MOLINA HEALTHCARE OF FLORIDA, INC.

PROVIDER SERVICES AGREEMENT

This Provider Services Agreement ("Agreement") is entered by and between Molina Healthcare of Florida, Inc., a Florida corporation ("Health Plan"), and Northwest Focal Point Senior Center District ("Provider").

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render certain health care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE - DEFINITIONS

1.1 Provider means the health care professional(s), or entity(ies) identified in Attachment A to this Agreement.

1.2 Capitalized words or phrases in this Agreement shall have the meanings set forth in Attachment B.

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall serve on Health Plan's panel of providers for the products specified in Attachment C. Provider agrees that its practice information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Practice information includes, but is not limited to, name, address, telephone number, hours of operation, type of practice, and ability to accept new patients. Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care.**

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's business and practice, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product

which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. Upon and following such referral, Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers").

f. **Member Eligibility Verification.** Provider shall verify eligibility of Members prior to rendering services.

g. **Admissions.** Provider shall cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

h. **Emergency Room Referral.** If Provider refers a Member to an emergency room for Covered Services, Provider shall provide notification to Health Plan within twenty four (24) hours of the referral.

i. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

j. **Subcontract Arrangements**. Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider's subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services. Provider shall provide Health Plan an executed letter of agreement in a form substantially similar to the form attached hereto for each physician or other licensed healthcare professional who is

contracted (directly or indirectly) with Provider ("IPA Providers") prior to the provision of Covered Services by such providers to Members

k. **Availability of Services**. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

l. **Treatment Alternatives**. Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of Covered Services limitations. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.

2.3 **Promotional Activities.** At the request of Health Plan, Provider shall (a) display Health Plan promotional materials in its offices and facilities as practical, and (b) cooperate with and participate in all reasonable Health Plan marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.4 **Nondiscrimination.**

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping.**

a. **Maintaining Member Medical Record.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for as long as required under applicable law.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **National Provider Identifier ("NPI").** Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.). Provider shall use its NPI to identify itself on all claims and encounters (both electronic and paper formats) submitted to Health Plan. Provider shall submit all NPI's and report any changes to existing NPI's or subparts to Health Plan within fifteen (15) business days of receipt.

e. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS studies, Health Plan's Quality Improvement Program, Consumer Assessment of Health Plans (CAHPS), or claims payment. Provider shall further provide direct access to said patient care information as requested by Health Plan and/or as required to any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

f. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 Program Participation

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services. If Provider is a medical group or IPA, Provider shall accept delegation of utilization management responsibilities from Health Plan at Health Plan's request.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. All additions of health professionals must be credentialed with Plan prior to treating Members. Any physician or health professional who is or subsequently becomes associated with Provider shall be required to execute a joiner to this Agreement in the form attached hereto as Attachment J; failure to do so may result in Plan's refusal to Credential such a health professional. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or reassign Members to another provider. If Provider is a medical group or IPA, Provider shall accept delegation of credentialing responsibilities at Health Plan's request and shall cooperate with Health Plan in establishing and maintaining appropriate credentialing mechanisms within Provider's organization.

e. **Provider Manual.** Provider is bound by the terms of Health Plan's Provider Manual, which may be amended from time to time at Health Plan's sole discretion. Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual and any additional operating procedures and policies for Providers which are communicated to Provider in writing by Health Plan. Provider acknowledges it received Health Plan's Provider Manual as set forth in Attachment G.

f. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through government sponsored programs. Provider shall comply with any term or condition of those government sponsored program contracts that are applicable to the services to be performed under this Agreement.

g. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall ensure that Provider promptly delivers to Provider's constituent providers, if any, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed to render health care services within the scope of Provider's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout

the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Staffing Privileges for Providers.** Consistent with community standards, every physician Provider shall have staff privileges with at least one Health Plan contracted Hospital as necessary to provide services to members under this Agreement, and shall authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of his/her hospital privileges.

e. **Liability Insurance**. Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. Every physician Provider shall maintain, at a minimum, professional liability insurance with limits of not less than two hundred fifty thousand dollars ($250,000) per occurrence and seven hundred fifty thousand dollars ($750,000) in the aggregate for the policy year and for each physician comprising Provider or other amount that meets; (i) Florida state law requirements, and (ii) Health Plan's credentialing requirements as approved by Health Plan. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider shall deliver copies of such insurance policies to Health Plan within five (5) business days of a written request by Health Plan. If Provider elects not to carry malpractice insurance, Attachment I must be completed and included as part of this Agreement. Documentation to this effect is also required as part of this Agreement. Specialty Provider shall keep Plan currently advised about such insurance, including the name of insurer, policy number, nature and extent of coverage, and expiration date and/or about other arrangements pertaining to malpractice protection. Provider shall notify Plan not less than ten (10) days prior to any reduction, cancellation, termination or expiration of insurance coverage.

2.8 **Claims Payment.**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and

procedures. Claims must be submitted by Provider to Health Plan within six months after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and Provider has been furnished with the correct name and address of the Member's health maintenance organization. If Health Plan is not the primary payer under coordination of benefits, Provider must submit claims to Health Plan within ninety (90) days after final determination by the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Health Plan within these timelines shall not be eligible for payment, and Provider hereby waives any right to payment therefor.

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments and deductibles, if any.

d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D.

e. **Offset.** In the event Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Health Plan may make a written request for repayment specifying the basis for the retroactive denial or overpayment within twenty four (24) months after the date that the payment was made, except that claims for overpayment may be sought beyond that time for providers convicted of fraud pursuant to F.S. 817.234. Provider must pay, deny, or contest Health Plan's claim for overpayment within forty (40) days of receipt of the claim. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

f. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices.

Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing access to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

g. **Payments which are the Responsibility of a Capitated Provider.** In the event a Participating Provider (such as a medical group, IPA, PHO or any other similar entity/organization) is contractually reimbursed by Health Plan on a capitation payment basis and is responsible for providing or arranging for Covered Services for certain Members (a "Capitated Provider"), such Capitated Provider, not Health Plan, is financially responsible for paying related claims, and Provider shall look to such Capitated Provider for payment of Covered Services rendered by Provider for such Members. In the event Health Plan receives any claims for Covered Services rendered by Provider that are the responsibility of a Capitated Provider, Health Plan shall return such claims to Provider and/or, at its election and upon written notice to Provider, redirect such claims to the Capitated Provider.

h. **Encounter Data.** Provider shall submit to Health Plan complete and accurate service level encounter data for all Covered Services provided to Members. All encounters shall be submitted via hard copy paper or electronically in the standard HIPAA transaction formats, namely the ANSI X12N 837 Transaction formats (P – Professional, I – Institutional, and D – Dental), and the National Council for Prescription Drug Programs NCPDP format (for Pharmacy services). Provider shall obtain and maintain in good standing during the term of this Agreement a unique Florida Medicaid Provider number. Provider is responsible for any noncompliance with this section, whether due to its own actions or the actions of an agent authorized to act on its behalf. In the event Provider fails to comply with this section, in addition to any remedies Health Plan has under the Agreement, Health Plan may require Provider to develop and adopt a corrective action plan that is acceptable to Health Plan.

