**Contract for**

**Medical services and coverage**

**Between Florida Healthy Kids Corporation**

**And**

**[Insurer]**

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**Contract to Provide Medical Services and Coverage**

This Contract is entered into between the Florida Healthy Kids Corporation (“FHKC”), a Florida not-for-profit corporation, pursuant to Chapter 617, Florida Statutes, and [Insurer] (“Insurer”) (each a “Party” and collectively, the “Parties”) to provide medical services and coverage, and supersedes all prior contracts, negotiations, representations or agreements either written or oral between the Parties relating to this Contract.

# Definitions and Acronyms

## Definitions

The capitalized terms used in this Contract shall have the meanings ascribed in this section unless otherwise expressly stated.

**Abuse:** Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care, or Enrollee practices that result in unnecessary cost to the Program.

**Act:** The Social Security Act.

**Adverse Benefit Determination:** the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by FHKC; the failure of Insurer to act within the timeframes required by law for standard resolution of Grievances and Appeals; and the denial of an Enrollee’s request to dispute a financial liability, including cost sharing, Copayments, premiums and other Enrollee financial liabilities.

**Agency for Health Care Administration:** the lead state agency for Title XXI of the Act for purposes of receipt of federal funds, reporting and for ensuring compliance with federal and state regulations and rules.

**Appeal:** a review by Insurer of an Adverse Benefit Determination.

**Applicant:** a parent or guardian of a child or a child whose disability of nonage had been removed under Chapter 743, Florida Statutes, who applies for determination of eligibility for health benefits coverage under Sections 409.810-820, Florida Statutes.

**Centers for Medicare and Medicaid Services:** the federal agency responsible for administering the Children’s Health Insurance Program.

**Children’s** **Medical Services Managed Care Plan (CMS Plan):** the statewide managed care system for children with special health care needs component of Florida’s CHIP.

**Contract Year:** January 1st through December 31st.

**{Coinsurance:** the percent of allowable charges that is an Enrollee’s financial responsibility to a Provider for Covered Services. *(Full-pay and subsidized)*}

**Copayment** or **Copay:** a specified dollar amount that is an Enrollee’s financial responsibility to a Provider for Covered Services at the time of receipt of services.

**Corrective Action Plan**: a step-by-step plan of action, including estimated dates of completion, developed and implemented to appropriately address errors or deficiencies in Insurer’s policies, processes, or other work under this Contract.

**Coverage Month:** the calendar month in which services for Covered Services may be provided.

**Covered Services:** Benefits and services covered under this Program applicable to this Contract as described in Attachment A.

**{Deductible**: a specified dollar amount that an Enrollee must pay for Covered Services before Insurer will pay for any Covered Services other than preventive care. *(Full-pay and subsidized)*}

**Effective Date:** January 1, 2020; the date on which Insurer commences performance of medical services and coverage to Enrollees.

**Emergency Medical Condition:** a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

**Emergency Services:** covered inpatient and outpatient services that are as follows:

1. Furnished by a provider that is qualified to furnish these services under Title 42.
2. Needed to evaluate or stabilize an Emergency Medical Condition.

**Enrollee:** an individual enrolled in Insurer’s Florida Healthy Kids plan.

**Execution Date:** the date on which the last Party to this Contract signed.

**Florida KidCare:** the health benefits program administered through Sections 409.810-409.821.

**Fraud:** an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes Fraud under applicable federal or state law.

**Full-pay Plan:** the non-Title XXI Florida Healthy Kids health insurance coverage available to children ages five through eighteen who are ineligible for subsidized Florida Healthy Kids coverage because of family income, reaching the lifetime limit for subsidized coverage, or any of the reasons provided in section 409.814(4), Florida Statutes, but are otherwise eligible for the Program.

**Grievance:** an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee’s rights regardless of whether remedial action is requested. Grievances also include an Enrollee’s right to dispute an extension of time proposed by Insurer to make an authorization decision.

**HIPAA**: As may from time-to-time may be amended, the (i) Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, including its Omnibus Rule; (ii) applicable provisions of the Health Information Technology for Economic and Clinical Health Act as incorporated in the American Recovery and Reinvestment Act of 2009; and (iii) their accompanying regulations, including the Privacy Rule (as defined herein) and the Security Rule (as defined herein). “Privacy Rule” means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR, part 160 and part 164, subparts A and E, providing for Federal privacy protections for an individual’s protected health information (“PHI”) held by entities subject to HIPAA requirements (each, a “Covered Entity”) and describing patient rights with respect to their PHI. “Security Rule” means HIPAA Security Standards (45 C.F.R. Parts 160, 162, and 164).

**Invitation to Negotiate:** ITN 2018-300-01 Medical Services and Coverage, and all addenda, issued by FHKC to competitively procure this Contract.

**Marketing:** communication from Insurer or Insurer’s employees, network Providers, agents or Subcontractors that can reasonably be interpreted as intended to influence an individual who is not enrolled with Insurer to enroll in Insurer’s particular Florida Healthy Kids product or to not enroll in or disenroll from another insurer’s Florida Healthy Kids product.

**Medically Necessary** or **Medical Necessity:** the use of any medical treatment, service, equipment or supply necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity and which is:

1. Consistent with the symptom, diagnosis and treatment of the Enrollee's condition;
2. Provided in accordance with generally accepted standards of medical practice;
3. Not primarily intended for the convenience of the Enrollee, the Enrollee's family or the health care Provider;
4. The most appropriate level of supply or service for the diagnosis and treatment of the Enrollee's condition; and
5. Approved by the appropriate medical body or health care specialty involved as effective, appropriate and essential for the care and treatment of the Enrollee's condition.

**Medical Services:** those services, medical equipment and supplies to be provided by Insurer in accordance with the standards set by FHKC and further described in Attachment A.

**Out-of-pocket Maximum:** an Enrollee’s maximum financial responsibility for Covered Services, including premiums paid, during {an Enrollee’s 12-month continuous eligibility period *(subsidized only)*} {a Title XXI Enrollee’s 12-month continuous eligibility period or, not including premiums paid, during a plan year for a Full-pay Enrollee *(Full-pay and subsidized)}*.

