

RESOLUTION NO. 2020-407

A RESOLUTION BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, APPROVING THE TERMS, PROVISIONS, CONDITIONS, AND REQUIREMENTS OF AMENDMENT 3 TO THE SERVICES AGREEMENT BETWEEN ST. JOHNS COUNTY AND COMMUNITY BASED CARE INTEGRATED HEALTH, LLC. (CBCIH) AND AUTHORIZING THE COUNTY ADMINISTRATOR TO EXECUTE THE AGREEMENTS ON BEHALF OF THE COUNTY.

WHEREAS, CBCIH and St. Johns County wish to amend the contract, entered in to between said parties on November 17, 2014; and

WHEREAS, the purpose of this amendment is to revise requirements to conform with the amended requirements in the Vendor Services Agreement between Sunshine Health and CBCIH; and

WHEREAS, the County has reviewed the terms, provisions, conditions, and requirements of the Agreements; and

WHEREAS, the County has determined that accepting the terms of the Agreements and entering into the Agreements will serve the interests of the County.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA:

**Section 1.** The above recitals are incorporated into the body of this resolution, and are adopted as findings of fact.

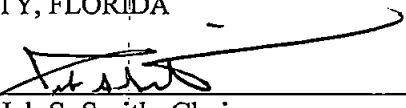
**Section 2.** The Board of County Commissioners approves the terms, provisions, conditions, and requirements of Amendment 3 between the St. Johns County and Community Based Care Integrated Health, LLC, and authorizes the County Administrator, or his designee, to execute Amendment 3 on behalf of the County.

**Section 3.** To the extent that there are typographical or administrative errors or omissions that do not change the tone, tenor, or context of this Resolution, then this Resolution may be revised, without subsequent approval of the Board of County Commissioners.

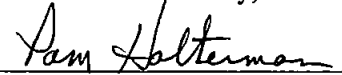
PASSED AND ADOPTED by the Board of County Commissioners of St. Johns County, Florida, this 20 day of October, 2020.

BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA

By:

  
Jeb S. Smith, Chair

Attest: Brandon J. Patty, Clerk

  
Deputy Sam Halterman  
Clerk of Circuit Court and Comptroller

RENDITION DATE 10/21/20



**FLORIDA MANAGED MEDICAL ASSISTANCE PROGRAM  
SERVICE AGREEMENT  
AMENDMENT 003**

**THIS AMENDMENT TO THE FLORIDA MANAGED MEDICAL ASSISTANCE PROGRAM SERVICES AGREEMENT** (the "Agreement"), is made by and between **COMMUNITY BASED CARE INTEGRATED HEALTH, LLC**, a Florida limited liability company ("CBCIH") and **THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY**, a political subdivision of the State of Florida ("CBC"). The Agreement is entered into and effective one hundred twenty (120) days following the latest signature date. CBCIH and CBC are sometimes referred to herein as a "Party" or collectively as the "Parties."

The primary purpose of this amendment is to revise requirements in CBC subcontracts to conform to the amended requirements in the Vendor Services agreement between Sunshine Health and CBCIH.

The parties agree to amend the Agreement by the following additions and deletions:

- 1. The Florida Managed Medical Assistance Program Services Agreement, 7. Agreement Subject to AHCA Agreement and Vendor Agreement, Page 5 is hereby amended to read:**

**7. Agreement Subject to AHCA Agreement and Vendor Agreement.** This Agreement shall be subject to the terms and conditions set forth in the Vendor Agreement between Sunshine Health and CBCIH, which is incorporated herein by reference and located at [www.cbcih.net/contract](http://www.cbcih.net/contract); the AHCA Model Health Contract between AHCA and Sunshine Health, which is incorporated herein by reference and located at [https://ahca.myflorida.com/Medicaid/statewide\\_mc/model\\_health\\_FY18-23.shtml](https://ahca.myflorida.com/Medicaid/statewide_mc/model_health_FY18-23.shtml); the Medicaid Regulatory Addendum Provider Subcontract Requirements, set forth on Exhibit D, attached hereto and incorporated herein.

- 2. The Florida Managed Medical Assistance Program Services Agreement, Exhibit A, Scope of Services, Pages 12-16, is hereby replaced in its entirety and attached hereto as page 12.**
- 3. The Florida Managed Medical Assistance Program Services Agreement, Exhibit D, AHCA Agreement Requirements, Pages 21 through 24, is hereby replaced in its entirety and attached hereto as pages 17 through 29.**

This Agreement is entered into by the following parties and effective one hundred twenty (120) days following the latest signature date.

All provisions in the agreement and any attachments thereto in conflict with this amendment are hereby changed to conform with this amendment.

All provisions in the agreement and any attachments thereto not in conflict with this amendment are still in effect and are to be performed in accordance with the level specified in the agreement.

This amendment and all its attachments are hereby made part of the **Florida Managed Medical Assistance Program Services Agreement**.

**IN WITNESS WHEREOF**, the parties hereto have caused this sixteen (16) page **Amendment 003** to be executed by their officials thereunto duly authorized.

