# ANCILLARY SERVICES PROVIDER AGREEMENT

**BETWEEN**

**INDEPENDENT LIVING SYSTEMS, LLC**

**AND**

NORTHWEST FOCAL POINT SENIOR CENTER DISTRICT

[PROVIDER NAME]

Entity Name if Different than Provider Name:

Entity Mailing Address

6009 NW 10th Street, Margate FL 33063

Provider License Type: ADULT DAY CARE CENTER

NAME (Authorized Person Signing) KARIN DIAZ

TITLE: PROJECT DIRECTOR

PROVIDER LICENSE #377 ADULT DAY CARE CENTER

ADDRESS: 6009 NW 10th Street, Margate FL33063

COUNTY NAME BROWARD COUNTY

REGION NUMBER PSA10

EMAIL (#1): karindiaz@margatefl.com

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MEDICARE # N/A

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# ANCILLARY SERVICES PROVIDER AGREEMENT

This Ancillary Services Provider Agreement ("Agreement"), by and between Independent Living Systems, LLC, a Florida limited liability company ("ILS"), and NORTHWEST FOCAL POINT SENIOR CENTER DISTRICT (NWFP), an ADULT DAY CARE CENTER (the "Provider"), is made and entered into as of this ___ day of _____, 2018.

## RECITALS

A. ILS has contracted with one or more Managed Care Plans to provide services to those Managed Care Plans and their Members and/or to support their network building for the Statewide Medicaid Managed Care program.

B. Provider is licensed or otherwise qualified to provide Health Care Services, as that term is defined herein, to Members, as that term is defined herein, who have been assigned to Managed Care Plan.

C. ILS and Provider desire to enter into this Agreement for the provision of Health Care Services to Members who have been assigned to Provider by one or more of the Managed Care Plan(s), and Provider desires to render such services and participate in one or more of the Managed Care Plans' network of providers in accordance with the terms and conditions of this Agreement.

NOW THEREFORE, in consideration of the mutual promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

1. ENGAGEMENT; AUTHORITY; OBLIGATIONS BINDING.

a. Engagement; Authority. ILS hereby engages Provider and Provider hereby accepts such engagement, to provide Health Care Services to Members under one or more of the Benefit Plans offered by the Managed Care Plan or Managed Care Plans with whom ILS has contracted including those identified on one or more Schedule 6s or as may be added as additional Managed Care Plans in accordance with Section 15(b) of this Agreement. ILS will have the right to add or delete a Managed Care Plan to or from Schedule 6s in the manner set forth in Section 15(b) of the Agreement. Provider hereby represents and warrants that it has the full and complete authority to bind, enter into and implement this Agreement in accordance with the terms and conditions of this Agreement. The credentials of its Professional Staff must be verified by the Provider and may be subject to approval by ILS and/or the applicable Managed Care Plan prior to any Health Care Services being rendered by its Professional Staff to Members of the applicable Managed Care Plan.

b. Obligations Binding on Professional Staff. Notwithstanding any contrary interpretation of this Agreement or of any contracts between Provider and Professional Staff, Provider and ILS acknowledge and agree that all requirements, obligations and rights contained in the provisions of this Agreement applicable to Provider shall apply to its Professional Staff, unless expressly and

clearly applicable only to Provider. Provider agrees that it is Provider's responsibility to assure that the obligations of its Professional Staff under this Agreement are fully satisfied. Provider will cause its Professional Staff to comply with and perform the terms and conditions of this Agreement. In the event of any inconsistency between this Agreement and the contracts entered into between Providers and its Professional Staff, the terms of this Agreement shall control with respect to the provision of services under this Agreement by the Professional Staff. Provider warrants that its Professional Staff are bound by the terms of their engagement with Provider to comply with the terms and conditions of this Agreement.

2. DEFINED TERMS. When used herein, the following defined terms shall have the respective meanings set forth below:

a. "AHCA" or "Agency" shall mean the Florida Agency for Health Care Administration. The Managed Care Plan(s) may be a party to an agreement with AHCA to provide health care services and benefits to beneficiaries of the Medicaid Program.

b. "Addendum" or "Addenda" shall mean those addenda, existing as of the Effective Date or thereafter added, including the Medicare Advantage Addendum and the Medicaid Addendum, if applicable and such other Addendums as may be applicable, which include applicable supplemental terms that are part of this Agreement as if contained in the main body hereof.

c. "Benefit Plan" shall mean any group or individual health insurance policy or plan that is offered by a Managed Care Plan(s) to a Member, including the rules, procedures, protocols, exclusions, limitations and other conditions to be followed by Participating Providers and Members with respect to the provision of Covered Medical Services under the applicable health insurance policy or plan in which a Member is enrolled, including plans under the Medicare Program and Medicaid Program and other policies or plans that may be incorporated into this Agreement through modifications or amendments.

d. "Clean Claim" shall mean a UB04 or CMS 1500, as applicable, in paper or electronic format, or any successor form, or other billing form as required by ILS or the Managed Care Plan(s) in connection with the applicable Benefit Plan, and with respect to electronic claim forms in the format and with the data content and data conditions specified in HIPAA, which has been fully and accurately completed, as applicable, with the components including, but not limited to, patient name and identification number, Member name and identification number, date of service(s), diagnosis(es), description of services, procedure code(s), charges, occurrence codes, condition codes, provider name and/or identification number, and such other information that may otherwise be required by ILS or the Managed Care Plan(s) in connection with the applicable Benefit Plan. A Clean Claim is a claim that is received timely by ILS or the applicable Managed Care Plan and has no defect, impropriety or lack of substantiating documentation from the Member's medical records. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

e. "CMS" shall mean the Centers for Medicare & Medicaid Services. The Managed Care Plan(s) may be a party to an agreement with CMS to provide health care services and benefits to beneficiaries of the Medicare Advantage Program.

f. "Compensation Schedule" shall mean one or more schedules attached hereto and incorporated herein by this reference, which sets forth the compensation to be paid to Provider by each of the Managed Care Plan(s) for Provider's provision of Health Care Services hereunder, including one or more Schedule 2s (Compensation Schedule).

g. "Copayment" shall mean any out-of-pocket amount payable by a Member to a Participating Provider for Covered Medical Services rendered in accordance with the Schedule of Benefits applicable to the particular Benefit Plan in which a Member is enrolled.

h. "Covered Medical Services" shall mean the Medically Necessary medical, hospital, and other professional health care services or supplies that a Member is entitled to receive according to the terms and conditions of the Benefit Plan in which the Member is enrolled as described in the applicable Schedule of Benefits.

i. "Effective Date" shall mean (i) after the execution of this Agreement by Provider, the date of execution by ILS of this Agreement; **and** (ii) receipt by Provider of verification from ILS that Provider and each applicable member of its Professional Staff to provide services under this Agreement has been credentialed in accordance with this Agreement, which Effective Date shall be entered by ILS on the Signature Page.

j. "Emergency Medical Condition" shall mean, as follows or such other meaning as may be established by AHCA, CMS or any other Governmental Agency, a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in:

(i) Serious jeopardy to the health of a patient, including a pregnant woman or a fetus,
(ii) Serious impairment to bodily functions,
(iii) Serious dysfunction of any bodily organ or part, or
(iv) Death

With respect to a pregnant woman, an emergency medical condition exists when:

(i) There is inadequate time to effect safe transfer to another hospital prior to delivery,
(ii) Transfer may pose a threat to the health and safety of the patient or fetus, or
(iii) There is evidence of onset of uterine contractions or rupture of the membranes.

k. "Emergency Services and Care" shall mean medical screening, exam, and evaluation provided by a Physician, or, to the extent permitted by all applicable laws and regulatory requirements,

by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists, and, when an Emergency Medical Condition does exist, it includes the care, treatment, or surgery for a Covered Medical Service by a Physician to relieve or eliminate the Emergency Medical Condition, within the service capability of a hospital.

l. "Governmental Agency" shall mean the Florida Agency for Health Care Administration ("AHCA"), the Centers for Medicare & Medicaid Services ("CMS"), the United States Department of Health and Human Services ("DHHS"), the United States Government Accountability Office ("GAO"), the Office of Inspector General ("OIG"), and/or the Florida Office of Insurance Regulation ("OIR"), and any other state or federal governmental agency with jurisdiction over ILS and/or the Managed Care Plan(s).

m. "Health Care Services" shall mean the Covered Medical Services described in Schedule 1, which are provided to Members by Provider.

n. "Inpatient Covered Medical Services" shall mean Covered Medical Services provided to a registered bed patient in a hospital or other authorized health facilities including but not limited to behavioral health facilities.

o. "Managed Care Plan" shall mean one or more of the health maintenance organizations, insurers, provider services networks and other managed care organizations with which ILS has contracted to provide or arrange for the provision of Health Care Services, as such may be identified on one or more Schedule 6s attached hereto, from time to time and such additional Schedule 6s as may be added or such existing Schedule 6s as may be removed, from time to time in accordance with the provisions of this Agreement.

p. "Mandates" shall mean all applicable State and Federal laws, rules and regulations, mandates, orders, directives, applicable Government contract requirements and statements of policy in existence at all times hereunder, including, without limitation, applicable Medicaid laws, Medicare laws, rules, regulations and CMS requirements.

q. "Medicaid Addendum" shall mean the Addendum entered into by the parties for the purpose of ensuring compliance with Florida and Federal laws, rules and regulations that are applicable to the Medicaid Benefit Plan(s) offered by the Managed Care Plan(s). In the event Provider provides Covered Medical Services to Members enrolled in a Medicaid Benefit Plan, Provider shall provide such Covered Medical Services to such Members in accordance with the terms of this Agreement and the Medicaid Addendum. To the extent there is any inconsistency between the terms and/or conditions of this Agreement and the Medicaid Addendum, the Medicaid Addendum shall prevail with respect to Provider's provision of Covered Medical Services to Members enrolled in a Medicaid Benefit Plan.

r. "Medicaid Member" shall mean a Member who is entitled to receive health benefits under Title XIX of the Social Security Act, and who resides in the Provider Service Area, and whose enrollment in the Medicaid Program has been confirmed by AHCA.

s. "Medicaid Program" shall mean the program for Medicaid beneficiaries covered under Title XIX of the Social Security Act, administered by AHCA.

t. "Medically Necessary" shall mean those medical services which are determined under the applicable utilization review and management program to be:

(i) Appropriate, necessary, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Member's needs; and

(ii) Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain and provide for the diagnosis or direct care and treatment of a medical condition; and

(iii) Consistent with generally accepted professional medical standards, or other applicable contractual requirements or regulatory programs, and not experimental or investigatory; and

(iv) Furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker, or Provider; and

(v) Consistent with the applicable medical policy, utilization management program, quality management program and the requirements of the applicable Benefit Plan under which the Covered Medical Services are rendered; and

(vi) Reflective of the service that can be safely furnished and for which no equally effective and more conservative or less costly treatment is available, statewide, and for hospital inpatient services, could not, 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; and

(vii) The most appropriate and cost effective service or supply consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving or the severity of the Member's condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The fact that a Physician or Participating Licensed Health Professional has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services Medically Necessary or a medical necessity or a Covered Medical Service. Only Covered Medical Services determined to be Medically Necessary by the applicable Managed Care Plan(s) will be reimbursed under the applicable Benefit Plan.

u. "Medical Service Provider" shall mean a health care ancillary service or other organization or facility, or a mobile unit which has contracted with ILS and/or Managed Care Plan to provide

Covered Medical Services or supplies, including imaging or diagnostic centers, mobile mammography facilities or mobile units, and medical equipment suppliers. The parties hereto recognize that ILS and/or Managed Care Plan may from time to time, amend its listing of Medical Service Providers.

v. "Medicare Advantage Addendum" shall mean the Addendum entered into by the parties for the purpose of ensuring compliance with federal laws, rules and regulations that are applicable to the Medicare Advantage Benefit Plan(s) offered by the Managed Care Plan(s). In the event Provider provides Covered Medical Services to Members enrolled in a Medicare Advantage Benefit Plan, Provider shall provide such Covered Medical Services to such Members in accordance with the terms of this Agreement and the Medicare Advantage Addendum. To the extent there is any inconsistency between the terms and/or conditions of this Agreement and the Medicare Advantage Addendum, the Medicare Advantage Addendum shall prevail with respect to Provider's provision of Covered Medical Services to Members enrolled in a Medicare Advantage Benefit Plan.