2.9 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to applicable state licensing statutes and regulations. Accordingly, Provider shall abide by those provisions set forth in Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment F.

c. Provider acknowledges that all Covered Services rendered in conjunction with the Medicare program are subject to the additional provisions set forth in Attachment H.

2.10 **Provider Non-solicitation Obligations**. Provider shall not unilaterally assign or transfer patients served under this Agreement to another medical group, IPA, or provider without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.11 **Fraud and Abuse Reporting**. Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) business days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the State, Provider shall consult with the appropriate State agency prior to and during the course of any such investigations.

2.12 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

2.13 **Reassignment of Members**. Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Health Plan reassigns Member(s), Provider shall forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Plan's or the Member's request to transfer the records.

2.14 **Reciprocity Agreements.** Provider agrees to provide Covered Services to Members who are enrolled in various government sponsored health products/programs offered by Health Plan's affiliates. Provider agrees to cooperate with such affiliate's Participating Providers in coordinating and scheduling such services, and agrees that all applicable terms of this Agreement, including compensation and rules on Member billing, shall apply to Provider to the extent any such services are provided to Members of Health Plan's affiliates. In the event Provider is or becomes a Capitated Provider, the parties are encouraged to make ad hoc contractual arrangements for Covered Services rendered by Provider to Members of Health Plan's affiliate. However, in the event the parties are unable to make such arrangements, Provider agrees to accept usual and customary allowable rates, and adhere to/comply with applicable billing rules in effect in the geographic area, for Covered Services provided to beneficiaries of the government-sponsored program (ie. Medicaid, Medicare) that covers such Member(s).

2.15 **Notification to Members when Network Change.** Where Provider is a medical group, independent practice association, or any other similar entity/organization, Provider shall provide Health Plan and Members with timely prior written notification in the event a constituent specialty provider terminates its contract with Provider. Said written notification shall be in compliance with all state and federal laws or government sponsored program requirements.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determinations shall be the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of the Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of both the; (a) medical, and (b) medically-related, scientific and technical aspects of Health Plan.

ARTICLE FOUR - TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for one (1) year; it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable statutes and regulations set forth in Attachment E, Attachment F and Attachment H.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least ninety (90) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached this Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination

has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

e. If Provider is capitated and Health Plan determines Provider to be financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan determines that Provider's facility and/or equipment is insufficient to render Covered Services to Members;

g. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise terminated as a provider by any state or federal health care program;

h. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement;

i. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety.

4.5 **Termination Notification to Members.** Upon receipt of termination by either Health Plan or Provider, Health Plan will inform affected Members of such termination notice in accordance with the process set forth in the Provider Manual. Health Plan will make a good faith effort to ensure that such notice is mailed no less than sixty (60) days prior to the expected termination effective date for a termination without cause and fifteen (15) days for a termination with cause. Members may then be required to select another provider contracted with Health Plan prior to the effective date of termination of this Agreement.

ARTICLE FIVE - GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The contract between the state and the Health Plan shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 **Amendment.** Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement. Health Plan may otherwise amend this Agreement upon sixty (60) days prior written notice to Provider. If Provider does not deliver to Health Plan a written notice of rejection of the amendment within that sixty (60) day period, the amendment shall be deemed accepted by and shall be binding upon Provider.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.8 **Arbitration**. Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions between appropriate representatives of the parties. Any remaining claim or controversy shall be resolved through binding arbitration conducted by a single arbitrator in accordance with the AAA Commercial Arbitration Rules, then in effect, in the city where Health Plan's principal Florida office is located; provided, however, matters that primarily involve Provider's professional competence or conduct shall not be eligible for arbitration. If possible, the arbitrator shall be an attorney with at least fifteen (15) years' experience, including at least five (5) years' experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to

such prevailing party in a court of law or award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within (1) one year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.9 **Notices.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Health Plan:
Molina Healthcare of Florida, Inc.
8300 NW 33rd Street, Ste. 400
Doral, FL 33122
Attention: President

If to Provider:
Northwest Focal Point Senior Center District
6009 NW 10th Street
Margate, FL 33063
Attention: Project Director

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

5.10 **Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement:

Attachment A – Provider Identification Sheet
Attachment B – Definitions
Attachment C – Products/Programs
Attachment D – Compensation Schedule
Attachment D –1 Compensation Schedule
Attachment E – Required Provisions (State Licensing Provisions)
Attachment F – Required Provisions (Medicaid/AHCA)
Attachment F – 1 Subcontract Requirements (Medicaid/AHCA)
Attachment F – 2 Required Provisions/ Diversion
Attachment G – Acknowledgment of Receipt of Provider Manual
Attachment H – Medicare Program Requirements – Health Care Services
[Attachment H-1 – Medicare Program Requirements – Delegated Services]
Attachment I – Malpractice Insurance Waiver
Attachment J – Joinder to Provider Services Agreement

*** * * THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK * * ***

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth by Health Plan below. The individual signing below on behalf of Provider acknowledges, warrants and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

Northwest Focal Point Senior Center District _____ Molina Healthcare of Florida, Inc.
(Provider Name)

Provider Signature:		Molina Signature:	
Signatory Name (Printed):	Tommy Ruzzano	Signatory Name (Printed):	Maritza Borrajero
Signatory Title (Printed):	Board Chair	Signatory Title (Printed):	President
Signature Date:		Signature Date:	
		Effective Date:	

(To be completed by Molina)

ATTACHMENT A
Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

☐ Primary Care Physician

☐ Specialist: type(s) _____

_____

☐ Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated herein)

☐ Hospital

☐ Ancillary Provider: type _____

_____

☐ Pharmacy

☒ Other: Adult Day Care

Please enter "N/A" for the following if not applicable or not available:

Provider Name	NWFP Senior Center Distri	Billing Address:
Telephone No.	954-973-0300	NW Focal Point Senior Center District 6009 NW 10th Str. Margate, FL 33063
Facsimile No.	954-969-0242	
Tax I.D. No. (TIN)	59-2154528	
License No.	377	
DEA No.	N/A	Physical Address (if different than above):
Florida I.D. No.	N/A	SAME
NPI (or UPIN if NPI not yet designated)	NPI: 1194163626 UPIN:	
Email Address	karindiaz@margatefl.com	

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement.)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

Provider Signature:	Karin Diaz
Signatory Name (Printed):	Karin Diaz
Signatory Title (Printed):	Project Director
Signature Date:	

ATTACHMENT A
Provider Identification Sheet
Continuation Page

Use one or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) are expected to bill Health Plan under more than one TIN and/or billing address. Please enter "N/A" for the following if not applicable or not available:

Provider Name	N/A	Billing Address:
Telephone No.		
Facsimile No.		
Tax I.D. No. (TIN)		
License No.		
DEA No.		Physical Address (if different than above):
Florida I.D. No.		
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	
Email Address		

Provider Name	N/A	Billing Address:
Telephone No.		
Facsimile No.		
Tax I.D. No. (TIN)		
License No.		
DEA No.		Physical Address (if different than above):
Florida I.D. No.		
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	
Email Address		

Provider Name	N/A	Billing Address:
Telephone No.		
Facsimile No.		
Tax I.D. No. (TIN)		
License No.		
DEA No.		Physical Address (if different than above):
Florida I.D. No.		
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	
Email Address		

(Use additional sheets as necessary.)

