID PBP**").

2. MA Organization shall comply with all applicable laws governing its operation and offering of an MA plan, except as specifically waived in writing in accordance with section 1115A of the Act.

3. MA Organization shall provide a mechanism for eligible enrollees to opt out of any benefits provided under the VBID Model (except for the Hospice Benefit Component as outlined in Appendix 3) at any time. If an enrollee opts out of benefits provided under the VBID Model or out of any VBID Component, MA Organization shall take the following actions:

a. Send a written acknowledgement to the enrollee of his or her request to opt out of the benefits provided under the VBID Model or out of the VBID Component;

b. Thereafter, provide the enrollee with coverage of benefits offered by the MA Organization under the PBP without benefits, items or services provided under the VBID Model; and

c. Not treat the enrollee as a Targeted Enrollee for purposes of the applicable VBID Component or for purposes of the Cash or Monetary Rebate Component, not send the Cash or Monetary Rebate to the enrollee.

If after opting out of the benefits provided under the VBID Model or out of a VBID Component, an enrollee who meets the criteria to be a Targeted Enrollee wishes to regain eligibility for or access to the benefits, items or services provided under the VBID Model or a VBID Component, MA Organization must honor that request and begin or resume providing benefits, items or services provided under the VBID Model or eligibility for or access to a VBID Component to the enrollee prospectively, consistent with the terms of this Addendum for a Targeted Enrollee.

4. MA Organization shall:

a. Implement the VBID Components in a manner that is consistent with the efficient and effective implementation of 42 CFR Parts 422 and 423 (as applicable) and Section 1115A of the Act;

b. Continually meet the applicable MA Organization eligibility conditions of the VBID Model, unless CMS has granted MA Organization an exception to participate in the Model;

c. Implement the VBID Components on the Start Date and consistent with the Approved Proposal;

d. Comply with the Model Monitoring Guidance, including the timely submission of data to facilitate model monitoring;

e. Not take any action that threatens the health or safety of any enrollee; and

f. Ensure that MA Organization's participation in the VBID Model does not result in lower quality of care or any other adverse outcomes for Targeted Enrollees.

C. WELLNESS AND HEALTH CARE PLANNING

1. The MA Organization's performance of the WHP Services described in this Article 3.C is a condition of participating in the VBID Model and of any program waiver provided under the VBID Model.

2. The MA Organization shall adopt and implement a plan to offer WHP Services to all enrollees in its VBID PBPs.

3. The plan to offer WHP Services to all enrollees in its VBID PBPs must include at a minimum:

i. The mechanisms to ensure that each enrollee is aware of the availability of WHP Services (e.g., descriptive language in the EOC or marketing materials regarding the opportunity to engage in advance care planning) and the manner in which the enrollee may receive WHP Services (e.g., Annual Wellness Visit, Health Risk Assessment, care management program, etc.); and

ii. Ways that the MAO is leveraging technology (e.g., Electronic Health Record, Electronic Medical Record, provider/patient portal) to communicate with enrollees about WHP Services and to document and track the use of WHP Services.

4. In accordance with the VBID Model Monitoring Guidelines, the MA Organization shall monitor and track the implementation and effectiveness of WHP Services and provide such information to CMS upon request.

D. PROVISION OF ADDITIONAL SUPPLEMENTAL BENEFITS

1. Consistent with the Approved Proposal, MA Organization may offer, and must provide to Targeted Enrollees that accept, additional supplemental benefits provided under the VBID Model in the form of:

a. Reduced cost sharing, which may include the elimination of cost-sharing, as follows:

i. Reduced cost-sharing for high-value services, as identified by the MA Organization pursuant to the Approved Proposal.

ii. Reduced cost-sharing for high-value providers, as identified by the MA Organization pursuant to the Approved Proposal.

iii. Reduced cost-sharing for covered Part D drugs.

iv. Reduced cost-sharing for new and innovative technologies or FDA-approved medical devices.

b. Additional services or items that comply with the requirements of 42 CFR Part 422 for supplemental benefits, except as those requirements are specifically waived under the Model, as follows:

i. Additional healthcare items or services, including new and innovative technologies or FDA-approved medical devices, that meet the criteria for supplemental benefits in the Medicare Managed Care Manual, Ch. 4, § 30.1.

ii. Additional items or services that are not primarily related to health ("non-primarily health-related supplemental benefits") but have a reasonable expectation of improving or maintaining the health or overall function of the Targeted Enrollee.

2. MA Organization shall provide the benefits identified in the Approved Proposal to Targeted Enrollees as mandatory supplemental benefits in accordance with 42 CFR §§ 422.2 and 422.102 and other applicable law.

3. If approved by CMS in the Approved Proposal to provide reduced cost-sharing based on an enrollee utilizing services from a high-value provider(s), the MA Organization must:

a. In determining the composition of a high-value provider network, adhere to the criteria and parameters for such providers in the Approved Proposal and the Value-Based Insurance Design Model Request for Applications for CY 2021, posted online at https://innovation.cms.gov/files/x/vbid-rfa2021.pdf, including the following:

i. MA Organization must use the rationale and standards in the Approved Proposal to identify high-value providers;

ii. High-value providers may be of any Medicare provider type, including physicians and practices, hospitals, skilled-nursing facilities, home health agencies, ambulatory surgical centers, and others;

iii. MA Organization must ensure that high-value providers are identified in connection with the specific clinical condition(s) or other factors as used to identify Targeted Enrollees;

iv. MA Organization must not identify high-value providers based on cost or coding accuracy or intensity alone; and

v. High-value providers must be available and accessible to Targeted Enrollees.

b. Not remove a provider from its roster of high-value providers during a contract year, unless the provider is terminated from the network, the provider requests exclusion from the high-value network or, with the concurrence of CMS, exclusion from the high-value network is warranted for the best interest of enrollees;

c. Clearly inform Targeted Enrollees which providers are considered high-value and the rationale for using high-value providers to encourage Targeted Enrollees to use high-value providers;

d. Notify Targeted Enrollees of the termination of a provider from its high-value provider network in accordance with the requirements of the VBID Model Communications and Marketing Guidelines, issued by CMS pursuant to Article 3.H; and

e. Notify CMS of any change to the composition of a high-value provider network in the same manner as if the change were a significant change to the provider network under Chapter 4, Section 110.1.2 of the Medicare Managed Care Manual (See http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-ManualsIOMs-Items/CMS019326.html)
regardless of whether such changes are considered "significant" with respect to the network-at-large.

4. MA Organization shall identify Targeted Enrollees for additional supplemental benefits based on chronic condition(s) and/or socioeconomic status as described in Article 3.D.5 and 3.D.6 and using criteria and methodologies in the Approved Proposal. The MA Organization shall retain all necessary data to allow CMS to replicate and verify targeting criteria. CMS may reject or request changes to the criteria used to identify Targeted Enrollees if CMS determines that the rejection or change is necessary to ensure the integrity of the VBID Model or to avoid harm to an enrollee. CMS may also reject or request changes to the criteria if it determines that the criteria is not in the best interest of an enrollee.

5. The methodologies and criteria used by the MA Organization to identify Targeted Enrollees must be able to be replicated by CMS, applied uniformly to all enrollees who meet the defined criteria, be evidence-based, and be expected to materially impact the health of the targeted population.

a. Targeting by Chronic Condition. When eligibility of enrollees is based on chronic condition, the MA Organization shall identify Targeted Enrollees by either:

i. a broad targeting methodology, such as targeting all enrollees with a specific chronic condition; or

ii. a tailored methodology, such as targeting enrollees with a specific level of a condition, as defined by ICD-10 codes or other data.

b. Targeting by Socioeconomic Status. When eligibility of enrollees is based on socioeconomic status, the MA Organization shall identify Targeted Enrollees by:

i. Low-income subsidy (LIS) status by subsidy level, as defined in the Plan Communication User Guide (PCUG) for Medicare Advantage and Prescription Drug Plans found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/Plan-Communications-User-Guide-v123-November-30-2018.pdf. Where a specific subsidy level is not identified in the Approved Proposal, all LIS enrollees are Targeted Enrollees.

ii. For enrollees in a U.S. territory, dual eligibility for both Medicare and Medicaid, using CMS identification of a dual-eligibility status in MARx.

c. Targeting Based on Additional Other Factors. The MA Organization may identify Targeted Enrollees using other factors that are present in addition to the chronic condition(s) and/or socioeconomic status, such as by requiring an LIS enrollee to also participate in a disease management program, or related program in order to be a Targeted Enrollee who is eligible for additional benefits described in Article 3.D.1.