**COMMUNITY BASED CARE INTEGRATED HEALTH, LLC**

a Florida limited liability company

TIN/EIN: 32-0405411

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Catherine Macina

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
CFO

\_\_\_\_\_  
Print Title

\_\_\_\_\_  
Date

**THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY**

a political subdivision of the State of Florida

TIN/EIN:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
County Administrator

\_\_\_\_\_  
Print Title

\_\_\_\_\_  
Date

**EXHIBIT A**  
**SCOPE OF SERVICES**

The services engaged under this agreement are considered to be delegated services from CBCIH to the CBC. Delegated services from CBCIH to the CBC must be prior approved by Sunshine Health using health plan standards and requirements which are in compliance with applicable statutes and rules. If the CBC chooses to sub-delegate services to another provider, the sub-delegated services from the CBC to the provider must be prior approved by CBCIH. CBCIH and Sunshine Health retain the right to modify, rescind or terminate at any time, any one or all delegated activities, regardless of any delegation or sub-delegation that may be approved.

CBC Lead Agencies shall identify Nurse Care Coordinator(s) and Behavioral Health Care Coordinators who perform the Healthcare Management Functions as set forth in the Vendor Agreement between Sunshine Health and CBCIH, which is incorporated herein by reference and located at [www.cbcih.net/contract](http://www.cbcih.net/contract).

- A. CBC shall maintain qualified staff and/or subcontractors who meet the following minimum staff qualifications:
- (i) Nurse Care Coordinators - Registered Nurse with current Florida nursing license with a minimum of three (3) years nursing experience, preferably in the child welfare or behavioral health care setting.
  - (ii) Behavioral Health Care Coordinator - Master's degree in a health or human services field, with a minimum of three (3) years' experience with child welfare and behavioral health services. Licensed mental health or social work professional preferred.
- CBC may request a waiver of the staff qualifications on a case-by-case basis, utilizing the Waiver Form. All such waivers are subject to approval by CBCIH.
- B. CBC represents and warrants that CBC shall at all times during this Agreement meet and maintain SH's criteria for CBC Nurse Care Coordinators and Behavioral Health Care Coordinators, which may be revised as needed.
- C. CBC shall maintain staff or subcontractors assigned as Nurse Care Coordinator(s) and Behavioral Health Care Coordinator(s) to fulfill the healthcare management functions required within this contract. If the CBC has a vacancy within either of these designated position assignments, the CBC shall notify the CBCIH of the vacancy and the plan to fill the vacant position.

## Exhibit D

### SUNSHINE HEALTH MEDICAID REGULATORY ADDENDUM PROVIDER SUBCONTRACT REQUIREMENTS

This Medicaid Regulatory Addendum is incorporated into the Agreement, and is applicable to the extent required by state and federal law.

- 1.1 Provider shall maintain hospital privileges if hospital privileges are required for the delivery of Covered Services.
- 1.2 Provider shall have a unique Florida Medicaid Provider number. Provider shall apply for a National Provider Identifier ("NPI") in accordance with Section 1173(b) of the Social Security Act, as enacted by Section 4707(a) of the Balanced Budget Act of 1997. Provider can obtain NPI(s) through the National Plan and Provider Enumerator System located at: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. Provider shall submit all NPIs for its physicians and other health care providers to Health Plan within fifteen (15) Business Days of receipt. NPIs are not required from (A) individuals or organizations that furnish atypical or nontraditional services that are only indirectly related to the provision of health care (examples include taxis, home and vehicle modifications, insect control, habilitation and respite services); and (B) individuals or businesses that only bill or receive payment for, but do not furnish, health care services or supplies (examples include billing services, repricers and value-added networks).
- 1.3 If Provider is a PCP, the following shall apply: Provider fully accepts and agrees to perform Case Management responsibilities and duties associated with the PCP designation. Provider agrees to provide or arrange for coverage of services, consultation or approval for referrals twenty-four (24) hours per day, seven (7) days per week by Medicaid enrolled providers who will accept Medicaid reimbursement. Such coverage shall consist of an answering service, call forwarding, provider call coverage or other customary means approved by Agency for Health Care Administration ("AHCA"). The chosen method of twenty-four (24) hour coverage must be accessible using the medical office's daytime telephone number. The PCP or covering medical professional must return the call within thirty (30) minutes of the initial contact. Provider agrees that its agreement to arrange for coverage of primary care services during the absences due to vacation, illness or other situations that require the PCP to be unable to provide services shall be with a Medicaid eligible PCP.
- 1.4 Provider shall meet appointment waiting time standards pursuant to the Medicaid Contract. If Provider is a PCP, Provider agrees that its services and referrals to specialists are available on a timely basis, as follows:
  - (i) urgent care-within one (1) Calendar Day;
  - (ii) routine sick patient care-within one (1) week; and
  - (iii) Well Care Visit-within one (1) month.
- 1.5 Provider represents and warrants that it is eligible for participation in the Medicaid program. Provider represents and warrants that it is not on the State or federal exclusions list. If provider is involuntarily terminated from the Medicaid program other than for purposes of inactivity, then the Provider is not considered eligible as a subcontractor under this Agreement. Provider acknowledges and agrees that all services and tasks related to the Agreement or this Product Attachment shall be performed in accordance with the terms of the Medicaid Contract.
- 1.6 Provider shall not seek payment from Covered Persons for any Covered Services provided to the Covered Person within the terms of the Medicaid Contract.