**Ownership Interest:** the possession of equity in the capital, the stock or the profits of a disclosing entity, as defined in 42 CFR 455.101.

**Ownership or control interest**: a person (individual or corporation) that:

1. Has an Ownership Interest totaling five percent (5%) or more in a disclosing entity;
2. Has an indirect Ownership Interest equal to five percent (5%) or more in a disclosing entity;
3. Has a combination of direct Ownership Interest and indirect Ownership Interest equal to five percent (5%) or more in a disclosing entity;
4. Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity if that interest equals at least five percent (5%) of the value of the property or assets of the disclosing entity;
5. Is an officer or director of a disclosing entity that is organized as a corporation; or
6. Is a partner in a disclosing entity that is organized as a partnership.

**Personally Identifiable Information:** information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

**Primary Care Provider:** A network Provider who furnishes primary care services to an Enrollee and who is board-certified in pediatrics or family medicine or has an exemption from the board-certification standard from FHKC.

**Post-stabilization Care Services:** Covered Services related to an Emergency Medical Condition that are provided after an Enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Enrollee’s condition pursuant to 42 CFR 422.113.

**Program:** the Florida Healthy Kids Title XXI authorized Children's Health Insurance Program (“CHIP”) and the Full-pay Plan administered by FHKC as created by and governed under section 624.91, Florida Statutes, and related state and federal laws.

**Protected Health Information**: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium except for individually identifiable health information:

1. In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;
2. In records described at 20 U.S.C. 1232g(a)(4(B)(iv);
3. In employment records held by a covered entity (under HIPAA) in its role as employer; and
4. Regarding a person who has been deceased for more than fifty (50) years.

**Providers:** an appropriately licensed individual or entity providing health care services.

**Renewal**: an additional Contract period after the initial Contract period, only if pursuant to Contract terms specifically providing for such renewal.

**Region:** any of the eleven (11) geographical areas designated by FHKC and encompassing specified Florida counties pursuant to Section 409.966, Florida Statutes.

**Service Area:** the designated Region(s) for which Insurer is authorized by the Contract to provide Covered Services to those {Title XXI or Full-pay *(Full-pay and subsidized)*} Enrollees whose home address is located in such Region(s){, treated as separate Service Areas regardless of any overlap in Regions *(Full-pay and subsidized)*}.

**Subcontractor:** any individual or entity with whom Insurer has a written agreement that relates directly or indirectly to the performance of Insurer’s obligations under this Contract. The term Subcontractor includes subsidiaries and affiliates. A network Provider is not a Subcontractor by virtue of the network provider agreement with Insurer.

**Subcontract:** a contract or other written agreement between Insurer and a Subcontractor or proposed Subcontractor.

**Waste:** overuse of services or other practices that, directly or indirectly, result in unnecessary costs to the Program, generally caused by the misuse of resources rather than criminally negligent actions.

## Acronyms

Acronyms commonly used in this Contract shall have the meanings ascribed in this section unless otherwise expressly stated.

**AHCA:** Agency for Health Care Administration

**BAA:** Business Associate Agreement

**CAP:** Corrective Action Plan

**CMS:** Centers for Medicare and Medicaid Services

**CHIP:** Children’s Health Insurance Program

**CHIPRA:** Children’s Health Insurance Program Re-Authorization Act of 2009

**COOP**: Continuity of Operations Plan

**EQR:** External Quality Review

**EQRO:** External Quality Review Organization

**HHS:** U.S. Department of Health and Human Services

**IRO:** Independent Review Organization

**ITN:** Invitation to Negotiate

**MLR:** Medical Loss Ratio

**PCP:** Primary Care Provider

**PHI:** Protected Health Information

**PII:** Personally Identifying Information

**PMPM**: Per member (i.e., Enrollee) per month

**Title XXI:** Children’s Health Insurance Program

# Entire Agreement

This Contract contains all terms and conditions agreed upon by the Parties relating to the subject matter of this Contract and supersedes all other agreements, negotiations, understanding, or representations, verbal or written, between the Parties relative to the subject matter hereof.

### Attachments

All attachments to this Contract are hereby incorporated into the Contract by reference.

### Modification of Terms

This Contract may be amended by mutual written consent of the Parties at any time.

The terms of this Contract shall be automatically modified without a written agreement to the extent necessary to comply with federal or state laws or regulations.

The terms of this Contract shall be automatically modified without a written agreement to the extent necessary to comply with the requirements of FHKC’s contract with the Agency for Health Care Administration (AHCA) upon FHKC’s notice to Insurer.

## Hierarchy of Documents

In the event of conflict among the Contract documents, the order of precedence is as follows:

1. This agreement
2. The attachments to this Contract

In the event the terms of this Contract conflict with federal or state laws or regulations, the federal or state laws or regulations prevail.

## Rules of Interpretation

This Contract is and shall be deemed jointly drafted and written by all Parties to it and shall not be construed or interpreted against the Party originating or preparing it.

Unless otherwise indicated or required by context, the following rules of interpretation apply:

1. All references to a section or attachment are to a section or attachment of this Contract;
2. The term “section” includes subsections, as indicated by the text;
3. The table of contents and section headings are for reference purposes only and do not limit or affect the meaning or interpretation of the text;
4. All singular terms include the plural and all plural terms include the singular.
5. Masculine, feminine and neutral gender terms include all genders;
6. The word “include” and its conjugations are deemed to be followed by the phrase “but not limited to”;
7. Reference to a governmental entity or person includes the authorized successors and assigns of the governmental entity or person; and
8. Reference to a federal or state law or regulation includes the federal or state law or regulation as amended or replaced.

# Contract Term; Service Area; Compensation

## Term

### Initial Term

The initial term of this Contract is three (3) years beginning on January 1, 2020 and ending after 11:59 P.M. on December 31, 2022 unless extended, terminated or renewed.

### Renewal Term

FHKC may elect to renew this Contract beyond the initial term for up to four (4), one (1) -year Renewal terms. FHKC may exercise the Renewal options of this Contract either in whole or in part.