6. MA Organization shall make reasonable efforts to identify, based on information known to MA Organization, Targeted Enrollees using the applicable criteria identified in this Article 3.D and the MA Organization's Approved Proposal.

7. MA Organization shall submit to CMS all targeting and engagement (e.g., data around outreach to Targeted Enrollees) data used to identify Targeted Enrollees in a form and manner and by a deadline specified by CMS in the Model Monitoring Guidelines.

8. MA Organization shall not require a Targeted Enrollee to receive, opt in, or otherwise register for benefits provided under the VBID Model, except as described in the Approved Proposal and in accordance with Article 3.D.5.c.

E. REWARDS AND INCENTIVES PROGRAMS

MA Organization shall implement any Part C RI Program and any Part D RI Program consistent with the Approved Proposal and this Addendum, including Appendix 2 of this Addendum. Any changes to a Rewards and Incentives Program are subject to prior CMS review and approval.

F. FLEXIBILITY TO SHARE BENEFICIARY REBATES SAVINGS MORE DIRECTLY WITH BENEFICIARIES IN THE FORM OF CASH OR MONETARY REBATES

1. The parties acknowledge that CMS has approved the MA Organization's proposal to offer a mandatory supplemental benefit in the form of Cash or Monetary Rebates to all enrollees in the VBID PBP(s) that have been approved for the Cash or Monetary Rebates Component.

2. The MA Organization shall not selectively market the Cash or Monetary Rebates to enrollees based on health status or risk profile or in a discriminatory manner. The MA Organization shall provide and market the Cash or Monetary Rebates in accordance with the anti-discrimination provisions of Section 1852(b)(1) of the Act, 42 CFR § 422.110, all other applicable federal and state anti-discrimination laws, this Article 3, and the VBID Model Communications and Marketing Guidelines.

3. Participating MA Organizations shall not use the Cash or Monetary Rebates to incentivize rationing of care or avoidance of medically necessary care, or to encourage enrollment in the VBID PBP or any other plan offered by the MAO.

4. The MA Organization shall not provide Cash or Monetary Rebates to enrollees until the Plan Year has started and must provide all Cash or Monetary Rebates during the Plan Year.

5. The parties acknowledge that the Approved Proposal contains the following:

a. The per unit value of the Cash or Monetary Rebates and the total value that an enrollee will receive during the Plan Year (e.g., a debit card with a per unit value of $50 provided quarterly for a total of $200 per year).

b. The amount and frequency of the Cash or Monetary Rebates to be provided to enrollees.

c. The type of Cash or Monetary Rebates to be provided to enrollees.

d. The administrative plan for how the MA Organization will distribute, track, and ensure receipt of the Cash or Monetary Rebates.

6. Provision of Cash or Monetary Rebates.

a. Consistent with the Approved Proposal, and subject to Article 3.F.8, MA Organization shall furnish a mandatory supplemental benefit in the form of Cash or Monetary Rebates to all enrollees in its VBID PBP(s) that participate in the Cash or Monetary Rebates Component.

b. The Cash or Monetary Rebates may be provided via check, debit card, or other form approved by CMS (e.g., a general purpose gift card).

c. MA Organization shall submit to CMS all engagement data (e.g., data regarding the number of enrollees, as permitted under the VBID Model and identified in the MA Organization's Approved Proposal, that received the Cash or Monetary Rebates) in a form and manner and by a deadline specified by CMS in the Model Monitoring Guidelines.

d. Cash or Monetary Rebates are subject to the annual limit per enrollee in the Approved Proposal and must be equal to or less than the amount of beneficiary rebates paid to the MA Organization for the applicable VBID PBP under section 1853(a)(1)(B)(i) and (a)(1)(E) of the Act and available under the PBP pursuant to section 1854(b) of the Act and any implementing regulations in 42 CFR Part 422.

e. If an enrollee joins a VBID PBP that is approved for the Cash or Monetary Rebates Component after the annual coordinated election period (e.g., during a Special Enrollment Period or the MA Open Enrollment Period described in 42 CFR § 422.62(a)(3)), the MA Organization shall provide the enrollee the Cash or Monetary Rebates within 30 calendar days after their enrollment start date, or in the subsequent calendar month.

f. In accordance with Article 4 of this Addendum (Additional Record Retention and Reporting Requirements), the MA Organization shall maintain and provide to CMS or other governmental authorities upon request, at least the following records for all enrollees in VBID PBPs that are offered Cash or Monetary Rebates under the VBID Model:

i. The identity of each enrollee who received Cash or Monetary Rebates;

ii. The nature and amount of the Cash or Monetary Rebates received by the enrollee;

iii. The date that the enrollee received the Cash or Monetary Rebates; and

iv. The per unit and total amount of Cash or Monetary Rebates received by the enrollee.

7. Beneficiary Notices Regarding Tax Consequences of Cash or Monetary Rebates.

a. Pre-Enrollment Marketing of Cash or Monetary Rebates. Prior to January 1, 2021, the MA Organization shall submit to CMS for review and approval all marketing materials. The marketing materials must describe information about the following:

i. the form (e.g., check, debit card, etc.), amount, and frequency of Cash or Monetary Rebates available to enrollees; and

ii. a notice that clearly describes any potential tax consequences of the combined impact of the Cash or Monetary Rebate and any rewards and incentives offered as part of a Rewards and Incentives Program.

b. Marketing of Cash or Monetary Rebates for Enrollees. The MA Organization shall submit to CMS for review and approval all marketing materials. The marketing materials must describe information about the following:

i. the form (e.g., check, debit card, etc.), amount, and frequency of the Cash or Monetary Rebates available to enrollees;

ii. the process for enrollees to opt-out of receiving the Cash or Monetary Rebates, which must be consistent with Article 3.F.8.; and

iii. A notice of the potential tax consequences associated with the provision of Cash or Monetary Rebates. This notice must be provided to the enrollee prior to the provision of the actual Cash or Monetary Rebate and no later than January 1, 2021.

c. MA Organization must also provide timely updated income and related tax reporting (e.g., 1099 reporting) for enrollees receiving Cash or Monetary Rebate consistent with applicable state and federal law.

8. MA Organization shall provide a mechanism for eligible enrollees to opt out of receipt to the Cash or Monetary Rebates at any time. If an enrollee opts out of receiving the Cash or Monetary Rebates provided under the VBID Model, MA Organization shall take the following actions:

a. Send a written acknowledgment to the enrollee of his or her request to opt out of the Cash or Monetary Rebates;

b. Thereafter, provide the enrollee with coverage of benefits offered by the MA Organization under the PBP without providing the Cash or Monetary Rebates; and

c. Not send the Cash or Monetary Rebate to the enrollee.

If after opting out of the Cash or Monetary Rebates, an enrollee wishes to regain eligibility for or access to the Cash or Monetary Rebates, MA Organization must honor that request and begin or resume providing Cash or Monetary Rebates, consistent with the terms of this Addendum.

9. The MAO shall not change the amount, timing, frequency, manner or form of the Cash or Monetary Rebates without advance written approval of CMS.

G. HOSPICE BENEFIT COMPONENT

If approved by CMS to participate in the Hospice Benefit Component, MA Organization shall implement the Hospice Benefit Component consistent with the Approved Proposal and this Addendum, including Appendix 3 of this Addendum. Any changes to an MA Organization's implementation of the Hospice Benefit Component are subject to prior CMS review and approval.