w. "Medicare Member" shall mean a Member who is entitled to receive health benefits under Title XVIII of the Social Security Act, and who resides in the Provider Service Area, and whose enrollment in the Medicare Program has been confirmed by CMS.

x. "Medicare Program" shall mean the program for Medicare beneficiaries covered under Title XVIII of the Social Security Act, administered by CMS.

y. "Member" or "Enrollee" shall mean any person, or eligible dependent of such person, who is eligible to receive benefits and who has been enrolled in a Benefit Plan offered by any of the Managed Care Plans.

z. "Outpatient Covered Medical Services" shall mean Covered Medical Services provided in a non-hospital based health care facility or at a hospital to patients who are ambulatory.

aa. "Participating Hospital, Nursing Home or Home Health Agency" shall mean a hospital, nursing home or home health agency with which a Managed Care Plan has contracted to render Inpatient Covered Medical Services or Outpatient Covered Medical Services or home care services to Members. The parties hereto recognize that the Managed Care Plan(s) may from time to time, amend its listing of Participating Hospital, Nursing Home or Home Health Agencies.

bb. "Participating Licensed Health Professional" shall mean a Physician or other provider of medical services or supplies, other than a Primary Care Physician, with whom the Managed Care Plan(s) has entered into a contract to render Covered Medical Services to Members. Provider shall refer Members to an appropriate Participating Licensed Health Professional when a Member is in need of Covered Medical Services which are outside the scope of services normally provided by Provider. Referrals to such providers may require the advance approval

of ILS and/or the applicable Managed Care Plan(s), in accordance with the policies and procedures of ILS and the Managed Care Plan(s).

cc. "Participating Provider" shall mean a Medical Service Provider, a Participating Hospital, Nursing Home or Home Health Agency, a Participating Licensed Health Professional, a Physician, or a Primary Care Physician, as the case may be, which or who has entered into an agreement with, or is otherwise engaged by the Managed Care Plan, to provide Covered Medical Services to Members. For avoidance of doubt, Participating Providers shall include those Participating Provider with which ILS contracts to provide or arrange for the provision of Covered Services to Members enrolled in a Benefit Plan offered by the Managed Care Plan(s).

dd. "Payor" shall mean a Managed Care Plan.

ee. "Physician" shall mean a medical doctor or an osteopathic physician duly licensed under Chapter 458 or 459, Florida Statutes, to practice medicine or osteopathic medicine, respectively, in the State of Florida.

ff. "Primary Care Physician" shall mean a Physician who is responsible for coordinating the total medical care of the Members who have chosen such Physician as their Primary Care Physician or who have been assigned to such Primary Care Physician. The Primary Care Physician will refer Members only to Participating Providers, when Medically Necessary, and be available twenty-four hours per day for Emergency Services and Care.

gg. "Professional Staff" shall mean physicians, nurses, medical technicians, advanced registered nurse practitioners and all other professional and technical personnel who (i) are employed, contracted or engaged by Provider to provide Health Care Services under this Agreement, (ii) are appropriately licensed and/or qualified to provide Health Care Services to Members within the range of such licensure and/or qualification, and (iii) meet all requirements contained in the Provider Handbook and this Agreement.

hh. "Provider Handbook" shall mean each of the Managed Care Plans', as applicable, policies and procedures, and standards for Participating Providers which may include, but not be limited to, requirements for claims submission and payment, credentialing and re-credentialing, referrals, Managed Care Plans' Quality Assurance and Utilization Review Program, case management, advance directives, provider complaints, and Member and Provider rights, grievances and appeals, and shall include manuals, bulletins, alerts and any other provider communications materials, all of which may be updated from time to time by each of the Managed Care Plans(s), as applicable, and ILS.

ii. "Provider Service Area" shall mean the counties in the State of Florida where the Service Delivery Sites are located and in which Managed Care Plan(s) is/are authorized to arrange for the provision of Covered Medical Services to Members.

jj. "Quality Assurance and Utilization Review Program" shall mean those program(s) developed by the Managed Care Plan(s) and/or ILS to monitor, review, manage and evaluate the quality of care and services provided to Members, including a corrective action protocol to promote quality care and ensure compliance with all applicable laws and regulatory requirements concerning the provision of medical and hospital services to Members.

kk. "Schedule of Benefits" shall mean the schedule of Covered Medical Services corresponding to a Member's Benefit Plan. The Schedule of Benefits also lists certain items or services which are excluded from a Member's Benefit Plan or, in certain instances, for which benefits are limited. Any service obtained by a Member that is excluded or that has exceeded the limitation for that service is not a Covered Medical Service and the Member will be financially responsible for such service.

ll. "Service Delivery Site" shall mean the location, including medical facility, office, or as defined in the definition of Telemedicine below, where Provider provides Health Care Services to Members or otherwise makes arrangements for the provision of Health Care Services as listed on Schedule 3.

mm. "Telemedicine" shall mean the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

3. DUTIES AND RESPONSIBILITIES OF PROVIDER.

a. Standards for Provision of Health Care Services. Provider agrees to provide Health Care Services to Members in accordance with the terms and conditions of this Agreement and in compliance with all Mandates applicable to Provider, ILS and/or the Managed Care Plan(s) and such policies and procedures of ILS and/or the applicable Managed Care Plan(s) including the applicable Provider Handbook. Provider agrees to provide medical services to Members in accordance with Provider's licensure and accreditation and the prevailing practices and standards of the profession and the community in which Provider is located. Provider agrees to provide Health Care Services to Members in the same manner and with the same availability as for all patients. Provider shall not discriminate against any Member in the provision of Health Care Services hereunder, whether on the basis of the Member's age, gender, race, color, religion, origin, sexual orientation, disability, health status, source of payment, utilization of medical or mental health services or supplies or other unlawful basis including, without limitation, the existence of a grievance by the Member against Provider.

b. Verification of Eligibility. Except in connection with the provision of Emergency Services and Care, Provider shall verify eligibility of Members before providing Health Care Services to such individuals and Provider shall not be entitled to compensation under this Agreement if it fails to verify eligibility of Members before providing Health Care Services to such individuals. In the case of Provider's provision of Emergency Services and Care, Provider shall notify the applicable

Managed Care Plan(s) and verify eligibility no later than the next business day following the provision of such services.

c. Credentials and Prior Approval of Provider. The credentials of Provider, must be verified and approved by ILS and/or the applicable Managed Care Plan(s) prior to this Agreement becoming effective and before any services are rendered by Provider to Members pursuant to this Agreement to the Members of a particular Managed Care Plan. Provider shall cooperate and promptly provide all information required or requested by ILS and/or the Managed Care Plan(s) related to credentialing. Provider has adopted and implemented and shall maintain credentialing procedures for the credentialing of its Professional Staff consistent with applicable law and the Provider Handbook and with the approval of ILS and the Managed Care Plan. Provider shall maintain accurate and complete provider credentialing information and records and shall promptly provide, from time to time as required by ILS and Managed Care Plan, all credentialing information and documents requested by ILS and/or Managed Care Plan. Notwithstanding anything to the contrary herein, this provision shall not be construed to authorize any member of the Professional Staff who has not been properly credentialed by Provider or ILS and/or Managed Care Plan to provide Health Care Services to Members.

d. Provider Availability. Provider agrees that it will accept new Members for as long as it is open to patients subject to the scope of Provider's licensure, accreditation or certification and any applicable laws and regulatory requirements including but not limited to provider-to-patient ratios. Provider shall provide at least ninety (90) days prior written notice to ILS and the applicable Managed Care Plan(s) if it or any of its Service Delivery Sites are no longer available to Members.

e. Submission of Encounter and Claims Data. Within ninety (90) days of rendering authorized Health Care Services to a Member, or sooner if required by ILS and/or the applicable Managed Care Plan(s) or by laws, rules or regulations applicable to ILS and/or Managed Care Plan(s), Provider shall remit encounter data and bill for such authorized Health Care Services rendered to the Member by submitting a Clean Claim to Managed Care Plan(s). Provider shall use its best efforts to submit Clean Claims electronically. Managed Care Plan(s) shall not be obligated to make any payments with respect to any claim for Covered Medical Services unless such claim is submitted (which is considered to be the date mailed or electronically transferred) to Managed Care Plan(s) at its designated claims-receipt location listed in the Managed Care Plans' Provider Handbook, within ninety (90) days from the date a Member: (1) is discharged for inpatient services; (2) received outpatient services or such shorter period of time as may be permitted under the applicable Managed Care Plan(s)' policies and procedures; or (3) receives Health Care Services.

f. Referrals to Participating Providers and Approvals. Except in connection with the provision of Emergency Services and Care, or as otherwise described in a Benefit Plan, or as otherwise required by law, Provider shall refer Members for Covered Medical Services only to Participating Providers, including but not limited to ancillary services such as laboratory and radiology. Provider shall use only Participating Providers which have been included on the applicable listing of approved Participating Providers for a particular Benefit Plan or have otherwise been specifically approved in advance by ILS and the applicable Managed Care Plan.

g. Non-Covered Medical Services. Provider shall not represent to any Member that any non-Covered Medical Service is a Covered Medical Service or that such non-Covered Medical Service should or will be paid by the applicable Managed Care Plan(s). Except as may be otherwise stated herein, nothing in this Agreement shall prohibit a Provider from seeking payment from a Member for non-Covered Medical Services, provided that Provider may render a non-Covered Medical Service to a Member only if the following conditions are met: (i) Provider advises the Member in writing in advance that the service is a non-Covered Medical Service; (ii) Provider advises the Member in writing that the applicable Managed Care Plan(s) will not pay for the service, and (iii) the Member consents to the service and agrees in writing to be responsible for payment. Nothing contained in this Agreement is intended to interfere with the provider-patient relationship or to prohibit or otherwise restrict Provider from freely communicating with or advising Members concerning the Member's health status, medical care or treatment options, or serving as an advocate on behalf of a Member regarding the Member's medical care or treatment options, regardless of benefit coverage limitations, including without limitation, any information Provider determines to be in the Member's best interests concerning (i) alternative treatments that may be self-administered, medication treatment options, and any other medical care and treatment options for the Member; (ii) the opportunity to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; or (iv) the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions. Nothing contained in this Agreement is intended to prohibit the provision of inpatient services in a participating hospital to a Member if such services are determined to be Medically Necessary and are Covered Medical Services.

h. Service Delivery Sites, Office Hours and After Hours Coverage. Provider shall maintain Service Delivery Sites which are clean, safe and are designed and maintained to provide Health Care Services to Members in an efficient and professional manner. All Service Delivery Sites must be equipped, staffed and designed to comply with all applicable laws and regulatory requirements and the requirements of ILS and the applicable Managed Care Plan(s). Provider shall not change any Service Delivery Site, including the addition of additional sites or closure of an existing site, without the prior written approval of ILS and the applicable Managed Care Plan(s) which approval shall be in the sole and absolute discretion of ILS and the applicable Managed Care Plan(s). Provider shall render Health Care Services under this Agreement at the Service Delivery Site(s) during normal business hours, and such other times as the Health Care Services may be required to be provided by the Managed Care Plan.

i. Medical or Clinic Director. If Provider is required to have a Medical or Clinic Director at all times during the term hereof, the individual shall be designated on Schedule 3, and shall act as Medical or Clinic Director as applicable. The Medical or Clinical Director shall coordinate with Provider, the Professional Staff on the one hand and with ILS and the applicable Managed Care Plan(s) on the other hand with respect to the medical/clinical management of the Members who are treated by Provider. The Medical/Clinical Director shall make certain that Members treated by Provider receive Medically Necessary services in conformance with standards of the medical community and ILS and the applicable Managed Care Plan(s) policies and procedures and the

terms and conditions of this Agreement. Provider may change its Medical or Clinical Director with the prior written consent of ILS and the applicable Managed Care Plan.

j. Administrator. Provider may utilize the services of an Administrator during the term of this Agreement. The Administrator will be responsible for the business and financial aspects of Provider related to the provision of Health Care Services hereunder and shall coordinate with ILS and the applicable Managed Care Plan and Provider and its Professional Staff. The Administrator will be designated on Schedule 3 hereto. Provider may notify ILS and the applicable Managed Care Plans within ten (10) days of changing its Administrator.

k. Provider Representations, Warranties and Covenants. Provider as to itself, and as to each member of its Professional Staff (to the extent applicable to such Professional Staff member's profession and to such Professional Staff member's provision of Health Care Services) represents, warrants and covenants that for the benefit of ILS and each applicable Managed Care Plan that each:

(i) is duly licensed and qualified and with respect to Provider, accredited, if applicable, to provide Health Care Services;

(ii) provides Health Care Services in compliance with all applicable local, state, and federal laws, rules, regulations and professional standards of care;

(iii) where applicable, is certified to participate in Medicare under Title XVIII of the Social Security Act and in Medicaid under Title XIX of the Social Security Act, has not been debarred, suspended or otherwise excluded from participation in the Medicare Program or Medicaid Program, as verified by monthly searches conducted by Provider, and Provider shall notify ILS and the applicable Managed Care Plan(s) immediately upon the disqualification of Provider and any of the Professional Staff from participation in the Medicare Program or Medicaid Program;

(iv) holds active staff privileges on the medical staff(s) of one or more participating hospitals, where applicable;

(v) holds a current DEA narcotic registration certificate, where applicable;

(vi) shall maintain all required or reasonably necessary licensure, compliance, certification, accreditation and registration, throughout the term of this Agreement and shall immediately notify ILS and the applicable Managed Care Plan(s) in the event any such licensure, compliance, certification, accreditation or registration is not maintained;

(vii) shall maintain a professional relationship with each Member to whom Provider renders Health Care Services are rendered, and shall be solely responsible to such Member for medical care; and

(viii) shall maintain all required professional credentials and meet all continuing education requirements necessary to retain certification or eligibility in Professional Staff's area(s) of

practice and shall immediately notify ILS and the applicable Managed Care Plan(s) in the event any such professional credentials are not maintained.

