FLORIDA SMMC PROGRAM REQUIREMENTS

1. Participation in Florida Contracts. Subject to and in accordance with the terms and conditions of the Provider Services Agreement, including these Requirements, Contracted Provider shall participate in Benefit Plans offered or administered by Health Plan under Florida Contracts (as defined below).

2. Compensation for Covered Services provided to Members of Benefit Plans under Florida Contracts is set forth in the Provider Services Agreement.

3. Additional Definitions.

   a. "**AHCA**" means the Florida Agency for Health Care Administration.

   b. "**Children's Medical Services Managed Care Plan**" means a specialty plan for children with chronic conditions operated by the Florida Department of Health's Division of Children's Medical Services as specified in section 409.974(4), Florida Statutes. The Children's Medical Services Managed Care Plan may also be referred to herein as the "CMS Plan".

   c. "**Emergency Behavioral Health Services**" means those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination, and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

   d. "**Emergency Medical Condition**" means: (i) a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following: (A)serious jeopardy to the health of a patient, including a pregnant woman or fetus; (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part; and (ii) with respect to a pregnant woman: (A) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (B) that a transfer may pose a threat to the health and safety of the patient or fetus; (C) that there is evidence of the onset and persistence of uterine contractions or rupture of membranes.

   e. "**Emergency Services**" means medical screening, examination, and evaluation by a physician, or if applicable, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a hospital.

   f. "**Florida Contract**" means a contract between AHCA (directly or indirectly) and Health Plan for Health Plan to provide or arrange for the provision of health care items and services and/or long term care services to enrollees in Florida's Statewide Medicaid Managed Care Program, including Comprehensive and Specialty plans, such as the CMS Plan. A copy of the Statewide Medicaid Managed Care Program model contract is available on AHCA's website. A Florida Contract is a Government Contract as defined in the Provider Services Agreement.

   g. "**LTC**" means the Long Term Care program under the Florida Statewide Medicaid Managed Care program.

h. "**Medicaid Member**" or "**Member**" means an individual enrolled in a Benefit Plan issued by Health Plan pursuant to a Florida Contract and eligible to receive Covered Services at the time such services are rendered.

i. "**Medically Necessary**" or "**Medical Necessity**" means medical or allied care, or long term care, goods or services and must meet the following conditions:

- be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
- be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- be furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the provider.

i. For those services furnished in a hospital on an inpatient basis, Medical Necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

ii. The fact that a provider has prescribed, recommended or approved medical, allied goods or long-term care services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a covered service/benefit.

j. "**MMA**" means the Managed Medical Assistance program under the Florida Statewide Medicaid Managed Care program.

k. "**PPC**" or "**Provider Preventable Conditions**" means a condition that meets the definition of a health care-acquired condition or other provider-preventable condition as defined in 42 CFR 447.26(b), and include such conditions in inpatient hospital and inpatient psychiatric hospital settings, including crisis stabilization units.

4. All provisions of the Provider Services Agreement and these Requirements are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between these Requirements and any part of the Provider Services Agreement, the provisions of this document shall prevail with respect to the Program describedherein. Contracted Provider agrees to include the terms contained in this Program Requirements document in its contracts with Providers and subcontractors. Any obligation of Contracted Provider herein shall apply to Providers to the same extent that it applies to Contracted Provider. Any rights or obligations herein that pertain to AHCA for the SMMC programs shall be deemed to include, in addition to AHCA, all Governmental Authorities such as the Florida Department of Health and the CMS Plan, to the extent necessary to comply with the Florida Contract.