- 1.7 Provider shall look solely to the Health Plan for compensation for Covered Services rendered, with the exception of nominal cost sharing, pursuant to the State Medicaid Plan and the Florida Coverages and Limitations Handbooks.
- 1.8 Health Plan shall make no specific payment directly or indirectly under a physician incentive plan to Provider as an inducement to reduce or limit Medically Necessary services to a Covered Person. Health Plan's incentive plans shall not contain provisions which provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.
- 1.9 Require, if the subcontractor is at substantial financial risk through a physician incentive plan, have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(c)(2).
- 1.10 Provider acknowledges and agrees that any contracts, agreements, or subcontracts entered into by the Provider for the purposes of carrying out any aspect of this Agreement or Product Attachment shall include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that the contract, agreement or subcontract includes all the requirements of the AHCA Medicaid Contract.
- 1.11 Provider shall cooperate with Health Plan's peer review, grievance, QIP and Utilization Management activities. The Provider represents and warrants that all licensed providers are credentialed in accordance with Health Plan's and AHCA's credentialing requirements.
- 1.12 Provider shall immediately transfer Covered Person to another PCP if the Covered Person's health or safety is in jeopardy.
- 1.13 Nothing in this Agreement or Product Attachment shall prohibit Provider from discussing treatment or non-treatment options with Covered Persons that may not reflect the Health Plan's position or may not be covered by the Health Plan. Nothing in this Agreement or Product Attachment shall prohibit Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the Covered Person's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered. Nothing in this Agreement or Product Attachment shall prohibit Provider from advocating on behalf of the Covered Person in any Grievance System or Utilization Management process, or individual authorization process to obtain necessary health care services.
- 1.14 If this Agreement or Product Attachment terminates during the course of a Covered Person's treatment by Provider, Provider shall provide for continuity of treatment through completion of treatment of a condition for which Covered Person was receiving care at the time of termination, until the Covered Person selects another treating provider, or during the next open enrollment period. None of the aforementioned may exceed six (6) months after the termination. If a pregnant Covered Person has initiated a course of prenatal care with Provider, regardless of the trimester in which care was initiated, Health Plan shall allow Covered Person to continue care until completion of postpartum care regardless of Provider's termination. Notwithstanding the provisions of this Section 2.13, Provider may refuse to continue to provide care upon termination to a Covered Person who is abusive or noncompliant. During continuation of care following termination, Health Plan and Provider shall continue to abide by the same terms and conditions as existed in the terminated Agreement.
- 1.15 Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as a willing Provider law, as it does not prohibit the Health Plan from limiting provider participation to the extent necessary to meet the needs of the Covered Persons. This provision does not interfere

with measures established by the Health Plan that are designed to maintain quality and control costs. Health Plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

- 1.16 Provider shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Records shall be maintained for a period not less than ten (10) years from the close of the Medicaid Contract, and shall be retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the Health Plan if the contract is continuous. Provider acknowledges and agrees that the United States Department of Health and Human Services ("DHHS"), Department of Elder Affairs (DOEA), AHCA, including the Bureau of Medicaid Program Integrity ("MPI"), or Medicaid Fraud Control Unit ("MFCU"), shall have the right to inspect, evaluate, and audit all of the following related to the Medicaid Contract: pertinent books, financial records, medical records, and documents, papers, and records of any provider involving financial transactions or any other records determined to be pertinent to the AHCA Medicaid contract by DOEA, AHCA or DHSS. Upon request, and as required by State and/or federal law, Provider shall make available to DOEA, AHCA, MPI, and/or MFCU any and all administrative, contractual, financial and medical records relating to the delivery of items or services for which Medicaid monies are expended. Upon request, and as required by State and/or federal law, Provider shall also allow access to DOEA, AHCA, MPI and/or MFCU to any place of business and all medical records. DOEA, AHCA, MPI and/or MFCU shall have access during normal business hours, except under special circumstances when DOEA, AHCA, MPI, and/or MFCU shall have after-hour admission. DOEA, AHCA, MPI and/or MFCU shall determine the need for special circumstances. Provider shall provide Covered Services, as set forth in Exhibit 1, Scope of Services, to Covered Persons in accordance with the Medicaid contract.

Provider and Contracted Provider(s) shall comply with audit and record keeping requirements to comply with public record laws as outlined in Section 119.0701, F.S.

- 1.17 Provider shall comply with Health Plan's cultural competency plan. Health Plan and Provider shall encourage the use of minority business enterprises.
- 1.18 Provider acknowledges and agrees that any marketing materials related to the Medicaid Contract and distributed by Provider shall be submitted to AHCA for written approval before use. All subcontracts specify that the subcontractor shall comply with the marketing requirements specified in Section IV., Marketing.
- 1.19 Health Plan shall require co-branding on all communications with enrollees and providers to ensure it is clear that the Health Plan is aware of and endorses the content contained within the communication.
- 1.20 Provider shall submit all reports and clinical information required by the Health Plan, including Child Health Check-Up reporting, if applicable.
- 1.21 If Provider is transitioning Covered Persons, Provider shall cooperate in all respects with other providers, including providers of other Health Plans if necessary, to assure maximum health outcomes for Covered Persons.
- 1.22 Provider shall submit notice of withdrawal from Health Plan's network at least ninety (90) Calendar Days prior to the effective date of such withdrawal.