## Service Area

Insurer’s Service Area comprises the following Regions:

{[Regions] *(reblend; subsidized only)*}

{Title XXI: [Regions]

{Full-pay: [Regions] *(Full-pay and subsidized)*}

## Compensation

Insurer agrees to perform all obligations under this Contract for the compensation and financial arrangements set forth in this Contract. No additional compensation shall be allowed unless specifically agreed upon in writing by the Parties.

### Payments to Insurer

FHKC shall make payments under this Contract monthly in accordance with the enrollment information maintained by FHKC’s system of record. Premiums are paid per Enrollee per month (PMPM) for the Enrollee’s Region of residency. {FHKC shall make separate payments for Title XXI Enrollees and Full-pay Enrollees *(Full-pay and subsidized)*} Insurer shall not invoice or bill FHKC.

FHKC will provide Insurer the total authorized premiums for the enrollment month and any retroactive enrollment changes no later than the twentieth (20th) day of the enrollment month. Retroactive disenrollments will be netted out from the active and retroactive enrollments.

FHKC reserves the right to delay premium payment without change in enrollment or any of Insurer’s obligations under this Contract when such payment delay is the result of any act described in Section 14 Force Majeure, changes to Florida’s CHIP State Plan or other temporary shortfalls resulting from mitigating actions for an emergency or urgent situation. In the event of such delay, FHKC shall act in good faith in resolving and making the delayed premium payments to Insurer.

Insurer shall only retain premium payments for Enrollees for the applicable Coverage Month. Premium payments made for individuals determined to be ineligible for coverage or who are otherwise disenrolled from Insurer’s plan for the Coverage Month shall be returned to FHKC.

#### Advanced Funds

Insurer agrees to use advanced funds only for the purposes identified under this Contract, if any.

#### Overpayments to Insurer

Insurer shall return any overpayments due to unearned or disallowed funds that were paid under this Contract to FHKC within forty-five (45) Calendar Days of identification by either Party.

#### {{Appropriations

FHKC’s ability and obligation to make payment for services performed under this Contract is contingent upon annual appropriate from the Florida Legislature and federal CHIP funding *(reblend; subsidized only)*} for Title XXI Enrollees *(full-pay and subsidized)*}}*.*

### Premiums

Effective January 1, 2020, the premium paid to Insurer shall be as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Region | {Subsidized PMPM *(subsidized only)*} | {Full-pay PMPM *(full-pay and subsidized)*} | {PMPM *(Reblend)*} |
|  |  |  |  |

### Premium Rate Modifications

#### Annual Premium Rate Adjustment Requests

Insurer shall provide an annual premium rate adjustment request for the upcoming Contract Year to FHKC by July 1 of each year unless there are no additional Renewal years available under the Contract or this provision is otherwise waived by FHKC. In the annual premium rate adjustment request, Insurer may request to reduce premium rates, make no change to premium rates, increase premium rates or any combination thereof for the Regions in Insurer’s Service Area.

The premium rate adjustment request shall be inclusive of Insurer’s Service Area. Insurer shall provide a premium rate adjustment for each Region in Insurer’s Service Area in the premium rate adjustment request. The health insurance provider’s fee provided for in section 9010 of the Act shall be incorporated into any rate adjustment request according to its applicability to the specific months in the rating period.

The premium rate adjustment request applies to an entire Contract year and apply to all of Insurer’s Enrollees in a Region. Premium rates shall not:

1. Include planned mid-plan year premium rate changes;
2. Require different premium rates based on when an Enrollee enrolls with Insurer;
3. Require different premium rates based on an Enrollee’s age;
4. Require different premium rates based on an Enrollee’s sex; or
5. Be discriminatory in any way.

Insurer shall not consider any claims paid to a network Provider, out-of-network Provider, Subcontractor or financial institution located outside the United States in the development of actuarially sound rates.

Insurer shall provide an actuarial memorandum supporting the premium rate adjustment request. The actuarial memorandum shall include the information and level of detail required by FHKC.

The proposed premium rates shall:

1. Be consistent with actuarially sound principles as required by 42 CFR 457.1203;
2. Not be excessive nor inadequate in accordance with the applicable requirements of Chapter 409, Florida Statutes; and
3. Be designed to reasonably achieve a medical loss ratio (MLR) standard that is at least equal to eighty-five percent (85%) for the Contract year and provides for reasonable administrative costs in accordance with 42 CFR 457.1203, Section 624.91, Florida Statutes, and section 9-5 of this Contract.

FHKC may choose to provide Insurer with available trend information that FHKC may utilize when reviewing the premium rate adjustment request.

FHKC may initiate and enter into premium rate adjustment negotiations following Insurer’s rate adjustment request submission. FHKC maintains the right to deny a rate adjustment request, require Insurer decrease rates or require Insurer hold rates flat based on the data provided by Insurer, FHKC’s analysis and other relevant factors as determined by FHKC.

Insurer shall respond to FHKC’s requests for additional or clarifying information during the premium rate adjustment review process.

Any changes to the premium rates must be approved by FHKC’s Board of Directors. Premium rate adjustments are also subject to the maximum average rate adjustment recommended by the Social Services Estimating Conference and approval by the Florida Legislature and Governor.

Failure to comply with the requirements of this provision may result in the denial of a premium rate adjustment request without recourse at FHKC’s sole discretion.

#### Benefit Schedule Change Premium Rate Adjustments

Changes in federal and state law may require changes to the benefit schedule during the Contract term.

FHKC shall notify Insurer of the required change in writing. Insurer may submit a premium rate adjustment request to accommodate the change within thirty (30) Calendar Days of receipt of notice in the manner specified by FHKC.

If the benefit schedule change results in a reduction in coverage or increases Enrollee cost sharing, FHKC may require that Insurer reduce its premium rate by an amount actuarially equivalent to the benefit reduction.