H. COMMUNICATIONS, MARKETING, AND DISCLOSURES

1. In addition to the marketing requirements and prohibitions in this Addendum and in the Underlying Contract, MA Organization shall comply with the 2021 VBID Model Communications and Marketing Guidelines issued by CMS and available on the VBID model website at https://innovation.cms.gov/initiatives/vbid/.

2. The MA Organization shall convey information about its participation in and benefits, items and services available for eligible Targeted Enrollees in approved VBID Components as described in the Approved Proposal to Targeted Enrollees consistent with CMS rules permitting marketing of covered benefits and rewards programs and the 2021VBID Model Communication Guidelines for the VBID Model.

3. If the eligibility for a VBID Component as a Targeted Enrollee (e.g., for a particular item under the Rewards and Incentives Program or for an additional benefit described in Article 3.D or 3.E.) is not assured or cannot be determined before a model year for a specific enrollee or enrollees, the MA Organization shall provide a disclaimer on all materials describing the benefit, item, or VBID Component. Such disclaimer must clearly state that eligibility for VBID Components or benefits and items available under the VBID Model is not assured and will be determined by the MA Organization after enrollment based on relevant criteria (e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program).

4. Evidence of Coverage and Plan Annual Notice of Change. MA Organization shall include in the Evidence of Coverage, all VBID Model Benefits, including WHP, along with language that ensures enrollees are aware of any conditional or targeting criteria. If the MA Organization is new to the VBID Model for Plan Year 2021, or offering new VBID Model Benefits for the 2021 Plan Year, the MA Organization shall include the VBID Model Benefits in the Plan Annual Notice of Change for existing enrollees.

5. Notice of Model Benefits. At the beginning of the contract year, MA Organization may, in addition to the Evidence of Coverage and, as applicable, Plan Annual Notice of Change, send all Targeted Enrollees who have been identified by MA Organization additional written materials summarizing participation in the Model and what is available to them under the model ("Notice of Model Benefits"). For additional benefits available pursuant to Article 3.C and 3.D, this includes at a minimum, the following information: what the additional benefits are, how to receive the benefits, restrictions or conditions placed on receipt of the benefits, and where to receive more information. For any approved VBID Component that includes specific providers, MA Organization shall provide, as part of the materials to enrollees, a list of these providers. CMS will specify the time periods for delivery of these materials in the VBID Model Communications and Marketing Guidelines.

6. MA Organization shall submit to CMS any Notice of Model Benefits as well as any other VBID Model-related enrollee communication materials designated in the VBID Model Communication Guidelines for review and approval, and shall not make use of such materials until they are approved by CMS.

7. In the event of a conflict between the marketing requirements in the Underlying Contract and the VBID Model Communications and Marketing Guidelines such that MA Organization cannot comply with both, MA Organization must comply with the VBID Model Communications and Marketing Guidelines.

I. NOTICE OF CHANGES TO CMS

Prior to the beginning of the 2021 Plan Year, MA Organization agrees to provide to CMS written notice of the following changes, including the method by which Targeted Enrollees will be notified of the changes, which it shall not make without obtaining prior written approval from CMS:

1. Changes to the benefits, including the formulary, that are permitted under Parts 422 and 423, offered by a VBID PBP to the extent benefits provided under the VBID Model are impacted.

2. Any change in circumstances which would constitute a material change to a fact or representation made in MA Organization's Approved Proposal. This includes not being able to implement or provide one or more of the benefits, items or services offered under the VBID Model.

3. Changes in the composition of a high-value provider network available as part of the VBID Model, as described in Article 3.D.

4. Such changes must be provided to CMS prior to the beginning of the 2021 Plan Year in accordance with process and timeline outlined in the VBID Model Communications and Marketing Guidelines.

J. RELEASE OF INFORMATION

1. MA Organization shall obtain prior approval from CMS during the term of this Addendum and for six months thereafter for the publication or release of any press release, external report or statistical/analytical material or other similar material that references MA Organization's participation in the VBID Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. When reviewing these materials, CMS intends to disapprove only those materials containing material misstatements of fact or conclusions based on improper methodology or inaccurate data, or that are inconsistent with the implementation of the VBID Model or other applicable laws, regulations or CMS instructions. CMS will make reasonable efforts to complete its review expeditiously. Any material describing MA Organization's participation in the VBID Model that is submitted to CMS for prior approval that is not disapproved in writing by CMS, or where CMS has requested additional time to review, within 30 calendar days after receipt by CMS will be deemed approved.

2. MA Organization agrees to include the following statement on the first page of all external reports and statistical/analytical material that are subject to this Section: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

K. NON-DISCRIMINATION

MA Organization shall comply with Section 1852(b)(1) of the Act concerning discrimination against enrollees.

Article IV
Additional Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

MA Organization shall maintain books, records, documents, and other evidence relating to the VBID Model for 10 years and provide access in accordance with the record retention provisions of the Underlying Contract.

B. DATA REPORTING AND COOPERATION WITH MONITORING AND EVALUATION

1. MA Organization shall cooperate with CMS's efforts to evaluate the effectiveness of each VBID Component implemented by the MA Organization and shall participate in all VBID Model monitoring, auditing, evaluation, and learning and diffusion activities.

2. CMS will issue Model Monitoring Guidelines, which will be designed to allow CMS to collect the necessary data to monitor the real-time impact of the Model and to perform the requisite model evaluation. The Model Monitoring Guidelines will include instructions regarding the collection and reporting of data regarding the MA Organization's participation in the VBID Model.

3. The MA Organization shall comply with the Model Monitoring Guidelines.

Article V
Termination of Addendum or MA Plan(s) Participation by CMS

A. CMS may terminate MA Organization's participation in the VBID Model, or terminate a particular MA Plan(s) from the VBID Model at any time, with or without advance notice if:

1. CMS terminates the VBID Model pursuant to Section 1115A(b)(3)(B) of the Act or otherwise;

2. CMS determines that MA Organization or a particular MA Plan or its subcontractors and/or downstream entities (as defined at 42 CFR § 422.2):

a. Has failed to comply with any term of this Addendum or documents incorporated herein;

b. Has carried out this Addendum in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Parts 417, 422 or 423 or Section 1115A of

the Act;

c. Has failed to continually meet the applicable MA Organization eligibility conditions, or does not have an exception to one or more eligibility conditions, of the VBID Model;

d. Has failed to implement or fully comply with the terms of a corrective action plan or other intermediate sanction imposed by CMS;

e. Has taken an action that threatens the health or safety of a beneficiary, or MA Organization's participation in the VBID Model is resulting in lower quality of care or any other adverse outcomes for beneficiaries;

f. Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the VBID Model;

g. Is subject to sanctions or other enforcement or corrective actions of an accrediting organization or federal, state or local government agency;

h. Is subject to investigation or action by HHS (including HHS-OIG and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct, including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, being named as a defendant in a False Claims Act qui tam matter in which the government has intervened or similar action;

i. Assigns or purports to assign any of the rights or obligations under this Contract and Addendum voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS;

j. 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;

k. Has committed any act that would be cause for termination of the Underlying Contract or imposition of any penalty or sanction thereunder, regardless of whether such termination, penalty or sanction is actually imposed by CMS; or

l. Has engaged in prohibited discrimination against a Medicare beneficiary.

B. Prior to terminating MA Organization or a particular MA Plan pursuant to Section A of this Article, CMS may afford MA Organization an opportunity to develop and implement a corrective action plan to correct deficiencies in accordance with the procedures of 42 CFR Section 422.510(c)(1). In addition to any sanction or penalty authorized under 42 CFR 422.750 and 423.750, CMS may rescind or make inapplicable on a prospective basis one or more waivers provided to MA Organization, or limit the benefits offered under the VBID Model that may be offered by MA Organization if CMS determines that an event identified in Paragraph A.2 of this Article has occurred.

Article VI
Termination and Surviving Obligations

A. As the term of this Addendum is from the start date through the 2021 Plan Year, if MA Organization does not wish for one or more of its VBID PBPs to participate in the VBID Model for the subsequent Plan Year, it must notify CMS in writing by the first Monday in June that precedes the start of that Plan Year.