- 1.23 Provider shall notify Health Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under State law.
- 1.24 Provider shall offer hours of operation that are no less than the hours of operation offered to commercial Health Plan members or comparable Fee for Service recipients if Provider serves only Medicaid Recipients.
- 1.25 Pursuant to 42 CFR 438.224 [Confidentiality], Provider shall safeguard information about Covered Persons. Provider shall also comply with federal HIPAA privacy and security provisions. Health Plan shall document compliance certification testing of transaction compliance with HIPAA for any subcontractor receiving enrollee data.
- 1.26 Provider acknowledges and agrees that neither Medicaid Recipients nor AHCA shall be held liable for any debts of Provider. This provision shall survive termination of the Agreement and/or this Product Attachment, including termination of the Agreement due to insolvency.
- 1.27 Provider shall indemnify, defend and hold AHCA and Health Plan's Covered Persons harmless from and against all claims, damages, causes of action, costs or expense, including court costs and reasonable attorney fees to the extent proximately caused by any negligent act or other wrongful conduct. Provider acknowledges that this provision shall survive the termination of the Agreement and/or this Product Attachment. AHCA may waive this requirement for itself, but not Health Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by AHCA.
- 1.28 If the Provider is a public health entity with statutory immunity, AHCA may waive this hold harmless requirement for itself, but not for Health Plan's Covered Persons, for damages in excess of the statutory cap on damages for public entities (all such waivers must be approved in writing by AHCA).
- 1.29 Provider shall secure and maintain during the life of this Agreement and Product Attachment workers' compensation insurance (complying with the Florida's Workers' Compensation Law) for all of its employees connected with the work under the Medicaid Contract unless such employees are covered by the protection afforded by the Health Plan.
- 1.30 Provider acknowledges and agrees that any provisions of the Agreement that are in conflict with the specifications of the AHCA Medicaid Contract shall be waived as they pertain to Medicaid Recipients.
- 1.31 Nothing in this Agreement or Product Attachment shall in any way prohibit or restrict Provider from entering into a commercial contract with any other health plan. Nothing in this Agreement or Product Attachment shall require Provider to contract for more than one (1) Health Plan product or otherwise be excluded. Nothing in this Agreement or Product Attachment shall prohibit Provider from providing inpatient services in a contracted hospital to a Covered Person if such services are determined to be Medically Necessary and Covered Services under the Medicaid Contract.
- 1.32 Provider shall cooperate fully in any investigation by AHCA, MPI, MFCU, DOEA or any other state or federal entity or subsequent legal action that may result from such an investigation.
- 1.33 In addition to any other right to terminate under this Agreement, and notwithstanding any other provision of the Medicaid Contract, Provider acknowledges and agrees that AHCA or Health Plan may request immediate termination of this Agreement and/or Product Attachment if, as determined

by AHCA, Provider fails to abide by the terms and conditions of this Agreement and Product Attachment, or in the sole discretion of AHCA, Provider fails to come into compliance with this Agreement and Product Attachment within fifteen (15) Calendar Days after receipt of notice from Health Plan specifying such failure and requesting Provider to abide by the terms and conditions thereof.

1.34 Provider shall utilize the applicable appeals procedures outlined in the Agreement if Provider is terminated for any reason. Provider acknowledges and agrees that no additional or separate right of appeal to AHCA or the Health Plan is created as a result of Health Plan's act of terminating, or decision to terminate Provider under the Medicaid Contract.

1.35 Provider shall comply with the following marketing requirements. Provider may give out health plan brochures at health fairs or in its own offices comparing benefits of different health plans; however, Provider cannot orally compare benefits among health plans, unless marketing representatives from each health plan are present. Provider may co-sponsor events, such as health fairs and cooperatively market and advertise with health plans in indirect ways such as television, radio, posters, fliers, and print advertisement.

Provider may announce a new affiliation with a health plan or give a list of health plans with which it contracts to its patients. Provider shall not furnish lists of its Medicaid Recipients to health plans with which it contracts, or any other entity, nor shall Provider furnish other health plans membership lists to any health plan, nor shall Provider take applications in its offices.

1.36 Health Plan and Provider shall make prompt submission of information needed to make payment. Provider shall mail or electronically transfer (submit) claims to Health Plan within six (6) months of:

- (i) the date of services of discharge from an inpatient setting; or
- (ii) the date on which Provider is furnished with the correct name and address of the Covered Person's Health Plan. When Health Plan is the secondary Payor, Provider shall submit the claim to the Health Plan within ninety (90) days of the final determination of the primary Payor. Health Plan agrees to make payment to Participating Health Care Providers and Network in accordance with applicable State and federal laws, rules and regulations, including but not limited to, s.409.967, F.S., s. 409.975(6) F.S., s. 409.982, F.S., s. 641.3155, F.S., 42 CFR 238.230, 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (d)(5) and (d)(6). All subcontracts for claims adjudication activities shall comply with 42 CFR 438.8(k)(3).
- (iii) In addition to the requirements set forth in Section 2.36(ii) immediately, above, all model and executed subcontracts and amendments used by the Health Plan under this Agreement and Medicaid Contract shall meet the following requirements: (i) identification of conditions and method of payment; (ii) provide for prompt submission of information needed to make payment; and (iii) provide for full disclosure of the method and amount of compensation or other consideration to be received from the Health Plan; Require any claims processing vendors to maintain accurate enrollee and provider information, including provider agreements reflecting the correct reimbursement rate and provider specialty, to ensure the correct adjudication of claims and proper payment to providers; (iv) require any payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Health Plan; (v) require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Health Plan; and (vi)

specify that the Health Plan shall assume responsibility for cost avoidance measures for third-party collections in accordance Section XII., Financial Requirements.