ATTACHMENT B
Definitions

1. **Agreement** means this Provider Services Agreement, all attachments and incorporated documents or materials.

2. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan and with all service and encounter information required by Health Plan.

3. **Clean Claim** means a claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

4. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.

5. **CMS Agreement** means the Medicare Advantage contract between Health Plan and CMS.

6. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan affiliate's product which covers the Member.

7. **Emergency Medical Condition** means (a) 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 reasonably be expected to result in any of the following: (i) Serious jeopardy to the health of a patient, including a pregnant woman or fetus; (ii) serious impairment to bodily functions; (iii) Serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (i) That there is inadequate time to effect safe transfer to another hospital or appropriate medical facility prior to delivery; (ii) That a transfer may pose a threat to the health and safety of the patient or fetus; (iii) That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes, in accordance with Section 395.002, F.S. (HPC Section I.)

8. **Emergency Services** means medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists. If an Emergency Medical Condition exists, Emergency Services includes the care or treatment that is necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the facility. (HPC Section I.)

9. **Grievance Program** means the procedures established by Health Plan to timely address enrollee and provider complaints or grievances.

10. **Health Plan** means Molina Healthcare of Florida, Inc.

11. **HEDIS** means the Healthcare Effectiveness Data Information Set.

12. **HPC** means the model health plan contract, or "Model Contract", between AHCA and Health Plan.

13. **IPA** means Independent Practice Association.

14. **Medically Necessary** means services that include medical or allied care, goods or services furnished or ordered to meet the following conditions: (a) Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain; (b) 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; (c). Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational; (d) Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and (e) Be furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the provider. Medically Necessary for those services furnished in a hospital or appropriate medical facility on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary or a Covered Service. (HPC Section I.)

15. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

16. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare-eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D services.

17. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.

18. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to received Covered Services.

19. **Model Contract** means the model health plan contract between the Health Plan and State of Florida, Agency for Health Care Administration (AHCA).

20. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Where Provider is a medical group, IPA or hospital, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the medical group, IPA or hospital. All of said persons are bound by the terms of this Agreement.

21. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

22. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

23. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

ATTACHMENT C
Products/Programs

Provider hereby agrees to participate as a panel provider for each of the following Health Plan products as offered and applicable.

1. Medicaid

2. Florida KidCare- N/A

3. Medicare - including but not limited to Medicare Advantage (Molina Medicare Options) and MA-SNP (Medicare Options and Molina Medicare Options Plus)- N/A

4. Long Term Care Managed Care Program

5. Other Products: Health Plan may from time to time add additional products, and Provider agrees to participate in these products.

ATTACHMENT D
Compensation Schedule

Fee for Service Payments

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with products/programs as specified in Attachment C, on a fee-for-service basis, at the allowable amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

- **Medicaid:**

  Covered Services shall be paid at an amount equivalent to the payable rate under the State of Florida, one hundred percent (100%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

  Notwithstanding the above, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the State of Florida Medicaid Fee-For-Service Program fee schedule as of the date(s) of service, shall not exceed an amount equivalent to the allowable payment rate of eighty percent (80%) of the prevailing Medicare Fee-For Service, as of the date of service.

- **Florida KidCare:**

  Covered Services shall be paid at an amount equivalent to the payable rate under the State of Florida, one hundred percent (100%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

  Notwithstanding the above, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the State of Florida Medicaid Fee-For-Service Program fee schedule as of the date(s) of service, shall not exceed an amount equivalent to the allowable payment rate of eighty percent (80%) of the prevailing Medicare Fee-For Service, as of the date of service.

- **Medicare:**

  Covered Services shall be paid at an amount equivalent to the payment rates of eighty percent (80%) of the prevailing Medicare Fee-For-service (adjusted for locality or geography), as of the date of service.

ATTACHMENT D-1
COMPENSATION SCHEDULE
HOME AND COMMUNITY BASED SERVICE PROVIDER

Fee for Service Payments:

Health Plan agrees to compensate **Home and Community Based Service Provider** for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs as specified in Attachment C, on a fee-for-services basis, at the lesser of; (i) Provider's billed charges, or (ii) the allowable amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

Long-Term Care and Diversion:

All services provided to Diversion and Long-Term Care Enrollees are subject to specific prior authorization by Health Plan. Such Health Plan prior authorization will specify: 1) the specific service authorized; 2) the dates and frequency of services authorized; and, 3) the duration of any time period for which services are authorized. Services not specifically authorized will not be compensated.

Services and Allowable Amounts:

Home and Community Based Service Provider is licensed and/or otherwise qualified to provide the services specified below and agrees to provide such services to Long-Term Care and Diversion Members for the allowable amount specified below:

Code/Service	Unit Measure	Allowable Amount
S5100 – Adult Day Health Care (Max not to exceed $55/day)	¼ hour	$2.25

Check all that apply:

N/A__ ADULT COMPANION CARE: Non-Medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollees with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

X____ **ADULT DAY HEALTH CARE**: Services provided pursuant to Chapter 429, Part III, F.S. Services furnished in an outpatient setting which encompass both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems and planned group therapeutic activities. Adult day care includes nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene, are also a component of this service. The inclusion of physical, occupational and speech therapy services, and nursing services as components of adult day health services does not require the Managed Care Plan to contract with the adult day health provider to deliver these services when they are included in an enrollee's plan of care. The Managed Care Plan may contract with the adult day health care provider for the delivery of these services or the Managed Care Plan may contract with other providers qualified to deliver these services pursuant to the terms of this Contract.

N/A__ ASSISTIVE CARE SERVICES: An integrated set of 24-hour services only for Medicaid-eligible residents.