# Insurer Organization Administration

## Independent Contractor

Insurer performs work under this Contract as an independent contractor and not as an agent, representative or employee of FHKC. Neither Party has the authority to make any representation, warranty or binding commitment on behalf of the other Party, except as expressly provided in this Contract or as otherwise agreed to in writing by the Parties.

## Assignment

Insurer shall not assign this Contract or any of Insurer’s obligations under the Contract without prior written consent of FHKC. Any purported assignment without consent is void. Approval of such assignment by FHKC shall not be deemed to provide for the incurrence of any obligation of FHKC in addition to the amount agreed upon in this Contract.

## Warranty of Security; No Offshoring

Insurer shall be located and conduct all obligations under this Contract within the United States. Additionally, Insurer shall not send, store or allow access to Florida Healthy Kids data outside the United States.

Insurer agrees that a violation of this section will result in immediate and irreparable harm to FHKC and entitles FHKC to a credit in the amount of fifty thousand dollars ($50,000). This credit is intended only to cover FHKC’s internal staffing and administrative costs as well as the diminished value of services provided under the Contract and will not preclude FHKC from recovering other damages it may suffer as a result of such violation. For purposes of determining damages due hereunder, a group of violations relating to a common set of operative facts (e.g., same location, same time period, same offshore entity) will be treated as a single event.

A violation of this provision will also entitle FHKC to recover any damages arising from a breach of this section and may result in the termination of this Contract.

Insurer shall provide an annual certification attesting compliance with the warranty of security.

## Ownership and Control

### Prohibited Affiliations

Insurer may not have a relationship with the following:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described above.

For this provision, relationship is defined as any of the following:

1. A director, officer, or partner of Insurer;
2. A person with beneficial ownership of five percent (5%) of more of Insurer’s equity;
3. A network Provider or person with an employment, consulting or other arrangement with Insurer for the provision of items and services that are significant and material to Insurer’s obligations under its contract with FHKC or the State; or
4. A Subcontractor.

Insurer understands that failure to comply with this provision is subject to 42 CFR 457.1285, which incorporates 42 CFR 438.610(d).

Insurer shall submit an annual disclosure of any prohibited affiliations to FHKC.

Insurer shall conduct, for any of its employed or subcontracted personnel or entities provided health care, administrative or management services under this Contract, appropriate screening for debarment, ineligibility or exclusion from participation in Medicare, Medicaid, CHIP and any other government health care program. Insurer shall submit a certification to FHKC regarding debarment, suspension, ineligibility and exclusion, as provided by FHKC, at the time of Contract Execution. Such certification attests that neither Insurer nor any of its owners, directors, officers, employees, Subcontractors or Providers is presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in the Contract by any federal agency. Insurer shall also require each of its Subcontractors to sign a copy of the certification.

### Public Entity Crimes

In accordance with Section 287.017, Florida Statute, a person or affiliate who has been placed on the convicted vendor list following a conviction for public entity crime may not be awarded or perform work as a contractor, supplier, Subcontractor, or consultant for thirty-six (36) months from the date of being placed on the convicted vendor list.

Section 287.017, Florida Statute, applies to this Contract by virtue of FHKC’s contractual relationship with AHCA.

### Ownership and Control Disclosures

Insurer shall provide written disclosures of the following Ownership and Control Interest information to FHKC upon Contract execution, upon any Renewal or extension of the Contract and within thirty-five (35) Calendar Days of any change in ownership of Insurer.

Insurer shall submit the following information for any person (individual or corporation) with an Ownership or Control Interest in Insurer:

1. Name;
2. Address;
   1. For corporations with Ownership or Control Interest, this includes the primary business address, every business location address and all P.O. Box addresses.
3. Date of birth and Social Security Number (in the case of an individual);
4. Tax identification number, for corporations with an Ownership or Control Interest in Insurer or in any Subcontractor in which Insurer has a five percent (5%) or more interest;
5. Whether the person with Ownership or Control Interest in Insurer is related to (as a spouse, parent, child or sibling) another person with Ownership or Control Interest in Insurer;
6. Whether the person with Ownership or Control Interest in any Subcontractor in which Insurer has a five percent (5%) or more interest is related to (as a spouse, parent, child or sibling) another person with Ownership or Control Interest in Insurer;
7. The name of any other disclosing entity, as defined in 42 CFR 455.101, in which an owner of Insurer has Ownership or Control Interest; and
8. The following information for Insurer’s managing employees, as defined in 42 CFR 455.101:
   1. Name;
   2. Address;
   3. Date of birth; and
   4. Social Security Number.

Failure to adhere to this requirement may result in Insurer’s ineligibility for federal financial participation in payments made to Insurer and may result in termination of this Contract or other consequences in accordance with the Contract terms and 42 CFR 457.1285 incorporating 42 CFR 438.610.

#### Determination of Ownership or Control Interest Percentages

Direct Ownership or Control Interest is determined by multiplying the percentage of interest that a person (individual or corporation) owns by the percentage of Insurer’s assets used to secure the obligation. By way of example, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of Insurer’s assets, the person’s direct interest in Insurer is six percent (6%) and must be reported.

Indirect Ownership or Control Interest is determined by multiplying the percentage of ownership in each entity. By way of example, if a person owns ten percent (10%) of the stock in a corporation which owns eighty percent (80%) of Insurer’s stock, the person’s indirect interest in Insurer is eight percent (8%) and must be reported.

## Change of Controlling Interest

No change in Insurer’s structure, ownership, or controlling interest releases Insurer from its obligations under this Contract.

Insurer shall give FHKC notice of regulatory agency approval, if applicable, prior to any transfer or change in control.

FHKC has the right to elect to continue or terminate this Contract, at its sole discretion, in the event of a change in Insurer’s ownership, structure or controlling interest. In such event, FHKC shall provide at least thirty (30) Calendar Days’ notice to Insurer of the decision to terminate the Contract.

## Conflicts of Interest

Insurer agrees that its obligations under this Contract are not in conflict with any other interest to which Insurer is obligated or from which Insurer benefits. Insurer affirms that it meets or exceeds the federal safeguards of 41 U.S.C. 423, section 27.