5. Compliance.

a. Contracted Provider shall comply, and take all steps necessary to cause such employees, independent contractors and subcontractors to comply, with (i) all applicable Laws, including applicable Medicaid laws and regulations and sub-regulatory guidance, 42 CFR § 438.230, 42 CFR

§ 438.3(k), 42 CFR § 455.104, 42 CFR § 455.105 and 42 CFR § 455.106; F.S.A. §§ 641.315, 641.3155, and 641.234, F.S.A. §20.055 (cooperation with OIG investigations), and F.S.A. §119.0701 (public records laws), the Florida Security of Communications Act (F.S.A. §§ 934.01, et seq), and the Electronic Communications Privacy Act, 18 USC 2510 et seq; (ii) directives from AHCA or another Governmental Authority; and (iii) the Florida Contract.

b. A Provider Services Agreement shall terminate if, pursuant to §641.234, Florida Statutes, as amended, the Florida Office of Insurance Regulation or other Governmental Authority orders the Health Plan to cancel or terminate such Provider Services Agreement.

c. In accordance § 641.315, Florida Statutes, Contracted Provider shall provide at least 60 days' advance notice to the Florida Office of Insurance Regulation before terminating its Provider Services Agreement in accordance with the termination provisions set forth in the Provider Services Agreement, for any reason. Nonpayment of goods or services rendered by the Contracted Provider or Provider to the Health Plan is not a valid reason for avoiding the 60-day advance notice of termination. Health Plan shall provide the Florida Office of Insurance Regulation 60 days' advance written notice before terminating the Provider Services Agreement without cause, except in a case in which the Member's health is subject to imminent danger or a Provider's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

6. Florida Contract Core Requirements.

a. Providers rendering Emergency Services shall make a reasonable attempt to notify Health Plan within 24 hours of the Member presenting for Emergency Behavioral Health Services or within 24 hours of learning the Member's identity.

b. Health Plan shall comply with all AHCA requirements for submission of this Agreement to AHCA for contract review and approval submission. If AHCA determines, at any time, that a Providers Services Agreement is not in compliance with the Florida Contract, Health Plan shall promptly amend it, upon notice to Contracted Provider, to bring it into compliance with the Florida Contract.

c. Nothing in a Provider Services Agreement shall prohibit Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is the Provider's patient regarding: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that might be self-administered; (ii) any information the Member needs to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; and (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (42 CFR 438.102(a)(1))

d. Nothing in a Provider Services Agreement shall prohibit Provider from advocating on behalf of a Member in any part of the grievance and appeal system or utilization management (UM) process, or individual authorization process to obtain necessary services (42 CFR 438.402(c)(1)(i)-(ii); 42 CFR 438.408).

e. Provider shall maintain hours of operation that are no less than the hours of operation offered to commercial health plan members or comparable Medicaid fee-for-service recipients if Provider serves only Medicaid recipients (42 CFR 438.206(c)(1)).

f. Provider shall ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Members with special health care needs, including physical or mental disabilities in accordance with 42 CFR 438.206(c)(3).

g. The population served under the Provider Services Agreement, and these Program Requirements, is Health Plan's Medicaid Members. Provider will render Covered Services set forth in the Provider Services Agreement to Health Plan's Medicaid Members that are within the scope of Provider's professional license and shall comply with Health Plan's prior authorization requirements and correct coding requirements as set forth in the Provider Services Agreement and the Provider Manual.

h. Provider shall immediately notify the Health Plan of a Member's pregnancy as set forth in the Provider Manual, whether such pregnancy is identified through medical history, examination, testing, claims or otherwise.

i. Provider shall meet the timely access standards set forth in the Florida Contract.

j. If Provider is a direct service provider, Provider shall complete abuse, neglect and exploitation training, including training to identify victims of human trafficking.

k. Provider shall ensure immediate transfer to another provider if the Member's health or safety is in jeopardy.

l. Provider shall cooperate in all respects with providers of other managed care plans to assure maximum health outcomes for transitioning Members.