N/A__ASSISTED LIVING: A service comprising personal care, homemaker, chore, attendant care, companion care, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in an assisted living facility, licensed pursuant to Chapter 429 Part I, F.S., in conjunction with living in the facility. Service providers must ensure that enrollees reside in a facility offering care with the following home-like environmental characteristics: choice of private or semi-private rooms; choice of roommate for semi-private rooms; locking door to living unit; access to telephone as well as length of use; flexible eating and snack preparation schedule; and participation in facility and community activities of their choice. Home-like environmental characteristics also include the ability to have: unlimited visitation and personal sleeping schedule. This service includes twenty-four- (24) hour onsite response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity independence, and to provide supervision, safety and security. Individualized care is furnished to persons who reside in their own living units (which may include dual occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The resident has a right to privacy. Living units may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing that the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. The facility must have a central dining room, living room or parlor, and common activity areas, which may also serve as living rooms or dining rooms. The

resident retains the right to assume risk, tempered only by a person's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Assisted living services may also include: physical therapy, occupational therapy, speech therapy, medication administration and periodic nursing evaluations. The LTC plan may arrange for other authorized service providers to deliver care to residents of assisted living facilities in the same manner as those services would be delivered to a person in their own home. ALF administrators, direct service personnel and other outside service personnel such as physical therapists have a responsibility to encourage enrollees to take part in social, educational and recreational activities they are capable of enjoying. All services provided by the assisted living facility shall be included in a care plan maintained at the facility with a copy provided to the enrollee's case manager. The LTC plan shall be responsible for placing enrollees in the appropriate assisted living facility setting based on each enrollee's choice and service needs.

N/A___ ATTENDANT CARE: Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity. Unskilled attendant care must have supervision provided by a registered nurse, licensed to practice in the state.

N/A___ BEHAVIORAL MANAGEMENT: This service provides behavioral health care services to address mental health or substance abuse needs of long-term-care plan members. These services are in excess of those listed in the Community Behavioral Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations Handbook. The services are used to maximize reduction of the enrollee's disability and restoration to the best possible functional level and may include, but are not limited to: an evaluation of the origin and trigger of the presenting behavior; development of strategies to address the behavior; implementation of an intervention by the provider; and assistance for the caregiver in being able to intervene and maintain the improved behavior.

N/A___ CAREGIVER TRAINING: Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to enrollees. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship or support to an enrollee. This service may not be provided to train paid caregivers. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the enrollee at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the enrollee. All training for individuals who provide unpaid support to the enrollee must be included in the enrollee's plan of care.

N/A___ CARE COORDINATION/CASE MANAGEMENT: Services that assist enrollees in gaining access to needed waiver and other State Plan services, as well as other needed medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provision as prescribed in each enrollee's plan of care.

N/A___ HOME ACCESSIBILITY ADAPTATION SERVICES: Physical adaptations to the home required by the enrollee's plan of care which are necessary to ensure the health, welfare and safety of the enrollee or which enable the enrollee to function with greater independence in the home and without

which the enrollee would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies, which are necessary for the welfare of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair or central air conditioning. Adaptations which add to the total square footage of the home are not included in this service. All services must be provided in accordance with applicable state and local building codes.

N/A___ HOME DELIVERED MEALS: Nutritionally sound meals to be delivered to the residence of an enrollee who has difficulty shopping for or preparing food without assistance. Each meal is designed to provide a minimum thirty-three and three tenths percent (33.3%) of the current Dietary Reference Intake (DRI). The meals shall meet the current Dietary Guidelines for Americans, the USDA My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

N/A___ HOMEMAKER SERVICES: General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.

N/A___ HOSPICE: Services are forms of palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill recipients and their families. Hospice care focuses on palliative care rather than curative care. An individual is considered to be terminally ill if he has a medical diagnosis with a life expectancy of six (6) months or less if the disease runs its normal course.

N/A___ INTERMITTENT AND SKILLED NURSING: The scope and nature of these services do not differ from skilled nursing furnished under the State Plan. This service includes the home health benefit available under the Medicaid state plan as well as expanded nursing services coverage under this waiver. Services listed in the plan of care that are within the scope of Florida's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Skilled nursing services must be listed in the enrollee's plan of care and are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or whose need is predictable.

N/A___ MEDICAL EQUIPMENT AND SUPPLIES: Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls or appliances that enable the enrollee to perceive, control or communicate the environment in which he or she lives; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address enrollee functional limitations; (e) necessary medical supplies not available under the State Plan including consumable medical supplies such as adult disposable diapers. This service includes the durable medical equipment benefits available under the state plan service as well as expanded medical equipment and supplies coverage under this waiver. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

N/A___ MEDICATION ADMINISTRATION: Pursuant to s. 400.4256, F.S., assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from

where it is stored and delivering it to the enrollee; removing a prescribed amount of medication from the container and placing it in the enrollee's hand or another container; helping the enrollee by lifting the container to their mouth; applying topical medications; and keeping a record of when an enrollee receives assistance with self-administration of their medications.

N/A___ MEDICATION MANAGEMENT: Review by the licensed nurse of all prescriptions and over-the-counter medications taken by the enrollee, in conjunction with the enrollee's physician. The purpose of the review is to assess whether the enrollee's medication is accurate, valid, non-duplicative and correct for the diagnosis; that therapeutic doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications and being assessed and prevented.

N/A___ NUTRITIONAL ASSESSMENT/RISK REDUCTION SERVICES: An assessment, hands-on care, and guidance to caregivers and enrollees with respect to nutrition. This service teaches caregivers and enrollees to follow dietary specifications that are essential to the enrollee's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and food preparation.

N/A___ NURSING FACILITY SERVICES: Services furnished in a health care facility licensed under Chapter 395 or Chapter 400, F.S. per the Nursing Facility Coverage and Limitation Handbook.

N/A___ PERSONAL CARE: A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

N/A___ PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS): The installation and service of an electronic device that enables enrollees at high risk of institutionalization to secure help in an emergency. The PERS is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The enrollee may also wear a portable "help" button to allow for mobility. PERS services are generally limited to those enrollees who live alone or who are alone for significant parts of the day and who would otherwise require extensive supervision.

N/A___ RESPITE CARE: Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility.

N/A___ OCCUPATIONAL THERAPY: Treatment to restore, improve or maintain impaired functions aimed at increasing or maintaining the enrollee's ability to perform tasks required for independent functioning when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

N/A___ PHYSICAL THERAPY: Treatment to restore, improve or maintain impaired functions by use of physical, chemical and other properties of heat, light, electricity or sound, and by massage and active, resistive or passive exercise. There must be an explanation that the patient's condition will be improved significantly (the outcome of the therapies must be measureable by the attending medical professional)

in a reasonable (and generally predictable) period of time based on an assessment of restoration potential, or a determination that services are necessary to a safe and effective maintenance program for the enrollee, using activities and chemicals with heat, light, electricity or sound, and by massage and active, resistive or passive exercise when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

N/A__ RESPIRATORY THERAPY: Treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Services include evaluation and treatment related to pulmonary dysfunction.

N/A__ SPEECH THERAPY: The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism, or neurological conditions that effect oral motor functions. Therapy services include the evaluation and treatment of problems related to an oral motor dysfunction when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

N/A__ TRANSPORTATION: Non-emergent transportation services shall be offered in accordance with the enrollee's plan of care and coordinated with other service delivery systems. This non-emergency transportation service includes trips to and from services offered by the LTC MC program.