Provider further represents and warrants to ILS and the applicable Managed Care Plan(s) that: (i) this Agreement constitutes the legal, valid and binding obligation of Provider, enforceable against Provider, in accordance with its terms, and the individual signing this Agreement on behalf of Provider has been duly authorized and empowered to execute the Agreement; (ii) that if it is a corporation or other entity, it is duly organized under applicable law and that its owners and principals are listed on Schedule 5 hereto; (iii) the execution, delivery and performance of this Agreement has been duly authorized by all required action of Provider; (iv) such execution, delivery and performance does not violate any provisions of the organizational documents of Provider, any agreement to which Provider is a party (including any agreement with any other health maintenance organization or managed care provider), or any laws or regulations applicable to Provider; and (v) it has the right and power to cause each member of the Professional Staff to comply with the terms of this Agreement and that it shall contractually cause each member of the Professional Staff to comply with the terms of this Agreement. Provider hereby represents and warrants that it shall maintain copies of its contracts with its Professional Staff and ILS shall be provided access to such contracts to perform periodic audits of Provider's files to confirm such contracts are in fact maintained by Provider.

l. Required Notifications. Provider shall immediately notify ILS and Managed Care Plans in writing of: (i) any suspension, disenrollment, revocation, condition, expiration or other restriction of any licensure, certification or accreditation of Provider or any member of the Professional Staff necessary to provide Health Care Services; and (ii) the suspension or bar from, or imposition of any sanctions against Provider or any member of the Professional Staff; (iii) any employees or staff assisting in the provision of Health Care Services pursuant to this Agreement being debarred, suspended or otherwise excluded from participation in the Medicare Program or Medicaid Program, as may be evidenced by their inclusion on the OIG's List of Excluded Individuals and Entities or otherwise. Provider must notify ILS promptly and in no event more than five (5) days after Provider's knowledge of: (i) any investigative or disciplinary action initiated by any regulatory body against Provider or any member of the Professional Staff; (ii) the suspension, limitation, revocation or termination of Provider's or any member of the Professional Staff's hospital privileges; (iii) any adverse incident or action concerning or brought by a Member against Provider or any member of the Professional Staff; (iv) any litigation brought against Provider, any member of the Professional Staff or any subcontractors or employees, that is related to the provision of Health Care Services; and (v) any settlement related to Health Care Services provided under this Agreement or any of the foregoing or any other occurrence that could reasonably be expected to impair the ability of Provider or any member of the Professional Staff to perform under this Agreement.

4. DUTIES AND RESPONSIBILITIES OF ILS.

a. Administration. ILS shall coordinate with Provider to perform the appropriate administrative, and regulatory, functions necessary to administer the agreements between ILS and

the Managed Care Plan(s) and the provision of Covered Services thereunder to Members, pursuant to all applicable laws and regulatory requirements.

b. Provider Handbook. ILS will make the Provider Handbook of the applicable Managed Care Plan(s) available to Provider via website or other alternate means. To the extent possible, Managed Care Plan will notify Provider in writing, by electronic notification (email) and posting to Managed Care Plan's website or other means, at least thirty (30) days prior to any material modification to the Provider Handbook, or such shorter time as may be required by applicable laws and regulatory requirements.

c. Enrollee Eligibility. ILS will coordinate with the Managed Care Plan(s) to furnish Provider with access to Member eligibility information through electronic or other means.

d. Accounting. ILS shall maintain, in accordance with generally accepted accounting principles, such accounting records as shall be necessary, appropriate and convenient to carry out the purposes of this Agreement. Provider acknowledges that ILS in its sole discretion may engage a third party to perform these functions.

e. Quality Assurance and Utilization Review. When delegated by the applicable Managed Care Plan(s), ILS shall be responsible for implementing the Managed Care Plans' Quality Assurance and Utilization Review Program.

5. QUALITY ASSURANCE AND UTILIZATION REVIEW MANAGEMENT.

Provider agrees to support the principles of managed care through participation in ILS' and the Managed Care Plans' Quality Assurance and Utilization Review Program and will cooperate with ILS and the Managed Care Plan(s) to determine the Medical Necessity of any Inpatient Covered Medical Service or Outpatient Covered Medical Service required by any Member. Provider further agrees to participate in the Quality Assurance and Utilization Review Program, which includes internal peer review, on-site external audit, and other procedures to ensure efficient, cost effective services. Provider shall be solely responsible for all medical advice and services provided to each Member including the quality of Health Care Services rendered by Provider, or through its Professional Staff.

6. PROVIDER FEES.

a. Payment. As compensation in full for the provision of Health Care Services hereunder (other than for any applicable Copayments or deductibles allowed by law and the applicable Benefit Plan), the applicable Managed Care Plan(s) shall pay Provider as set forth in the applicable Compensation Schedule for such Managed Care Plan(s) and any other schedule or Addenda that discusses compensation. Managed Care Plan shall make payments directly to Provider for the provision of Health Care Services under this Agreement. Provider is solely responsible for the payment of compensation to Professional Staff Member or their employees and agents, if any, and under no circumstances will Managed Care Plan be responsible for the payment of compensation

to any individual of the member of the Professional Staff, its employees or agents. Provider will hold Managed Care Plan harmless for all costs, expenses, and liabilities incurred by Managed Care Plan in connection or as a result of Provider's non-payment of its obligations to its member of the Professional Staff and/or their employees and agents.

b. No Member Liability for Charges. Provider agrees that in no event, including, but not limited to non-payment by ILS and/or the applicable Managed Care Plan(s), insolvency of ILS and/or the applicable Managed Care Plan(s), or breach of this Agreement, shall Provider bill, charge or collect a deposit from, seek compensation remuneration or reimbursement from, or have a recourse against Members or persons other than ILS and/or the applicable Managed Care Plan(s), including, without limitation, seeking the difference between the amount paid under this Agreement and Provider's normal charges. This provision does not prohibit Provider from collecting applicable Copayments or reasonable charges for non-Covered Medical Services from Members or others, or from coordinating with third party payors for services rendered. This provision shall survive the termination or expiration of this Agreement for any reason. The provisions of this paragraph shall be included in every agreement between Provider and each member of its Professional Staff providing services to Members.

c. Adjustments; Right to Offset. Unless Provider disputes a payment from ILS and/or the applicable Managed Care Plan(s) in writing within (60) days of receipt of payment, or such shorter time frame as may be required by the applicable Managed Care Plan or any applicable laws or regulatory requirements, prior payment of the disputed claim(s) shall be considered final payment in full and will not be further reviewed by ILS and/or any Managed Care Plan(s). Provider shall promptly report and return to ILS and/or Managed Care Plan(s) any funds received in error or in excess of the amount to which Provider is entitled within sixty (60) days of identifying the overpayment or of which ILS and/or Managed Care Plan(s) notifies Provider. Subject to applicable laws and regulatory requirements, ILS and/or Managed Care Plan(s) may recover any overpayments made to Provider or other obligations of Provider owed to ILS and/or Managed Care Plan by offsetting them against payments due Provider from ILS and/or Managed Care Plan(s), as applicable. ILS and/or Managed Care Plan(s) shall also have the right to receive (or offset) from Provider and/or Provider shall have an obligation to indemnify ILS and/or Managed Care Plan(s) for, all costs, and damages incurred by ILS and/or Managed Care Plan(s) as a result of the default of Provider, including, without limitation, the cost of correcting any default, or the amount of reduction in the value of the services rendered by Provider, as well as any other costs, expenses, damages, expert fees and attorneys' fees. ILS and/or Managed Care Plan(s) shall have, in addition to any other remedies that it may have under this Agreement or at law or in equity, the right to obtain damages and to seek specific performance. Notwithstanding any provision to the contrary, termination of this Agreement shall not relieve Provider from any liability arising prior to termination, nor shall it affect Provider's obligations with respect to the portion of the services performed by Provider prior to termination of this Agreement, nor shall it relieve Provider of any other duties under this Agreement, including the indemnification obligations of Provider under this Agreement. ILS and/or Managed Care Plans' right to offset and Provider's obligation to indemnify ILS and/or Managed Care Plan(s) shall include any and all penalties that any

Governmental Agency may assess against ILS and/or Managed Care Plan(s) due to Provider's failure to comply with the terms and conditions of this Agreement or any applicable law or regulatory requirement.

7. TERM OF AGREEMENT.

a. Term and Termination Without Cause. The term of this Agreement shall commence on the Effective Date and shall continue for an initial term of one (1) year. Thereafter, the term of this Agreement shall automatically renew for additional successive terms of one (1) year each unless sooner terminated in accordance with the terms of this Agreement. Notwithstanding the foregoing, subject to Provider's obligations to continue to perform services for certain Members under Section 7(e) of this Agreement, either party may, without cause, terminate this Agreement by providing not less than ninety (90) days prior written notice the other party.

b. Termination for Cause by ILS. This Agreement may be terminated by ILS with written notice containing the basis for termination and specifying the effective date of termination upon the occurrence of any of the following events:

(i) Immediate Termination by ILS.

A. Insolvency. ILS may terminate this Agreement immediately in the event Provider commences an action for relief as a debtor under the United States Bankruptcy laws, or any bankruptcy, receivership, insolvency, reorganization, dissolution, liquidation or similar proceeding is instituted against Provider or any of the principals thereof.

B. Member Care. ILS may terminate this Agreement immediately due to failure of Provider or any member of the Professional Staff to render Health Care Services in accordance with the standards of quality established by the medical community or in the event ILS and/or Managed Care Plan(s) determines that Provider's or any member of the Professional Staff continued participation under this Agreement will adversely affect the health, safety or welfare of any Member; provided that ILS and/or Managed Care Plan(s) may in any event require immediate transfer and Provider shall cause the immediate transfer to a qualified Participating Provider of any Member whose health, safety or welfare is in jeopardy.

C. Criminal Charges. ILS may terminate this Agreement immediately if Provider (or any of its officers, directors, or shareholders), or any member of the Professional Staff, is charged with, indicted for, pleads guilty or nolo contendere to, or is convicted of, a felony or misdemeanor (excluding minor traffic violations).

(ii) Termination for Material Breach. ILS may terminate this Agreement for any material breach of this Agreement by Provider, which breach is not cured to the reasonable

satisfaction of ILS within thirty (30) days after receipt by Provider of written notice from ILS to Provider regarding the noncompliance by Provider or any member of the Professional Staff with the provisions of this Agreement, the policies and procedures of ILS or any applicable laws or regulatory requirements. Notwithstanding the prior notice requirement hereof, ILS may elect to automatically terminate this Agreement for cause due to a material breach of this Agreement which cannot be cured. Whether or not a material breach is capable of cure shall be solely within the discretion of ILS.