B. If the MA Organization does not wish to continue participation in the VBID Model for one or more MA Plans, the MA Organization shall notify each Targeted Enrollee who is eligible for benefits provided under the VBID Model. Such notice must be in writing and must inform the enrollee of any changes to their benefits for the next Plan Year. The MA Organization must comply with the Model Communications Guidelines to notify Targeted Enrollees of the change to benefits to be effective January 1 of the upcoming Plan Year. The MA Organization shall submit to CMS the notification to enrollees for changing model benefits in accordance with the Model Communications and Marketing Guidelines.

C. MA Organization shall ensure the timely transfer of any data or files to CMS necessary for evaluation, transition or close-out of MA Organization's model-related activities, and shall comply with all other CMS-specified close-out procedures.

D. Upon any termination of this Addendum (other than pursuant to Article 5), MA Organization shall continue to provide coverage for items and services other than benefits that were offered under the VBID Model consistent with applicable law and the Underlying Contract as if this Addendum had never been executed. CMS may require MA Organization to make appropriate adjustment to its bid submission for a contract year to account for the absence of benefits that were offered under the VBID Model.

E. Termination of this Addendum by either party shall not affect the rights and obligations of the parties accrued prior to the effective date of the termination or expiration of this Addendum. The rights and duties set forth in this Article, Article 4; and Article 11 shall survive the termination or expiration of this Addendum. The termination of this Addendum does not relieve either party of any claims against it that arise under this Addendum before the Addendum is terminated, including the remedies of Article 5, Section B.

Article VII
Amendment

A. This Addendum may be amended at any time by written mutual consent.

B. CMS may amend this Addendum without the consent of the MA Organization for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, or accreditation standards. To the extent practicable, CMS shall provide the MA Organization with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date. If the MA Organization does not wish to be bound by the unilateral amendment, it may terminate this Addendum by providing CMS with 30 days advance written notice.

Article VIII
Order of Precedence & Relationship to Other Agreements

A. This Addendum does not supersede or modify Sections 1851 through 1859, and Sections 1860D-1 through 1860D-43 of the Act, or 42 CFR, Parts 422 or 423, except as specifically waived in Appendix 1 of this Addendum.

B. This Addendum specifies additional rights and obligations of the parties with respect to the VBID Model only and does not relieve the parties from, or modify any rights and obligations with respect to, the operation of a Medicare Advantage coordinated care plan (and, if applicable, a Part D prescription drug plan) in general or pursuant to the Underlying Contract.

C. In the event of any conflict among the documents or other requirements that might govern the conduct of CMS and MA Organization in their administration of or participation in the VBID Model, the order of priority to interpret the obligations of the parties shall be as follows

1. This Addendum (including Appendices);
2. The Underlying Contract to which this Addendum is attached, and other addenda;
3. Any Model-Test related guidance issued by CMS, including guidance on communications or data collection; and
4. MA Organization's Approved Proposal.

D. The termination of this Addendum by either party shall not, by itself, relieve the parties from their obligations under the Underlying Contract and its other addenda, if any.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
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Article IX
Attestation of Compliance

The MA Organization hereby attests that:

A. The VBID Components identified in each VBID PBP in the Health Plan Management System (HPMS) are consistent with the benefits detailed in MA Organization's Approved Proposal

B. Each bid pricing tool (BPT) submitted for each VBID PBP has been completed in a manner consistent with the actuarial assumptions and projections contained in the actuarial component of MA Organization's Approved Proposal and take into account all costs associated with MA Organization's implementation of the Approved Proposal as required in this Addendum.

C. MA Organization has not made changes to a VBID Model-participating PBP's benefit structure, formulary, network, or otherwise that discriminate against enrollees in the MA Plan who are not eligible for special benefits under the VBID Model.

Article X
Appeals and Limitation on Review

A. There is no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:

1. The selection of MA Organizations or MA Plans to participate in the VBID Model, including the decision by CMS to terminate this Addendum or to direct the termination of any Plan's participation in the VBID Model;

2. The elements, parameters, scope, and duration of the VBID Model;

3. Determinations regarding budget neutrality under section 1115A(b)(3);

4. The termination or modification of the design and implementation of a model under section 1115A(b)(3)(B); or

5. Decisions about expansion of the duration and scope of a model under subsection 1115A(c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

B. MA Organization may dispute such matters for which review is not precluded in accordance with the procedures of 42 CFR Part 422, Subpart N or Section 422.756, as appropriate.

Article XI
Severability

In the event that one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Addendum, and this Addendum shall be construed as if such invalid, illegal or unenforceable provisions had never been contained herein, unless the deletion of such provision or provisions would result in such a material change so as to cause completion of the transactions contemplated herein to be unreasonable.

Article XII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this Addendum shall have the meaning given such terms in the Underlying Contract, or 42 CFR Parts 422 or 423, as applicable.

B. NOTICES

All notifications required under this Addendum shall be submitted by MA Organization to CMS by electronic mail to VBID@cms.hhs.gov, and by CMS to MA Organization by electronic mail to the person designated in the Approved Application Proposal as the MA Organization's primary point of contact, or via a Health Plan Management System broadcast email.

C. COMPLIANCE WITH LAWS

1. The MA Organization shall comply with the applicable terms of this Addendum, the Underlying Contract and all applicable statutes, regulations, and guidance, including without limitation (a) federal criminal laws; (b) the federal False Claims Act (31 U.S.C. § 3729 et seq.); (c) the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the federal civil monetary penalties law (42 U.S.C. § 1320a-7a); (e) the federal physician self-referral law (42 U.S.C. § 1395nn), and (f) applicable State laws.

2. This Addendum does not provide any waivers of the fraud and abuse laws. The MA Organization must comply with all applicable fraud and abuse laws, except as such laws may be waived pursuant to section 1115A(d)(1) of the Act specifically for the VBID Model.

In witness whereof, the parties hereby execute this contract. This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/27/2020 2:21:28 PM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/18/2020 3:51:31 PM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
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9/18/2020 3:51:31 PM

Date

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

9/18/2020 3:51:31 PM

Date

Amy Bassano
Deputy Director
Center for Medicare and
Medicaid Innovation

Appendix 1: Program Waivers
Appendix 2: Rewards and Incentives Programs
Appendix 3: Hospice Benefit Component

Appendix 1:
Program Waivers

A. Pursuant to Section 1115A(d)(1) of the Act, in its sole discretion, CMS waives the following requirements for MA Organizations participating in the VBID Model. These waivers are granted only to the extent necessary to implement MA Organization's Approved Proposal in accordance with the Addendum. CMS may modify or rescind any or all of these waivers at any time, in its sole discretion.

1. Uniformity and Accessibility of Benefits: Targeted Enrollees shall be identified as described in the Article 3. The following are waived to the extent necessary to permit organizations to offer supplemental benefits to Targeted Enrollees, rather than to all enrollees in the MA Plan(s) participating in the VBID Model:

a. Sections 1852(d)(1)(A) and 1854(c) of the Act [42 USC § 1395w-22(d)(1)(A) and §1395w-24(c)]; 42 CFR §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.102(a)(2),

b. 422.254(b)(2), 422.262(c)(1); Section 1860D–2(a) of the Act [42 USC § 1395w-102(a)]; and

c. 42 CFR §§ 423.104(b)(2), 423.265(c).

2. Uniform Cost Sharing: Targeted Enrollees shall be identified as described in the Article 3. The following are waived to the extent necessary to offer reductions in cost-sharing to Targeted Enrollees, rather than to all enrollees in the MA Plan(s) participating in the VBID Model:

a. Sections 1852(d)(1)(A) and 1854(c) of the Act [42 USC § 1395w-22(d)(1)(A) and §1395w-24(c)]

b. 42 CFR §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.254(b)(2) 422.262(c)(1);

c. Section 1860D–2(a) of the Act [42 USC § 1395w-102(a)]; and42 CFR §§ 423.104(b)(2) & 423.265(c).