Insurer shall submit the conflict of interest disclosure form provided by FHKC identifying any potential conflicts of interest:

1. Within five (5) Business Days after Insurer’s receipt of the executed Contract;
2. Annually by January 15th; and
3. Within ten (10) Business Days after becoming aware of any potential conflicts of interest.

FHKC shall be the sole determiner of whether a conflict of interest exists and the action needed to resolve the conflict.

## Lobbying Disclosure

Insurer shall disclose information regarding the lobbying activities of Insurer, its Subcontractors or its authorized agents in compliance with applicable state and federal requirements. Insurer shall certify that no state or federal funds have been or will be used in lobbying activities. Insurer shall provide the lobbying certification at Contract execution and annually by January 15th.

## Gift Prohibitions

Insurer shall not offer any gifts, including any meal, service or item of value, even if such value is *de minimis*, to FHKC board members, FHKC ad hoc board members or FHKC employees.

## Non-Solicitation

Insurer acknowledges that FHKC recruits and trains personnel to perform work directly and indirectly related to this Contract and that this is a costly and time-consuming effort. Insurer agrees that during the term of this Contract and the twelve (12) months following the termination of this Contract, Insurer shall not recruit or directly or indirectly employ any individual who is employed by FHKC during the term of this Contract, unless FHKC waives such instance in writing.

## Insurance

During the term of this Contract and entirely at Insurer’s expense, Insurer shall continuously maintain insurance coverage that may be reasonably associated with the Contract. Providing and maintaining the required insurance coverage is a material obligation and failure to comply with these requirements shall constitute a material breach. Insurer shall not perform any work in connection with this Contract until such insurance has been secured by Insurer and approved by FHKC. Such coverage must include the following:

1. Commercial general liability insurance. Insurer must continuously maintain commercial general liability insurance (inclusive of any amounts provided by an umbrella or excess policy) in the face amount of [amount]. Such insurance shall include a hold harmless agreement in favor of FHKC and must include FHKC as an additional named insured for the entire length of the Contract.
2. Professional liability/errors and omissions insurance. Insurer must continuously maintain professional liability or errors and omissions insurance with a minimum limit of [amount] per occurrence and [amount] per aggregate. Such insurance shall include an agreement that Insurer shall provide thirty (30) Calendar Days’ prior notice of any cancellation of coverage to FHKC.
3. Cyber liability insurance. Insurer must continuously maintain cyber liability insurance in a minimum limit of [amount] per occurrence and [amount] per aggregate. If Insurer self-insures for cyber liability insurance, Insurer shall provide FHKC with the total amount self-insured and the total amount of any excess coverage in place. If Insurer’s self-insured amount is lower than the minimum required aggregate, Insurer must provide proof of insurance coverage for an amount that at least meets the minimum required amount in combination with the self-insurance.
4. Worker’s compensation insurance. Insurer shall comply with all worker’s compensation laws and regulations. Insurer may be self-insured to the extent permitted by law and such self-insurance shall comply with the Florida Worker’s Compensation law. In the event hazardous work is being performed by Insurer’s employees under this Contract and any class of employees performing the hazardous work is not protected under worker’s compensation statutes, Insurer shall provide adequate insurance satisfactory to FHKC for the protection of its employees not otherwise covered. Insurer shall ensure all Subcontractors comply with this provision.

Insurer shall provide a certificate of insurance as proof of coverage for each type of insurance required within ten (10) Business Days of Contract execution. Insurer shall provide proof of continuing coverage to FHKC by December 31st each year or by the date of expiration of the certificate of insurance, whichever is earlier.

## Employment; E-Verify

Insurer shall comply with section 274A (e) of the Immigration and Nationalization Act. FHKC shall consider the employment by any contractor of unauthorized aliens a violation of this act. If Insurer knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. Insurer shall include this provision in all Subcontractor Written Agreements with private organizations for work related to this Contract.

Insurer shall use the U.S. Department of Homeland Security’s E-Verify Employment Eligibility System to verify the employment status of all new employees employed by Insurer during the term of this Contract.

Insurer shall require all Subcontractors to utilize the E-Verify system to verify the employment status of all new employees contracted by the Subcontractor during the term of the Contract and include such requirement in all Subcontracts.

Compliance with this section is a condition of funds provided through this Contract.

## Background Screening

Insurer shall perform, or ensure performance of, a criminal background screening comparable to a level 2 background screening as described in Section 435.04, Florida Statutes, for all individuals employed, directly or indirectly, by Insurer or Insurer’s Subcontractor(s) in the performance of Insurer’s obligations under this Contract who have access to Personal Health Information (PHI), Personally Identifiable Information (PII) or financial information related to this Contract prior to such individual’s access to data. Such background screening shall be required to be completed for each individual every five (5) years. Insurer shall maintain documentation of all background screening records pursuant to section 10 Record Retention.

Unless an exemption is granted, Insurer shall not allow any individual to perform work under this Contract who has unacceptable background screening results as described in:

1. Described in Section 435.04(2) and (3), Florida Statutes;
2. Relating to the criminal use of PII as described in Chapter 817, Florida Statutes;
3. Offenses described in Sections 812.0195, 815.04, 815.08, Florida Statutes; or
4. That were subject to criminal penalties for the misuse of PHI under 42 U.S.C. 1320d-5.

Insurer shall develop and submit policies and procedures related to the background screening requirement, including a procedure to grant an exemption from disqualification for disqualifying offenses revealed by background screening, as described in Section 435.07, Florida Statutes, to FHKC for approval by the date required in the approved implementation plan.

Insurer shall provide an annual attestation of compliance with this provision.

# Subcontractors

Insurer may delegate performance of work required under this Contract to Subcontractors with prior written approval from FHKC; however, Insurer maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract. Insurer is responsible for all acts or omissions of Subcontractors Insurer utilizes during the term of the Contract. FHKC has no liability of any kind for any Subcontractor demands, losses, damage, negligence or direct or indirect expenses.

In the event FHKC determines a Subcontract is not in compliance with the requirements of this Contract, Insurer must correct the deficiency to receive FHKC approval. FHKC has the right to withhold approval of any Subcontracts or amendments to approved Subcontractor contracts.