ATTACHMENT E
Required Provisions
(Health Care Service Plans)

The following provisions are required to be included in contracts between health maintenance organizations and providers of health care services pursuant to Florida statutes and regulations that apply to health maintenance organizations. To the extent not otherwise prohibited by law, these provisions shall be automatically modified to conform to subsequent amendments to such statutes and regulations. Any purported modifications to these provisions inconsistent with such statutes and regulations shall be null and void.

1. Provider agrees that the Member is not liable to the Provider for any services for which the Health Plan is liable as specified in F.S. 641.3154. (F.S. 641.315(1).)

2. Provider acknowledges and agrees that it must give sixty (60) days' advance written notice to the Health Plan and the Office of Insurance Regulation of the Financial Services Commission before canceling this Agreement with the Health Plan for any reason. Provider also acknowledges and agrees that nonpayment for goods or services rendered by the Provider to the Health Plan is not a valid reason for avoiding the 60-day advance notice of cancellation. (F.S. 641.315(2)(a).)

3. Health Plan will provide sixty (60) days' advance written notice to Provider and the Office of Insurance Regulation of the Financial Services Commission before canceling, without cause, this Agreement with Provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency. (F.S. 641.315(2)(b).)

4. Provider acknowledges that upon receipt by the Health Plan of a sixty (60) day cancellation notice, the Health Plan may, if requested by Provider, terminate this Agreement in less than sixty (60) days if the Health Plan is not financially impaired or insolvent. (F.S. 641.315(3).)

5. Provider acknowledges and agrees that Health Plan and Provider may not terminate this Agreement unless the party terminating this Agreement provides the terminated party with a written reason for terminating this Agreement, which may include termination for business reasons of the terminating party. The reason provided in the notice required or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. (F.S. 641.315(7).)

ATTACHMENT F
Required Provisions
(Medicaid/AHCA)

The State of Florida, Agency for Health Care Administration (AHCA) requires health maintenance organizations that participate in the Florida Medicaid program to include the following provisions in all contracts between such health maintenance organizations and hospitals that provide Medicaid services. Unless otherwise indicated, all citations are to the contract between the Health Plan and AHCA (the "Model Contract"). To the extent not otherwise prohibited by law, these provisions shall be automatically modified to conform to subsequent amendments to the Model Contract.

1. Health Plan agrees to make payments to Provider in accordance with Section 2.8 of the Provider Services Agreement (Claims Payment) and all State and federal laws, rules and regulations, including F.S. 641.3155, F.S., 42 C.F.R. 447.46, and 42 C.F.R. 447.45(d)(2), (3), (d)(5), and (d)(6). Health Plan and Provider agree to the terms of Section 2.8(d) (Coordination of Benefits) with respect to recovery of resources from third parties.

2. When presenting a claim for payment to the Health Plan, Provider is indicating an understanding that the Provider has an affirmative duty to supervise the provision of, and the responsible for, the covered services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for Health Plan - covered services:

   (1) Have actually been furnished to the Member by the Provider prior to submitting the claim; and
   (2) are medically necessary

3. If there is a physician incentive plan, Health Plan shall make no specific payment directly or indirectly to Provider as an inducement to reduce or limit Medically Necessary services to an Member, and any such incentive plan does not contain provisions which provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

4. Provider shall ensure timely access to physician appointments as follows: (i) appointments for urgent care shall be available no later than one (1) day of a request for such an appointment; (ii) appointments for routine sick care shall be available no later than one (1) week of a request for such an appointment; and (iii) appointments for well care visits shall be available no later than one (1) month of a request for such an appointment.

5. Evidence that the Health Plan has determined that the following documents are posted in the provider's waiting room/reception area: the Agency's statewide consumer call center telephone number, including hours of operation, and a copy of the summary of Florida's Patient's Bill of Rights and Responsibilities, in accordance with s. 381.026, F.S. The provider must have a complete copy of the Florida Patient's Bill of Rights and Responsibilities, available upon request by an enrollee, at each of the provider's offices.

6. In addition to any other right to terminate this Agreement, and not withstanding any other provision of the Model Contract, AHCA or Health Plan may request immediate termination of this Agreement if, as determined by AHCA, Provider fails to abide by the terms and conditions of this Agreement, or in the sole discretion of AHCA, Provider fails to come into compliance with this Agreement within fifteen (15) calendar days after receipt of notice from Health Plan specifying such failure and requesting Provider abide by the terms and conditions thereof.

7. In the event Health Plan delegates responsibility for any administrative function(s) to Provider, the following shall apply: (1) Health Plan oversees and is accountable for any delegated functions and responsibilities. (2) Prior to any delegation, Health Plan will evaluate the Provider's ability to perform the delegated function(s). (3) The parties shall provide in writing (i) the specific activities and report responsibilities delegated to Provider; and (ii) in the event Provider's performance of such delegated functions does not meet or exceed the performance requirements imposed by Health Plan and/or AHCA, Health Plan may revoke responsibility for such functions or require Provider to undertake a written corrective action plan that is subject to Health Plan's approval. (4) Health Plan shall monitor Provider's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. (5) If Health Plan identifies deficiencies or areas for improvement, Health Plan and Provider shall take corrective action.

8. Any Provider whose participation is terminated pursuant to this Agreement for any reason shall utilize the applicable appeals procedures outlined in the Provider Agreement. 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 Model Contract. Notwithstanding the termination of this Agreement, the Model Contract shall remain in full force and effect with respect to all other Providers.

9. Provider must be eligible to participate in the Florida Medicaid program. Any Provider who has involuntarily terminated from the Florida Medicaid program, other than those terminated for inactivity, is not considered to be an eligible Medicaid provider.

10. Health Plan shall not employ or contract with individuals on the State or Federal exclusions list.

11. This Agreement does not in any way relieve Health Plan of any responsibility for the provision of services duties under the Model Contract. Health Plan ensures that all services and tasks related to this Agreement are performed in accordance with the terms of the Model Contract. Health Plan shall identify in this Agreement any aspect of service that may be subcontracted by the Provider, if any.

12. Provider shall not seek payment from Members for any Covered Services provided to the Member within the terms of the Model Contract.

13. Provider shall look solely to Health Plan for compensation for services rendered, with the exception of nominal cost sharing, pursuant to the Florida State Medicaid Plan and the Florida Coverage and Limitations Handbooks.

14. If there is a physician incentive plan, Health Plan shall make no specific payment directly or indirectly under a physician incentive plan to Provider as an inducement to reduce or limit Medically Necessary services to Members, and incentive plans shall not contain provisions which provide incentives, monetary or otherwise, for the withholding of Medically Necessary services.

15. Any contracts, agreements, or subcontracts entered into by Provider for the purposes of carrying out any aspect of this Agreement must 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 Model Contract.

