ARCADIAN
COMMUNITY CARE
With you every step of the way
Provided by Arcadian Health Plan of Louisiana, Inc.

TO: **Northeast Louisiana Physician Hospital Organization**

FROM: _____

DATE: _____

RE: **Arcadian Health Plan – Medicare Advantage Coordinated Care Plan**

NORTHEAST LOUISIANA PHYSICIAN HOSPITAL ORGANIZATION has finalized a Network Medical Services Agreement with Arcadian Health Plan ("Arcadian") on behalf of the physicians, hospitals and ancillary providers in the **NORTHEAST LOUISIANA PHYSICIAN HOSPITAL ORGANIZATION** ("Network") effective _____. **NORTHEAST LOUISIANA PHYSICIAN HOSPITAL ORGANIZATION** Network providers may continue to choose to participate in Arcadian's Medicare Advantage HMO health plan product, called " ARCADIAN COMMUNITY CARE for Medicare beneficiaries by signing the attached acceptance notice. The **NORTHEAST LOUISIANA PHYSICAN HOSPITAL ORGANIZATION** is recommending - _____ providers participate in the Arcadian product so that the Medicare beneficiaries in our area can have a better option for their healthcare benefits than Original Medicare. If you would like to be a participating provider, please complete and FAX the attached **"Acceptance/Non-Acceptance Notice"** in order to participate with Arcadian.

Medicare Advantage Coordinated Care HMO Plans are very helpful to Medicare beneficiaries who need them for protection from Original Medicare's high out-of-pocket costs and the high premiums associated with supplemental Medigap policies and Private Fee-For-Service (phasing out in 2010) plans or PPOs. Furthermore, the coordinated care model helps support quality and cost-effective care for patients. Arcadian's plans offer affordable coverage and desirable benefits not covered under Medicare such as pharmacy, vision, dental and many preventive health care services including fitness center access.

What distinguishes Arcadian from other Medicare Advantage Health Plans? Arcadian Health Plan is a company founded by a physician, and dedicated to the trust and security of a community-based, local network of care. Arcadian's local staff is committed to simplifying complex Medicare options to ensure that each senior member understands and enjoys community-based, affordable health care that fits best into their lives and budget. Arcadian is considered a "value-leader" " ***and "member-centric"*** in its markets. Arcadian only offers Medicare plans, therefore Arcadian has a sole focus to be the best option for Medicare beneficiaries and the providers that care for them.

The Arcadian product replaces Original Medicare and includes all of the healthcare services offered under Original Medicare, plus additional benefits. The Annual Election Period for Medicare patients begins each November 15th and benefits are _____.

Some of the positive aspects of the Arcadian Agreement are:

- Arcadian has a focus on offering valued Medicare Advantage products in underserved, smaller to medium-sized communities.
- Arcadian offers other benefits not currently covered by Medicare such as annual physicals, vision, dental, health club membership access, and other preventative services for your patients.
- Arcadian Health Plan only requires a simple *notification* via its online Web-based system (or fax) for referral authorizations. Certain high-dollar services may require prior authorizations from Arcadian, which would be approved according to Medicare guidelines. PCP to Specialist referrals are auto-approved, requiring only a simple on-line or fax notification. There is only one claim to file and no billing to Medicare supplemental insurance companies. Providers need only collect a copay at the time of service and then submit bill to Arcadian.
- Arcadian offers fast claims payment (approx. 11 days) using Medicare rules and a free, easy to use online system to check eligibility and claims status. Arcadian will also have staff in the area to support network providers.
- Primary care physicians have the flexibility to keep their practice open to new Arcadian Medicare patients, or keep their practice open only to existing Medicare patients that choose to enroll in the Arcadian plan.
- Providers also have the opportunity to share in Arcadian's incentive bonus program included in the Network Agreement with **NORTHEAST LOUISIANA PHYSICIAN HOSPITAL ORGANIZATION**. This bonus program requires no risk or investment on the part of _____ providers. The incentive bonus program is essentially a budget surplus-sharing program that has no downside risk.