(iii) Termination Automatic. This Agreement is subject to automatic termination in the event Provider or any member of the Professional Staff is no longer eligible to participate in any portion of the Medicare Program, the Medicaid Program or any other state or federal health care program or, as a result of any State or Federal regulatory action, is unable to fulfill its obligations under this Agreement or upon the expiration, surrender, revocation, restriction or suspension (whether voluntary or involuntary) of Provider or member of the Professional Staff's license or credentials to practice medicine or otherwise provide Health Care Services in Florida or failure to comply with the requirements in Section 3(l).

(iv) Termination of Professional Staff. In the event ILS shall determine that any member of the Professional Staff is not in compliance with the terms of this Agreement, ILS may elect to so notify Provider, and, rather than terminate the Agreement as provided above, notify Provider of the remedial action to be taken by Provider to cure the deficiency within a period not less than thirty (30) days from Provider's receipt of such notice. In the event the deficiency has not been cured within the required period, to the satisfaction of ILS, ILS shall notify Provider of its determination to terminate the Agreement unless Provider undertakes to terminate the Professional Staff member's employment or engagement with Provider. The election of ILS to suggest remedial action shall in no way limit its right to terminate the Agreement.

(v) In the event this Agreement is terminated pursuant to this Section 7(b) for any reason may utilize the applicable appeals procedures, if any, provided in the Provider Handbook.

c. Termination for Cause by Provider. Provider may terminate this Agreement if ILS breaches any material obligation under this Agreement; provided, however, that Provider shall give ILS written notice of the breach of the Agreement, and ILS shall have thirty (30) days from receipt of such written notice to cure. If ILS fails to cure, termination shall be effective the later of (i) the last day of the month subsequent to the thirty (30) day cure period, or (ii) ninety (90) days from the date Provider gave ILS and the OIR written notice of Provider's termination of this Agreement as required under Section 641.315, Florida Statutes. As required by Section 641.315, Florida Statutes, nonpayment for goods or services rendered by Providers shall not be a valid reason for avoiding the ninety (90) day advance notice of cancellation.

d. Statutory Termination. The OIR, pursuant to Section 641.234, Florida Statutes, as amended, may order this Agreement to be canceled if it determines that the fees to be paid under this Agreement, are so unreasonably high as compared with similar contracts entered into by the applicable Managed Care Plan(s) or as compared with similar contracts entered into by other health maintenance organizations in similar circumstances, such that this Agreement is detrimental to the subscribers, stockholders, investors or creditors of the applicable Managed Care Plan(s). Accordingly, as required under Section 641.234, Florida Statutes, this Agreement shall be terminated if ordered by the OIR.

e. Continuation of Services. Provider acknowledges and understands that, pursuant to Section 641.285, Florida Statutes, the applicable Managed Care Plan(s) is required to maintain a plan for insolvency protection which provides for the continuation of benefits and payments to unaffiliated providers for services rendered both prior to and after insolvency for the duration of the contract period for which payment or by or on behalf of the subscriber has been made, or the discharge of the subscriber from an inpatient facility, whichever occurs later. Further, Provider acknowledges and understands that a Managed Care Plan may be removed from the Managed Care Plan Schedule without terminating this Agreement between ILS and the Provider.

f. Final Accounting and Financial Reconciliation. Within two hundred seventy (270) days of termination or expiration of this Agreement, ILS shall perform a final accounting and financial reconciliation of monies due and owing Provider under this Agreement, if any; provided that ILS shall have the right to extend such period of time if the Managed Care Plan(s) with which ILS has contracted and for which Provider has provided or arranged for the provision of Health Care Services has not completed a final accounting or reconciliation with respect to Provider. All determinations by Managed Care Plan shall be binding and final in the absence of fraud or mistake.

g. Transition Obligations. In the event of a termination of this Agreement, Provider will cooperate with ILS and the applicable Managed Care Plan(s) in connection with the orderly transfer of Members, and Member's records, who are treated by Provider to another Participating Provider as necessary and in accordance with all applicable laws and regulatory requirements to secure the continuation of care and to assure maximum health outcomes of each Member. This Section shall survive the expiration or termination of this Agreement for any reason.

8. ADMINISTRATIVE AND MEDICAL RECORDS AND REPORTS; INSPECTION AND AUDITS.

a. Reports. Provider shall promptly submit to ILS and the Managed Care Plan(s) all encounter data and utilization reports, clinical information, and such additional reports concerning the treatment of Members and as requested by ILS and/or the Managed Care Plan(s) and/or any Governmental Agency with authority over Provider, ILS and the Managed Care Plan(s) or this Agreement, in such form and at such times as required or requested by ILS and the Managed Care Plan(s) and/or a Governmental Agency. Provider acknowledges and agrees that Provider's failure

to submit such reports and information in such form and at such times as required or requested by ILS and/or the Managed Care Plan(s) and/or a Governmental Agency shall constitute a material breach of this Agreement and shall subject Provider to ILS' and/or Managed Care Plan(s)' right to offset and Provider's obligation to indemnify ILS and the Managed Care Plan(s) for any and all penalties that any Governmental Agency or any third party may assess against ILS and/or the Managed Care Plan(s) due to Provider's failure to comply with this Section, as further described in Section 6(c).

b. Referral Forms. For services requiring a referral form, Provider shall complete and utilize the form supplied by the applicable Managed Care Plan and/or ILS for each referral, as required by the applicable Managed Care Plan. Provider further agrees, and shall ensure its Professional Staff agree, to provide Health Care Services requiring a referral form only upon receipt of a properly completed form.

c. Administrative and Medical Records. Provider agrees to create and maintain administrative and medical records of its services, charges, dates, and other necessary and commonly accepted information elements for the Health Care Services provided to Members which conform to record-keeping standards of the medical community, including requirements as to confidentiality in accordance with Florida and federal laws and regulations including the Health Insurance Portability and Accountability Act of 1996, as amended, ("HIPAA") and the regulations promulgated thereunder and which also comply with all other applicable laws and regulatory requirements. ILS and the applicable Managed Care Plan(s) shall document compliance certification (business-to-business) testing of transaction compliance with HIPAA for Provider. Provider shall take appropriate measures to prevent the disclosure of protected health information other than as permitted by HIPAA. Provider shall make available to ILS, the applicable Managed Care Plan(s), the Member and/or another Participating Provider, copies of such records, upon request, for a period of ten (10) years from the date service was rendered. Provider shall not charge, ILS, any Managed Care Plan(s), any Member or a Participating Provider for the provision or copying of such records.

d. Retention of Records. Provider shall maintain patient records until the later of: (i) ten (10) years after the termination of this Agreement, (ii) ten (10) years after the completion of any audit or investigation, or (iii) such longer period required by law or shorter period as may be indicated in the Medicaid Addenda or an applicable Mandate.

e. Inspection and Audit of Records. Provider agrees that, upon request, and from time to time, ILS and/or the applicable Managed Care Plan(s) or any Governmental Agency with authority over Provider, ILS and/or the applicable Managed Care Plan(s) or this Agreement, and their respective designees, shall have the right to inspect, evaluate and audit administrative records, medical records, financial records, documents, papers, electronic records, books, reports and any other pertinent records kept by Provider in relation to the services provided to Members hereunder. Provider shall cooperate and assist with any such inspection, audit, investigation or subsequent legal action by providing access to the aforementioned records and access to its Service Delivery

Sites, as requested by such parties. Failure to cooperate with any such inspections, evaluations or audits will constitute a material breach of this Agreement.

9. INSURANCE AND INDEMNIFICATION.

a. Insurance. Provider shall at all times during the term of this Agreement maintain at its sole expense policies of liability insurance, professional liability insurance and Workers Compensation insurance in accordance with Mandates, with carriers acceptable to ILS and/or the Managed Care Plan and in such amounts as shall be required by Mandates or required by the Managed Care Plan; provided, however that Provider shall maintain professional liability insurance in a minimum amount per claim according to Mandates or as may be reasonably required by the Managed Care Plan, with such policies providing coverage for Provider and Members against any claim for damages arising as a result of injury to property or person, including death, in connection with the provision of services under this Agreement and the maintenance of Provider's Service Delivery Sites and equipment. Provider shall provide ILS with evidence of such coverage upon request, shall notify ILS within two (2) business days of any termination, cancellation or material modifications to any policy for all or any portion of the coverage, and shall require the carriers to provide ILS with notice within thirty (30) days of any policy termination, cancellation or material modification. This provision shall survive the termination of this Agreement for no less than the Statute of Limitations applicable to personal injury in the State of Florida.

b. Sovereign Immunity. Without waiving the right to sovereign immunity as may be provided in Mandates, the Provider may acknowledge by attestation it is self-insured for general liability under a State's sovereign immunity statute with monetary waiver limits per person and per occurrence, as such limits may be changed and set forth by State law. Provider agrees to notify ILS if, during the term of this Agreement, any change occurs regarding Provider's entitlement to sovereign immunity.

c. Notice of Claim. In the event Provider receives notice of a claim threatening or alleging professional negligence or malpractice by Provider, a member of its Professional Staff or ILS or Managed Care Plan, or any incident occurs that may result in legal proceedings or meets the incident reporting guidelines of ILS or Managed Care Plan, Provider shall provide notice to ILS and/or Managed Care Plan within forty-eight (48) hours of receipt, or such lesser period of time required by any applicable law or regulatory requirement. Provider shall also provide such notice in the event of a claim regarding any occurrence or incident which is required to be reported pursuant to Florida law.

d. Indemnification. Each party hereby agrees to fully indemnify and hold harmless the other party, and the other party's affiliates, shareholders, members, directors, officers, employees, servants, agents, heirs, successors and assigns from and against all and any claims, losses, liabilities, damages, costs, expenses, actions and causes of action, including reasonable attorneys' fees whether or not litigation is instituted, and if instituted, at both trial and appellate levels, suffered or incurred by the other in connection with any (including any threatened or proposed)

action, suit, proceeding, regulatory proceeding, demand, assessment or judgment arising out of or related to any damage or injury to persons or property suffered, or claimed to have been suffered, due to the indemnifying party's and/or the indemnifying party's affiliates, shareholders, members, directors, officers, employees, servants, agents, heirs, successors and assigns misconduct, acts, omissions or negligence in the performance of its obligations under this Agreement. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

10. AUTHORIZATION FOR ADVERTISING AND MARKETING.

a. Authority to Publish. Without further notice to Provider or authorization, ILS and Managed Care Plan(s) may utilize the name, address, telephone number, hours of operation and such other relevant information of Provider, in its provider lists, marketing materials and other community outreach materials.

b. Approval for Advertising. Provider shall not advertise or market utilizing ILS and Managed Care Plans' name or its Benefit Plans, or utilize any trademarks, trade names, logos or other intangible property of ILS or the Managed Care Plans without its respective prior written approval.

11. ASSIGNMENT, TRANSFER AND ENROLLMENT OF MEMBERS.

a. Assignment of Members. Nothing in this Agreement shall be construed to require any Managed Care Plan to assign or refer any minimum or maximum number of Members to Provider. By written notice to Provider, any Managed Care Plan may suspend Provider's treatment of Members to if any Managed Care Plan determines in its sole discretion that Provider is not complying with (1) the terms of this Agreement, (2) any Managed Care Plan's policies and procedures, or (3) any applicable law or regulatory requirement.

b. Transfers. Provider shall not encourage Member transfers from one Physician to another, and shall assist any Member who requests a transfer or disenrollment.

c. Enrollment. Provider acknowledges that Florida law requires that the applicable Managed Care Plan(s) has sole authority with regard to the enrollment of Members and Provider agrees that it shall not participate in any manner in the enrollment or disenrollment of Members.

12. COORDINATION OF BENEFITS.

a. Other Available Insurance Coverage. Provider shall cooperate with the applicable Managed Care Plan(s) in the coordination of benefits with other health plans or insurance coverages, subrogation, and/or reimbursements and in providing the necessary information and documentation to obtain payment of any kind from a third party for any service rendered. To the extent Provider has knowledge of any other insurance coverage available to a Member, or of any

legal action under which a Member is seeking damages for medical services rendered, Provider shall notify the applicable Managed Care Plan(s).

b. Third Party Payor. Provider shall bill third party payors directly for services provided to Members covered under a health plan which is primary to the coverage provided by the applicable Managed Care Plan(s), which may include, without limitation, casualty policies which pay for medical expenses resulting from accident or injury. Provider agrees to promptly notify the applicable Managed Care Plan(s) of any claim made to a third party payor on behalf of a Member and to remit such funds to the applicable Managed Care Plan(s) upon receipt.