m. Provider shall provide for continuity of care for the course of treatment in the event the Provider Services Agreement terminates during the course of the Member's treatment. Following termination of the Provider Services Agreement, except in the case of termination for cause, Provider shall continue to provide medically necessary services to Members who are existing patients until the earlier of: (1) the Member's selection of another provider, or (2) the expiration of 60 days from the date of termination, or such other time period as determined by Health Plan. Such continuation of care activities that continue post-termination shall be provided in accordance with the terms of the Provider Services Agreement.

n. Provider shall look solely to Health Plan for compensation for Covered Services rendered to a Member, with the exception of nominal cost sharing and Member Expenses, if applicable.

o. The requirements for institutional care programs, hospice and assisted living facilities regarding collection of patient responsibility, including prohibiting the assessment of late fees, is set forth in the Provider Manual.

p. Provider shall cooperate with Health Plan's peer review, grievance, quality improvement and utilization management activities, as directed by the Health Plan.

q. The monitoring and oversight activities the Health Plan will follow, including monitoring of Covered Services rendered to Members by the Health Plan, are set forth in the Provider Manual.

r. The measures, metrics, and frequency of measurement that shall be used by the Health Plan to monitor the quality and performance of the Provider are set forth in the Provider Manual.

s. Provider shall only display marketing materials related to the Florida Contract that have been approved by AHCA, in writing, prior to use. To the extent that Provider distributes Health Plan's marketing materials, Provider shall remain neutral in discussing Health Plan benefits with current and potential enrollees.

t. Contracted Provider shall maintain adequate record systems for recording services, charges, dates and all other commonly accepted information elements for services rendered to Health Plan's Members.

u. Provider shall maintain records for a period not less than 10 years from the close of the Florida Contract, and retained further if the records are under review or audit until the review or audit is complete, pursuant to 42 C.F.R. § 438.3(u). Prior approval for the disposition of records must be requested and approved by the Health Plan if the Provider Services Agreement is continuous. Furthermore, Contracted Provider shall follow the Member record standards set forth at Florida Administrative Code Rule 59G-1.054.

v. Provider shall cooperate fully with Health Plan, and all Governmental Authorities including, but not limited to, AHCA (or its designee), federal CMS, the Office of the Inspector General (OIG), the Comptroller General, and Attorney General's Office for the inspection, evaluation, and auditing of any records or documents (medical or financial) of the Health Plan or its subcontractors at any time, related to the Florida Contract.

w. Provider shall cooperate fully in any investigation by Health Plan, AHCA, Medicaid Program Integrity Bureau (MPI), Medicaid Fraud Control Unit (MFCU) or other state or federal entity and in any subsequent legal action that may result from such an investigation involving the Florida Contract.

x. The specific reports and clinical information required by Health Plan for quality improvement or other administrative purposes out of claims processing is contained in the Provider Services Agreement and the Provider Manual.

y. Contracted Provider shall submit timely, complete and accurate claims and encounter data to Health Plan in accordance with the Information Management and Systems requirements set forth in the Florida Contract, at a minimum.

z. Provider shall comply with the background screening requirements set forth in the Florida Contract and the Provider Manual, including appropriate level of background screening and conflicts of interest checks, if applicable.

aa. Provider shall comply with HIPAA privacy and security provisions and safeguard Member information in accordance with 42 CFR § 438.224.

bb. Contracted Provider shall submit written notice of withdrawal from the Health Plan's network at least 90 days before the effective date of such withdrawal.

cc. If Health Plan terminates a Provider's participation under the Provider Services Agreement for any reason, Provider shall utilize the applicable appeals procedures outlined in the Provider Services Agreement and the Provider Manual. No additional or separate right of appeal to AHCA or Health Plan is created as a result of the Health Plan's act of terminating, or decision to terminate, any Provider under the Florida Contract.

dd. Contracted Provider shall not hold Medicaid Members or AHCA liable for any debts of Contracted Provider, including for any breach of the Provider Services Agreement that results from Contracted Provider's insolvency. This provision shall survive termination of the Provider Services Agreement.