- 1.37 If Provider is a hospital, Provider shall notify Health Plan of births where the mother is a Covered Person. The Health Plan is responsible for completing the Department of Children and Family Services (DCF) Excel spreadsheet for unborn activation and include Provider-Preventable Conditions (PPC) reporting requirements to DCF.
- 1.38 Provider acknowledges and agrees this Agreement complies with 42 CFR 438.230, 42 CFR 438.3(k), 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106 and all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and Medicaid Contract provisions, and any other applicable State or federal law.
- 1.39 Health Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with Section XII, Financial Requirements of the AHCA Medicaid contract.
- 1.40 Health Plan, AHCA and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed by Provider or Network.
- 1.41 Provider agrees that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Health Plan Covered Person. (42 CFR 438.210(e))
- 1.42 Provider agrees to immediately notify the Health Plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims, or otherwise.
- 1.43 Provider agrees that all direct service providers will complete abuse, neglect, and exploitation training.
- 1.44 Health Plan shall, with any claims payment to Provider, include an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of the Health Plan.
- 1.45 Provider shall comply with the background screening requirements of the Health Plan's contract with AHCA in accordance with s. 408.809, F.S.
- 1.46 If Provider is approved by the Health Plan to provide services through telemedicine, the provider shall have protocols in place to prevent fraud and abuse that address at a minimum; the authentication and authorization of users; the authentication of the origin of the information; the prevention of unauthorized access to the system or information; system security, including the integrity of information that is collected, program integrity and system integrity; and maintenance of documentation about system and information usage.
- 1.47 If the Provider is a nursing facility and/or hospice, the bed hold days provision shall comport with the Medicaid FFS bed hold days policies and procedures.
- 1.48 If Provider is a Hospital, in addition to the requirements s.409.967 F.S., the rates shall be in accordance with s.409.975(6), F.S.

- 1.49 Claims or Encounter Submission. Provider or Contracted Provider shall submit to Payor claims or encounters for Covered Services in accordance with the Provider Manual. Payor reserves the right to deny payment to Provider or Contracted Provider if Provider or Contracted Provider fails to submit in accordance with the Provider Manual. If applicable, based on Provider and Contracted Provider's compensation arrangement, Provider or Contracted Provider shall submit encounter data to Payor in a timely fashion, which shall contain such statistical and descriptive medical and patient data and identifying information as specified in the Provider Manual. Encounter Data - All model and executed subcontracts and amendments used by the Health Plan under this Agreement and Medicaid Contract shall require subcontractors to submit timely, complete and accurate encounter data to the Health Plan in accordance with the requirements of Section X.D., Information Management Systems.
- 1.50 Compensation. Payor shall pay Clean Claims from Provider or Contracted Provider for Covered Services provided to Covered Persons in accordance with the applicable exhibit less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility.
- 1.51 Covered Person Hold Harmless. Provider and Contracted Provider agree that in no event including, but not limited to, non-payment by Health Plan, Health Plan insolvency, or breach of this Agreement, shall Provider or Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or other amounts that are the Covered Person's financial responsibility. This provision shall survive termination or expiration of this Agreement for any reason, shall be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between the Provider or Contracted Provider and a Covered Person.
- 1.52 Health Plan shall delegate those administrative functions outlined in a separate attachment. If such attachment is not executed, no administrative functions shall be deemed as delegated. Initial delegation and delegation renewal will be subject to review, on an ongoing basis, and approval of Provider's performance of delegated administrative functions and compliance by Provider of all Health Plan and regulatory guidelines. Health Plan retains the right to approve, suspend, or terminate delegated functions. Failure of Provider to perform delegated administrative functions, including delegated credentialing activities, in compliance with Health Plan's policies and procedures as determined by AHCA, CMS, or Health Plan, shall result in revocation of delegation or imposition of other sanctions for one or all of the administrative functions that have been delegated. Provider acknowledges and agrees that its agreements with subcontractors are subject to review and approval by Health Plan, CMS, State and other applicable regulatory agencies. Any services or other activity performed by related entity, contractor, subcontractor, or first-tier or downstream entity of the Provider, in accordance with this contract, are consistent and comply with the Health Plan's contractual obligations.

The Health Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement and Medicaid Contract, and may, delegate performance of work required under this Agreement and Medicaid Contract to a subcontractor. The Health Plan shall submit any proposed delegation to AHCA for prior written approval. The Health Plan shall submit all subcontracts for Agency review at least ninety (90) days before the proposed effective date of the subcontract or change. If the submission is for management of a covered service, the Health Plan shall include the following in its submission to AHCA in a manner prescribed by AHCA:

- (i) Draft subcontract that complies with subcontract requirements specified in this section, AHCA Standard Contract, 42 CFR 438.230(c)(1)(i), and 42 CFR 438.3(k);
- (ii) Test PNV file as proof of provider network adequacy;