13. PROPRIETARY INFORMATION, CONFIDENTIALITY, AND NON-SOLICITATION.

a. Proprietary Information. Provider acknowledges and agrees that ILS and each Managed Care Plan, as applicable, has developed, at a substantial investment, a going concern that has among its assets the Members, contracts, manuals, advertising and marketing materials, marketing plans, methods of doing business, personnel information, policies and procedures and other property. Provider further acknowledges and agrees that all records, reports, data, financial information, including the rates of compensation hereunder, business opportunities, Benefit Plan development and/or implementation and any other non-publicly available information given or transmitted to Provider by ILS and each Managed Care Plan, as applicable, are the confidential and proprietary information of ILS and each Managed Care Plan, as applicable. Provider acknowledges the proprietary interest of ILS and each Managed Care Plan, as applicable, and agrees that Provider shall keep, and shall ensure each member of its Professional Staff keeps, all such information and any other information concerning this Agreement, and Members, including, without limitation, Member names, addresses and phone numbers confidential in the same manner as a trade secret under Florida law. Provider shall not, and shall ensure that each member of its Professional Staff shall not, during the term of this Agreement and after termination or expiration of this Agreement for any reason, disclose such information to any third parties, except Provider's accountants, attorneys or other authorized representatives or as required for Provider's performance of its obligations under this Agreement or except as required by process of any applicable law or regulatory requirement. In the event of an actual or threatened breach of this provision, ILS and each Managed Care Plan, as applicable, shall be entitled to an injunction enforcing the foregoing in addition to all other remedies available at law. The terms and provisions of this Section shall survive the termination or expiration of this Agreement (without regard to whether the termination of this Agreement is consistent with or in contravention of the terms of this Agreement), and shall be fully enforceable despite and after any such termination.

b. Non-solicitation Restriction. During the term of this Agreement (including any renewal hereof) and for a period of one (1) years following termination or expiration of this Agreement (whether such termination is consistent with or in contravention of the terms of this Agreement), Provider and its affiliates, employees, shareholders, members, directors, officers, agents and/or owners shall not directly or indirectly engage in the Solicitation of Participating Providers or Members, or any person or entity that employs any such Members or Participating Providers,

without the prior written consent (which consent may be withheld in such parties' sole discretion) of ILS and each applicable Managed Care Plan (with respect to such Managed Care Plan's Members). For the purposes of this Section, "Solicitation" means any action by Provider, that will or may aid, cause or encourage (i) any Member or Participating Provider to discontinue their respective relationship with ILS or a Managed Care Plan; (ii) any Member to disenroll from a Managed Care Plan; (iii) any Participating Provider to discontinue performing services for ILS or a Managed Care Plan; (iv) or any Member to receive healthcare services from Provider or others without the prior written approval of applicable Managed Care Plan, which such consent Managed Care Plan may decline in its sole discretion; or (v) the loss by ILS of a Member for whom ILS provides or arranges for the provision of Covered Services under a contract with a Managed Care Plan. Provider, conclusively stipulate and admit that any violations of this Section by Provider or its affiliates, employees, shareholders, members, directors, officers, agents or owners will cause irreparable injury to ILS and/or the Managed Care Plan(s), that ILS or a Managed Care Plan will not have an adequate remedy at law for such a violation, and that ILS and/or the Managed Care Plan(s) shall be entitled to injunctive relief to halt such violation (without the necessity of posting bond, cash or otherwise), without prejudice to any right they may have to seek damages from Provider. The terms and provisions of this Section shall survive the termination or expiration of this Agreement (without regard to whether the termination of this Agreement is consistent with or in contravention of the terms of this Agreement), and shall be fully enforceable despite and after any such termination. This Section is not intended to limit a Physician's access to medical records or retention of records.

14. MALPRACTICE CLAIMS AND GRIEVANCE PROCEDURES.

Provider shall and shall cause its Professional Staff members to participate in the arbitration of medical malpractice claims arising out of the Covered Medical Services provided under this Agreement, in accordance with the applicable grievance and appeal procedures of the applicable Managed Care Plan(s). Provider also agrees and shall cause its Professional Staff members to participate in and be bound by the grievance procedure adopted by the applicable Managed Care Plan(s) pursuant to applicable laws and regulatory requirements.

15. GENERAL PROVISIONS.

a. Recitals. The statements made in the Recitals are true and correct in all material respects.

b. Amendments. All amendments to this Agreement, or any of its Addenda or schedules, proposed by Provider must be agreed to in writing by ILS in advance of the effective date thereof. Any amendment to this Agreement, including any of its Addenda or Schedules, proposed by ILS, including, but not limited to, the modification of a Benefit Plan by a Managed Care Plan or the development or implementation of new Benefit Plan products and/or payment mechanisms by a Managed Care Plan, shall be effective thirty (30) days after ILS has given written notice to Provider of the amendment, unless Provider notifies ILS in writing during the thirty (30) days of Provider's rejection of the requested amendment. In the event Provider rejects the requested amendment, the parties shall confer in good faith to reach an agreement. If an agreement cannot

be reached, the requested amendment shall not apply and ILS may, at its sole discretion, terminate the Agreement upon (90) days written notice to Provider or amend the Agreement by removing the applicable Managed Care Plan from the applicable Schedule 6 to this Agreement. ILS shall have the right to add to and remove from one or more Schedule 6s Managed Care Plans in its sole discretion upon thirty (30) days advance written notice to Provider. Provider shall provide Health Care Services to any such Managed Care Plan's Members in accordance with the provisions of this Agreement, unless within fifteen (15) days of having received notice from ILS of the addition of a Managed Care Plan, Provider delivers written notice to ILS of its intention not to provide Health Care Services to such Managed Care Plan's Members. Schedule 6s shall be deemed amended upon the addition of a Managed Care Plan in accordance with the provisions of this Section. Notwithstanding the foregoing, a change to the compensation required to be paid to Provider pursuant to this Agreement shall require the approval of Provider.

c. Regulatory Requirements. Notwithstanding the foregoing provision, the parties acknowledge that this Agreement, including any of its Addenda or schedules, and the provision of services hereunder is regulated by both state and federal law and regulatory requirements, and that this Agreement including any of its Addenda or schedules, may be required to be amended from time to time to comply with same. The parties agree that (i) any changes in applicable law or regulation that do not require this Agreement to be modified by a written amendment shall be automatically incorporated herein and (ii) where any changes in applicable law or regulation require this Agreement to be modified, such modification shall occur automatically without the need for the parties to execute any amendment to this Agreement. The terms and provisions of any such Amendment shall supersede any contrary terms or provisions of this Agreement. Additionally, to the extent applicable, Provider agrees to be bound by the terms of the Medicare Advantage Addendum and the Medicaid Addendum, as applicable, to this Agreement, which Addenda provide for certain regulatory requirements. Consistent with the provisions of Section 15(b) and this Section, the terms of such Addenda shall be amended in response to changes in applicable state or federal law or regulatory requirements, which amendments shall be binding upon Provider as provided in this Section. Any amendment to this Agreement, including any of its Addenda or schedules, requiring prior approval of or notice to any federal or state regulatory agency shall not become effective until all necessary approvals have been granted or all required notice periods have expired. In the event of a conflict between the terms and conditions of this Agreement and any applicable Addendum, the terms and conditions of the applicable Addendum will govern with respect to Provider's provision of Health Care Services to Members enrolled in the Benefit Plan covered by the applicable Addendum.

d. Assignment; Binding Effect. Except as otherwise expressly permitted herein, neither this Agreement, nor any rights, interests nor obligations hereunder may be assigned by Provider without the prior written consent of ILS. Any such assignment without the prior consent of ILS shall be null and void and shall have no effect. ILS may assign this Agreement in whole or in part to an affiliate or to a purchaser of all or substantially all of its assets or to another third party. This Agreement will be binding upon and is for the benefit of the parties hereto and their permitted successors, transfers and assigns, and is not for the benefit of any other person or entity.

e. Freedom to Contract. Nothing contained in this Agreement is intended to prohibit or restrict Provider from entering into a commercial contract with any other managed care plan.

f. Entire Agreement. This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

g. Network Development. Provider acknowledges and agrees that this is a non-exclusive agreement with respect to ILS and Managed Care Plan(s), and that ILS and Managed Care Plan(s) is/are free to contract with such providers of health care goods and services as ILS and Managed Care Plan, in its sole discretion, determines is desirable.

h. Waiver of Certain Restrictions. Provider agrees to waive and hereby waives with respect to ILS and Managed Care Plan(s) all exclusivity and non-competition restrictions contained in Provider's agreements with its Professional Staff members that may limit its Professional Staff members from providing services to Members. ILS and Managed Care Plan(s) shall be free to contract with the Professional Staff members with respect to the provision of Covered Medical Services to Members. The provisions of this Section shall survive termination of this Agreement.

i. Notice. Any notice required or permitted to be given under this Agreement in writing shall be delivered (i) in person; (ii) by certified mail, postage pre-paid, return receipt requested; (iii) on the date of transmission by facsimile; (iv) by commercial courier that guarantees delivery and provides a receipt; or (v) verification of Provider pickup at a Provider internet portal. Any notice shall be effective only upon delivery, which for any notice given by facsimile, shall mean notice that has been received by the party to whom it is sent as evidenced by confirmation of transmission by the sender. Such notices to Provider shall be addressed to the address set forth on the Signature Page unless changed in conformity with this Section. Either party may from time to time specify in writing to the other party a change in address for purposes of notice hereunder.

j. Governing Law. This Agreement, and the rights and obligations of the parties hereunder, shall be construed, interpreted and enforced in accordance with, and governed by, the laws of the State of Florida. Any suit, action or proceeding arising out of or relating to this Agreement shall only be commenced and maintained in a court of competent jurisdiction in Miami-Dade County, Florida, and each party waives objection to such jurisdiction and venue.

k. Waiver. No waiver of any default in the performance of any of the duties or obligations arising under this Agreement shall be valid unless in writing and signed by the waiving party. Waiver of any one default shall not constitute or be construed as creating a waiver of any other default or defaults. No course of dealing between the parties shall operate as a waiver or preclude the exercise of any rights or remedies under this Agreement. Failure on the part of either party to object to any act or failure to act of the other party, or to declare the other party in default, regardless of the extent of such default, shall not constitute a waiver by such party of its rights hereunder.

l. Cumulative Remedies. Remedies provided for in this Agreement shall be in addition to and not in lieu of any other remedies available to either party and shall not be deemed waivers or substitutions for any action or remedy the parties may have under law or equity.

m. Enforceability and Captions. The unenforceability or invalidity of any paragraph or subparagraph of this Agreement shall not affect the enforceability and validity of the balance of this Agreement. In the event any state or federal laws or regulations, now existing or promulgated after the Effective Date, are interpreted by judicial decision, a regulatory agency, or legal counsel or either party in such a manner as to indicate that the structure or substance of this Agreement may be in violation of such laws or regulations, ILS and Provider shall confer in good faith to amend this Agreement to comply with such laws or regulations while preserving, to the maximum extent possible, the underlying economic and financial arrangements. Captions in this Agreement are for convenience only and do not constitute substantive provisions nor affect the intent or interpretation of this Agreement.

n. Relationship between the Parties. The relationship between ILS, Managed Care Plan(s) and Provider, as well as their respective employees and agents, is that of independent contractors, solely for the purposes of carrying out the terms of this Agreement, and except as otherwise provided herein, neither shall be considered an agent or representative of the other party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose.

o. Third Party Beneficiaries. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of ILS, the Managed Care Plan(s) and Provider. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party.

p. Attorneys' Fees. In the event of any action, dispute, litigation or other proceeding arising in connection with this Agreement, the prevailing party in the action, dispute, litigation or other proceeding shall be entitled to recover from the non-prevailing party all reasonable fees, costs, and expenses of counsel incurred in connection with such proceedings, whether or not suit is instituted and if instituted, at both trial and appellate levels.

q. Authority. Each party executing this Agreement represents and warrants that it possesses all necessary capacity and authority to act for, sign and bind the respective entity on whose behalf it is signing.

r. Counterparts. This Agreement may be executed in separate counterparts, each of which shall be deemed an original, but both of which together shall constitute one and the same instrument. This Agreement shall become binding when one or both counterparts hereof, individually or taken together, shall bear the signatures of the parties.

s. Further Assurances. Each party hereto agrees to do all acts and things and to make, execute and deliver such written instruments as will from time to time be reasonably required to carry out the terms and provision of this Agreement.