3. Provision of Supplemental Benefits that are Non-Primarily Health Related: Targeted Enrollees shall be identified as described in the Article 3. The following are waived to the extent necessary to allow MA Organization to offer to certain Targeted Enrollees additional supplemental benefits that are "non-primarily health related" supplemental benefits that have a reasonable expectation of improving or maintaining the health or overall function of the Targeted Enrollee with regard to the chronic condition or socioeconomic status of the targeted enrollee population:

a. Section 1852(a)(3)(D)(i), (ii)(I) and (iii) of the Act [42 U.S.C. §§ 1395w– 22(a)(3)(D)(i), (ii)(I) and (iii)] and any implementing regulations.

4. Provision of Supplemental Benefits in the form of Cash or Monetary Rebates: The following are waived to the extent necessary to permit mandatory supplemental benefits in the form of cash or monetary rebates that are not limited to paying for health care and are provided subject to the terms of the Model. This includes a waiver, to the extent necessary, of the requirement that participating MAOs incur a non-zero direct medical cost in the provision of these specific mandatory supplemental benefits under the Model:

- Sections1852(a)(3)(A) of the Act;
- 42 CFR 422.100(c)(2), 422.102, and 422.266(b);
- Sections 1851(h)(4)(A) and 1854(d)(1) of the Act [42 U.SC §§ 1395w-21(h)(4)(A) and 1395w-24(d)(1); and
- 42 CFR §§ 422.262(d) and 422.2268(b)(1).

5. Communications, Disclosures and Marketing: The following are waived to the extent necessary for MA Organization to comply with model-specific guidance on communications, including disclosures and marketing, with Targeted Enrollees, enrollees or potential enrollees.

a. Section 1852(c)(1)(B) & (F) of the Act [42 USC §§ 1395w-22(c)(1)(B) & (F)];

b. 42 CFR § 422.111(a) & (b);

c. Section 1860D-4(a)(1)(A) of the Act [42 USC § 1395w-102(a)]; and 4

d. 2 CFR § 423.128(a) & (b)(2).

6. Increased Value for Rewards and Incentives: The following are waived to the extent necessary to allow MA Organization to offer Rewards and Incentives Programs, subject to the terms of the Model, that: are available only to Targeted Enrollees, as identified in Article 3, and Appendix 2; are based on the anticipated benefit (rather than the value) of the associated healthcare item or service and subject to an annual limit of $600.00 per enrollee for all rewards received by the enrollee; or are associated with Part D benefit:

a. 42 CFR §§ 422.134(b)(1), (b)(2), (c)(1)(i) and (c)(1)(ii), related to availability and eligibility for rewards and incentives;

b. 42 CFR § 422.134(c)(1)(i), related to completion of the entire activity or service prior to receiving the reward and incentive; and

c. 42 CFR § 422.134(c)(1)(iii), related to the monetary limit on rewards and incentives.

B. The waivers of paragraph A above, as well as the waivers included in Appendix 3 (Hospice Benefit Component) are (1) each contingent on compliance with the terms and conditions of this Addendum and documents incorporated therein; (2) granted only to the extent necessary to implement MA Organization's Approved Proposal; (3) granted only to MA Organization as to those MA PBPs (or MA Plans) for which CMS has approved a Proposal; and (4) granted only for the term of this Addendum.

Appendix 2:
Rewards and Incentives Programs

The MA Organization may, subject to certain conditions and CMS approval, provide a Rewards and Incentives Program to Targeted Enrollees. The MA Organization shall implement any Rewards and Incentive Program ("RI Program") under the VBID Model during the term of the Addendum in accordance with the terms of this Addendum, this Appendix 2, and the Approved Proposal.

1. Rewards and Incentives Programs:

A. The parties acknowledge that MA Organization has submitted as part of its application for participation in the VBID Model, a proposal to offer a Rewards and Incentives Program to Targeted Enrollees.

B. MA Organization shall identify Targeted Enrollees without discrimination and using objective criteria that comply with the terms of this Appendix 2 and are specified in the Approved Proposal or are otherwise approved in writing, in advance by CMS. Such objective criteria must be designed to identify either (i) all enrollees or (ii) a subset of enrollees who would receive the greatest health care value from receiving the benefits or participating in the activities associated with a particular reward or incentive in the Part C RI Program or Part D RI Program

C. The parties acknowledge that that the Approved Proposal contains the following:

1. The goals of each RI Program.

2. The nature and scope of each RI Program, including the criteria for identifying Targeted Enrollees, the eligibility criteria that must be met for an individual enrollee to receive the reward or incentive, and the associated healthcare activity (or service) that must be completed for the reward or incentive to be available.

3. The per unit value of the reward and incentive and the total value that an enrollee can receive (e.g., a gift card with a per unit value of $25 offered quarterly for a total of $100 per year) up to $600 annually per enrollee. (The value of any Cash or Monetary Rebate is not included in this $600 limit.)

4. The amount and frequency of the reward or incentive that may be obtained by a Targeted Enrollee for participation in an RI Program.

5. The evidence base and theory of change used to develop the reward or incentive and the intended goals of the RI program.

D. MA Organization may implement a Rewards and Incentives Program that is specific to participation in a disease management program, transition of care program, or similar programs that are evidence-based and approved by CMS.

E. The MA Organization shall:

1. Comply with the standards for reward programs in 42 CFR § 422.134 and as outlined in Chapter 4, sections 100 through 100.5 of the Medicare Managed Care Manual (posted at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf), issued and effective 04-22-2016, for both its Part C RI Program and its Part D RI Program, except as waived or otherwise modified in the Addendum, Appendix 1, or this Appendix 2;

2. Not provide any individual reward or incentive the value of which exceeds the value of the expected benefit of the health care item or service; an individual reward or incentive may have a value beyond the cost of the health-related service or activity itself, subject to this limit tied to the expected benefit of the health care item or service; and

3. Limit the provision of rewards and incentives to Targeted Enrollees to a maximum annual per enrollee limit of $600.00 in the aggregate for all rewards and incentives, which applies across all RI Programs in the VBID PBP.

2. Part C RI Programs

Except to the extent that certain provisions are identified as waived in Appendix 1, MA Organization shall comply with 42 CFR § 422.134 in connection with its Part C RI Program. Notwithstanding any other provision of this Addendum or its appendices, the MA Organization shall comply with all relevant fraud and abuse laws, including the anti-kickback statute and civil money penalty prohibiting inducements to beneficiaries, except as explicitly provided in any separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the VBID Model. Any such waiver will apply solely to the VBID Model and may differ in scope or design from waivers granted for other programs and models.

3. Part D RI Program Requirements

A. MA Organization shall implement a Part D RI Program only in connection with a PBP for which the MA Organization has executed a Part D Addendum such that the PBP is an MA-PD plan.

B. Except to the extent that certain provisions are identified as waived in Appendix 1, MA Organization shall implement any Part D RI Program in compliance with the terms of 42 CFR § 422.134 (as if such regulation applied to Part D plans). Notwithstanding any other provision of this Addendum or its appendices, the MA Organization shall comply with all relevant fraud and abuse laws, including the anti-kickback statute and civil money penalty prohibiting inducements to beneficiaries, except as explicitly provided in any separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the VBID Model. Any such waiver will apply solely to the VBID Model and may differ in scope or design from waivers granted for other programs and models.

C. If the MA Organization offers a Part D RI Program, the rewards and incentives in any such Part D RI Program must be furnished to reward or incent one of the following:

1. Participation in a plan sponsor medication therapy management program (MTMP).

2. Participation in receipt of covered Part D vaccines and other drug therapies that focus on preventive health.

3. Participation in a program that allows enrollees to better understand their Part D plan benefit, costs, and therapeutic-equivalent coverage alternatives, including biosimilars and generics.

D. In offering any reward or incentive for participation in an MTMP, the MA Organization shall comply with existing CMS requirements for MTMPs, as set forth 42 CFR § 423.153.