Insurer shall submit any proposed new or amended Subcontracts to FHKC for review at least ninety (90) Calendar Days before the proposed effective date of the delegation or amendment. FHKC may, at its sole discretion, waive the submission timeframe upon Insurer request and evidence of good cause.

All requests for Subcontractor approval shall include a copy of the Subcontract. If a request solely involves an amendment, Insurer may submit the proposed amendment without a copy of the approved Subcontract in effect with prior approval from FHKC.

Insurer shall provide Subcontractor disclosures pursuant to 42 CFR 457.1285, which incorporates 42 CFR 438.608(c).

Insurer shall provide the following information about Insurer’s Grievance and Appeal process to applicable Subcontractors upon entrance into the Subcontract in accordance with 42 CFR 457.1260, which incorporates 42 CFR 438.414:

1. The right to file Grievances and Appeals;
2. The requirements and timeframes for filing a Grievance or Appeal;
3. The availability of assistance in the filing process; and
4. The right to request an independent review after Insurer has made an adverse Appeal determination.

Insurer’s failure to comply with the provisions of this section shall constitute a material breach of this Contract.

## Subcontracts

All Subcontracts must ultimately be executed by both Insurer and the Subcontractor before work directly or indirectly related to this Contract begins. Insurer shall provide any executed Subcontracts to FHKC within seven (7) Business Days after request of such documents.

The Subcontract shall:

1. Specify the delegated activities or obligations, including related reporting responsibilities;
2. Require performance of the delegated activities and reporting responsibilities specified in compliance with Insurer’s obligations under this Contract;
3. Provide for the revocation of the delegation of activities or obligations or specify other remedies in instances where either Party determine that the Subcontractor has not performed satisfactorily;
4. Require compliance with all applicable laws, regulations and subregulatory guidance and contract provisions, including audit and record retention requirements; and
5. Require Subcontractor to maintain complete and accurate records.

If the Subcontractor delegation involves coverage of services and claims payment, the Subcontract shall require the Subcontractor to implement and maintain arrangements or procedures designed to detect and prevent Fraud, Waste and Abuse.

If the Subcontractor delegation is for management of Covered Services, including pharmacy benefits management, durable medical equipment or behavioral health services, Insurer shall also include the following in the Subcontractor approval request:

1. Documentation supporting network adequacy and capacity to serve, as applicable for the specific delegations;
2. Copy of applicable licensure, as appropriate;
3. Specification of the Regions covered by the Subcontractor;
4. Description of Insurer’s plan to monitor compliance;
5. Confirmation of the Subcontractor’s ability to accurately process and pass claims and encounter data to Insurer in a manner that can be stored and utilized by Insurer, including seamless passthrough to FHKC, AHCA and their designees. The confirmation shall include a summary description of Insurer’s testing activities with the proposed Subcontractor.
6. For Subcontractors delegated any functions related to behavioral health Covered Services, Insurer shall provide an analysis of the Subcontractor’s compliance with 42 CFR 457.496 and a plan to assure continued compliance with parity of nonquantitative treatment limitations should Subcontractor or Insurer make any changes to utilization management controls or other aspects impacting nonquantitative treatment limitations. The mental health and substance abuse disorder parity analysis and plan are subject to FHKC’s acceptance.

## Subcontractor Monitoring

Insurer shall conduct routine monitoring of all Subcontractors. Insurer shall also conduct risk assessments of all Subcontractors and their delegated activities related to this Contract. The outcome of the risk assessment shall directly inform Insurer’s Subcontractor monitoring plan. Insurer shall conduct non-routine monitoring, as needed. Insurer shall provide a Subcontractor monitoring schedule for all Subcontractors by the date established in the approved implementation plan and then annually by December 1st.

Insurer shall provide a quarterly summary of Subcontractor monitoring, including any findings and corrective action taken during the quarter. FHKC, at FHKC’s sole discretion, may require more frequent reporting should Insurer’s performance, the Subcontractor’s performance, other risk or perceived value of increased reporting frequency compel such change.

Insurer shall have a contingency plan for each Subcontractor to safeguard performance of the delegated obligations should the Subcontractor cease to perform or adequately perform its obligations under the Subcontract.

In the event FHKC determines a Subcontractor is not in compliance with the requirements of this Contract, Insurer shall promptly correct the Subcontractor’s non-compliance.

Insurer shall inform FHKC of any Subcontractor termination, in whole or in part, within the following timeframes:

1. For Subcontractors delegated management of a Covered Benefit: ninety (90) Calendar Days prior to termination;
2. For Subcontractors terminated for cause: one (1) Business Day of the earlier of the date Insurer notifies Subcontractor of intention to terminate or the date of termination; and
3. For all others: thirty (30) Calendar Days prior to termination.

## Subcontractor Solvency

In the event Insurer learns that a Subcontractor has become insolvent or is at unacceptable risk for insolvency, Insurer shall promptly cease delegation of any obligations directly or indirectly related to this Contract to Subcontractor.

Insurer shall notify FHKC within one (1) Business Day of the insolvency or the filing of a petition for bankruptcy by or against a principal Subcontractor.

FHKC, at its sole discretion, may choose to continue or terminate this Contract in the event any of Insurer’s Subcontractors file a petition for bankruptcy or for approval of a plan of reorganization or arrangement under the Bankruptcy Act.

# Systems; Security

Insurer shall maintain policies, procedures and practices related to system security and integrity that are in line with national industry standards and best practices. Insurer shall regularly, no less frequently than annually, review and update its policies, procedures and practices for the following areas:

1. Telework and remote access;
2. External data loss risk management;
3. Internal data loss risk management; and
4. Information and data security.

Insurer shall provide ninety (90) Calendar Days’ prior notice of any planned, significant system changes, including changes or upgrades to claims processing, customer service, enrollment or operating systems or any other systems that may materially impact services provided under this Contract.

Insurer shall notify FHKC within three (3) Business Days of identification of any issues impacting Insurer’s claims processing related to this Contract.

