Aetna Network Management
FLMedicaidContracting@aetna.com

LETTER OF INTENT (LOI) and USE-OF-NAME-CONSENT

Aetna supports the healthcare goals of the State of Florida ("State") to improve access, ensure quality, and provide affordability for the State's residents. As a result, Aetna is pursuing exciting growth opportunities.

Aetna seeks you/your organization's commitment to participate in the provider network of Aetna Better Health of Florida ("ABHFL") by signing this Letter, and acknowledging you: (a) are willing to contract with ABHF to participate in the provider network for ABHFL; (b) intend to use commercially reasonable efforts to enter into a provider agreement with ABHFL to memorialize your/your organization's participation; (c) are willing and have capacity to accept existing and/or new ABHFL members into your practice, and (d) consent to Aetna's use of your/your organization's name and/or descriptive information in connection with any State or Agency for Health Care Administration ("AHCA") submission for the procurement/ITN process.

Your signature below evidences your intent to participate in this provider network, and substantial progress towards that goal. We plan to submit to you a written Participating Provider Agreement ("Agreement") that will include the terms, conditions and disclosures required by federal and State law. The Agreement will require adherence to standard terms and obligations, including, but not limited to, those terms required by AHCA. The parties intend for such required terms to be part of their future anticipated Agreement, and those terms specifically include those set forth in Exhibit A attached hereto, which is Aetna's AHCA approved Florida Medicaid Compliance Addendum.

You will have the opportunity to review this Agreement before you decide whether to participate in our provider network. This Letter of Intent and Use of Name Consent ("LOI") does not bind either party to enter into an Agreement and is not exclusive to the party named below. Please sign, date and return this LOI to FLMedicaidContracting@aetna.com along with the Letter of Intent Information Form attached to this LOI as soon as possible as a step towards joining our network of participating providers.

Important note: Please include your State of Florida Medicaid Identification Number for each location you/your organization intends to see Medicaid enrollees, or that you have applied for such Identification number or intend to apply for an Identification number to participate as a provider in the State's Managed Medicaid Program, as appropriate:

- ☐ I/my organization have/has a Florida Medicaid Identification number
- ☐ I/my organization do not/does not currently have a Florida Medicaid Identification Number but indicates plans to apply to be a Medicaid provider (or has a pending application).

For avoidance of doubt, this Letter of Intent is not a contract, not a provider agreement itself, nor an application for participation, but instead documents the parties' desire and intent to enter into a provider agreement.

Sincerely,

Elba Tapanes

Regional Contracting Lead Director, On behalf of Aetna Better Health Inc. dba Aetna Better Health of Florida

Entity Name: _____ **Date:** _____
Signature: _____ **TIN Number:** _____
Printed Name: _____ **Person of contact phone:** _____
Title: _____ **Person of contact email:** _____

Aetna Network Management
FLMedicaidContracting@aetna.com

Letter of Intent Information Form

Requestor Information		
Last Name:	First Name:	
Phone Number:	Fax Number:	
Email Address:		

Facility Information		
Facility Name:		
Tax ID:	National Provider Identifier (NPI):	
Medicaid ID:	License Number:	
Specialty:		
Office Address:		
City:	State:	Zip:

Additional Locations (s):		
Address:		
City:	State:	Zip Code:
Phone #:	Fax #:	
Medicaid ID # (if applicable):	NPI:	
Additional Locations (s):		
Address:		
City:	State:	Zip Code:
Phone #:	Fax #:	
Medicaid ID # (if applicable):	NPI:	

PLEASE NOTE: This is not a guarantee of Contract and is not representative of an application or a Legal Agreement. Forms are reviewed and processed by Aetna in consideration of a potential agreement in the order they are received and take 7-14 business days to process. Responses will be sent to the email provided on the Letter of Intent Information Form.

Exhibit A

Florida Medicaid, Long Term Care (LTC) and Florida Healthy Kids Compliance Addendum – Facility

This Addendum is incorporated by this reference into and becomes a part of the Agreement, and all of the terms and conditions of both parts of the incorporated document are applicable unless there is an explicit conflict between the two that prohibits compliance with both. If there is any conflict between the terms of this Addendum and any of the other terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement other than this Addendum, the terms of this Addendum shall govern and control; provided, however, if there is any conflict between any of the terms of the Agreement, including this Addendum, and the State Contract (as defined in the Agreement), then the terms of the State Contract will govern and control. This Addendum is effective as of the latest date of signature by the parties.

For purposes of this Addendum, Government Sponsor shall be the Florida Agency for Health Care Administration ("AHCA" or "Agency"), and the term "Provider" shall mean the health care provider, or physician, group, facility or hospital executing this Agreement, as identified on the first page of the Agreement. The term "Member" shall also include the term "Enrollee" or "enrollee" when used in this Addendum.