E. In offering any reward or incentive for participation in preventive health services, the MA Organization may design a program with the overall goal of improving medication adherence, however the MA Organization shall not condition any such reward or incentive on prescription fills or clinical outcomes, and shall not furnish any such reward or incentive for a service that is not clinically indicated for the beneficiary.

F. Consistent with the Approved Proposal, the value of the reward or incentive provided pursuant to a Part D RI Program may exceed the cost of the health-related service or activity on which receipt of the reward or incentive is based, but must not exceed the value of the expected benefit of using the service or item, up to an annual per enrollee limit of $600.00 in the aggregate for all rewards and incentives.

G. In implementing and operating its Part D RI Program, the MA Organization shall not:

1. Use prescription fills or adherence as the sole basis for providing a reward or incentive.

2. Incentivize enrollees to use mail service pharmacies, preferred pharmacies or any other specific network providers.

3. Identify Targeted Enrollees based on the identity of their pharmacy provider.

4. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a drug manufacturer. This includes, but is not limited to, the use of personnel affiliated with a drug manufacturer, manufacturer-financed coupons or discounts provided to a beneficiary, or manufacturer supplied education materials.

5. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a pharmacy or entity that owns or operates pharmacies. This includes use of personnel affiliated with a pharmacy, pharmacy-financed coupons or other discounts provided to a beneficiary, or pharmacy supplied education materials.

4. Record Retention

A. In accordance with Article 4 of this Addendum (Additional Record Retention and Reporting Requirements), the MA Organization shall maintain the following records regarding all RI Programs under this Model:

1. The identity of each enrollee who received a reward or incentive;

2. The Part C RI Program, Part D RI Program, or both, pursuant to which the enrollee received a reward or incentive;

3. The nature and date(s) of the activities or other conduct engaged in by the enrollee that enabled the enrollee to qualify for the reward or incentive;

4. The nature and amount of the reward or incentive received by the enrollee; and

5. The cost of the healthcare activities or services with which eligibility for a reward or incentive is associated and the value of the expected benefit of such healthcare activities and services.

B. The MA Organization shall submit semi-annual reports to CMS, in a form and manner and by a deadline specified by CMS, regarding its implementation of any Part C RI Program or Part D RI Program. The MA Organization shall provide CMS with supplemental information upon request regarding its implementation of any Part C RI Program or Part D RI program.

5. Compliance and Enforcement

A. MA Organization shall have in place a protocol for monitoring the implementation and administration of each approved Part C RI Program and Part D RI Program. MA Organization shall make this protocol available to CMS upon request.

B. In accordance with Article 5 of the Addendum (Termination of Addendum or MA Plan(s) Participation by CMS), CMS may terminate or suspend the MA Organization's implementation of any Part C RI Program or Part D RI Program, or take other remedial action, if -

1. The MA Organization fails to comply with the terms and conditions of the Addendum or this Appendix 2; or

2. CMS determines that the MA Organization's implementation of such a program might compromise the integrity of the Model.

C. If CMS determines that the MA Organization has failed to comply with the terms of Article 3.D of this Addendum or this Appendix 2, CMS may prohibit the MA Organization from participating in the VBID Component regarding Rewards and Incentives Programs, regardless of whether the MA Organization has corrected or otherwise resolved the noncompliance.

Appendix 3:
Hospice Benefit Component

The MA Organization may, subject to the terms and conditions of the VBID Model and this Addendum and Appendix 3 and CMS's approval of its Proposal, cover the Medicare hospice benefit as part of the participating PBP's benefits in combination with offering palliative care services outside the hospice benefit for enrollees with serious illness, and providing individualized transitional concurrent care services during a hospice benefit period, as set forth in sections 1812(a)(4) and (d) of the Act. The MA Organization shall implement the Hospice Benefit Component under the VBID Model during the term of the Addendum only in accordance with the terms of this Addendum, including this Appendix 3, and the Approved Proposal.

The MA Organization must comply with all applicable laws and regulations governing the Medicare hospice benefit, except those laws and regulations that are waived pursuant to section 1115A(d)(1) of the Act specifically for the Model as identified in Appendix 1 and Appendix 3 of the Addendum.

1. Hospice Benefit Component Definitions

"Hospice Care" means a comprehensive set of items and services (described at § 1861(dd)(1) of the Act) that are identified and coordinated by an interdisciplinary care team to provide for the physical, psychosocial, spiritual, and emotional needs of a Terminally Ill (as defined below) patient and/or family members, as delineated in a specific patient plan of care (42 CFR § 418.3). These items and services include core and non-core services. With the exception of physician services, substantially all core services must be provided directly by hospice employees on a routine basis. These services must be provided in a manner consistent with acceptable standards of practice. Core services (42 CFR § 418.64) include physician, nursing, medical social services, counseling, bereavement, and spiritual services. Nursing services, physician services, and drugs and biologicals must be made routinely available on a 24-hour basis seven days per week. In addition to the hospice core services, the following services must be provided by a hospice provider, either directly or under arrangements with other providers, to meet the needs of the patient and family as part of non-core services: Physical and occupational therapy and speech-language pathology services; hospice aide services; homemaker services; volunteers; medical supplies (including drugs and biologicals) and use of medical appliances related to the terminal illness and related conditions; and short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management (42 CFR §§ 418.70-418.78; 418.100)).

"Hospice Election" means the voluntary decision made by eligible individuals in accordance with 42 CFR § 418.24 (as amended from time to time) to receive Hospice Care. The content of the hospice election statement must also be consistent with the Fiscal Year (FY) 2020 Hospice Wage Index Final Rule (84 FR 38484), which requires the hospice to provide, at the request of the patient or their representative, an addendum that includes information aimed at increasing coverage transparency for patients under a hospice election.

"Hospice Enrollee" means an enrollee who meets the statutory definition of "terminally ill" as defined below, and has voluntarily elected to receive Hospice Care through a Hospice Election.

"Palliative Care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR § 418.3).

"Terminally Ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course (42 CFR § 418.3).

"Transitional Concurrent Care" means clinically appropriate continuing care needs related to the treatment of Hospice Enrollees' terminal conditions.

2. Hospice Benefit Component Structure and Content

A. With regard to an MA Organization that is implementing the Hospice Benefit Component under the Model pursuant to the Addendum, the parties acknowledge that MA Organization has submitted as part of its application for participation in the VBID Model, a proposal to offer the Hospice Benefit Component and that CMS has approved that proposal.

B. Provision of the Full Scope of Medicare Hospice Benefits.

The MA Organization shall:

i. Provide the full scope of Hospice Care, as set forth in section 1861(dd) of the Act and all implementing regulations at 42 CFR Part 418 to all Hospice Enrollees in their VBID PBPs participating in the Hospice Benefit Component;

ii. Maintain each enrollee's choice to elect or revoke the hospice benefit in accordance with section 1812(d) of the Act and in CMS regulations at 42 CFR §§ 418.24 and 418.28.

C. Palliative Care Strategy.

The MA Organization shall:

i. Consistent with the Approved Proposal, develop and implement a strategy regarding access to and delivery of palliative care services to all enrollees with serious illness who are either not eligible for or who have chosen not to (or not yet chosen to) receive hospice services.

ii. Identify to CMS any costs related to the provision of Palliative Care that are in the basic bid.

D. Transitional Concurrent Care Strategy.

The MA Organization shall:

i. Consistent with the Approved Proposal, develop and implement a strategy around the provision of Transitional Concurrent Care by in-network hospice providers and non-hospice providers that is clinically appropriate and reflective of Hospice Enrollees' and caregivers' needs as identified in the plan and goals of care and does not duplicate the services covered in the Medicare hospice benefit.

ii. In accordance with the VBID Model Monitoring Guidelines, the MA Organization shall report to CMS the costs related to the provision of Transitional Concurrent Care during the Plan Year and a comparison of actual experienced costs to the costs projected in the Approved Proposal.