ee. Contracted Provider shall secure and maintain during the life of the Provider Services Agreement workers' compensation insurance, in compliance with the Florida workers' compensation law, for all of its employees connected with the work under the Florida Contract, unless such employees are covered by the protection afforded by Health Plan.

ff. Contracted Provider shall notify Health Plan in the event of a lapse in general liability or medical malpractice insurance or if its assets fall below the amount necessary for licensure under Florida Statutes.

gg. Provider shall indemnify, defend, and hold the Florida Department of Health, the CMS Plan and its designees, AHCA and its designees, and Health Plan's Members harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Provider Services Agreement. This provision shall survive the termination of the Provider Services Agreement, including breach due to insolvency. AHCA may waive this requirement for itself, but not Members, for damages in excess of the statutory cap on damages for public entities, if the Provider is a State agency or subdivision as defined by Florida Statutes §768.28 or a public health entity with statutory immunity. All such waivers shall be approved in writing by AHCA.

hh. Provider shall cooperate with recovery efforts, including audits and repayments, as set forth in the Provider Services Agreement and Provider Manual, whether such efforts are taken by Health Plan, AHCA MFCU, or other authorized entity. Upon Provider's identification of an Overpayment, Provider shall report and return such Overpayment to Health Plan in writing within 60 days from the date on which the Overpayment was identified, including information regarding the reason for the Overpayment, as indicated in the Provider Manual. (42 CFR § 438.608(d)(2))

ii. Any contracts or agreements entered into by the Contracted Provider for the purposes of carrying out any aspect of the Florida Contract shall include assurances that the individuals who are signing the contract or agreement are so authorized; and that any such contract or agreement includes all the requirements of the Florida Contract.

jj. If copayments are waived as an expanded benefit, Provider shall not charge the Member copayments for Covered Services; provided, however, if copayments are not waived as an expanded benefit; the payment for Covered Services shall be the compensation amount set forth in the Provider Services Agreement, less any applicable copayments.

kk. Nothing in the Provider Services Agreement shall in any way relieve Health Plan of its responsibility for the provision of services or performance of duties under the Florida Contract. Health Plan assures that all services and tasks related to the Provider Services Agreement are performed in accordance with the terms of the Florida Contract. Health Plan shall identify in the Provider Services Agreement any aspect of service that may be delegated by the Provider.

ll. Health Plan reserves the right to execute the Provider Services Agreement pending the outcome of the provider enrollment process. Health Plan shall terminate the Provider Services Agreement immediately upon notification from AHCA if Contracted Provider cannot be enrolled, or upon expiration of the 120-day period without enrollment of the Contracted Provider, and notify

affected Members in accordance with 42 CFR § 438.602(b)(2). Health Plan is authorized to recoup any payments made under the Provider Services Agreement if the credentialing process is not successfully completed within 120 days and the delay is not caused by the Health Plan.

mm. Provider shall comply with social networking requirements set forth in the Florida Contract.

nn. If Provider is an Urgent Care Center, Provider agrees to provide all relevant clinical information regarding a Member's visit to Member's primary care Provider within five business days following the Member's visit. Such relevant clinical information includes, but is not limited to, diagnosis, treatment and services provided to Member during the visit.

7. Managed Medical Assistance Requirements. If Provider renders MMA services to Members, the following provisions shall apply:

a. If the Provider Services Agreement includes a physician incentive plan, Health Plan shall make no specific payment directly or indirectly to Contracted Provider under the physician incentive plan as an inducement to reduce or limit Medically Necessary services to a Member and Health Plan and Contracted Provider agree that such incentive plans shall not contain provisions which provide incentives, monetary or otherwise, for the withholding of medically necessary care, in accordance with 42 CFR 422.208(c)(1) and 42 CFR 438.3(i). If the physician incentive plan under the Provider Services Agreement places Provider at substantial financial risk, pursuant to 42 CFR 422.208(a)(d), for services that Provider does not furnish itself, Health Plan shall assure that such Providers have either aggregate or per-patient stop-loss protection, in accordance with 42 CFR 422.208(c)(2) and 42 CFR 422.208(f).