1. **Definitions**. Capitalized terms used and not otherwise defined in this Addendum shall have the meanings set forth in the Agreement or, if not defined in the Agreement, in the State Contract or under Florida law. For this Addendum, the terms below shall be defined as follows:

   A. Clean Claim — A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

   B. Emergency Medical Condition —

      a. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could result in any of the following:
         1) serious jeopardy to the health of a patient, including a pregnant woman or fetus;
         2) serious impairment to bodily functions;
         3) serious dysfunction of any bodily organ or part.

      b. With respect to a pregnant woman:
         1) that there is inadequate time to effect safe transfer to another hospital prior to delivery;
         2) that a transfer may pose a threat to the health and safety of the patient or fetus;
         3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes. (see s. 395.002, F.S.).

   C. Medically Necessary or Medical Necessity — Services that include medical, allied, or long-term care, goods or services furnished or ordered to:

      a. Meet the following conditions:

         1) Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;

         2) Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;

         3) Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;

         4) Be reflective of the level of service that can be safely furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and

         5) Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.

      b. 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.

c. The fact that a provider has prescribed, recommended or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

2. Notice Requirements upon Termination of Agreement or Withdrawal from Company's Network.

   A. Provider must give 60 days' advance written notice to Company and the OIR before canceling the Agreement for any reason; and nonpayment for goods or services rendered by Provider to Company or a Member is not a valid reason for avoiding the 60-day advance notice of cancellation. Company will provide 60 days' advance written notice to Provider and the OIR before canceling, without cause, the Agreement, except in a case in which a Member or patient'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. (§ 641.315, Florida Statutes).

   B. In the event Provider wishes to withdraw from Company's provider network for providing coverage to Members enrolled through the Medicaid program (through termination of the Agreement or otherwise), Provider must also submit a notice of withdrawal from the Company's network to Company at least ninety (90) days before the effective date of such withdrawal. Within 7 days of receiving notice that a hospital Provider is terminating network participation, Company shall advise the Agency accordingly.

3. If the Agreement is terminated for any reason other than for cause, each party shall allow Members for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the Member was receiving care at the time of the termination, until the Member selects another treating provider, or during the next open enrollment period offered by Company, whichever is longer, but not longer than 6 months after termination of the contract. Each party to the Agreement shall allow a Member who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent provider from refusing to continue to provide care to a Member who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subsection, Company and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of the Agreement are effective only if agreed to by both parties. (§ 641.51(8), Florida Statutes).

4. All providers, service and product standards specified in AHCA's Medicaid Services Coverage & Limitations Handbooks and Company's provider handbooks are incorporated into this Agreement, including professional licensure and certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in the State Contract.

5. The parties agree to comply with the requirements of 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, 42 CFR 455.106, Section 119.0701, Florida Statutes, Section 641.315, Florida Statutes, and all applicable Medicaid laws and regulations, including sub-regulatory guidance and Contract provisions and any other applicable state or federal law.

6. Provider shall comply with Section 274A(e) of the Immigration and Nationality Act and the Immigration Reform and Control Act of 1986 and shall utilize the E-Verify system (https://e-verify.uscis.gov/emp) to verify employment

   eligibility of new employees hired during the term of this contract. Violation of this section shall be cause for unilateral cancellation of this Agreement by Company.

7. The Provider must ensure compliance with all federal regulations regarding required standard electronic transactions and standards for privacy and individually identifiable health information as identified in the HIPAA of 1996 and the HITECH Act of 2009 and associated regulations. Provider shall maintain an adequate record system for recording services, charges, dates and other commonly accepted information elements for services rendered under this Agreement.

8. Nothing in the Agreement shall be construed to:

   A. Prohibit Provider from acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient for the enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
   B. Prohibit Provider from discussing treatment or non-treatment options with enrollees, to assist enrollees in deciding among all relevant treatment options;
   C. Prohibit Provider from discussing the risks, benefits, and consequences of treatment or non-treatment, or;
   D. Prohibit Provider from advising or advocating regarding the enrollee'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)).

9. Nothing in the Agreement shall be construed to prohibit Provider from advocating on behalf of the enrollee in any 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).

10. Provider shall offer hours of operation that are no less than the hours of operation offered to Company's commercial Members or comparable Medicaid fee-for-service recipients if Provider serves only Medicaid recipients. (42 CFR 438.402(c)(1)).

11. Provider shall timely notify Company of any change in directory information.

12. Provider shall immediately notify Company of a Member's pregnancy, whether identified through medical history, examination, testing, claims, or otherwise. Provider shall further comply with delegated responsibilities and the applicable reporting requirements and encounter data submissions of the State Contract.