Insurer’s mail gateways shall be capable of, and Insurer shall send, encrypted emails to FHKC when PHI, PII or other confidential information is involved. Insurer shall also ensure its mail gateways are capable of receiving FHKC’s encrypted emails.

Insurer shall obtain a National Institute of Standards and Technology (NIST) compliant information security risk assessment conducted by an independent third party at least every three (3) years with the first assessment obtained within the first Contract Year unless such an assessment was completed within two (2) years prior to the Contract Effective Date.

## Security Incidents

Insurer shall report all security incidents to FHKC in accordance with Attachment B. Insurer shall be liable for financial consequences in the amount of five hundred dollars ($500) per Calendar Day for failure to provide all necessary information to FHKC in the format and timeframe required. Financial Consequences apply to each Calendar Day beyond the due date until provided to FHKC in the required format, inclusive of the day provided to FHKC.

## Health Information System

Insurer shall maintain a health information system that collects, analyzes, integrates and reports data, including utilization, claims, and Grievances and Appeals.

At a minimum, Insurer’s health information system must:

1. Comply with Section 6504(a) of the Affordable Care Act;
2. Collect data on Enrollee and Provider characteristics;
3. Collect data on all services provided to Enrollees through an encounter data system, including data sufficient to identify the Provider who delivers any item or service to Enrollees;
4. Ensure that data received from Providers is accurate and complete by:
   1. Verifying the accuracy and timeliness of reported data, including data reported by Providers with a capitated payment arrangement;
   2. Screening the data for completeness, logic and consistency; and
   3. Collecting data from Providers in standardized formats to the extent feasible and appropriate.
5. Make all collected data available to FHKC, AHCA and CMS, upon request.

## Continuity of Operations Plan

Insurer shall have a continuity of operations plan (COOP), or disaster recovery and business continuation plan, along with corresponding policies and procedures, that:

1. Include alternate locations for the provision of key services to Enrollees and Providers such as:
   1. Member services
   2. Claims processing
   3. Appeals and Grievances
2. Maintains information systems backups in a manner than mitigates disruption of service (including system access) and ensures against loss of data and data integrity due to hardware or software failures, operational errors, destruction (physical and otherwise), and malicious attacks, including:
   1. Alternate locations for data storage or other means of off-site data backup.
   2. Safeguards and regular testing against malicious external activities.
   3. Appropriate partitioning and system monitoring to mitigate the risk of malicious and inadvertent harmful actions by internal parties.
3. Include regular, periodic testing of such plans and procedures, including identification and timely correction of any failures, errors or opportunities for improvement. At a minimum, Insurer shall conduct at least one mock-disaster exercise per Contract Year.
4. Appropriately consider access and use of protected information.
5. Insurer reviews and updates COOP and/or disaster recovery and business continuation plan on a regular basis, and no less than annually.

Insurer shall cooperate with FHKC’s COOP including providing a designated emergency contact to provide and receive status updates.

## Remote Access; Telework

Insurer shall maintain policies and procedures for telework and remote access. Such policies and procedures, and other related documents, shall meet the standards required for compliance with all laws and regulations, including HIPAA and the Gramm-Leach-Bliley Act.

In addition, Insurer’s policies and procedures shall at least meet the recommendations and best practices identified in the Guide to Enterprise Telework, Remote Access, and Bring Your Own Device (BYOD) Security published by the National Institute of Standards and Technology (NIST), U.S. Department of Commerce (Special Publication 800-46, Revision 2) or its replacement, including the recommendations and best practices contained in relevant cross-referenced NIST publications. Insurer shall conduct and consider risk assessments when developing, implementing or changing its telework security policy, particularly for those aspects of the telework security policy for which various approaches may provide acceptable safeguards or for which unauthorized access to PHI or PII is likely to occur without appropriate safeguards.

Insurer shall require multifactor authentication or more stringent practices for any level of remote access. Additionally, Insurer shall provide training and education to its employees with remote access, as appropriate for the level of remote access granted to the employee. Such training and education shall include how to detect and handle phishing attacks and other forms of social engineering involving remote access, as well as information on the importance of adhering to Insurer’s policies and procedures.

Insurer shall also maintain policies related to safeguarding information accessed via telework or remote access from physical access by unauthorized individuals. Such policies may be tiered by level of risk and other factors.

Insurer shall provide FHKC with enough information to assure FHKC that appropriate policies, procedures and practices are in place, upon request. Such release of information is not required to be at the level of detail that may present a notable security risk.

# Confidentiality; Public Records

Insurer shall not use or disclose any PHI, PII or other information protected by law that is obtained through its performance under this Contract in any manner not in conformity with state and federal laws, including HIPAA and Sections 624.91 and 409.821, Florida Statutes. This provision does not prohibit the disclosure of information in summary, statistical or other form which does not identify particular individuals.

In accordance with Section 409.821, Florida Statutes, PII shall be disclosed upon request to the following:

1. A governmental entity in the performance of its official duties and responsibilities;
2. The Department of Revenue for purposes of administering the state Title IV-D program;
3. The Florida Health Choices, Inc., for purposes of administering the program authorized pursuant to Section 408.910, Florida Statutes; and
4. Any person who has the written consent of the Applicant.

An Enrollee’s legal guardian may also obtain confirmation of coverage, dates of coverage, the name of the Enrollee’s health plan and the amount of premium being paid.

Insurer shall maintain all individual medical and other health and enrollment information records with confidentiality and in accordance with state and federal guidelines. Insurer shall comply with all applicable state and federal laws governing the confidentiality of minors and the privacy of PHI and PII.

Insurer’s policies and procedures for handling medical records and protected health information shall comply with HIPAA. Such policies shall include provisions describing when an Enrollee’s PHI may be used or disclosed without consent or authorization.

Insurer shall also make the purpose for which information is maintained or used, as well as to whom and for what purpose Insurer will disclose the information, available upon an Enrollee’s request.