- (iii) Copy of applicable licensure, if appropriate;
  - (iv) Enrollee materials;
  - (v) Population covered by the subcontract;
  - (vi) Provider materials;
  - (vii) Model provider agreement template as specified in Section VIII., Provider Services; and
  - (viii) Approximate number of impacted enrollees.
- 1.53 No subcontract that the Health Plan enters into with respect to performance under the contract shall, in any way, relieve the Health Plan of any responsibility for the performance of duties under this contract. The Health Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of this contract and shall provide AHCA with its monitoring schedule annually by December 1. All executed subcontracts and amendments used by the Health Plan under this contract shall be in writing, signed, and dated by the Health Plan. The Health Plan shall identify in its subcontracts any aspect of service that may be further subcontracted by the subcontractor.
- 1.54 If Provider is a Hospital or Crisis Stabilization Unit (CSU), pursuant to Section 2702 of the Patient Protection and Affordable Care Act (ACA), the Florida Medicaid State Plan and 42 CFR Sections 434.6(12), 438.6(f) and 447.26, the Health Plan is prohibited from making payments for any amounts expended for provider-preventable conditions (PPCs). Provider is required to identify and report all PPCs to Health Plan in the claims submissions.
- 1.55 If AHCA determines, at any time, that a subcontract is not in compliance with a Medicaid Contract requirement, the Health Plan shall promptly revise the subcontract into compliance. In addition, the Health Plan may be subject to sanctions pursuant to Section XI, Sanctions, and/or liquidated damages pursuant to Section XII, Liquidated Damages, as determined by AHCA.
- 1.56 Provider to comply with Section 274A (e) of the Immigration and Nationality Act, AHCA will consider the employment of any contractor of unauthorized aliens a violation of this Act. If the Provider knowingly employs unauthorized aliens, such a violation shall be cause for unilateral cancellation of this Agreement and Medicaid Contract. The Provider shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Agreement and Medicaid Contract.
- 1.57 Provider to comply with The Immigration Reform and Control Act of 1986, which prohibits employers from knowingly hiring illegal workers. The Provider shall only employ individuals who may legally work in the United States (U.S.) - either U.S. citizens or foreign citizens who are authorized to work in the U.S. The Provider shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, <https://e-verify.uscis.gov/emp>, to verify the employment eligibility of all new employees hired by the Provider during the term of this Agreement and Medicaid Contract and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to this Agreement and Medicaid Contract.
- 1.58 The Health Plan shall not delegate provider network management to a subcontractor that meets both of the following: (i) the subcontractor is owner or has controlling interest in any provider(s) included in the network; and (ii) the subcontractor limits enrollee choice of network providers through a requirement for a referral/authorization process to access network providers.
- 1.59 Provider to comply with reporting its financial status (i.e. periodic financial reporting, financial statements) to the Health Plan through quarterly unaudited and annually audited financial statements. The quarterly unaudited financial statements shall be submitted to the Health Plan within (60) days

of the end of the quarter and annual audited financial statements shall be submitted within one hundred twenty (120) days of the end of the year.

Health Plan's contract with AHCA requires that Health Plan provide, upon request, copies of the financial statements, including documentation of the Health Plan's financial review. Failure to obtain required financial statement shall result in liquidated damages as specified in Section XIV, Liquidated Damages.

- 1.60 Require, if the subcontractor is at financial risk and/or is delegated to process and pay claims, the subcontractor shall maintain a surplus account to meet its obligations.
- 1.61 Require the subcontractor to maintain an insolvency account to meet its obligations. The insolvency account shall be funded in an amount equal to two percent (2%) of the annual contract value. In the event that the subcontractor has filed for bankruptcy or has otherwise been determined to be insolvent by a regulating entity, the insolvency account may be drawn upon solely by the Health Plan to disburse funds to meet Medicaid financial obligations incurred by the subcontractor under the contract between the Health Plan and subcontractor. Documentation of the insolvency account, including account balances and governing agreements, shall be provided to AHCA upon request. Failure to establish a required insolvency account shall result in liquidated damaged in accordance with Section XIV, Liquidated Damages.
- 1.62 Require that the subcontractor timely notify the Health Plan of changes in directory information.
- 1.63 Monitoring and Inspections. All model and executed subcontracts and amendments used by the Health Plan under this Agreement and Medicaid Contract shall meet the following requirements with respect to provisions for monitoring and inspections:
  - (i) Provide that AHCA, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate, or inspect the subcontractor's premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's subcontractor, pertaining to any aspect of services and activities performed, or determination of amounts payable under the Health Plan's Contract with the State. In accordance with 42 CFR 438.230(c)(3)(iii), the subcontractor shall agree that the right to audit exists through ten (10) years from the final date of this Agreement and Medicaid Contract period or from the date of completion of any audit, whichever is later;
  - (ii) Provide that the subcontractor shall make available for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Medicaid enrollees pertinent to this Agreement and Medicaid Contract by AHCA, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS; (42 CFR 438.3(h); s. 1903(m)(2)(A)(iv) of the Social Security Act)
  - (iii) Require full cooperation in any investigation by AHCA, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, DOEA, or other State or federal entity or any subsequent legal action that may result from such an investigation.
  - (iv) In addition to record retention requirements for practitioner or provider licensure, require subcontractors to retain, as applicable, the following information in accordance with 42 CFR 438.3(u): enrollee grievance and appeal records in 42 CFR 438.416; base data in 42 CFR 438.5(c); MLR reports in 42 CFR 438.8(k); and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period not less than ten (10) years from the close of this Agreement and Medicaid Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by