13. All direct service providers must complete abuse, neglect and exploitation training, including training to identify victims of human trafficking.

14. All claims processing vendors shall maintain accurate enrollee and provider information reflecting the correct reimbursement rate and provider specialty area to ensure the correct adjudication of claims and payment.

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

16. In situations where Members are transitioning to or from other providers or managed care organizations providing Medicaid coverage, Provider agrees to cooperate in all respects with providers of other managed care plans to assure maximum health outcomes for Members.

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

18. Pursuant to s. 409.967(2)(m), F.S.., claims payments by Company shall be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the Member's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of Company.

19. Provider payments shall be made in accordance with applicable State and federal laws and regulation including s. 409.967, F.S., s, 409.975(6), F.S., s. 409.982, F.S, s. 641.3155, F.S., 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (5) and (6) in addition to sub regulatory guidance and the provisions of this Contract.

20. If an overpayment is made to Provider, Provider is required to return the overpayment to Company within 60 calendar days after the date in which the overpayment was identified by Provider. Payment must be returned by Provider along with written notice explaining the reason for the overpayment. If Company identifies that a claim is overpaid, Provider will receive a letter via U.S. mail from Company requesting the return of monies paid in error in accordance with Florida statute.

21. Provider must cooperate with Company's peer review, grievance, Quality Improvement ("QI") and UM activities, provide for monitoring and oversight, including monitoring of services rendered to enrollees, by Company (or its subcontractor), and Company will identify the measures that will be used by Company to monitor the quality and performance of the provider.

22. If credentialing is delegated to a subcontractor, the subcontract agreement must ensure that all providers are credentialed in accordance with Company's and the Agency's credentialing requirements as outlined in the State Contract.

23. Company may revoke Provider participation and any delegated service or impose sanctions upon a finding that Provider performance under this Agreement is inadequate.

24. Any marketing materials related to the State Contract that are displayed by Provider must have been submitted to AHCA for written approval before use.

25. If the Provider chooses to distribute health plan marketing materials the Provider must remain neutral and must do so for all Managed Care Plans with which it contracts.

26. The United States Department of Health & Human Services; AHCA; the Florida Department of Elder Affairs; Medicaid Program Integrity Bureau ("MPI"), Office of the AHCA Inspector General; and the Florida Medicaid Fraud Control Unit ("MFCU"), Office of the Attorney General, shall have the right to inspect, evaluate, and audit all of the following related to the Agreement:

    A. Pertinent books;
    B. Financial records;
    C. Medical/case records; and
    D. Documents, papers and records of any provider involving financial transactions;

    Provider shall retain such information as required by 42 CFR 438.3(u), 438.416, 438.5(c), 438.8(k), 438.604, 438.606, 438.608, s. 1902(a)(68) of the Social Security Act, and 438.610 for a period not less than ten (10) years from the close of this Contract, and retained further if records are under review or audit until completion of the review or audit.
    Disposition of records shall comply with the terms and conditions of 42 CFR 438.3(h)as applicable. Prior approval for the disposition of records shall be requested and approved by the Company if this Agreement is continuous.

27. Provider shall cooperate fully in any investigation by the Agency, MPI, MFCU, CMS, the OIG, the Comptroller General, Attorney General's Office or other state or federal entity and in any subsequent legal action that may result from such an investigation involving the State Contract. In accordance with 42 CFR 438.20(c)(3)(iii) Provider agrees that the right to audit exists through ten (10) years from the final date of this Contract period or from the date of completion of any audit, whichever is later. In addition, Provider shall cooperate fully with AHCA (or its designee), CMS, the 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 Company or its subcontractors at any time, related to the State Contract (42 CFR 438.3(h)).

28. Provider shall familiarize itself with the terms and conditions of the False Claims Act, Section 6032 of the federal Deficit Reduction Act of 2005, whistleblower protections and the penalties for submission of false claims and statements. Provider shall use best efforts to monitor, detect, and prevent fraud, waste and abuse under this Agreement.