Please note, in order for you to be eligible to participate in the Arcadian Medicare Advantage Plan, you must be a "Medicare Participating Provider."

In the pages attached, you will find an "Acceptance/Non-Acceptance Notice" for the Arcadian product. Please complete the attached forms and fax to Jan Tidwell Hummel at the following fax number: 318-387-7452_____ by or before _____, so we can accurately document your decision.

If you have any questions or would like additional information please contact me at Da'Vida Williams Armstrong or visit *www.arcadianhealth.com*.

Finally, thank you for our interest in the Arcadian Medicare Advantage product offered through NORTHEAST LOUISIANA PHYSICIAN HOSPITAL ORGANIZATION

ACCEPTANCE/NON-ACCEPTANCE NOTICE
Arcadian Health Plan-Medicare Advantage

_____ {provider legal name} has reviewed the **Arcadian Health Plan ("Health Plan") Medicare Advantage Plan Participation Proposal** and reimbursement offer through _____ ("Network"), and hereby notify Network that the providers listed below;

☐ ACCEPT

☐ DO NOT ACCEPT

the offer to be a Network Provider with Network for the Health Plan product at the following reimbursement;

Service	Reimbursement Rate
Primary Care Physician/Practitioner Services	105% of Medicare Allowable
Referral (Specialty) Physician/Practitioner Services	100% of Medicare Allowable
Hospital Services	100% of Medicare
Ancillary and other Covered Services	100% of Medicare Allowable
Covered Services with no Medicare fee schedule	70% of Billed Charges

The provisions of this letter are effective as of the Commencement Date indicated in the Network Medical Services Agreement ("Agreement") between Health Plan and Network, and shall remain in effect until terminated by Health Plan or Network according to the termination provisions that exist in the Agreement. Network Provider shall remain bound to the terms of the Agreement and this letter until such time that Network Provider provides notice to terminate participation. The effective date such a termination shall not be less than one hundred twenty (120) days after advance written notice is provided by Network Provider to Network and Health Plan. This advance notification period is necessary to minimize the disruption of services to Health Plan Members. The provisions in this letter shall take precedence over any conflicting provisions that may exist in the current agreement between Network and Network Provider.

By signing below, Network Provider accepts of all terms in this letter, including the attached Medicare Advantage Regulatory Requirements in Appendix 1, and states that Network Provider is a Medicare Participating Provider. Network Provider must maintain status as a Medicare Participating Provider in order to participate with Health Plan.

NETWORK PROVIDER ENTITY LEGAL NAME: _____

BY {sign}: _____

NAME {print}: _____

TITLE: _____

ADDRESS: _____

_____

DATE: _____

TAX ID NUMBER: _____

ARCADIAN HEALTH PLAN
MEDICARE ADVANTAGE REGULATORY REQUIREMENTS
APPENDIX 1

The CMS regulatory provisions contained in this "Appendix" are made part of the Agreement between Health Plan and Provider, Hospital, Facility, Ancillary Provider, Network or Network Provider, hereafter referred to as "Provider." Provider has agreed to provide services to Medicare beneficiaries receiving coverage under Medicare Advantage agreements between the Centers for Medicare and Medicaid Services ("CMS") and Health Plan.

SECTION 1 – APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Beneficiaries. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except as required by applicable law.

SECTION 2 – DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

2.1 **Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which Health Plan is obligated to provide coverage of Covered Services for a Member.

2.2 **CMS Agreement:** A contract between the Centers for Medicare & Medicaid Services ("CMS") and Health Plan for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 **Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Member, including deductibles, coinsurance, and copayments.

2.4 **Covered Service:** A health care service or product for which a Member is entitled to receive coverage from Health Plan, pursuant to the terms of the Member's Benefit Plan with Health Plan.

2.5 **Dual Eligible Member:** A Health Plan Member who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.6 **Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by Health Plan as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act.

2.7 **Member:** A person eligible and enrolled to receive coverage from Health Plan for Covered Services.