- the Health Plan if the subcontract is continuous.); (42 CFR 438.3(h))
- (v) Provide for monitoring and oversight by the Health Plan and the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the Health Plan's and AHCA's credentialing requirements as found in Section VIII., Provider Services, if the Health Plan has delegated the credentialing to a subcontractor;
  - (vi) Provide for monitoring of services rendered to Health Plan enrollees through the subcontractor.
- 1.64 All subcontracts must contain provisions wherein the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with Section XVI., Reporting Requirements, and the SMMC Report Guide.
- 1.65 Provide that the subcontractor shall establish, enforce, and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.
- 1.66 Health Plan's contract with AHCA requires the Health Plan to advise AHCA, within two (2) days of discovery, if based on the Health Plan's review of financial statements or other information, of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor. Provider and Contracted Provider(s) shall comply with the aforementioned requirement by immediately notifying the Health Plan pursuant to all of the applicable terms and conditions of the Agreement, including, but not limited to, Section 2.12 (Notice of Certain Events) and Section 8.11 (Notices) of the Agreement.
- 1.67 Health Plan's contract with AHCA requires subcontracts with providers shall ensure that providers are obligated to cooperate with recovery efforts, including participating in audits and repay overpayments. Provider and Contracted Provider(s) shall comply with and be obligated to cooperate with recovery efforts, including participating in audits and repay overpayments.
- 1.68 If Provider is a Pharmacy Benefit Manager (PBM), Health Plan's contract with AHCA requires the Health Plan to transfer accurate and complete encounter prescription data, including actual amounts paid to the provider, within forty-five (45) days of PBM implementation. Provider acknowledges that the transfer of prescription data is required by the ACA and that AHCA will invoice pharmaceutical manufacturers for federal rebates mandated under federal law, and for supplemental rebates negotiated by AHCA according to s. 409.912(8)(a)7, F.S. Failure to provide the necessary data to AHCA may cause the Health Plan to be subject to sanctions, application of liquidated damages, or reduction of capitation payments in the amount of estimated combined federal and supplemental rebates. Failure to provide claim and provider information that assists AHCA in dispute resolution between AHCA and a drug manufacturer regarding federal drug rebates, and that prevents AHCA from collecting drug rebates, may result in AHCA recouping any determined uncollected rebates from the Health Plan.
- 1.69 If Provider is the Fiscal/Employer Agent (F/EA), Provider shall provide enrollees with at least thirty (30) days' notice informing them that the Health Plan shall utilize Provider to perform certain F/EA duties. Provider shall perform all F/EA responsibilities as specified in the Participant Direction Option Manual, as provided by AHCA.

#### **FALSE CLAIMS ACT INFORMATION**

Employees, subcontractors, providers and agents of the Provider must comply with the Federal False Claims Act ("FCA"). The following sets out information regarding the FCA, penalties for violating the FCA, protections for "whistleblowers" under the FCA, and the law's role in preventing and detecting fraud, waste and abuse and the responsibility of all employees, subcontractors, providers and agents of the Provider relating to detection and prevention of FCA violations.

Summary of the FCA. The federal False Claims Act ("FCA") is one of several laws the federal government has implemented to prevent and detect fraud, abuse and waste in federal health care programs (31 U.S.C. 3729 through 3733). The FCA applies to claims presented to federal health care programs for payment and permits the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. The FCA provides that anyone who "knowingly" presents, or causes to be presented, a "false or fraudulent claim" is liable for damages up to three (3) times the amount of the erroneous payment, mandatory penalties for each claim submitted, and administrative remedies such as exclusion from future participation in government health care programs. The FCA prohibits retaliation against any teammate that reports any actual or potential violation of the FCA.

What the FCA Prohibits. The FCA prohibits persons from making any type of fraudulent claim for payment to the federal government. Specifically, the False Claims Act prohibits persons from:

- (i) Knowingly presenting, or causing the presentation of, a false or fraudulent claim for payment or approval by the federal government (including any federal health care program);
- (ii) Knowingly making, using, or causing a false record or statement to get a false or fraudulent claim paid or approved by the federal government;
- (iii) Conspiring to defraud the federal government by getting a false or fraudulent claim allowed or paid; or
- (iv) Knowingly making, using, or causing a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government.

For purposes of the FCA, "knowing" and "knowingly" mean that a person, with respect to information:

- (i) has actual knowledge of the information;
- (ii) acts in deliberate ignorance of the truth or falsity of the information; or
- (iii) acts in reckless disregard of the truth or falsity of the information.

While the FCA imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false, and no proof of specific intent to defraud is required. A person who acts in "reckless disregard" or in "deliberate ignorance" of the truth or falsity of the information also can be found liable under the FCA. In sum, the FCA imposes liability on any person who submits a claim to the federal government or to the state Medicaid program (including Health Plan) when the person knows (or should know) the claim is false. An example may be a physician who submits a bill to Medicare for medical services he/she knows has not been provided.

The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor, such as Health Plan, or its subcontracted vendors who submits records that he/she knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

The third area of liability includes those instances in which someone may obtain money from the federal government or the Health Plan program to which he may not be entitled, and then uses false statements or records in order to retain the money.

Penalties for Violations of the FCA. Each false claim violation under the FCA may be punishable by civil penalties between \$5,000 and \$10,000, plus three times the amount of the damages sustained by the government.

Information Regarding State and Federal Whistleblower Protections. Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against with respect to the terms and conditions of employment as a result of initiating a qui tam relator action under the False Claims

Act, or otherwise assisting in the investigation or litigation of a False Claims Act violation, may be entitled to certain remedies from his or her employer. Such remedies include reinstatement at the same seniority status that such employee would have had but for the allegedly discriminatory actions of the employer; payment of twice the amount of backpay accrued by the employee; and compensation for any special damages sustained by the employee as a result of the discrimination, including litigation costs and reasonable attorney's fees.