29. Provider shall be in compliance with the background screening requirements of the State Contract.

30. Notwithstanding any other provision of the State Contract, the Agency or Company may request immediate termination of a the Agreement if, as determined by the Agency, Provider fails to abide by the terms and conditions of the Agreement, or in the sole discretion of the Agency, Provider fails to come into compliance with the Agreement within fifteen (15) days after receipt of notice from Company specifying such failure and requesting that Provider abide by the terms and conditions thereof. If the Agency determines that a subcontract is not in compliance, the Company shall revise the subcontract into compliance and may be responsible for any sanctions and /or liquidated damages assessed. The Company is ultimately responsible for compliance with the State Contract but may delegate certain of its responsibilities to subcontractors under this Agreement upon review and approval by AHCA. Company shall submit all such subcontracts for review by the Agency at least ninety (90) days prior to effective date. Company shall monitor services rendered to enrollees by Provider and subcontractor as applicable and shall provide the Agency with a monitoring schedule for all subcontractors by December 1 of each Contract year. Notwithstanding the foregoing, any agreements entered into by Company in connection with the State Contract, shall not in any way relieve Company of any responsibility for the provision of services or duties under the State Contract. The Company shall assure that all services and tasks related to the Agreement are performed in accordance with the terms of the State Contract. The Company shall identify in the Agreement any aspect of service that may be delegated by the Provider.

31. If Provider participation is terminated pursuant to the Agreement for any reason, Provider shall utilize the applicable appeals procedures outlined in the Agreement. No additional or separate right of appeal to the Agency or Company is created as a result of Company's act of terminating, or decision to terminate, any provider under the State Contract. Notwithstanding the termination of the Agreement with respect to any particular provider, the State Contract shall remain in full force and effect with respect to all other providers. Notwithstanding the above, Company shall advise the Agency within seven (7) days of notice that a hospital Provider is terminating network participation.

32. Provider assures that neither Members nor the Agency shall be held liable for any debts of the Provider. This clause shall survive termination of the Agreement, including breach of the Agreement due to insolvency.

33. Provider shall secure and maintain during the life of the Agreement workers' compensation insurance (complying with the Florida workers' compensation law) for all of its employees connected with the work under the State Contract, unless such employees are covered by the protection afforded by the Company. In addition, Provider shall notify the Company in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida Statutes.

34. Provider agrees to indemnify, defend and hold the Agency and 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 Agreement. This clause shall survive the termination of the Agreement, including breach due to insolvency. If Provider is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity, the Agency may waive this requirement for itself, but not Members, for damages in excess of the statutory cap on damages for public entities. All such waivers shall be approved in writing by the Agency.

35. If applicable a Provider delegated for financial risk and/or claims payment agrees 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 the Provider files for bankruptcy or has otherwise been determined to be insolvent by a regulating entity, the insolvency account may be drawn upon solely by Company to disburse funds to meet Medicaid financial obligations incurred by the Provider under the Contract between Company and the Provider. Documentation of the insolvency account, including account balances and governing agreements, must be provided to the Agency upon request. Failure to establish an insolvency account will result in sanctions. The Provider shall submit quarterly unaudited and annual audited financial statements to the Company.

36. The Provider must immediately advise the Company of the insolvency of insolvency or of the filing of a petition in bankruptcy by or against a principal subcontractor.

37. Any contracts, agreements or subcontracts entered into by Provider for purposes of carrying out any aspect of the State Contract shall include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of the State Contract.

38. Information in the Provider's system must be maintained in electronic form for three (3) years in live systems and for an additional ten (10) years in archival systems. Enrollee grievance and appeal records (42 CFR 438.416) base data (42 CFR 438.5(c)), MLR reports (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 428.610 shall be maintained for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u) in live and/or archival systems, or longer for audits or litigation as specified elsewhere in the Agreement.

39. The Provider shall look solely to the Company for compensation for services rendered, with the exception of cost sharing and patient responsibility (if applicable).

40. Subcontractor and Provider agree to provide at least 60 days' notice to Company prior to discontinuing any of the commitments contained within the contract. Company shall maintain a contingency plan for each subcontract to provide for continuity of care should the subcontractor cease to provide services that are the subject of the subcontract.

41. Subcontractors and providers must be eligible for participation in the Medicaid program; however, the subcontractor is not required to participate in the Medicaid program as a provider. Subcontractors involuntarily terminated from the Medicaid program for purpose other than inactivity shall not be considered an eligible subcontractor.

42. Company shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for the following:

    1) Home health care services provided by an agency or organization, unless the agency provides the state with a surety

bond as specified in Section 1861(o)(7) of the Social Security Act;

2) Items or services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend payments; and
3) Any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

43. In deciding whether to provide substitute services when providing Behavioral Health Services, Provider shall use clinical rationale for determining the benefit of the service for the Member.

44. In accordance with s. 409.912(16), F.S., the Provider must have document in the enrollee record express written and informed consent of the enrollee's authorized representative prescriptions for psychotropic medication (i.e., antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years.