b. Providers shall ensure that appointments for medical services and behavioral health services are available to Members on a timely basis, in accordance with the Provider Manual.

c. If Provider is a Primary Care Provider, Provider fully accepts and agrees to the responsibilities and duties associated with the primary care provider designation.

d. Nothing in the Provider Services Agreement prohibits Primary Care Providers from providing inpatient services to a Member in a Medicaid participating hospital if such services are determined to be medically necessary and covered services under the Florida Contract.

e. For hospital Providers, the compensation for Covered Services to Members shall be in accordance with s. 409.975(6), Florida Statutes.

f. For hospital Providers, Health Plan shall complete the DCF Excel spreadsheet for unborn activation.

g. For hospital Providers, Provider shall include PPC information in all encounter data submissions to Health Plan in a manner that meets the PPC identification requirements and other reporting requirements required under Section X, Administration and Management of the Florida Contract for reporting PPC and the Provider Manual.

h. If Provider renders telemedicine Covered Services under the Provider Services Agreement, Provider shall have protocols to prevent fraud and abuse, including authentication and authorization of users, 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 the system and information usage.

i. For public health Providers, Provider shall contact Health Plan prior to rendering Covered Services to Members and provide Health Plan with the results of the office visit, including test results.

8. Long Term Care Requirements. If Provider renders LTC services to Members, the following provisions shall apply:

a. Provider shall develop and maintain policies and procedures for back-up plans in the event of absent employees. Provider shall maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees.

b. For assisted living facility or adult family care home Providers, Provider shall conform to the home and community-based settings requirements, including the following requirements:

i. Provider will support the Member's community inclusion and integration by working with the case manager and Member to facilitate the Member's personal goals and community activities.

ii. Members residing in Provider's facility shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

A. Choice of:

- Private or semi-private rooms, as available;
- Roommate for semi-private rooms;
- Locking door to living unit;
- Access to telephone and unlimited length of use;
- Eating schedule;
- Activities schedule; and
- Participation in facility and community activities.

B. Ability to have:

- Unrestricted visitation; and
- Snacks as desired.

C. Ability to:

- Prepare snacks as desired; and
- Maintain personal sleeping schedule.

c. For assisted living facility Providers, Provider hereby agrees to accept monthly payments from Health Plan for Member services as full and final payment for all long term care services detailed in the Member's plan of care which are to be provided by Provider. Members remain responsible for the separate assisted living facility room and board costs as detailed in their resident contract. As Members age in place and require more intense or additional long term care services, Provider may not request payment for new or additional services from a Member, their family members or personal representative. Provider may only negotiate payment terms for services pursuant to the Provider Services Agreement with Health Plan.

d. For adult day health care Providers, Provider shall conform to the home and community-based settings requirements and the following requirements:

i. Provider will support the Member's community inclusion and integration by working with the case manager and Member to facilitate the Member's personal goals and community activities.

ii. Members accessing adult day health services in Provider's facility shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

A. Choice of:

- Daily activities;
- Physical environment;
- With whom to interact;
- Access to telephone and unlimited length of use;
- Eating schedule;
- Activities schedule; and
- Participation in facility and community activities.

B. Ability to have:

- Right to privacy;
- Right to dignity and respect;
- Freedom from coercion and restraint; and
- Opportunities to express self through individual initiative, autonomy, and independence.

e. For home and community-based services Providers, Provider shall report critical incidents to Health Plan in a manner and format specified by Health Plan, so as to ensure reporting of such critical incidents to AHCA within 24 hours of the incident. Health Plan does not require nursing facilities or assisted living facilities to report critical incidents or provide incident reports to the Health Plan. Critical incidents occurring in nursing facilities and assisted living facilities will be addressed in accordance with Florida law, including but not limited to §§ 400.147 and § 429.23, F.S. and Chapters 39 and 415, F.S.

f. For nursing facility Providers, Provider shall maintain their active Medicaid enrollment and submit required cost reports to AHCA.

g. For hospice Providers, Provider shall maintain their active Medicaid enrollment and submit room and board cost logs to AHCA.