Preventing, Detecting and Reporting Fraud, Waste, and Abuse. Health Plan is strongly committed to detecting and preventing fraud, waste, and abuse. To this end, Health Plan has adopted an active Compliance and Ethics Program and operates under a code of conduct. The Health Plan compliance program requires compliance with both legal requirements and ethical standards and is composed of the following key elements:

- (i) Support for the program comes from the highest levels of the organization.
- (ii) A Compliance Officer leads Health Plan's compliance efforts.
- (iii) A Compliance and Ethics Program sets forth Health Plan's expectations concerning compliant behavior and there are policies and procedures that support the compliance effort and address key compliance areas.
- (iv) The program provides for safe, secure, and confidential reporting mechanisms to report employee concerns (anonymously, if requested) and to seek guidance on compliance issues.
- (v) The program provides for training employees, providers, subcontractors, and related parties on the elements of the program.
- (vi) There is an effective system of internal controls to monitor compliance efforts.
- (vii) The program calls for an on-going compliance risk assessment and annual assessment and renewal of the compliance program.

All Health Plan employees, subcontractors, providers and agents are required to act in a manner consistent with the requirements of the Health Plan Compliance and Ethics Program and to review the Health Plan Code of Conduct issued by the Health Plan Compliance Office, the principles and requirements of which apply to all dealings with Health Plan.

Should any Health Plan employee, subcontractor, provider or agent (or employee of the same) obtain information that reasonably leads it, him, or her to believe there has or may have been a violation of law or of Health Plan's compliance program by Health Plan or any of its employees, subcontractors, providers or agents, such person must promptly report and disclose the same to the Health Plan Compliance Office and provide such office with all information related to such belief. Such person also must cooperate with the Compliance Office in any audit or investigation instituted by Health Plan related to any compliance matters or other actions taken pursuant to Health Plan's compliance program. Health Plan prohibits any form of retaliatory conduct or action against any employee or person who reports any compliance violation or concern pursuant to Health Plan's compliance program.

The Health Plan Compliance Office has a toll-free hotline for compliance reporting and for reporting potential fraud, abuse and waste. Any report may be made anonymously, if desired. All reports to the Health Plan Compliance Office are treated as confidential to the greatest extent possible. Further, all forms of information received, transmitted, discussed, or archived by the Health Plan Compliance Office, including but not limited to, verbal and written communications, documents, reports, correspondence, network transmissions, and electronically or magnetically stored data are treated as confidential information.

Provider Responsibilities. Provider shall ensure that Health Plan policies related to this Amendment are available to all employees, including management, as well as all subcontractors, providers and agents. Should any Provider employee, subcontractor, provider or agent (or employee of the same) obtain information that reasonably leads it, him, or her to believe there has or may have been a violation of the

FCA or of Health Plan's compliance program by Provider or any of its employees, subcontractors, providers or agents, such person must promptly report and disclose the same to the appropriate individual at the Provider, who shall report the same, along with all information related to such belief, to the Health Plan. Provider also must cooperate with the Health Plan in any audit or investigation instituted by Health Plan related to any compliance matters or other actions taken pursuant to Health Plan's compliance program. Health Plan prohibits any form of retaliatory conduct or action against any employee or person who reports any compliance violation or concern pursuant to the program.

In addition to the False Claims Act Information provisions set forth above, with respect to Section 6032 of the federal Deficit Reduction Act of 2005, the following are required (42 CFR 438.608(a)(6); s. 1902(a)(68) of the Social Security Act):

i. PROGRAM INTEGRITY REQUIREMENTS UNDER THE CONTRACT (438.608(a)(6)).

ADMINISTRATIVE AND MANAGEMENT ARRANGEMENTS OR PROCEDURES TO DETECT AND PREVENT FRAUD, WASTE AND ABUSE. THE STATE, THROUGH ITS CONTRACT WITH THE MCO, PIHP OR PAHP, MUST REQUIRE THAT THE MCO, PIHP, OR PAHP, OR SUBCONTRACTOR TO THE EXTENT THAT THE SUBCONTRACTOR IS DELEGATED RESPONSIBILITY BY THE MCO, PIHP, OR PAHP FOR COVERAGE OF SERVICES AND PAYMENT OF CLAIMS UNDER THE CONTRACT BETWEEN THE STATE AND THE MCO, PIHP, OR PAHP, IMPLEMENT AND MAINTAIN ARRANGEMENTS OR PROCEDURES THAT ARE DESIGNED TO DETECT AND PREVENT FRAUD, WASTE, AND ABUSE. THE ARRANGEMENTS OR PROCEDURES MUST INCLUDE THE FOLLOWING: IN THE CASE OF MCOS, PIHPs, OR PAHPs THAT MAKE OR RECEIVE ANNUAL PAYMENTS UNDER THE CONTRACT OF AT LEAST \$5,000,000, PROVISION FOR WRITTEN POLICIES FOR ALL EMPLOYEES OF THE ENTITY, AND OF ANY CONTRACTOR OR AGENT, THAT PROVIDE DETAILED INFORMATION ABOUT THE FALSE CLAIMS ACT AND OTHER FEDERAL AND STATE LAWS DESCRIBED IN SECTION 1902(A)(68) OF THE ACT, INCLUDING INFORMATION ABOUT RIGHTS OF EMPLOYEES TO BE PROTECTED AS WHISTLEBLOWERS.

ii. STATE PLANS FOR MEDICAL ASSISTANCE (42 CFR 438.608 (A) (6); s. 1902 (A) (68) of the Social Security Act).

A STATE PLAN FOR MEDICAL ASSISTANCE MUST PROVIDE THAT ANY ENTITY THAT RECEIVES OR MAKES ANNUAL PAYMENTS UNDER THE STATE PLAN OF AT LEAST \$5,000,000, AS A CONDITION OF RECEIVING SUCH PAYMENTS, SHALL:

(i) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code[33], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));

(ii) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(iii) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.