45. The Provider must develop a special service process to authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary.

46. Emergency medical conditions:

    A. If Provider is a hospital, and Provider has determined that a Member has an emergency medical condition, and Provider or Provider's emergency personnel otherwise have knowledge that Member is an enrollee of Company, Provider must make a reasonable attempt to notify:
        (i) Member's primary care physician ("PCP"), if known; or
        (ii) Company (this provision constitutes written documentation that it be notified directly of the existence of the emergency medical condition).
    B. If Provider, or any of its affiliated providers, do not know the Member's PCP, or have been unable to contact the PCP, Provider must:
        (i) Notify Company as soon as possible before discharging Member from the emergency care area; or
        (ii) Notify Company within twenty-four (24) hours or on the next business day after the enrollee's inpatient admission

47. In providing Emergency Behavioral Health Service, in cases in which Member has no identification, or is unable to orally identify himself/herself when presenting for behavioral health services, Provider shall notify Company within twenty-four (24) hours of learning Member's identity.

48. Company shall make available and encourage all Members who are pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, including discussion of all appropriate methods of contraception, counseling and services for family planning to all women and their partners. If Provider is a PCP, an obstetrician or other provider who supplies such services, it shall maintain documentation in the Member's medical records to reflect this provision. See s. 409.967(2), F.S.

49. If Provider is a PCP, an obstetrician or other provider who supplies such services, it shall offer Florida's Healthy Start prenatal risk screening to each pregnant enrollee as part of her first prenatal visit, as required by s. 383.14, F.S., s. 381.004, F.S., and 64C-7.009, F.A.C.

50. If Provider is a birthing facility not participating in the Department of Health electronic birth registration system, Provider shall file required birth information with the CHD within five (5) business days of the birth, keep a copy of the completed Healthy Start (Postnatal) Risk Screening Instrument in the enrollee's medical record and mail a copy to Member.

51. For Members who are under five (5) years of age, If Provider is a PCP, a pediatrician or other provider who supplies such services, it must coordinate with the local WIC office to provide the required referral data from the most recent CHCUP. Each time Provider completes a WIC referral form, Provider must give a copy of the form to Member and keeps a copy in Member's medical record.

52. If Provider is a PCP, an obstetrician or other provider who supplies such services, it must give all women of childbearing age HIV counseling and offer them HIV testing in accordance with the Chapter 631, F.S.

53. If Provider is a PCP, a pediatrician or other provider who supplies such services, it shall test infants born to HBsAg-positive enrollees for HBsAg and Hepatitis Be surface antibodies six (6) months after the completion of the vaccine series to monitor the success of failure of the therapy. Providers shall report to the local CHD a positive HBsAg result in any child age twenty-four (24) months or less within twenty-four (24) hours of receipt of the positive test results.

54. If Provider is a PCP, an obstetrician or other provider who supplies such services, it shall supply nutritional assessments and counseling to all pregnant Members.

55. If Provider is a PCP, an obstetrician or other provider who supplies such services, it must document preterm delivery risk assessments in Member's medical record by week twenty-eight (28).

56. To the extent applicable, Provider shall participate in the Vaccines for Children Program (VFC), which is federally financed and administered by the DOH, Bureau of Immunizations. The VFC program is a public-private partnership designed to improve the health of Florida's children by providing for timely and appropriate childhood immunizations. Medicaid Members between the ages of birth through 18 years are eligible for the VFC program, if the Medicaid Member meets at least one of the following criteria:

    A. Are enrolled in Medicaid; or
    B. Have no health insurance; or
    C. Are American Indian or Alaskan Native; or
    D. Are covered by health insurance that does not provide for immunizations.

    Requirements for hospital Provider enrollment are as follows:

    A. Administer VFC program vaccines to VFC eligible children;
    B. Maintain Patient Eligibility Screening Records (PESRs) for a minimum of three (3) years;
    C. Comply with the immunization schedule, dosage and contraindications as established by the Advisory Committee on Immunization Practices (ACIP);
    D. Provide up to date vaccine information statements (VIS) and maintain records in accordance with the National Vaccine Inquiry Act;
    E. Not impose a fee for the cost of the vaccine for MMA and LTC members;
    F. Charge a vaccine administration fee that is not above the fee cap established by the State for MMA and LTC members;
    G. Not deny administration of a VFC supplied vaccine to a child due to the accompanying adult's inability to pay an administration fee;
    H. Comply with the requirements for reporting and other requirements as outlined in the Hospital Profile and Vaccine Reorder forms; and
    I. Assume responsibility for the proper handling and storage of VFC provided vaccines after delivery to the Hospital's facility.