9. Subcontractor Provisions. The following additional provisions apply if Health Plan and Contracted Provider ("**Subcontractor**") have entered into an agreement pursuant to which Subcontractor has agreed to provide such administrative services on Health Plan's behalf:

a. Subcontractor shall comply with Section 274 of the Immigration and Nationality Act. AHCA will consider the employment by Subcontractor of unauthorized aliens a violation of the Act. If the Subcontractor knowingly employs unauthorized aliens, such violation shall be cause for termination of the Provider Services Agreement.

b. Subcontractor shall comply with the Immigration Reform and Control Act of 1986, which prohibits employers from knowingly hiring illegal workers. Subcontractor shall only employ individuals who may legally work in the United States – either U.S. citizens or foreign citizens who are

authorized to work in the U.S. Subcontractor 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 Subcontractor performing work or providing services pursuant to the Florida Contract.

c. Subcontractor shall provide the service(s) and/or goods as indicated in the Provider Services Agreement.

d. Subcontractor shall perform the delegated activities and reporting responsibilities specified in the Provider Services Agreement in compliance with Section XVI, Reporting Requirements, of the Florida Contract and the Statewide Medicaid Managed Care Program Report Guide.

e. Subcontractor shall establish, enforce, and monitor solvency requirements that assure its ability to meets its obligations under the Provider Services Agreement. Subcontractor shall immediately advise Health Plan of its insolvency or if a petition in bankruptcy is filed by or against Subcontractor so that Health Plan can timely notify AHCA.

f. The Subcontractor acknowledges that Health Plan is required to have a contingency plan for each Subcontractor to provide for continuity of care should the Subcontractor cease to provide services. Subcontractor will cooperate with the Health Plan as reasonably requested to develop and maintain this plan.

g. Subcontractor must be eligible for participation in the Medicaid program; however, Subcontractor is not required to participate in the Medicaid program as a provider.

h. If Subcontractor was involuntarily terminated from the Medicaid program other than for purposes of inactivity, Subcontractor is not an eligible subcontractor.

i. Subcontractor shall not be delegated for provider network management if Subcontractor: (i) is owner or has controlling interest in any Participating Provider; and (ii) limits the Member's choice of network providers through a requirement for a referral/authorization process to access network providers.

j. Health Plan shall make payment to Subcontractor pursuant to all state and federal laws, rules and regulations, including § 409.967, F.S., § 409.975(6), F.S., § 409.982, F.S., § 641.3155, F.S., 42 CFR § 238.230, 42 CFR § 447.46 and 42 CFR § 447.45(d)(2), (3), (5) and (6) in addition to sub regulatory guidance and provisions of the Florida Contract.

k. The conditions and method of payment are indicated in the Provider Services Agreement.

l. Subcontractor shall make prompt submission of information needed for Health Plan to make payment.

m. The Provider Services Agreement fully discloses the method and amount of compensation or other consideration to be received from the Health Plan.

n. If Subcontractor is delegated for claims processing, Subcontractor shall maintain accurate Member 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.

o. Any payment made by Subcontractor to a provider must be accompanied by an itemized accounting of the individual's claims included in the payment, including but not limited to the Member's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Health Plan.

p. Health Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with Section XII, Financial Requirements of the Florida Contract.

q. Health Plan, the CMS Plan, AHCA, federal 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 Florida Contract with the state. In accordance with 42 CFR § 438.230(c)(3)(iii), Subcontractor agrees that the right to audit exists through 10 years from the final date of the Florida Contract period or from the date of completion of any audit, whichever is later.