16. Provider shall cooperate with Health Plan's peer review, grievance, QI and UM activities, provide for monitoring and oversight, including monitoring of services rendered to Members, by the Plan (or its subcontractors), and identify the measures that will be used by the Plan to monitor the quality and performance of the Provider. If the Plan has delegated the credentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Plan's and the Agency's credentialing requirements as found in the Model Contract.

17. If a Member's health or safety is in jeopardy, Provider shall immediately contact Health Plan to arrange for the immediate transfer of Member to another primary care physician or Health Plan as necessary.

18. Nothing in this Agreement prohibits Provider from discussing treatment or non-treatment options with Members that may not reflect Health Plan's position or may not be covered by Health Plan.

19. Nothing in this Agreement prohibits Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered.

20. Nothing in this Agreement prohibits Provider from advocating on behalf of the Member in any grievance system or UM process, or individual authorization process to obtain necessary health care services.

21. Provider shall meet all appointment waiting time standards pursuant to the Model Contract.

22. Provider shall provide for continuity of treatment in the event this Agreement terminates during the course of a Member's treatment by Provider. Provider shall allow enrollees in active treatment to continue care when such care is medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or during the next open enrollment period. None of the above may exceed six (6) months after the termination of the provider's contract.

23. Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as a willing Provider law, as it does not prohibit the Health Plan from limiting provider participation to the extent necessary to meet the needs of the Members. This provision does not interfere with measures established by the Health Plan that are designed to maintain quality and control costs.

24. Health Plan shall not discriminate against Providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

25. Provider shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Health Plan.

26. Provider shall maintain records for a period not less than six (6) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if this Agreement is continuous.)

27. Department of Health and Human Services (DHHS), AHCA, including Medicaid Program Integrity (MPI) and Medicaid Fraud Control Unit (MFCU), shall have the right to inspect, evaluate, and audit all of the following related to the contract: (i) pertinent books, (ii) financial records, (iii) medical records, and (iv) documents, papers, and records of any Provider involving transactions, financial or otherwise, related to the Model Contract.

28. This Agreement specifies Covered Services and populations to be served under this Agreement which are outlined in Health Plan's Provider Manual.

29. Providers shall comply with the Health Plan's cultural competency plan.

30. Any community outreach materials related to the Model Contract that are displayed by Provider shall be submitted to AHCA for written approval before use.

31. Provider shall submit all reports and clinical information required by Health Plan, including Child Health Check-Up reporting (if applicable). The "Child Health Check-Up Program" (CHCUP) is a comprehensive and preventative set of health examinations which are provided on a periodic basis and are aimed at identifying and correcting medical conditions in Children/Adolescents. Policies and procedures are described in the Child Health Check-Up Services Coverage and Limitations Handbook set forth by AHCA.

32. Providers of transitioning Members shall cooperate in all respects with providers of other health plans to assure maximum health outcomes for Members.

33. Providers shall submit notice of withdrawal from the network at least ninety (90) calendar days prior to the effective date of such withdrawal.

34. Providers who participate in the network as primary care physicians shall perform case management responsibilities and duties associated with the primary care physician designation.

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

36. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial HMO members or comparable to Non-Reform Medicaid Recipients if the provider serves only Medicaid recipients.

37. Provider shall safeguard information about Members in accordance with 42 CFR, Part 438.224.

38. Provider shall comply with HIPAA privacy and security provisions.

39. Neither Members nor AHCA shall be held liable for any debts of Provider. This provision survives termination of this Agreement, including breach of Agreement due to insolvency.

40. AHCA and Members shall be indemnified and held harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees to the extent proximately caused by any negligent act or other wrongful conduct arising from this Agreement: (i) this clause survives termination of this Agreement, including breach due to insolvency, and (ii) AHCA may waive this requirement for itself, but not for Members, for damages in excess of the statutory cap on damages for public entities if Provider is a public health entity with statutory immunity (all such waivers must be approved in writing by AHCA).

41. Provider shall secure and maintain during the life of this Agreement worker's compensation insurance (in compliance with the State of Florida's Workers' Compensation Law) for all of its employees connected with the services provided as part of the Model Contract, unless such employees are covered by the protection afforded by the Health Plan.

42. Provider agrees to waive any terms of this Agreement, which, as they pertain to Members, are in conflict with the specifications of the Model Contract.

43. This Agreement does not contain any provision that in any way prohibits or restricts the Provider from entering into a commercial contract with any other plan (pursuant to Section 641.315, F.S.).

44. This Agreement contains no provision requiring the Provider to contract for more than one Health Plan product or otherwise be excluded (pursuant to Section 641.315, F.S.).

45. This Agreement contains no provision that prohibits the Provider from providing inpatient services in a contracted hospital to a Member if such services are determined to be Medically Necessary and Covered Services under the Model Contract.

46. Providers must cooperate fully in any audit, investigation by AHCA, review by Health Plan, Medicaid Program Integrity (MPI), or Medicaid Fraud Control Unit (MFCU), other state or federal entity, or any subsequent legal action that may result from such an audit investigation or review involving this contract.

47. If Provider fails to fully cooperate in investigations, reviews or audits conducted by the Health Plan, Agency, MFCU or any other state or federal entity, including but not limited to allowing access to the premises, allowing access to Medicaid-related records, or furnishing copies of documentation upon request may constitute a material breach of this Agreement and render it immediately terminated.

48. Molina Healthcare requires providers to submit timely, complete and accurate encounter data to Molina in accordance with the requirements of the Model Contract.

49. Physicians shall immediately notify the Health Plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims or otherwise, of any Member presenting themselves for healthcare services. The form to be utilized for such notification can be found in the Provider Manual.

50. Provider shall comply with the terms of the Health Plan's Provider Manual.

51. All claims payment will be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of the Managed Care Plan.

52. If co-payments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if co-payments are not waived as an expanded benefit, the amount paid to providers shall be the contracted amount less any applicable co-payments.

53. Provider will report adverse incidents to Plan within twenty-four (24) hours after the incident. Provider is required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours after the incident. Reporting will include information including the Member's identity, description of the incident and outcomes including current status of the Member.

54. Provider will comply with marketing requirements specified in Section III. D. of the Model Contract. Marketing materials that are to be displayed by the Provider must be submitted to the Health Plan for approval before use. If the Health Plan approves the marketing materials, the Health Plan will forward to the Agency for written approval. No marketing materials are to be displayed until a written approval from the Agency has been received.

ATTACHMENT F-1
Subcontract Requirements
(Medicaid/AHCA)

MFL will ensure it meets BMHC Subcontract requirements which include;

MFL is responsible for all work performed under this contract, but may, with the prior written approval of the Agency, enter into subcontracts for the performance of work required under this contract.

1. All subcontracts must comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106. All subcontracts and amendments executed by the health plan shall meet the following requirements.