57. If Provider is a PCP, a pediatrician or other provider who supplies such services, it must supply the highest level of care for newborns beginning immediately after birth, and such care shall include, but not be limited to, the following:

    A. Instilling of prophylactic eye medications into each eye of the newborn;
    B. When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
    C. Weighing and measuring of the newborn;
    D. Inspecting the newborn for abnormalities and/or complications;
    E. Administering one half (.5) milligram of vitamin K;
    F. APGAR scoring;
    G. Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen; and
    H. Newborn screening services in accordance with s. 383.14, F.S., which outlines the required laboratory screening process to test for metabolic, hereditary and congenital disorders known to result in significant impairment of health or intellect. These required laboratory tests shall be processed through the State Public Health Laboratory. The Company shall reimburse for these screenings at the established Medicaid rate and must enter into a provider agreement or a contract with the State Public Health Laboratory.

58. When delivering postpartum care, if Provider is a PCP, an obstetrician or other provider who supplies such services, it shall supply voluntary family planning, including a discussion of methods of contraception, as appropriate.

59. Pursuant to section 2702 of the Patient Protection and Affordable Care Act (ACA), the Florida Medicaid State Plan and 42 CFR 434.6(12) and 447.26, the following requirements shall apply to Provider:

    A. If Provider is a hospital, Provider shall identify Provider-Preventable Conditions (PPCs) in their claims as directed in Section 2702 of the Patient Protection and Affordable Care Act, the Florida Medicaid State Plan and 42 CFR 434.6(12) and 447.26.
    B. Provider shall be denied reimbursement for PPCs occurring after admission in any inpatient hospital or inpatient psychiatric hospital setting, including Crisis Stabilization Units (CSUs), as listed under Forms at: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/Managed_Care_contracting/MHMO/docs/Policy_Transmittals/2013/13-05_Attach1_MMC-PT-PPC-HCAC_6-6-13.pdf
    C. Such non-payment for PPCs shall not prevent Member access to services;
    D. Documentation of PPC identification must be kept and accessible for reporting to the Agency;
    E. Encounter data submissions must include PPC information in order to meet the PPC identification requirements;
    F. Relative to the above requirements, the Agreement does not
        i. Limit inpatient days for services that are unrelated to the PPC diagnosis present on admission (POA);
        ii. Reduce authorization to a provider when the PPC existed prior to admission;
        iii. Deny reimbursement to inpatient hospitals and inpatient psychiatric hospitals, including CSUs, for services occurring prior to the PPC event;
        iv. Deny reimbursement to surgeons, ancillary and other providers that bill separately through the CMS 1500;
        v. Deny reimbursement for health care settings other than inpatient hospital and inpatient psychiatric hospital, including CSUs; or
        vi. Deny reimbursement for clinic services provided in clinics owned by hospitals.

60. If Provider is a transportation provider, Provider shall comply with the following requirements:

    A. Provider shall comply with standards set forth in Chapter 427, F.S., and Rules 41-2 and 14-90, F.A.C. These standards include drug and alcohol testing, safety standards, driver accountability, and driver conduct;
    B. Provider shall maintain vehicles and equipment in accordance with State and federal safety standards and the manufacturers' mechanical operating and maintenance standards for any and all vehicles used for transportation of Medicaid recipients;
    C. Provider shall comply with applicable state and federal laws, including, but not limited to, the Americans with Disabilities Act (ADA) and the Federal Transit Administration (FTA) regulations;
    D. Provider shall remove from service any vehicle that does not meet the Florida Department of Highway Safety and Motor Vehicles licensing requirements, safety standards, ADA regulations, or Contract requirements and re-inspect the vehicle before it is eligible to provide transportation services for Medicaid recipients under this Contract. Vehicles

shall not carry more passengers than the vehicle was designed to carry. All lift-equipped vehicles must comply with ADA regulations;

E. Provider shall submit encounter data;

F. Provider shall deliver services consistent with 42 CFR 438.12 to ensure there is no discrimination in serving high-risk populations or people with conditions that require costly transportation; and

G. Provider shall maintain sufficient liability insurance to meet requirements of Florida law. Provider shall notify the Company in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida Statutes.

H. Provider shall ensure adequate seating for paratransit services for each Member and escort, child, or personal care attendant, and shall ensure that the vehicle meets the following requirements and does not transport more passengers than the registered passenger seating capacity in a vehicle at any time:

i. Member property that can be carried by the passenger and/or driver, and can be stowed safely on the vehicle, shall be transported with the passenger at no additional charge. The driver shall provide transportation of the following items, as applicable, within the capabilities of the vehicle:
   a) Wheelchairs;
   b) Child seats;
   c) Stretchers;
   d) Secured oxygen;
   e) Personal assistive devices; and/or
   f) Intravenous devices.

ii. Each vehicle shall have posted inside Company's toll-free telephone number for enrollee complaints.