SECTION 3 - PROVIDER REQUIREMENTS

3.1 **Data.** Provider shall cooperate with Health Plan's efforts to report to CMS all statistics and other information related to its business, as may be required or requested by CMS, including but not limited to risk adjustment data as defined in 42 CFR 422.310(a). Provider shall send to Health Plan, all risk adjustment data and other Medicare Advantage program-related information as may be requested by Health Plan in a form that meets Medicare Advantage program requirements. Provider represents to Health Plan, and upon Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful.

3.2 **Policies.** Provider shall cooperate and comply with Health Plan's policies and procedures.

3.3 **Member Protection.** Provider agrees that in no event, including but not limited to, nonpayment by Health Plan, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Health Plan Member for services provided pursuant to the Agreement or for any other fees that are the legal obligation of Health Plan under the CMS Agreement. This provision does not prohibit Provider from collecting from Health Plan Members allowable Cost Sharing. This provision also does not prohibit Provider and a Health Plan Member from

agreeing to the provision of services solely at the expense of the Member, in accordance with applicable law, that the Member's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of Health Plan insolvency or other cessation of operations or termination of Health Plan's agreement with CMS, Provider shall continue to provide Covered Services to a Member through the later of the period for which premium has been paid to Health Plan on behalf of the Member, or, in the case of Members who are hospitalized as of such period or date, the Member's discharge. This provision shall be construed in favor of the Member, shall survive the termination of the Agreement regardless of the reason for termination.

3.4 **Dual Eligible Members.** Provider agrees that in no event, including but not limited to, non-payment by a State Medicaid Agency or other applicable regulatory authority, other state source, or breach by Health Plan of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Member, person acting on behalf of the Dual Eligible Member, Health Plan (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of Health Plan as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Member, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Member from agreeing to the provision of services solely at the expense of the Dual Eligible Member, as long as Provider has clearly informed the Dual Eligible Member, in accordance with applicable law, that the Dual Eligible Member's Benefit Plan may not cover or continue to cover a specific service or services.

3.5 **Eligibility.** Provider agrees to immediately notify Health Plan in the event Provider is or becomes excluded from participation in any Federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that has been excluded from participation in any Federal or state health care program under Section 1128 or 1128A of the Social Security Act.

3.6 **Laws.** Provider shall comply with all applicable Federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) 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 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

3.7 **Federal Funds.** Provider acknowledges and agrees that Health Plan receives Federal payments under the CMS Agreement and that payments Provider receives from or on behalf of Health Plan are, in whole or in part, from Federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving Federal funds.

3.8 **CMS Agreement**. Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with Health Plans' contractual obligations under the CMS Agreement.

3.9 **Records.**
(a) Maintenance, Privacy, Confidentiality and Member Access. Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to Health Plan Member medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for at least ten (10) years or such longer period as required by law. Provider shall safeguard Members privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular Member, and shall comply with all Federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that Members have timely access to medical records and information that pertain to them, in accordance with applicable law.

b) Government Access to Records. Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, medical records, patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Agreement. This right shall extend through ten (10) years from the later of the final date of the CMS Agreement period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations. For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to Members, and any additional relevant information CMS may require.

(c) Health Plan Access to Records. Provider shall grant Health Plan or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for Health Plan to comply with its obligations under the CMS Agreement. Whenever possible, Health Plan will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place.

3.10 **MA Organization Accountability; Delegated Activities.** Provider acknowledges and agrees that Health Plan oversees and is accountable to CMS for any functions and responsibilities described in the CMS Agreement and applicable Medicare Advantage regulations, including those that Health Plan may sub-delegate to Provider. If Health Plan has sub-delegated any of its functions and responsibilities under the CMS Agreement to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Appendix:

(a) Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.

(b) If Health Plan has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by Health Plan or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by Health Plan or its designee.

(c) If Health Plan has delegated to Provider the selection of health care providers to be participating providers in the Health Plan's Medicare Advantage provider network, Health Plan retains the right to approve, suspend or terminate the participation status of such health care providers.