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

   b. If a subcontractor was involuntarily terminated from the Medicaid program other than for purposes of inactivity, that entity is not considered an eligible subcontractor.

   c. The Agency encourages use of minority business enterprise subcontractors. See Section VII, C., Provider Contract Requirements, Attachment II, for provisions and requirements specific to provider contracts.

   d. Subcontractors are subject to background checks. The health plan shall consider the nature of the work a subcontractor or agent will perform in determining the level and scope of the background checks.

   e. MFL shall document compliance certification (business-to-business) testing of transaction compliance with HIPAA for any subcontractor receiving enrollee data.

   f. No subcontract that Molina enters into with respect to performance under the contract shall, in any way, relieve the health plan of any responsibility for the performance of duties under this contract. MFL shall assure that all tasks related to the subcontract are performed in accordance with the terms of this contract and shall provide BMHC with its monitoring schedule annually by December 1. MFL shall identify in its subcontracts any aspect of service that may be further subcontracted by the subcontractor.

2. All model and executed subcontracts and amendments used by the health plan under this contract must be in writing, signed, and dated by the health plan and the subcontractor and meet the following requirements:

   a. Identification of conditions and method of payment:

      (1) The health plan agrees to make payment to all subcontractors pursuant to all state and federal laws, rules and regulations, specifically, s. 641.3155, F.S., 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (d)(5) and (d)(6);

      (2) Provide for prompt submission of information needed to make payment;

(3) Make full disclosure of the method and amount of compensation or other consideration to be received from the health plan;

(4) Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the health plan;

(5) Specify that the health plan shall assume responsibility for cost avoidance measures for third party collections in accordance with Section XV, Financial Requirements, Attachment II, and;

(6) Specify that the subcontractor may not seek payment from a Medicaid Pending enrollee on behalf of the Managed Care Plan.

b. Provisions for monitoring and inspections:

(1) Provide that the Agency and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;

(2) Provide for inspections of any records pertinent to the contract by the Agency and DHHS;

(3) Require that records be maintained for a period not less than ten (10) years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Health Plan if the subcontract is continuous.)

(4) Provide for monitoring and oversight by the health plan and the subcontractor to provide assurance that all licensed medical professionals and other subcontractors are credentialed in accordance with the health plan's and the Agency's credentialing requirements as found in Section VI, Provider Network, if the health plan has delegated the credentialing to a subcontractor; and

(5) Provide for monitoring of services rendered to health plan enrollees through the subcontractor.

c. Specification of functions of the subcontractor:

(1) Identify the population covered by the subcontract;

(2) Provide for submission of all reports and clinical information required by the health plan, including CHCUP reporting (if applicable); and

(3) Provide for the participation in any internal and external quality improvement, utilization review, peer review, and grievance procedures established by the health plan.

d. Protective clauses:

(1) Require safeguarding of information about enrollees according to 42 CFR, Part 438.224;

(2) Require compliance with HIPAA privacy and security provisions;

(3) Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that Medicaid recipients or the Agency will not be held liable for any debts of the subcontractor; and

(4) If there is a health plan physician incentive plan, include a statement that the health plan shall make no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care.

(5) Require full cooperation in any investigation by the Agency, MPI, MFCU or other state or federal entity or any subsequent legal action that may result from such an investigation.

(6) Contain a clause indemnifying, defending and holding the Agency and the health plan's enrollees 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 subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency may waive this requirement for itself, but not health plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency.

(7) Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this contract unless such employees are covered by the protection afforded by the health plan. Such insurance shall comply with Florida's Workers' Compensation Law.

(8) Specify that if the subcontractor delegates or subcontracts any functions of the health plan, that the subcontract or delegation includes all the requirements of this contract.

(9) Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this contract.

(10) Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate.

(11) Provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

(12) Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:

(a) The False Claim Act;

(b) The penalties for submitted false claims and statements;

(c) Whistleblower protections;

(d) The law's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

e. Termination Procedure:

(1) In conjunction with Section III, B., Termination, on page eight of the standard contract, all provider contracts and subcontracts shall contain termination procedures.

ATTACHMENT F-2
Required Provisions
(AHCA/DOEA)

The State of Florida, Department of Elder Affairs (DOEA) and the Agency for Healthcare Administration requires health maintenance organizations that participate in the Long-Term Care and the Diversion program to include the following provisions in all contracts between such health maintenance organizations and providers.

Long-Term Care and Diversion is a Medicaid waiver program. Accordingly all Required Provisions in Attachment F also apply.

1. Department of Health and Human Services (DHHS), the Florida Department of Elder Affairs (DOEA), AHCA, including Medicaid Program Integrity (MPI) and Medicaid Fraud Control Unit (MFCU), shall have the right to inspect, evaluate, and audit all of the following related to the contract: (i) pertinent books, (ii) financial records, (iii) medical records, and (iv) documents, papers, and records of any Provider involving transactions, financial or otherwise.
2. Health Plan has agreed to initially provide services to Members who meet the eligibility requirements of the Long-Term Care and Diversion program as determined by the DOEA and/or AHCA.
3. Facility and Home health providers will provide notice to Health Plan within twenty four (24) hours when a Member dies, leaves the facility, or moves to a new residence.
4. Neither Members, DOEA, nor AHCA shall be held liable for any debts of Provider. This provision survives termination of this Agreement, including breach of Agreement due to insolvency.
5. AHCA, DOEA and Members shall be indemnified and held harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees to the extent proximately caused by any negligent act or other wrongful conduct arising from this Agreement: (i) this clause survives termination of this Agreement, including breach due to insolvency, and (ii) AHCA may waive this requirement for itself, but not for Members, for damages in excess of the statutory cap on damages for public entities if Provider is a public health entity with statutory immunity (all such waivers must be approved in writing by AHCA).
6. Provider acknowledges and agrees that it must give sixty (60) days' advance written notice to the Health Plan, DOEA, AHCA, and the Office of Insurance Regulation of the Financial Services Commission before canceling this Agreement with the Health Plan for any reason. Provider also acknowledges and agrees that nonpayment for goods or services rendered by the Provider to the Health Plan is not a valid reason for avoiding the 60-day advance notice of cancellation. (F.S. 641.315(2)(a).)
7. Health Plan will provide sixty (60) days' advance written notice to Provider, DOEA, AHCA and the Office of Insurance Regulation of the Financial Services Commission before canceling, without cause, this Agreement with Provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency, in which case notification will be provided immediately. (F.S. 641.315(2)(b).)
8. Provider agrees that all direct service personnel or contractors will attend and complete Abuse, Neglect & Exploitation Training.
9. Provider will have in place, and follow, written policies and procedures for processing request for initial and continuing authorization of services.
10. All providers with assisted living facilities will maintain a copy of the current care plan in the Member's record for inspection by state and Federal agencies.