[Signature Page Follows]

**Provider acknowledges receipt, review and approval of the Medicaid Addendum and Medicare Advantage Addendum attached hereto.**

**IN WITNESS WHEREOF,** the parties hereto have executed this Agreement effective as of the Effective Date.

**Effective Date:**_____

**INDEPENDENT LIVING SYSTEMS, LLC**

**BY:** _____
**NESTOR J. PLANA**
CHAIRMAN & CEO

**DATE** _____

**PROVIDER**

SIGNATURE: _____
PRINT NAME: ARLENE SCHWARTZ
TITLE: BOARD CHAIR

ADDRESS: 6009 NW 10th Str.
Margate, FL33063
EMAIL (#1): karindiaz@margatefl.com
EMAIL (#2): tlieberman@margatefl.com

TAX ID #: 59-2154528
NPI #: 1194163626
MEDICAID #: 687817200
MEDICARE # N/A

## SCHEDULE 1 HEALTH CARE SERVICES

Provider has been engaged by ILS to render ancillary Health Care Services ("Ancillary Health Care Services") to Members. Provider agrees to provide the below-listed Ancillary Health Care Services, which must be within the scope of Provider's licensure and accreditation, if any, in accordance with the Managed Care Plan's Provider Handbook.

List of Ancillary Health Care Services:

ADULT DAY HEALTH

The above list of Ancillary Health Care Services to be provided by Provider may be amended by ILS and/or the Managed Care Plan from time to time to include additional Ancillary Health Care Services which are services and procedures which reasonably are considered to be part of the above-listed ancillary services.

## SCHEDULE 2 - COMPENSATION SCHEDULE

SCHEDULE 2 is based on the type of Ancillary Health Care Services and the Managed Care Plan requirements. The parties agree the Compensation Schedule for Schedule 1, Health Care Services, in the Florida Statewide Medicaid Managed Care (SMMC) program will be the current prevailing fee schedule that is finalized as part of the readiness process for SMMC enrollments effective January 1, 2018.

*(If using the DocuSign system and the above is checked, an attachment icon will appear. Click that icon for more information. You will have the option to upload or fax the attachment.)*

**INDEPENDENT LIVING SYSTEMS, LLC**

**BY:** _____

**NESTOR J. PLANA**
CHAIRMAN & CEO

**DATE** _____

**PROVIDER**

SIGNATURE: _____
PRINT NAME: ARLENE SCHWARTZ
TITLE: BOARD CHAIR

ADDRESS: 6009 NW 10th Street
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EMAIL (#1): karindiaz@margatefl.com
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TAX ID #: 59-2154528
NPI #: 1194163626
MEDICAID #: 687817200
MEDICARE # N/A

## SCHEDULE 3 - SERVICE DELIVERY SITES

Provider will provide Health Care Services under this Agreement at the Service Delivery Sites listed below. Provider shall notify ILS within ten (10) business days of any change in information below; provided, however, that Provider shall provide at least ninety (90) days prior written notice to ILS if its Service Delivery Sites are no longer available to Members, and Provider shall not change any Service Delivery Site, including the addition of additional sites or closure of an existing site, without the prior written approval of ILS which approval shall be in the sole and absolute discretion of ILS. (If more than one Service Delivery Site, attach separate sheet as necessary. Below table represents the information to provider).

**Provider may choose to add an attachment for this Schedule. If so, add the Schedule number, Schedule name, your provider name, and date to the attachment. Check here if attachment** ____

*(If using the DocuSign system and the above is checked, an attachment icon will appear. Click that icon for more information. You will have the option to upload or fax the attachment.)*

| | SERVICE DELIVERY SITE | PAYMENT LOCATION IF DIFFERENT THAN "SITE" |
|---|---|---|
| FACILITY NAME | NWFP SENIOR CENTER DISTRICT | |
| ADDRESS | 6009 NW 10th Street | |
| CITY, STATE | Margate, FL33063 | |
| COUNTY location in Florida | BROWARD COUNTY | N/A |
| REGION served in Florida | PSA10 | N/A |
| TELEPHONE | 954-973-0300 | |
| EMERGENCY # | 954-973-5679 | |
| MEDICAL or CLINIC DIRECTOR | N/A | |
| ADMINISTRATOR | Karin Diaz | |
| EFFECTIVE DATE | | IF DIFFERENT THAN THIS AGREEMENT |

HOURS OF OPERATION.

PLEASE IDENTIFY THE "FROM" and "TO" TIME BY DAY OF THE WEEK. (For instance, 8am to 4:30pm, Mon, Tue, Wed, Thu, Fri, Sat, Sun.) Include this information below or in any attachment.

Mon, Tue, Wed, Thu, Fri. 8:00am to 4:00pm

## SCHEDULE 4 - ANCILLARY PROVIDER'S "PROFESSIONAL STAFF"

List all Professional Staff who will be providing Health Care Services as Professional Staff at the Service Delivery Site(s) listed above. Include information as requested in the format below. The credentials of every Professional Staff must be verified by the Ancillary Provider and may be subject to approval by ILS and/or Managed Care Plan(s) prior to any Health Care Services being rendered by the individual Professional Staff to Members (Attach separate sheet if necessary).

**Provider may choose to add an attachment for this Schedule. If so, add the Schedule number, Schedule name, your provider name, and date to the attachment.**
***Check here if attachment*_____**

*(If using the DocuSign system and the above is checked, an attachment icon will appear. Click that icon for more information. You will have the option to upload or fax the attachment.)*

| # | STAFF NAME | SPECIALTY IF ANY | LICENSE TYPE | LICENSE NUMBER | NPI NUMBER | MEDICARE PROVIDER NUMBER | MEDICAID PROVIDER NUMBER |
|---|---|---|---|---|---|---|---|
| 1 | Maria Silva | N/A | LPN | PN5145060 | | | |
| 2 | Carol Tretakis | N/A | RN | RN2011462 | | | |
| 3 | Ripley Howell | N/A | CNA | CNA69173 | | | |
| 4 | Eileen Nembhard | N/A | CNA | CNA137517 | | | |
| 5 | Marie Charles | N/A | CNA | CNA128477 | | | |
| | | | | | | | |

## SCHEDULE 5- OWNERSHIP

The individuals listed below, comprise all of the owners, directors and key management of Provider (the "Principals"), shall be bound by the provisions of this Agreement. Provider shall have a continuing obligation to notify ILS of any changes to the information listed below.

Provider shall notify ILS of any change of ownership involving more than five percent (5%) of the ownership of the entity listed below. ILS retains the right to cancel this Agreement, without further notice, in the event the new ownership is not acceptable to ILS.

1. Name of legal entity: SPECIAL DISTRICT/MUNICIPALITY
2. Type of Entity, i.e. PA, INC., LMTD PNTRSHIP, LLC: _____
3. List the names and addresses of all principals and key management of Provider, and include percent ownership of all owners of the entity named above. (Format example below.)

NAME OF OWNER: N/A
OWNER'S %: _____
ADDRESS FOR OWNER: _____

**Provider may choose to add an attachment for this Schedule. If so add the Schedule number, Schedule name, your provider name, and date to the attachment. Check here if attachment** ☐

(If using the DocuSign system and the above is checked, an attachment icon will appear. Click that icon for more information. You will have the option to upload or fax the attachment.)

## SCHEDULE 6

## MANAGED CARE PLAN and PAYOR CONTRACT(S) Participation Schedule

Unless ILS is notified otherwise in writing, Provider agrees to participate in the Managed Care Plans and other health benefit programs listed herein including:

- Those State of Florida Managed Care Plans and programs offered by ILS or any client Managed Care Plan of ILS pursuant to a Payor Contract with the State of Florida, and more specifically those listed below.
- Provider shall be a Participating Provider with ILS under the Managed Care Plan Contract and Payor Contract indicated below until Provider opts out in writing per the provisions of the Agreement:
- Facility Based Providers agree that they may be listed in ILS and the Managed Care Plan's Provider Directories for all adjacent State counties to better accommodate enrollees geographic options to access eligible services.

| Managed Care Plan Contract | Payor Contract / Program |
|---|---|
| Florida Community Care, LLC<br>c/o ILS<br>5200 Blue Lagoon Dr, Ste 500<br>Miami FL 33126 | Florida Statewide Medicaid Managed Care<br>SMMC, LTC and MMA component as<br>applicable to provider services |

Claims (delegee) and other contact information, including how Managed Care Plan handbooks sections are made available to Providers electronically, will be in the Managed Care Plan Cover Letter. Provider will acknowledge receipt of handbook(s) referenced and will agree to comply with all applicable terms and conditions contained therein. At minimum, a 30-day written notice is given for material changes to Provider Handbooks.

The Managed Care Plan and Payor identified are beneficiaries of this Agreement and may enforce any of its rights per the provisions of this Agreement.

**DATE** _____

**PROVIDER:**

SIGNATURE: _____
PRINT NAME: ARLENE SCHWARTZ
TITLE: BOARD CHAIR

ADDRESS: 6009 NW 10th Street
Margate, FL33063

EMAIL (#1): karindiaz@margatefl.com
EMAIL (#2): tlieberman@margatefl.com
TAX ID #: 59-2154528
NPI #: 1194163626
MEDICAID #: 687817200
MEDICARE # N/A

## SCHEDULE 6

## SCHEDULE 6 - MANAGED CARE PLAN and PAYOR CONTRACT(S) Participation Schedule

Unless ILS is notified otherwise in writing, Provider agrees to participate in the Managed Care Plans and other health benefit programs listed herein including:

- Those State of Florida Managed Care Plans and programs offered by ILS or any client Managed Care Plan of ILS pursuant to a Payor Contract with the State of Florida, and more specifically those listed below.
- Provider shall be a Participating Provider with ILS under the Managed Care Plan Contract and Payor Contract indicated below until Provider opts out in writing per the provisions of the Agreement:
- Facility Based Providers agree that they may be listed in ILS and the Managed Care Plan's Provider Directories for all adjacent State counties to better accommodate enrollees geographic options to access eligible services.

| Managed Care Plan Contract | Payor Contract / Program |
|---|---|
| | Florida Statewide Medicaid Managed Care SMMC, LTC and MMA component as applicable to provider services |

Claims (delegee) and other contact information, including how Managed Care Plan handbooks sections are made available to Providers electronically, will be in the Managed Care Plan Cover Letter. Provider will acknowledge receipt of handbook(s) referenced and will agree to comply with all applicable terms and conditions contained therein. At minimum, a 30-day written notice is given for material changes to Provider Handbooks.

The Managed Care Plan and Payor identified are beneficiaries of this Agreement and may enforce any of its rights per the provisions of this Agreement.

**DATE** _____

**PROVIDER:**

SIGNATURE: _____
Print name: ARLENE SCHWARTZ
BOARD CHAIR
Title: _____

ADDRESS: 6009 NW 10th Street
Margate, FL 33063

EMAIL (#1): karindiaz@margatefl.com
EMAIL (#2): tlieberman@margatefl.com
TAX ID #: 59-2154528
NPI #: 1194163626
MEDICAID #: 687817200

# MEDICARE ADVANTAGE ADDENDUM

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Independent Living Systems, LLC and Provider not inconsistent herein shall remain in full force and effect. This amendment shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

**Definitions:**

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

**Required Provisions:**

Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with [Entity Name], (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (iv)]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that

exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Independent Living Systems, LLC and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]

    a. Provider and any related entity, contractor or subcontractor will comply with respect to all clean claims submitted by or on behalf of providers within 14 days for electronic claims and within 30 days for claims submitted otherwise. 42 CFR § 422.520 and section 3.7 of the Management Services Agreement.

8. Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

9. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

    i. The delegated activities and reporting responsibilities are specified in Attachment B of the Management Services Agreement.

    ii. CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

    iii. The MA organization will monitor the performance of the parties on an ongoing basis in accordance with section 3.12 of the Management Services Agreement.

    iv. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis. Credentialing will be performed and monitored in accordance with section 3.4 of the Management Services Agreement.

v. If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

**[END OF DOCUMENT]**

# MEDICAID ADDENDUM

THIS MEDICAID ADDENDUM (the "Addendum") supplements the terms and conditions of the Agreement by and between ILS and Provider. Pursuant to the Agreement, Provider renders Health Care Services to Members. Managed Care Plan as identified in Schedule 6 has entered into an agreement with AHCA (the "Medicaid Contract") to arrange for the provision of health care services to Members eligible for the Medicaid Program and enrolled in a Medicaid Benefit Plan offered by said Managed Care Plan (the "Medicaid Benefit Plan"). The following requirements specifically apply to any Members that are enrolled under a Medicaid Benefit Plan ("Medicaid Members"). This Addendum is entered into for the purpose of ensuring compliance with Florida and Federal Medicaid laws, rules and regulations with respect to the Medicaid Benefit Plan and applies to Provider in its provision of services to Members of the applicable Managed Care Plan.

The provisions of this Addendum supplement the terms of the Agreement and are to be interpreted in a manner consistent with the terms of the Agreement, provided that to the extent the terms and conditions set forth in this Addendum conflict and cannot be reconciled with similar provisions elsewhere in this Agreement with respect to the provision of health care services to Medicaid Members, the terms or conditions of this Addendum shall prevail. In addition, to the extent that the terms or conditions of this Addendum conflict with a Medicaid Contract, the Medicaid Contract shall control as to Medicaid Members who are enrolled in a Medicaid Benefit Plan. Since the provisions of this Addendum apply to Provider, its Provider Practitioners, employees, contractors, subcontractors, and individuals or entities performing services for on behalf of Provider or any of the above named individuals or entities performing services related to the Agreement all references to Provider herein shall also be references to its Professional Staff, employees, contractors, subcontractors and individuals or entities performing services for or on behalf of Provider. Except as expressly modified by this Addendum, the Agreement remains in full force and effect and all capitalized terms in this Addendum (which are not otherwise defined) shall have the meaning ascribed to them in the Agreement.

1. **Compliance with Federal & State Laws.** The parties shall, to the extent applicable, comply with Chapter § 641.315, F.S., 42 CFR § 438.230, 42 CFR § 455.104, 42 CFR § 455.105 and 42 CFR § 455.106.

2. **Subcontracted and Downstream Providers.** Any obligation of Provider in this Attachment shall apply to all subcontracted and employed Providers to the same extent it applies to Provider. Provider agrees to include the terms and conditions contained herein in its contracts with Providers or other subcontractors.

3. **Enrollment in Medicaid Program.** Provider shall be enrolled in or is eligible for participation in the Medicaid program, consistent with provider disclosure, screening and enrollment requirements. Provider acknowledges and agrees that if Provider was involuntary terminated from the Medicaid Program other than for purposes of inactivity, Provider is not considered eligible.

4. **Covered Services & Other Requirements.** The Agreement and Provider Manual specify Covered Services, including applicable prior authorization requirements, acceptable billing codes, and populations to be served under the Agreement.

5. **Current Agreement with AHCA.** Provider shall have a current provider agreement with the Agency, as prescribed by the Agency.

6. **Indemnification.** Provider shall indemnify and hold AHCA and any Medicaid Member harmless from and against any and all claims, damages, causes of action, costs or expense, including court costs and reasonable attorneys' fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause survives the termination of the Agreement, including breach due to insolvency. AHCA may waive this requirement for itself, but not Medicaid Members, for damages in excess of the statutory cap on damages for public entities, if the provider is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers shall be approved in writing by AHCA.

7. **Workers' Compensation Insurance.** Provider shall secure and maintain during the life of the Agreement workers' compensation insurance coverage for all of its employees connected with services provided to Medicaid Members pursuant to the Medicaid Contract and in compliance with the Florida Workers' Compensation Laws.

8. **Lapse in Insurance Coverage.** Provider shall notify ILS and Managed Care Plan in the event of a lapse in general liability or medical malpractice insurance or if its assets fall below the amount necessary for licensure under Florida statutes.

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

10. **Recordkeeping.** Provider shall maintain adequate record systems for recording services, charges, dates and all other commonly accepted information elements for services rendered to Managed Care Plan's Members.

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

12. **Investigations and Inspections.** Provider shall cooperate fully with ILS, Managed Care Plan, AHCA (or its designee), CMS, the Office of the Inspector General (OIG), the Comptroller General, and Attorney General's Office for the inspection, evaluation, and

auditing of any records or documents (medical or financial) of the Managed Care Plan or its subcontractors at any time related to the Medicaid Contract (42 CFR 438.3(h)).

13. **Cooperation with Investigations.** Provider shall cooperate fully in any investigation by ILS, Managed Care Plan, AHCA, Medicaid Program Integrity Bureau (MPI), Medicaid Fraud Control Unit (MFCU) or other state or federal entity and in any subsequent legal action that may result from such an investigation involving the Medicaid Contract.

14. **Required Quality Improvement Reports and Clinical Information.** The specific reports and clinical information required of the Provider by the Managed Care Plan for quality improvement or other administrative purposes out of claims processing is contained in the Agreement and the Provider Manual.

15. **Notification of Pregnancy**. Provider shall immediately notify Managed Care Plan of a Member's pregnancy, including the mechanism of doing so, whether the pregnancy was identified through medical history, examination, testing, claims, or otherwise.

16. **Timely Access Standards.** Provider shall meet timely access standards pursuant to the Medicaid Contract.

17. **No Restriction on Provider**. This Agreement does not prohibit or restrict Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Medicaid Member who is his or her patient regarding:

    a. The Medicaid Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

    b. Any information the Medicaid Member needs to decide among all relevant treatment options.

    c. The risks, benefits and consequences of treatment or non-treatment.

    d. The Medicaid Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions (42 CFR § 438.102(a)(1))

18. **Advocating on behalf Provider**. This Agreement does not prohibit Provider from advocating on behalf of the Medicaid Member in any part of the grievance and appeal system or utilization management process, or individual authorization process to obtain necessary services; (42 CFR § 438.402(c)(1)(i)-(ii); 42 § CFR 438.408).

19. **Provider Termination.** Provider shall submit written notice of withdrawal from the Managed Care Plan's network at least ninety (90) days before the effective date of such withdrawal.

20. **Abuse, Neglect, and Exploitation Training.** All direct service Providers shall complete abuse, neglect, and exploitation training, including training to identify victims of human trafficking.

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

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

23. **Continuity of Care.** Provider shall provide for continuity of care for the course of treatment in the event the Agreement terminates during the course of a Medicaid Member's treatment. Following termination of the Agreement, except in the case of termination for cause, Provider shall continue to provide medically necessary services to Medicaid Members who are existing patients of Provider until the earlier of: (1) the Medicaid Member's selection of another provider, or (2) the expiration of sixty (60) days from the date of termination, or such other time period as determined by Managed Care Plan.

24. **Compensation.** Provider shall look solely to Managed Care Plan for compensation for services rendered, with the exception of any applicable cost-sharing and patient responsibility.

25. **Collection of Patient Responsibility.** Requirements for institutional care programs, hospice and assisted living facilities regarding collection of patient responsibility, including prohibiting the assessment of late fees is contained in the Provider Manual.

26. **Provider Participation.** Provider shall participate in Managed Care Plan's peer review, grievance, quality improvement, and utilization management activities, as directed by Managed Care Plan.

27. **Monitoring & Oversight Activities.** The monitoring and oversight activities the Managed Care Plan will follow, including monitoring of Covered Services rendered to Medicaid Members by the Managed Care Plan, are contained in the Provider Manual and/or Medicaid Contract.

28. **Measures of Quality & Performance.** The measures, metrics, and frequency of measurement that shall be used by the Managed Care Plan to monitor the quality and performance of the Provider are contained in the Provider Manual.

29. **Marketing Materials.** Provider shall only display marketing materials related to the Medicaid Contract that have been approved by AHCA, in writing, prior to use. To the extent that Provider distributes Managed Care Plan marketing materials, Provider shall remain neutral in discussing Managed Care Plan benefits with current and potential enrollees.

30. **Claims Submission.** Provider shall submit timely, complete and accurate claims to Managed Care Plan in accordance with the requirements of the Medicaid Contract, Section X.D, Information Management and Systems.

31. **Background Screening**. Provider shall comply with the background screening requirements set forth in the Medicaid Contract.

32. **HIPAA Privacy & Security.** Provider shall comply with HIPAA privacy and security provisions (42 CFR § 438.224).

33. **Appeals.** Any Provider whose participation is terminated pursuant to the Agreement for any reason shall utilize the applicable appeals procedures outlined in the Agreement and Provider Manual. No additional or separate right of appeal to AHCA or Managed Care Plan is created as a result of the Managed Care Plan's act of terminating, or decision to terminate, any provider under the Medicaid Contract.

34. **Provider Liability.** Provider shall not hold Medicaid Members or AHCA liable for any debts of Provider. This provision shall survive termination of the Agreement, including termination due to insolvency.

35. **Overpayments.** Upon Provider's identification of an overpayment, Provider shall report and return such overpayment to Managed Care Plan in writing within sixty (60) days from the date on which the overpayment was identified, including information regarding the reason for the overpayment, as indicated in the Provider Manual. (42 CFR § 438.608(d)(2))

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

37. **Copayments.** If copayments are waived as an expanded benefit, Provider must not charge Medicaid Members copayments for Covered Services; and if copayments are not waived as an expanded benefit; that the amount paid to providers shall be the contracted amount, less any applicable copayments.

38. **Responsibility of Health Plan.** No provider contract that the Managed Care Plan enters into with respect to performance under the Medicaid Contract shall in any way relieve the Managed Care Plan of any responsibility for the provision of services or duties under the Medicaid Contract. Managed Care Plan assures that all services and tasks related to the Agreement are performed in accordance with the terms of the Medicaid Contract. Managed Care Plan will identify in the Agreement any aspect of service that may be delegated by the Provider.

39. **Pending Agreement.** Managed Care Plan reserves the right to execute this Agreement pending the outcome of the provider enrollment process. Managed Care Plan shall terminate this Agreement immediately upon notification from AHCA if Provider cannot

be enrolled, or upon expiration of the one hundred twenty (120) day period without enrollment of the provider, and notify affected Medicaid Members in accordance with 42 CFR § 438.602(b)(2). Managed Care Plan is authorized to recoup any payments made under the Agreement if the provider does not successfully complete the credentialing process within one hundred twenty (120) days and the delay is not caused by the Managed Care Plan.

40. **National Provider Identification Submission**. Each Provider must have a national provider identifier (NPI) in accordance with Section 1173(b) of the Social Security Act, as enacted by Section 4707(a) of the Balanced Budget Act of 1997; and must submit any and all NPI numbers to Managed Care Plan.

41. **Report unlicensed ALFs and AFCHs.** Provider must report any assisted living facility or adult family care home that is suspected to be unlicensed to AHCA pursuant to Florida Statutes § 408.812.

42. **Hours of Operation**. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial managed care plan members or comparable Medicaid fee-for-service recipients, if the Provider serves only Medicaid recipients.

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

44. **Physician Incentive Plan.** If Managed Care Plan and Provider enter into a physician incentive plan, Managed Care Plan shall make no specific payment directly or indirectly under the physician incentive plan to Provider as an inducement to reduce or limit, Medically Necessary services to a Medicaid Member, and the incentive plan(s) shall not contain provisions that provide incentives, monetary or otherwise, for withholding Medically Necessary care.

45. **Primary Care Physician (PCP) Designation.** Provider agrees and shall cause each Provider Practitioner to agree to perform Medicaid Member case management responsibilities and duties associated with its designation as a PCP.

46. **Inpatient Services.** Provider agrees that this Agreement contains no provisions that prohibits the PCP from providing inpatient services in a participating hospital to an enrollee if such services are determined to be Medically Necessary and covered Services under the Medicaid Contract.

47. **Telemedicine Services**. Provider agrees that if Provider is approved by Managed Care Plan to provide services through telemedicine, then Provider is required to have and implement protocols to prevent telemedicine fraud and abuse that address:

- Authentication and authorization of users;
- Authentication of the origin of the information;

- The prevention of unauthorized access to the system or information;
- System security, including the integrity of information that is collected, program integrity and system integrity; and
- Maintenance of documentation about system and information usage.

48. **Public health Providers.** If Provider is a Public Health Provider, Provider shall contact Managed Care Plan before providing health care services to Medicaid Members and provide the Managed Care Plan with the results of the office visit, including test results.