E. Coverage of Hospice Care Furnished by In-Network and Out-of-Network Providers

1. The MA Organization must provide access to a network of high-quality hospice providers that meet all Medicare requirements for furnishing Hospice Care. The MA organization must cover all Hospice Care furnished by either an in-network hospice provider or an out-of-network (non-contracted) hospice provider to a Hospice Enrollee who is enrolled in the VBID PBP that is participating in the Hospice Benefit Component.

2. Consistent with the approved proposal, and as approved by CMS on an ongoing basis during the Plan Year, in ensuring beneficiary access to a network of high-quality hospice providers, the MA Organization may:

i. Prohibit access to a hospice provider that presents a risk of harm to enrollees if the hospice provider meets one or more of the following criteria:

a. The hospice provider was found through publicly available data or sources to pose a risk for beneficiary harm.

b. The hospice provider consistently has not offered all four levels of Hospice Care, has infrequently provided physician services, or has rarely provided care on weekends.

ii. Prohibit access to a hospice provider that does not respond to the MA Organization's requests for information that the MA Organization must use to document a determination that the hospice provider does or does not meet the criteria in Article 2.E.i. of Appendix 3 (e.g., as part of the MA Organization's credentialing attempts).

3. In ensuring beneficiary access to a network of hospice providers, the MA Organization shall:

i. Offer access to in-network hospice providers as well as out-of-network hospice providers except those not allowed by the MA Organization due to posing risk of harm to beneficiaries as described in 2.E.i-ii of this Appendix 3.

ii. In implementing any type of consultation service approved by CMS related to Hospice Care, such service must provide specially trained staff that are accessible by phone and other means available 24/7 with enhanced standards for average speed of answer and first call resolution in accordance with the VBID Model Monitoring Guidelines, and serviced in a way that is clear, immediately available, culturally competent, and knowledgeable about the hospice benefit and choices.

iii. For Hospice Enrollees that utilize an out-of-network hospice provider, cover Hospice Care provided by the out-of-network hospice provider and make payments at the same amount that the hospice provider would receive from Original Medicare for Hospice Care. Hospice Enrollees shall not be balanced billed.

iv. Clearly and explicitly inform the Hospice Enrollee that payments will be made on his or her behalf to out-of-network hospice providers that have participation agreements with Medicare and are not prohibited by the MA Organization as described in 2.E.ii of this Appendix 3.

v. Make timely and reasonable payments to or on behalf of the Hospice Enrollee for services obtained from a provider or supplier that does not contract with the MA Organization to provide benefits covered by the participating MA plan in accordance with 42 CFR § 422.520.

vi. Count toward the maximum out-of-pocket (MOOP) limit (required pursuant to 42 CFR § 422.100(f) and/or 422.100(d)) those amounts for which the Hospice Enrollee is responsible.

vii. Comply with the requirements of 42 CFR Part 422, subpart E.

G. In ensuring beneficiary access to a network of hospice providers, the MA Organization shall not:

i. Charge higher cost sharing for Hospice Care provided in-network or out-of-network than the cost sharing levels permitted under Medicare as set forth in section 1813 of the Act, 42 U.S.C. § 1395e.

ii. Impose any additional coinsurance or deductibles for Hospice Care furnished to Hospice Enrollees during the period of a Hospice Election, regardless of the setting of the services.

iii. Require prior authorization or implement other utilization management protocols in connection with the coverage or provision of Hospice Care, unless approved by CMS.

H. Additional Mandatory Hospice Supplemental Benefits.

Consistent with the Approved Proposal, MA Organization may offer, and must provide to Targeted Enrollees that accept, the following additional mandatory hospice supplemental benefit(s) provided under the VBID Model:

i. Reduced cost sharing, which includes reduction in cost-sharing to zero, as follows:

a. Reduced cost sharing for services, items and/or covered Part D drugs that an enrollee receives during the period of Hospice Care and that are unrelated to the treatment of the enrollee's terminal illness and related conditions.

b. Reduced cost sharing for services, items and/or drugs or biologicals that an enrollee receives during the period of Hospice Care and that are related to the treatment of the enrollee's terminal illness and related conditions.

ii. Additional items or services as follows:

a. Additional healthcare items or services that meet the criteria for supplemental benefits.

b. Additional items or services that are not primarily related to health ("non-primarily health-related supplemental benefits") but have a reasonable expectation of improving or maintaining, improving, or slowing the progressive decline of the health or overall function of an Hospice Enrollee.

iii. MA Organization shall provide the additional mandatory hospice supplemental benefits identified in the Approved Proposal to all Hospice Enrollees as mandatory supplemental benefits in accordance with 42 CFR § 422.102 and other applicable law. Such additional mandatory hospice supplemental benefits must have a reasonable expectation of maintaining or slowing the progressive decline of the health or overall function of the enrollee with regard to the chronic condition or socioeconomic status of the targeted enrollee population during Hospice Election.

iv. In accordance with the VBID Model Communications and Marketing Guidelines, MA Organizations that provide additional mandatory hospice supplemental benefits must clearly identify the items and services restricted to Hospice Enrollees, as well as any use of care managers or other approaches based on objective standards that allow for the provision of these supplemental benefits for Hospice Enrollees.

3. Hospice Capitation Amount

A. Payment Structure of the Hospice Benefit Component.

For Plan Year 2021, MA Organizations participating in the VBID Model will continue to be paid consistent with current law for their enrollees who do not elect hospice. For Hospice Enrollees in an MA Organization's VBID PBPs that are offering the Hospice Benefit Component, CMS will pay the MA Organization, for each Hospice Enrollee, using the following methodology:

i. For the first month of Hospice Election, consistent with 42 CFR § 422.320(c), the basic benefit capitation rate will only be paid if as of the first day of the month an enrollee is not under Hospice Election status.

ii. For all calendar months that an enrollee elects Hospice Care, including the first month of Hospice Election, the MA Organization will receive the following payments from CMS for each Hospice Enrollee:

a. The monthly Hospice Capitation Amount as specified in 3.B of this Appendix 3;

b. Consistent with 42 CFR § 422.320(c)(2), the beneficiary rebate amount as described in 42 CFR§ 422.304(a); and

c. Consistent with 42 CFR § 422.320(c), the monthly prescription drug payment described in 42 CFR § 423.315 (for MA-PDs).

B. Hospice Capitation Amount.

The Hospice Capitation Amount means the county capitation rate published by CMS that reflects the amount for coverage for a Hospice Enrollee in an MA Organization's VBID PBP that is offering the Hospice Benefit Component for a month. The Hospice Capitation Amount payment varies by a monthly rating factor.

CMS published the Hospice Capitation Amount rates for the 2021 Plan Year here: https://innovation.cms.gov/data-and-reports/2020/cy-2021-hospice-capitation-payment-ratebook-xls.

C. Monthly Rating Factor.

The Hospice Capitation Amount payment for the first month varies based on the number of days of Hospice Care occurring in the first calendar month of a hospice stay (which is the period of time between a Hospice Election and discharge from Hospice Care), split into the following three tiers: 1-6 days, 7-15 days, and 16 or more days of Hospice Care delivered in the first calendar month of the hospice stay. The monthly rating factor for each tier is: 0.34, 0.64 and 1.02 respectively.

The Hospice Capitation Amount does not vary for the second and/or additional calendar months of a hospice stay; the monthly rating factor for additional calendar months beyond the first calendar month is 1.0.

D. Timing of Hospice Capitation Amount Payments.

CMS shall pay the Hospice Capitation Amount for the first calendar month of a Hospice Enrollee's hospice stay in a lump-sum retrospectively to MA Organizations on a quarterly basis, if the Hospice Election did not occur on the first of the calendar month. If the Hospice Election occurred on the first of the calendar month, CMS shall make an advance monthly payment for the Hospice Capitation Amount and retrospectively adjust the Hospice Capitation Amount to reflect the monthly rating factor in its lump-sum payment to the MA Organization.

For Hospice Enrollees with hospice stays that include additional calendar months beyond the first calendar month, CMS shall make advance monthly payments of the Hospice Capitation Amount for coverage of services for a Hospice Enrollee for a month.