r. 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 Members pertinent to the Florida Contract by Health Plan, the CMS Plan, AHCA, federal CMS, the United States Department of Health and Human Services (DHHS) Inspector General, the Comptroller General or their designees, and DHHS (42 CFR § 438.3(h); § 1903(m)(2)(A)(iv) of the Social Security Act.

s. Subcontractor shall fully cooperate in any investigation by Health Plan, the CMS Plan, AHCA, Medicaid Fraud Control Unit, federal CMS, the DHHS Inspector General, the Comptroller General, or their designees, Department of Elder Affairs, or other state or federal entity or any subsequent legal action that may result from such an investigation.

t. Subcontractor shall retain, as applicable, the following information in accordance with 42 CFR § 438.3(u): Member grievance and appeal records in 42 CFR § 438.416; base data in 42 CFR § 438.5(c); medical loss ratio 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 10 years from the close of the Florida 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 Agreement is continuous. (42 CFR § 438.3(h)).

u. If Subcontractor is delegated credentialing, Health Plan shall provide ongoing monitoring and oversight of the Subcontractor to assure that all licensed medical professionals are credentialed in accordance with the Health Plan's, the CMS Plan's, and AHCA's credentialing requirements set forth in Section VIII, Provider Services, of the Florida Contract.

v. Health Plan shall provide ongoing monitoring of services rendered by Subcontractor to Members.

w. If Subcontractor is delegated claims processing and payment, Subcontractor shall: (i) Report its financial status (i.e. periodic financial reporting, financial statements) to Health Plan at a frequency determined by Health Plan; and (ii) if at financial risk or delegated to process and pay claims, Subcontractor shall maintain a surplus account to meet its obligations.

x. If Subcontractor further delegates or subcontracts any functions of the Provider Services Agreement, the subcontract or delegation shall include all the requirements of the Florida Contract. Any such sub-delegation must have been approved by Health Plan in writing, in advance of such delegation.

y. Any terms of the Provider Services Agreement that are in conflict with the specifications of the Florida Contract as they pertain to Medicaid Members are hereby waived.

z. Health Plan may revoke the delegation or impose other sanctions permitted in the Provider Services Agreement if the Subcontractor's performance is inadequate.

aa. If Subcontractor is delegated for utilization management activities, compensation under the Provider Services Agreement shall not be structured so as to provide incentives for Subcontractor to deny, limit or discontinue medically necessary services to any Member (42 CFR § 438.210(e)).

bb. Subcontractor shall timely notify the Health Plan of changes in directory information.

cc. The following information on the False Claims Act (31 U.S.C. §§ 3729 – 3733) is provided pursuant to section 6032 of the Deficit Reduction Act of 2005 (See 42 CFR § 438.608(a)(6); § 1902(a)(68) of the Social Security Act.):

i. The Federal False Claims Act imposes liability on any person or entity who knowingly files a false or fraudulent claim; or uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program. "Knowingly" means having actual knowledge that the information on the claim is false; or acting in deliberate ignorance or reckless disregard of whether the claim is true or false.

ii. A person or entity found liable under the False Claims Act is, generally, subject to civil money penalties and three times the amount of damages that the government sustained because of the illegal act.

iii. Under the False Claims Act individuals with knowledge of potential violations may file suit on behalf of the government in federal court. These individuals may be entitled to a percentage of the amount recovered by the government. An individual who brings action under the False Claims Act is called a qui tam relator or whistleblower. Federal law prohibits employers from retaliating against employees who file suits on behalf of the government under the False Claims Act.

iv. The False Claims Act creates a system for preventing and detecting fraud, waste and abuse in federal and state health care programs by providing governmental agencies with the appropriate authority and mechanisms to investigate and punish fraudulent activity. Health Plan and Provider shall be dedicated to detection and prevention of false claims.

v. To report Medicaid fraud, call the Florida Attorney General's Medicaid Fraud Control Unit at 1-866-966-7226.