iii. The interior of all vehicles shall be free from dirt, grime, oil, trash, torn upholstery, damaged or broken seats, protruding metal or other objects or materials which could soil items placed in the vehicle or cause discomfort to enrollees.

iv. Provider shall provide Member with boarding assistance, if necessary or requested, to the seating portion of the vehicle. Such assistance shall include, but not be limited to, opening the vehicle door, fastening the seat belt or wheelchair securing devices, storage of mobility assistive devices and closing the vehicle door. In the door-through-door paratransit service category, the driver shall open and close doors to buildings, except in situations in which assistance in opening and/or closing building doors would not be safe for passengers remaining in the vehicle. The driver shall provide assisted access in a dignified manner.

v. Provider shall ensure that smoking, eating and drinking are prohibited in any vehicle, except in cases in which, as a medical necessity, the enrollee requires fluids or sustenance during transport.

vi. All vehicles must be equipped with two-way communications, in good working order and audible to the driver at all times, by which to communicate with the transportation services hub or base of operations.

vii. All vehicles must have working air conditioners and heaters.

viii. Vehicle transfer points shall provide shelter, security, and safety of enrollees.

ix. Provider shall maintain a passenger/trip database for each enrollee it transports.

x. Provider shall cooperate with and provide requested material and information to Company to assist Company in providing an annual attestation to the Agency by January 1 of each Contract Year that all drivers providing transportation services have passed background checks and meet all qualifications specified in law and in rule.

61. If Company and Provider have entered into a physician incentive plan, Company shall make no specific payment directly or indirectly under such physician incentive plan to Provider as an inducement to reduce or limit, medically necessary services to a Member, and the incentive plan shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care.

62. Provider must meet timely access standards pursuant to the State Contract.

63. If Provider is a PCP, Provider agrees to fully accept the responsibilities and duties associated with the PCP designation.

64. If Provider is a PCP, Provider shall not be prohibited from providing inpatient services in a participating hospital to a Member if such services are determined to be medically necessary and covered services under the State Contract.

65. If Provider is a hospital, rates under the Agreement are in accordance with s. 409.975(6), F.S. In accordance with Florida Statute 409.975(6), Company and Provider shall negotiate mutually acceptable rates, methods, and terms of payment. For

rates, methods, and terms of payment negotiated after the State Contract is executed, Company shall pay Provider, at a minimum, the rate that the Agency would have paid on the first day of the Agreement. Such payments to Provider may not exceed 120 percent of the rate that the Agency would have paid on the first day of the Agreement, unless specifically approved by the Agency. The Agency's payment rates may be updated periodically.

66. If Provider is a hospital, Provider will complete the DCF Excel spreadsheet for unborn activation and include Provider-Preventable Conditions (PPC) reporting requirements as specified in the "Administration and Management" section of the State Contract. Company shall extract and upload data sets, upon request, to an Agency-hosted secure File Transfer Protocol (FTP) site to enable authorized Agency personnel, or Agency's agent, on a secure and read-only basis, to build and generate reports for management use. Agency and Company shall arrange technical specifications for each data set as required for completion of the request.

67. If copayments are waived as an expanded benefit, Provider must not charge Members copayments for covered services; and if copayments are not waived as an expanded benefit, the amount paid to providers shall be the contracted amount, less any applicable copayments.

68. If Provider has been approved by Company to provide services through telemedicine, Provider shall have protocols to prevent fraud and abuse. Provider must implement such telemedicine fraud and abuse protocols that address:

    A. Authentication and authorization of users;
    B. Authentication of the origin of the information;
    C. The prevention of unauthorized access to the system or information;
    D. System security, including the integrity of information that is collected, program integrity and system integrity; and
    E. Maintenance of documentation about system and information usage.

    In addition, public health providers, as applicable, shall be required to contact the Company before providing health care services to Members and shall be required to provide the Company with the results of the office visit, including test results.

69. If Provider is an assisted living facility or adult family home provider, it shall comply with the HCB characteristic requirements of State Contract, Attachment II, Exhibit II-B, Section VIII, C.5.., and Provider shall be in compliance with the Assisted Care Communities Resident Bill of Rights per s. 429.28, Florida Statutes.

70. If Provider is an assisted living facility or adult family home provider, Company shall not place, shall not continue to place, and shall not receive reimbursement for, Members with the Provider that does not meet the HCB characteristics of the State Contract, and/or does not have an effective provider agreement including the HCB characteristic language provided AHCA.

71. Providers shall screen enrollees for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.

72. Providers must report any and all suspected cases of abuse, neglect and/or exploitation to Company and the Florida Abuse Hotline pursuant to s. 415.1034 F.S.