49. **Conform to HCB Setting Requirements for ALFs and AFCHs.** To the extent Provider is an assisted living facility or adult family care home, Provider shall conform to the home and community-based settings requirements, including the following requirements:

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

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

    c. Choice of:
        i. Private or semi-private rooms, as available;
        ii. Roommate for semi-private rooms;
        iii. Locking door to living unit;
        iv. Access to telephone and unlimited length of use;
        v. Eating schedule;
        vi. Activities schedule; and
        vii. Participation in facility and community activities.

    d. Ability to have:
        i. Unrestricted visitation; and
        ii. Snacks as desired.

    e. Ability to:
        i. Prepare snacks as desired; and
        ii. Maintain personal sleeping schedule

50. **Payment for New or Additional Services.** To the extent Provider is an assisted living facility, Provider hereby agrees to accept monthly payments from Managed Care Plan for Medicaid Member services as full and final payment for all long term care services detailed in the Medicaid Member's plan of care which are to be provided by Provider. Medicaid Members remain responsible for the separate assisted living facility room and board costs as detailed in their resident contract. As Medicaid Members age in place and require more intense or additional long term care services, Provider may not request payment for new or additional services from a Medicaid Member, their family members or personal

representative. Provider may only negotiate payment terms for services pursuant to this provider agreement with Managed Care Plan.

51. **HCB Setting Requirements for ADHC.** To the extent Provider is an adult day health care provider, Provider shall conform to the home and community-based settings requirements and the following requirements:

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

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

    c. Choice of:
        i. Daily activities;
        ii. Physical environment;
        iii. With whom to interact;
        iv. Access to telephone and unlimited length of use;
        v. Eating schedule;
        vi. Activities schedule; and
        vii. Participation in facility and community activities.

    d. Ability to have:
        i. Right to privacy;
        ii. Right to dignity and respect;
        iii. Freedom from coercion and restraint; and
        iv. Opportunities to express self through individual initiative, autonomy, and independence.

52. **Reporting of Critical Incidents.** To the extent Provider is a home and community-based services provider, Provider shall report critical incidents to Managed Care Plan in a manner and format specified by Managed Care Plan, so as to ensure reporting of such critical incidents to AHCA within twenty-four (24) hours of the incident. Managed Care Plan does not require nursing facilities or assisted living facilities to report critical incidents or provide incident reports to the Managed Care Plan. Critical incidents occurring in nursing facilities and assisted living facilities will be addressed in accordance with Florida law, including but not limited to ss. 400.147 and 429.23, F.S., and Chapters 39 and 415, F.S.

53. **Timely access for appointments.** Provider agrees to ensure that appointments for medical services and behavioral health services are available on a timely basis as provided in the Medicaid Contract.

54. **Additional requirement for nursing facilities.** Participating nursing facilities shall maintain their active Medicaid enrollment and submit required cost reports to AHCA.

55. **Additional requirement for hospices.** Participating hospices shall maintain their active Medicaid enrollment and submit room and board cost logs to AHCA.

**[END OF DOCUMENT]**

# ATTACHMENTS

## CODE OF ETHICS ACKNOWLEDGEMENT OF RECEIPT

ACKNOWLEDGEMENT FOR FIRST TIER, DOWNSTREAM AND RELATED ENTITIES ON CODE OF ETHICS ASSESSMENT, FORMS, FREQUENTILY ASKED QUESTIONS, TRAINING AND RECEIPT OF CODE OF ETHICS SUPPORTING DOCUMENTATION

I _____(*Name)* acknowledge the receipt of the ILS Code of Ethics Training, completion of the Providers and Subcontractors Assessment, and a copy of the ILS Code of Ethics for FDR. I understand the ILS Code of Ethics and agree to comply with the requirements. I understand that my failure to comply with the requirements of the ILS Code of Ethics may subject me to disciplinary action which may include termination of the business relationship.

**PROVIDER**

NORTHWEST FOCAL POINT SENIOR CENTER DISTRICT

ADDRESS: 6009 NW 10th Street
Margate, FL33063

EMAIL (#1): karindiaz@margatefl.com
EMAIL (#2): tlieberman@margatefl.com

TAX ID #: 59-2154528
NPI #: 1194163626
MEDICAID #: 687817200
MEDICARE # N/A

SIGNATURE: _____

# PROVIDER MANUAL ACKNOWLEDGEMENT FORM

| Document Owner(s) | | | Project/Organization Role |
|---|---|---|---|
| Independent Living Systems, LLC | | | |
| **Version** | **Date** | **Author** | **Change Description** |
| 1 | 2018-2019 | | Health Plan, Medicare Advantage, Medicaid |

The Plan provider manual is available in both digital and print format. Refer to the Health Plan Cover Letter or the Provider Manual for detailed information about Plan Contacts, Telephone Numbers, Addresses, and Office Hours including but not limited to the following:

- Plan Grievance Coordinator
- Claims Mailing Address
- Program Administrator
- Case Manager Offices

A copy of the manual may be downloaded from www.ilshealth.com/providers and a printed copy requested at:

**MAIL**
Independent Living Systems, LLC
4601 NW 77th Ave
Doral, FL 33166

**PHONE/FAX**
Phone: (888) 262-1292
Fax: (888) 827-6170

**EMAIL:**
floridaproviders@ilshealth.com

Note: The PLAN, at its option, may change, delete, suspend, or discontinue parts or the Provider manual in its entirety, at any time without prior notice. The content of the provider manual does not constitute nor should it be construed as a promise by the plan as to Provider status or as a contract between Health Advantage Florida, Inc. (The Plan) and any of its Providers.

I hereby acknowledge on behalf of the provider(s) named herein that the plan. made the provider manual available to my organization as required by the Centers for Medicare and Medicaid Services, State and local regulatory agencies.

**PROVIDER**
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SIGNATURE: _____

## PROVIDER TRAINING ACKNOWLEDGEMENT FORM

I _____ (Name), as an authorized representative of the provider(s) named herein on schedule 3 and attachments, do hereby acknowledge that my organization(s) has read, understood and agree to abide by all guidelines, plan process, policies and procedures as outlined the training materials listed below. My organization further agrees to make said training materials available to our staff as deemed appropriate and to satisfy all requirements as set by the Centers for Medicare and Medicaid Services, State, Independent Living Systems, LLC and shall furnish written proof of training for all staff members upon request.

I acknowledge that I have read and agree to comply with all of the plan written compliance policies and procedures and Standards of Conduct, and will implement and distribute them to all employees and board members of my organization.

| Mandatory Training Modules | Plan Specific Training Modules |
|---|---|
| — Abuse, Neglect & Exploitation Training<br>— Cultural Sensitivity and Competency Training<br>— Fraud, Waste & Abuse Training<br>— HIPAA Compliance Training<br>— General Compliance Training | Other: _____<br>Other: _____<br>Other: _____<br>Other: _____<br>Other: _____ |

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MEDICARE # N/A

SIGNATURE: _____

## ABUSE, NEGLECT, AND EXPLOITATION TRAINING – PROVIDER ATTESTATION

All providers, who are mandated reporters of abuse, neglect, and exploitation, must attest that their staff has received the appropriate training. Please complete this Attestation by marking next to the applicable statement.

_____ We are a mandated reporter of Abuse, Neglect, and Exploitation. Our staff has received the appropriate training and update training as applicable. We are current with this requirement.

_____ We are NOT a mandated reporter of Abuse, Neglect, and Exploitation and will update this attestation should we become a mandated reporter.

Additionally, all providers and their employees with direct contact with enrollees must have completed Abuse, Neglect, and Exploitation Training. Please complete this Attestation as evidence of your compliance by marking next to the applicable statement.

_____ Our license requires that we provide Abuse, Neglect, and Exploitation training to our direct care staff upon orientation and annually. We are current with this requirement.

_____ Our licensure requires that we provide Abuse, Neglect, and Exploitation training to our direct care staff upon orientation only. We are current with the requirement.

_____ Our license does not require Abuse, Neglect, and Exploitation Training; however our policy and procedures require our staff to have this in-service training upon orientation. We are current with this requirement.

_____ Our license does not require Abuse, Neglect, and Exploitation Training and we request information or assistance to provide this annual training to our staff. We will complete this Provider Attestation again when we are current with this training requirement.

**PROVIDER**

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TAX ID #: 59-2154528
NPI #: 1194163626
MEDICAID #: 687817200
MEDICARE # N/A

SIGNATURE: _____

## HOME LIKE ENVIRONMENT AND COMMUNITY INTEGRATION ATTESTATION

***(Residential Facilities Only) If not applicable to your organization check here*** N/A

CMS technical guidance and State requirements, recognizes the importance of ensuring that enrollees who reside in Residential Facilities reside in Home-Like Environments (HLE) and experience community inclusion to the fullest extent possible. There is specific provider contract language on this subject.

To access Medicaid Home and Community Based funding the Residential Facility Provider must assure that they maintain a home-like environment and community integration. Please document the HLE characteristics of your facility and the **Community Integration Goal Planning below. Comment on any "NO" responses at the bottom.**

| HOME-LIKE ENVIRONMENTS (HLE) CHARACTERISTICS | Y/N |
|---|---|
| 1. The unit/room should be a specific physical place that can be owned or rented by the person receiving services, and the person should have, at a minimum, the same protections from eviction that the state's tenants have under landlord/tenant law. | |
| 2. Privacy: Units should have lockable entrance doors, with appropriate staff having keys to doors. | |
| 3. Privacy: Residents should share units only at the residents' choice. | |
| 4. Privacy: Unless residents sharing a unit are spouses or partners, each resident should have an individual bedroom. | |
| 5. Privacy: Residents should have the freedom to furnish and decorate their living units. | |
| 6. Residents should have the freedom and support to control their own schedules and activities, and should have access to food at any time. | |
| 7. Residents should be able to have visitors of their choosing at any time. | |
| Comment on any NO answers: | |

| COMMUNITY INTEGRATION GOAL PLANNING DOCUMENTATION | Y/N |
|---|---|
| 1. Are identified goals documented in the care plan in resident file? | |
| 2. Are identified barriers documented in the care plan in resident file? | |
| 3. Are interventions documented in the care plan in resident file? | |
| 4. Is progress documented in the care plan in resident file? | |
| Comment on any NO answers: | |

**I attest, acknowledge, and agree that we are, and will maintain, compliance with the agreement language on Home-Like Environment characteristics, Community Integration, and the applicable Resident Bill of Rights.**

**PROVIDER**

NORTHWEST FOCAL POINT SENIOR CENTER DISTRICT

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Margate,FL33063

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SIGNATURE: _____

# SCHEDULE 2 - COMPENSATION SCHEDULE

**Adult Day Care COMPENSATION and SERVICES**

SMMC LTC SERVICES:
**Adult Day Health**: Per Half Day Unit (up to 5 hours) with Rate = $30.00
**Adult Day Health**: Per Day Unit (over 5 hours) with Rate = $55.00

**Home Delivered Meals –** Older Americans Act (OOA) Per Meal Unit Rate = $_____
*Document your status as OAA Provider or other basis to provide HD Meals.*

**Respite Care** – Facility-Based: Per Day Unit with Rate = $55.00

**Transportation if licensed per Ch. 322, F.S.** – initial here _____ and submit proposal.

ADDITIONAL SERVICES that require a qualified, credentialed nurse would include:
**Behavior**: **Management*:** 15 Minute Unit Rate= $15.00
**RN-2 years of direct experience working with adult populations diagnosed with Alzheimer's disease, other dementias or persistent behavioral problems.*

**Caregiver Training, LPN, RN**: 15 Minute Unit with Rate = $13.00
**Medication Administration, LPN, RN:** 15 Minute Unit with Rate =$ 13.00
**Medication Management, LPN, RN**: 15 Minute Unit with Rate = $13.00
**Nutritional Assessment and Risk Reduction LPN, RN**: 15 Minute Unit with Rate = $ 13.00

ADDITIONAL SERVICES require a qualified, credentialed Therapist or OT, PT. ST assistant.
**Therapy, Occupational:** 15 Minute Unit with Rate = $17.50
**Therapy, Physical:** 15 Minute Unit with Rate = $17.50
**Therapy, Speech:** 15 Minute Unit with Rate = $17.50

Provider Signature: _____ Date _____
(Name/Title)

Provider Name: _____

ILS Signature: _____ Date _____
Nestor Plana, Chief Executive Officer, Independent Living Systems, LLC.