dd. The Provider Services Agreement may be terminated in accordance with the termination provisions in the Provider Services Agreement; provided, however, that Subcontractor notifies Health Plan of such termination at least 90 days in advance of the effective date of termination, or such longer timeframe as set forth in the Provider Services Agreement.

ee. Subcontractor shall comply with the marketing requirements indicated in Section IV, Marketing, of the Florida Contract.

ff. Subcontractor is subject to background checks. Health Plan shall consider the nature of the work of a Subcontractor in determining the level and scope of the background checks in accordance with § 408.809, Florida Statutes. Subcontractor shall comply with Health Plan's process for background checks and screening as necessary for Health Plan to maintain compliance with the Florida Contract.

gg. Health Plan embraces, supports and encourages supplier diversity and the participation of small and minority business enterprises in contracting. Subcontractor can contact the Florida Office of Supplier Diversity online at http://osd.dms.state.fl.us/ for information on minority vendors who may be considered for subcontracting opportunities.

hh. Privacy and Security.

i. Subcontractor shall comply with the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996. Subcontractor is held to the same confidentiality requirements as Health Plan.

ii. Subcontractor shall not use or disclose any confidential information, including social security numbers that may be supplied under the Florida Contract pursuant to Law, and also including the identity or identifying information concerning a Medicaid recipient or services under the Florida Contract for any purpose not in conformity with State and Federal laws, except upon written consent of the recipient, or his/her guardian.

iii. All personally identifiable information, including Medicaid information, obtained by Subcontractor shall be treated as privileged and confidential information and shall be used only as authorized for purposes directly related to the administration of the Florida Contract. Subcontractor must have a process that specifies that patient-specific information remains confidential, is used solely for the purposes of data analysis or other responsibilities under the Florida Contract, and is exchanged only for the purpose of conducting a review or other duties outlined in the Florida Contract.

iv. Any patient-specific information received by Subcontractor can be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Subcontractor is retained by Health Plan. Subcontractor must have in place written confidentiality policies and procedures to ensure confidentiality and to comply with all Federal and State laws (including the HIPAA and HITECH Acts) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).

v. Subcontractor shall comply with the requirements of § 501.171, F.S. and shall, in addition to the reporting requirements therein, report to AHCA any breach of personal information.

vi. Any releases of information to the media, the public, or other entities require prior approval from Health Plan and AHCA.

ii. Subcontractor shall comply with the Patents, Royalties, Copyrights, Right to Data, and Works for Hire/Software requirements set forth in the Florida Contract, and shall provide disclosures, if applicable, as required under that section.

jj. Subcontractor shall provide to Health Plan its ownership disclosure information, as defined in the Florida Contract, using the form prescribed by AHCA for business transactions, in accordance with 42 CFR 438.608(c) and shall notify Health Plan of any changes in its ownership disclosure information within five days of Subcontractor's knowledge and at least 60 days before the change takes effect.

kk. Subcontractor shall not discriminate against any Member in violation of: (i) Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d *et seq*., which prohibits discrimination on the basis of race, color, or national origin.; (ii), Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap; (iii) Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 *et seq*., which prohibits discrimination on the basis of sex; (iv) the Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 *et seq*., which prohibits discrimination on the basis of age; (v) Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs; (vi) the Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities; (vii) Florida Statutes, Chapter 409; (viii) Florida Administrative Code § 62-730.160, pertaining to standards applicable to generators of hazardous waste; (ix) all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 *et seq*.; (x) the Medicare-Medicaid Fraud and Abuse Act of 1978; (xi) other Federal omnibus budget reconciliation acts; (xii) the Balanced Budget Act of 1997; and (xiii) all regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

ll. Subcontractor shall work with Health Plan to co-brand all communications with Members and Providers. Subcontractor shall not send any communication to Members or Provider, as applicable, unless Health Plan reviews the content of the communication and endorses the communication prior to it being used by the Subcontractor.