73. Providers shall comply with the voluntary, involuntary and transport provisions of the Baker Act, pursuant to Chapters 394, 400, and 429, F.S. for LTC residents with psychiatric issues.

74. As applicable, Provider shall comply with all credentialing and contracting requirements of the State Contract.

75. A Provider meeting the definition of "direct service provider" who has a disqualifying offense is prohibited from providing services to enrollees. No additional Level II screening is required of the Provider if the Provider is a Limited Enrolled or Fully Enrolled Medicaid provider. No additional Level II screening is required of an employee or volunteer of the Provider who is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment.

76. Provider shall develop and maintain policies and procedures for back-up plans in the event of absent employees and shall

maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees.

77. If Provider is an Institutional Care Program, Hospice, or assisted living facility ("ALF"), Provider shall comply with Company's requirements for such facilities regarding collection of patient responsibility. Provider is prohibited from the assessment of late fees.

78. If Provider is an ALF or adult family care home ("AFCH"), Provider shall conform to the HCB characteristics pursuant to the State Contract. In addition, *(Insert ALF/AFCH identifier)* will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

    Enrollees residing in *(insert ALF/AFCH identifier)* shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

    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; and
    - Participation in facility and community activities.

    Ability to have:

    - Unlimited visitation; and
    - Snacks as desired.

    Ability to:

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

79. If Provider is an ALF, it hereby agrees to accept monthly payments from *(insert plan identifier)* 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 *(insert ALF identifier*). Members remain responsible for the separate ALF 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, *(insert ALF identifier)* may not request payment for new or additional services from Member, their family members or personal representative. *(Insert ALF identifier)* may only negotiate payment terms for services pursuant to this provider contract with *(insert plan identifier).*

80. If Provider is an Adult Day Health Care (ADHC) provider, it shall conform to the Home and Community Based ("HCB") characteristics pursuant to the State Contract. In addition, *(insert ADHC provider identifier)* will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

    Enrollees accessing adult day health services in (insert ADCC identifier) shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

    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.

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.

81. If Provider is a nursing facility or hospice, Provider shall maintain active Medicaid enrollment and submit required cost reports to the Agency for the duration of the Agreement.

82. If Provider is a Home and Community Based Services ("HCBS") provider, it shall report adverse incidents to Company within twenty-four (24) hours of the incident. Company shall not require nursing facilities or assisted living facilities to report adverse incidents or provide incident reports to Company. Rather, adverse incidents occurring in nursing facilities and assisted living facilities will be addressed in accordance with Florida law, including but not limited to ss. 400.147, 429.23, Chapter 39 and Chapter 415, F.S.

83. The Company may transfer the responsibility for collecting its enrollees' patient responsibility to residential providers and compensate these providers net of the patient responsibility amount. If the Company transfers collection of patient responsibility to the provider, the provider contract shall specify complete details of both parties' obligations in the collection of patient responsibility. The Company shall either collect patient responsibility from all of its residential providers or transfer collection to all of its residential providers.

84. Provider shall submit timely, complete, and accurate claims to the Company in accordance with the State Contract "Information Management and Systems" requirements, at a minimum.

85. Company reserves the right to execute the Agreement pending the outcome of Provider's enrollment process. Company shall terminate this Agreement immediately upon notification from the Agency that Provider cannot be enrolled, or upon expiration of the sixty (60) day period without Provider's enrollment and shall notify affected Members in accordance with 42 CFR 438.602(b)(2).

86. Company shall ensure that appointments for medical services and behavioral health services are available on a timely basis.

Paragraphs 87 through 88 are applicable when providing coverage to Members pursuant to the Florida Healthy Kids Corporation ("FHKC") Contract.

87. FHKC may appoint temporary management, pursuant to 42 CFR 438.702(a)(2) and 42 CFR 438.706. FHKC retains authority to impose additional sanctions under 42 CFR 438.700, or other applicable Florida or federal law that addresses areas of noncompliance.

88. Provider shall provide oral translation services to any Member who speaks any non-English language. Provider shall notify Members of the availability of oral interpretation services and inform Members of how to access such services.

    Written materials critical to obtaining services must be made available in alternative formats upon request of a potential Member or Member at no cost, and shall include notices of nondiscrimination and taglines in the prevalent non-English languages in Provider's service area, pursuant to Section 1557 of the Patient Protection and Affordable Care Act and 42 CFR 438.10. The taglines shall be written in a conspicuously visible font size and shall explain the availability of written or oral translation, information on how to request auxiliary aids and services, and the toll-free and TTY/TDY telephone number of Provider's customer service unit. Provider shall provide translation services, auxiliary aids, and similar services to Members at no cost.

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