11. Provider will develop and maintain policies and procedures for back-up plans in the event of absent employees, and will maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employee.
12. Provider will assume full responsibility for third party collections.
13. Applicable to residential facilities: Provider will collect any patient responsibilities and will not assess any late fees.
14. Provider will complete a Level 2 criminal history background screening to determine whether provider or any employees or volunteers of the provider who meet the definition of "direct service provider", have disqualifying offenses as provided for in s. 430.0402 F.S as created and s. 435.04 F.S.
    a. For the purpose of this section, the term "direct service provider" means a person 18 years of age or older who, pursuant to a program to provide services to the elderly, has direct, face-to-face contact with a client while providing services to the client or has access to the client's living areas or to the client's funds or personal property. This term includes coordinators, managers, and supervisors of residential facilities and volunteers.
    b. A signed affidavit will be provided to the Plan by each provider attesting to their compliance with this requirement; or with the requirements of their licensing agency if it requires Level 2 screening of direct services providers. The affidavit will be maintained by the Plan in the provider contracting record.
    c. Plan will verify compliance of this requirement during monitoring activities.
15. Provider will report the filing of a claim for bankruptcy, including (1) the date of filing of the bankruptcy petition; (2) the case number; (3) the court name and division in which the petition was filed; and (4) the name, address and telephone number of the bankruptcy attorney.
16. Provider will not participate in cold-call or other unsolicited marketing. Any marketing materials related to this contract must be submitted to the Plan prior to displaying or using. Plan will submit the materials to the DOEA and/or AHCA for written approval before use. Materials are not to be used unless approved by the Plan and the DOEA, and/or AHCA.
17. Provider agrees to cooperate and comply with the goal of an integrated and coordinated service delivery system for the Member, including activities required for appropriate coordination and continuity of care.
18. Provider shall ensure timely access to services and appointments.
19. Provider will immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96ABUSE).
20. Provider will implement and Plan will approve a systematic process for incident reporting and notify Plan within 48 hours of occurrence of an incident that may jeopardize the health, safety and welfare of a Member or impair continued service delivery. Reportable conditions include but are not limited to:
    a. Closure of subcontracted facilities due to license violations;
    b. Contractor or subcontractor financial concerns/difficulties;
    c. Loss or destruction of Member records;
    d. Compromise of data integrity;
    e. Fire or natural disasters; and
    f. Critical issues or adverse incidents that affect the health, safety, and welfare of Members.
21. Applicable to Nursing Facility and Hospice Providers: Provider will comply with Medicaid bed hold days policies and procedures, including bed hold days for hospitalization stays and therapeutic leaves. Provider must inform the Plan, residents and their representatives in writing of the Medicaid bed-hold policy at the time of admission and at the time resident leaves the facility for a hospitalization or therapeutic leave. A copy of the Providers Bed Hold Policy must be provided to the Plan.

22. Applicable to Nursing Facility and Hospice Providers: Provider shall maintain active Medicaid enrollment and submit required cost reports to the Agency for the duration of this agreement.
23. Applicable to Assisted Living Facilities and Adult Family Care Homes: Provider 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 Assisted Living Facilities and Adult Family Care Homes must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options:
    a. Private or semi-private rooms;
    b. Roommate for semi-private rooms;
    c. Locking door to living unit;
    d. Access to telephone and length of use;
    e. Eating schedule; and
    f. Participation in facility and community activities.
    g. Ability to have:
        1) Unlimited visitation; and
        2) Snacks as desired.
    h. Ability to:
        1) Prepare snacks as desired; and
        2) Maintain personal sleeping schedule.
24. Assisted Living Facilities hereby agrees to accept monthly payments from Plan for enrollee services as full and final payment for all long-term care services detailed in the enrollee's plan of care which is to be provided by Assisted Living Facility. Enrollees remain responsible for the separate ALF room and board costs as detailed in their resident contract. As enrollees age in place and require more intense or additional long-term care services, Assisted Living Facility may not request payment for new or additional services from an enrollee, their family members or personal representatives. Assisted Living Facility may only negotiate payment terms for services pursuant to this agreement with the Plan.

ATTACHMENT G
Acknowledgment of Receipt of Provider Manual

Provider hereby acknowledges receipt of Health Plan's Provider Manual and acknowledges that Health Plan's Provider Manual was made available to Provider for review prior to Provider's decision to enter into this Agreement. Health Plan's Provider Manual is available in printed form and at the Health Plan's website.

Date of receipt: _____

Initials of authorized
representative of Provider _____

ATTACHMENT H
MEDICARE PROGRAM REQUIREMENTS--HEALTH CARE SERVICES

This attachment sets forth the applicable Government Program requirements, covering the provision of health care services, that are required by CMS to be included in contracts and/or agreements between; (i) health plans / health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).
2. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR422.504(i)(2)(ii).).
3. Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)
4. Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii).) In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a:
    a. Medicare Advantage Special Needs Plan will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.

b. Capitated Financial Alignment Demonstration/Medicare-Medicaid Plan will not be held liable for any Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services will be provided at zero-cost share to the Member.

5. Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment H-1 of this Agreement. (42 CFR 422.504(i)(3)(ii).)
6. Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 42 CFR 422.504(i)(4).)
7. Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for services that are covered by Medicare within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. Any Claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b).)
8. Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8).)
9. Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)
10. Benefit Continuation. Provider agrees to provide for continuation of Member health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 42 CFR 422.504(g)(2)(ii) and 42 CFR 422.504(g)(3).)
11. Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. (42 CFR 422.112(a)(8).)

ATTACHMENT H-1
MEDICARE PROGRAM REQUIREMENTS--DELEGATED SERVICES

This attachment sets forth the applicable Government Program requirements, covering the delegation to Provider of any management responsibilities or administrative services if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans / health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii))
2. Medicare Compliance. Provider agrees to require all of its downstream, related entity(s) and transferees to comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)
3. Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)
4. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR 422.504(i)(2)(ii).)
5. Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 422.504(i)(4)(i) and 42 CFR 422.504(a)(8).)
6. Revocation of Delegated Activities. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked. (42 CFR 422.504(i)(4)(ii).)
7. Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(3)(iii).)
8. Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health

Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).)

9. Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(4).)
10. Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5)

ATTACHMENT I
MALPRACTICE INSURANCE WAIVER

I have decided not to obtain malpractice insurance. As a continuing condition for staff privileges, I will comply with State Statute 458.320 by:

Please Check Appropriate Item:

_____ Maintaining an unexpired irrevocable letter of credit in an amount not less than $250,000 per claim with a minimum aggregate of not less than $750,000. (submit copy)

_____ Maintaining an escrow account consisting of cash or assets in an amount not less than $250,000 per claim with a minimum aggregate of not less than $750,000. (submit copy)

_____ _____
Physician Signature Date

_____
Print Name

ATTACHMENT J
JOINDER OF AGREEMENT

By signing below, the Participating Physicians agree to the terms and conditions set forth in this Agreement. Effective this _____ day of _____, 200__.

Provider Group Name N/A

Provider Group Tax ID: _____

NAME (Please Print)	Specialty (MD, ARNP, PA, CNA, RN)	SIGNATURE	Employed Yes or No	DATE