(d) Provider acknowledges that Health Plan or its designee shall monitor Provider's performance of any delegated activities on an ongoing basis. If Health Plan or CMS determines that Provider has not performed satisfactorily, Health Plan may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with Health Plan regarding the transition of any delegated activities or reporting requirements that have been revoked by Health Plan.

3.11 **Subcontracts.** If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Appendix, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Provider shall provide proof of such to Health Plan upon request. Provider further agrees to promptly amend its agreements with subcontractors, in the manner requested by Health Plan to meet any additional CMS requirements that may apply to the services.

3.12 **Off shoring.** Unless previously authorized by Health Plan in writing, all services provided pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories.

SECTION 4 – OTHER

4.1 **Confidentiality of Protected Health Information (HIPAA).** Health Plan and Provider each acknowledge that it is a "Covered Entity," as defined in the Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164) pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rule"). Each party shall protect the confidentiality of Protected Health Information and shall otherwise comply with the requirements of the Privacy Rule and with all other State and Federal Laws governing the confidentiality of medical information.

4.2 **Prompt Payment.** Health Plan or its designee shall promptly process and pay or deny Provider's claim within thirty (30) calendar days following receipt of a Clean Claim by Health Plan. If Provider is responsible for making payment to subcontracted providers for services provided to Health Plan Members, Provider shall pay them no later than thirty (30) days after Provider receives request for payment for those services from subcontracted providers.

4.3 **Regulatory Amendment.** Health Plan may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. Health Plan shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

PROVIDER DEMOGRAPHIC INFORMATION

*****PLEASE COMPLETE THIS FORM OR ATTACH OTHER DOCUMENT YOU MAY HAVE WITH SAME INFORMATION*****

PRACTICE NAME: _____

PRIMARY PRACTICE LOCATION			**SECONDARY PRACTICE LOCATION**		
Clinic Name:			**Clinic Name:**		
Address:	**County/Parish:**		**Address:**	**County/Parish:**	
City:	**State:**	**ZIP:**	**City:**	**State:**	**ZIP:**
Phone:	**Fax:**		**Phone:**	**Fax:**	
Email Address:			**Email Address:**		
Office Manager:			**Office Manager:**		
Authorized Agreement Signatory(ies):					

PAYMENT & BILLING INFORMATION (please complete this section if different from practice info above)			
Insurance/Billing Contact:	**Phone:**	**Fax:**	
Payment Tax Identification #:	**Group/Practice NPI:**		
Pay To Address:	**City:**	**State:**	**ZIP:**
Pay To Email Address:	**Medicare #:**	**Medicaid #:**	
Pay To Name:	**Electronic Claims Submission (Y/N):** **EDI Clearinghouse:**	**Paper (Y/N):**	

PROVIDER INFORMATION

Name of Physician or HealthCare Professional who is part of this Agreement	Title	M/F	Date of Birth	Specialty 1. Primary 2. Secondary (if applicable)	Board Certified Y/N	Accepts New Pts. Yes/No	"List All Hospitals Where Staff Privileges are Held"	1. Medical License # 2. DEA# 3. NPI# 4. CAQH	Languages Spoken (other than English)
				1.			1.	1.	
							2.	2.	
				2.			3.	3.	
							4.	4.	
				1.			1.	1.	
							2.	2.	
				2.			3.	3.	
							4.	4.	

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Name of Physician or HealthCare Professional who is part of this Agreement	Title	M/F	Date of Birth	Specialty 1. Primary 2. Secondary (if applicable)	Board Certified Y/N	Accepts New Pts. Yes/No	"List All Hospitals Where Staff Privileges are Held"	1. Medical License # 2. DEA# 3. NPI# 4. CAQH	Languages Spoken (other than English)
				1.			1.	1.	
							2.	2.	
				2.			3.	3.	
							4.	4.	
				1.			1.	1.	
							2.	2.	
				2.			3.	3.	
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				2.			3.	3.	
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				1.			1.	1.	
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				2.			3.	3.	
							4.	4.	
				1.			1.	1.	
							2.	2.	
				2.			3.	3.	
							4.	4.	