E. Adjustment of Payments.

CMS shall adjust payments retroactively to take into account any difference between the actual number of Hospice Enrollees in an MA Organization's VBID PBPs that are offering the Hospice Benefit Component and the number of which it based an advance monthly payment consistent with 42 CFR 422.308(f). The period of time and manner in which adjustments are calculated and processed will be determined at CMS' sole discretion.

4. Record Retention

A. In accordance with Article 4 of this Addendum (Additional Record Retention and Reporting Requirements), the MA Organization shall maintain the following records regarding the Hospice Benefit Component.

B. The MA Organization shall submit reports to CMS, in a form and manner and by a deadline specified by CMS, regarding its implementation of Hospice Benefit Component. The MA Organization shall provide CMS with supplemental information upon request regarding its implementation of the Hospice Benefit Component.

5. Compliance and Enforcement

A. MA Organization shall have in place a protocol for monitoring the implementation and administration of the Hospice Benefit Component. MA Organization shall make this protocol available to CMS upon request.

B. CMS may terminate or suspend the MA Organization's implementation of Hospice Benefit Component, or take other remedial action in accordance with Article 5 of the Addendum, including without limitation if –

i. The MA Organization fails to comply with the terms and conditions of the Addendum or this Appendix 3; or

ii. CMS determines that the MA Organization's implementation of the Hospice Benefit Component might compromise the integrity of the Model.

C. CMS reserves the right to investigate MA Organization and downstream entities if there is evidence that indicates that the organization's participation in the Model is adversely impacting enrollee quality of care, and exercise all available remedies in appropriate instances, including potential termination of MA Organization or any of its downstream entities from the Model test.

D. With respect to the MA Organization implementing the Hospice Benefit Component of the model, the MA Organization must comply with all disclosure requirements set out at 42 CFR § 422.111 and include information about the Hospice Benefit Component and the benefits covered by the MA Organization as part of its participation in the Hospice Benefit Component in such mandatory disclosures. The MA Organization must make updates to the evidence of coverage for its Hospice Benefit Component VBID PBPs to reflect the change as well as propose to CMS a way to ensure Hospice Enrollees and their families or caregivers are made aware of any changes. Such notices must be in writing and must inform beneficiaries of any changes to their benefits for the next Plan Year. MA Organization must continue to cover, through discharge, Hospice Care of a non-plan enrollee if the individual was an enrollee at the time of the admission to Hospice Care. If an MA Organization chooses not to participate in a future year, MA Organizations must continue to cover, through discharge, Hospice Care furnished to an enrollee who has elected hospice in the prior year during which the MA Organization participated through the future year an MA Organization is not participating, if applicable.

E. Without limiting the foregoing, the parties agree that if CMS determines that the MA Organization has failed to comply with the terms of Article 3 of this Addendum or this Appendix 3, CMS may prohibit the MA Organization from offering the Hospice Benefit Component in one or more future Plan Years, regardless of whether the MA Organization has corrected or otherwise resolved the noncompliance.

6. Hospice Benefit Component Programmatic Waivers. Pursuant to Section 1115A(d)(1) of the Act, in its sole discretion, CMS waives the following programmatic requirements for MA Organizations participating in the Hospice Benefit Component. These waivers are granted only to the extent necessary to implement MA Organization's Approved Proposal in accordance with the Addendum and this Appendix 3. CMS may modify or rescind any or all of these waivers at any time, in its sole discretion.

a. Coverage of Medicare Hospice Benefit: Section 1852(a)(1) of the Act and 42 CFR Part 422, to the extent necessary but only to remove the exclusion of hospice care from the scope of coverage of Part A and Part B benefits that MA Organizations cover so that MA Organizations participating in the Hospice Benefit Component of the VBID Model may furnish or cover Hospice Care.

b. Hospice Capitation Rate Payment. 42 CFR § 422.320 with respect to payment to the extent necessary to permit payment to participating MAOs as provided under the Hospice Benefit Component and Appendix 3.

c. Transitional Concurrent Care Costs and The Basic Bid: Section 1854(a)(6) of the Act, and provisions in 42 CFR Part 422, subpart F that limit the basic bid to benefits covered under Original Medicare to the extent necessary to permit the basic bid to include the costs of Transitional Concurrent Care by MAOs participating in this component of the VBID Model.

d. Transitional Concurrent Care: Section 1812(d)(2)(A)(ii)(I) of the Act, to the extent necessary, with respect to waiver of payment for treatment of the individual's condition(s) with respect to which the diagnosis of terminal illness has been made, so that in-network Transitional Concurrent Care required as part of the Model may be treated as a Part A and B benefit.

e. Uniformity and Accessibility of Benefits: To be waived to the extent necessary to permit organizations to offer additional mandatory supplemental benefits to the Targeted Enrollee population, rather than to all enrollees, in the VBID PBPs participating in the Hospice Benefit Component as described in 3.G of this Appendix 3. The targeted enrollee population may be identified based on Hospice Election AND (i) one or more chronic conditions, or (ii) low income status (LIS) eligibility or (iii) a combination of both these health conditions and socioeconomic statuses.

a. Sections 1852(d)(1)(A) and 1854(c) of the Act [42 USC § 1395w-22(d)(1)(A) and § 1395w-24(c)]

b. 42 CFR. §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.102(a)(2), 422.254(b)(2), 422.262(c)(1); and

c. Section 1860D-2(a) of the Act [42 USC § 1395w-102(a)]; and 42 CFR. §§ 423.104(b)(2), 423.265(c).

f. Uniform Cost-Sharing: To be waived to the extent necessary to offer reductions in cost sharing to the targeted enrollee population, but not to all enrollees, in the VBID PBPs participating in the Hospice Benefit Component as described in 3.G of this Appendix 3. The targeted enrollee population may be identified based on Hospice Election AND (i) one or more chronic conditions, or (ii) low income status (LIS) eligibility or (iii) a combination of both these health conditions and socioeconomic statuses.

a. Sections 1852(d)(1)(A) and 1854(c) of the Act [42 USC § 1395w-22(d)(1)(A) and § 1395w-24(c)]

b. 42 CFR. §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.254(b)(2), 422.262(c)(1); and o Section 1860D-2(a) of the Act [42 USC § 1395w-102(a)]; and

c. 42 CFR. §§ 423.104(b)(2) & 423.265(c).

g. Requirements for Supplemental Benefits to Permit Coverage by a Participating MA Plan of Supplemental Benefits that are not Primarily Health Related: To be

waived to the extent necessary to allow plans to offer to the targeted enrollee population, but not to all enrollees, in the VBID PBPs participating in the Hospice Benefit Component certain additional supplemental benefits as described in 3.H of this Appendix 3 that are "non-primarily health related" supplemental benefits. Such supplemental benefits must have a reasonable expectation of maintaining or slowing the progressive decline of the health or overall function of the enrollee with regard to the chronic condition or socioeconomic status of the targeted enrollee population during Hospice Election. The targeted enrollee population may be identified based on Hospice Election AND (i) one or more chronic conditions, or (ii) LIS eligibility, or (iii) a combination of both these health condition and socioeconomic statuses. In using one or more chronic conditions to identify eligible enrollees, an applicant may propose for CMS consideration and approval a targeted population that does not meet the statutory definition of "chronically ill enrollee" in section 1852(a)(3)(D)(iii).

a. Section 1852(a)(3)(D)(i), (ii)(I) and (iii) of the Act [42 USC §§ 1395w- 22(a)(3)(D)(i), (ii)(I) and (iii)] and any implementing regulations.

h. Application of the Hospice Inpatient Cap and Hospice Aggregate Cap: Sections 1861(dd)(2) and 1814(i)(2)(A) of the Act and 42 CFR §§ 418.302 and 418.302, to the extent necessary, to remove the inclusion of Hospice Enrollees in an MA Organization's VBID PBPs that are offering the Hospice Benefit Component in the calculation of the hospice inpatient cap and the hospice aggregate cap.