Records produced or used in relation to the performance of this Contract may be subject to Section 119.0701, Florida Statutes, and other applicable parts of the Florida Public Records Act. Section 409.821, Florida Statutes, provides certain public records exemptions to Florida KidCare. Insurer shall ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law.

Insurer shall provide the public with access to public records on the same terms and conditions that AHCA would provide the records and at a cost that does not exceed the cost provided in Section 119.07, Florida Statutes, or as otherwise provided by law. Insurer agrees to advise FHKC prior to the release of any such information and, upon FHKC’s request, provide FHKC with a copy of the requested records at no cost. All records stored electronically must be provided to FHKC in a format that is compatible with the FHKC’s information technology systems.

The Parties shall maintain the integrity of the other Party’s confidential, trade secret or proprietary information obtained in relation to the performance of this Contract to the extent provided by state and federal law. Neither Party will disclose or allow others to disclose such information by any means without prior written approval of the other Party.

In the event Insurer provides records to FHKC that contain information Insurer believes to be confidential, trade secret, proprietary, or otherwise not subject to disclosure pursuant to Chapter 119, Florida Statutes, or other authority, Insurer shall provide an electronic redacted copy of the record simultaneously with the non-redacted record. The non-redacted record must be clearly marked as confidential, trade secret or proprietary, as applicable. The redacted copy shall be clearly marked as “Redacted Copy”. The following methods of marking the non-redacted method are insufficient and shall not be used:

1. Statements to the effect that the record “may” contain confidential, trade secret or proprietary information;
2. Ephemeral placements outside the body of the record such as in an electronic document title or in the body of an email providing the record;
3. Placement or formatting that interferes with FHKC’s ability to access the information such as using an opaque watermark.

The redacted record must redact only the specific information that constitutes the confidential, trade secret or proprietary information. Both the redacted and non-redacted records shall also specify the grounds for claiming exemption to the public records law, including the specific statutory or regulatory citation for the exemption.

Insurer shall be responsible for defending its claim that the redactions are exempt from public records disclosure. Insurer shall protect, defend and indemnify FHKC for any and all claims arising from or relating to Insurer’s claim of exemption, including any indemnification of any costs assessed against FHKC by a court of law related to this matter.

If Insurer fails to submit a redacted copy to FHKC, FHKC may produce the entire, unredacted, record in response to a public record request for the record.

Records in which the sole confidential information is PHI or PII are excluded from this redaction requirement.

# Intellectual Property

Intellectual property rights existing prior to the Effective Date of this Contract will remain with the respective Party. Intellectual property developed by Insurer specifically for FHKC under this Contract shall be the property of FHKC.

FHKC shall have unlimited rights to use, disclose and duplicate all information and data developed, derived or provided by Insurer under this Contract regardless of whether such information and data is copyrightable, patentable or trademarkable.

Insurer’s use of intellectual property in connection with this Contract that results in any royalties or costs are understood to be included in Insurer’s compensation under this Contract and shall not be charged to FHKC, without exception.

Insurer shall indemnify and hold FHKC harmless from any loss, liability or expense resulting from any intellectual property provided by Insurer. Insurer shall not be held liable when such a claim results solely from FHKC’s alteration of the intellectual property or solely from the combination, operation or use of the intellectual property with material that was not provided by Insurer.

# Financial Requirements

## General Financial Requirements

At a minimum, Insurer shall meet the solvency requirements necessary to maintain a certificate of authority in the State of Florida, as determined by the applicable laws and regulations and the Office of Insurance Regulation.

In no event shall FHKC or Enrollees be held liable for Insurer’s debt. Insurer shall make sufficient provision against the risk of insolvency to ensure Enrollees will not be liable for Insurer’s debt in the event Insurer becomes insolvent.

Insurer shall provide Insurer’s audited financial statements to FHKC for Insurer’s preceding fiscal year by July 1st each year.

Failure to comply with the solvency requirements of this provision constitutes a material breach.

## Bankruptcy

Insurer shall provide FHKC notice of intent to petition for bankruptcy or reorganization or arrangement at the time of the filing and immediately provide a copy of such filing to FHKC. In the event FHKC chooses to terminate the Contract in accordance with Section 34-3 Termination for Insolvency or Bankruptcy, FHKC shall provide Insurer thirty (30) Calendar Days’ notice.

## Enrollee Protections from Collection

Neither Insurer nor any representative of Insurer shall collect or attempt to collect from an Enrollee any money for services covered by the Program or any monies owed to Insurer by FHKC.

In no event shall an Enrollee be held liable for monies owed to a Provider by Insurer for Covered Services. If a Provider is paid less than billed charges, neither the Provider nor Insurer may hold the Enrollee liable for the remainder of the charges. Enrollees shall remain responsible for any applicable Copayment. Insurer shall include such a prohibition in all Provider contracts for Insurer’s Florida Healthy Kids network.

Insurer shall indemnify, defend and hold Enrollees harmless from all financial loss caused by Insurer’s failure to comply with this Contract or state or federal laws or regulations.

## Third Party Liability

### Subrogation Rights

In the event Insurer provides an Enrollee Covered Services for which a third party is liable, Insurer shall seek reimbursement from the third party or Enrollee, if he or she received third-party payment for medical expenses provided to him or her, for the actual cost of benefits provided.

Insurer is not entitled to reimbursement in excess of the Enrollee’s monetary recovery for medical expenses provided from the third party.

### Coordination of Benefits

In accordance with Section 624.91(5)(c), Florida Statutes, Florida Healthy Kids insurers are the payers of last resort.

Insurer shall coordinate benefits with any other third-party payer that may be liable for an Enrollee’s medical care. Insurer shall adhere to the third party liability requirements at 1902(a)(25) of the Act, including cost avoidance and “pay and chase” requirements.

Insurer shall notify FHKC of any Enrollees Insurer identifies as covered under other health insurance by the fifteenth day of each month. At a minimum, Insurer shall include the Enrollee’s name, Florida Healthy Kids member ID, identification of the other carrier, and the effective and termination dates of the other coverage, if available. Insurer shall identify any Enrollees as having other coverage through Florida Medicaid separately.

Insurer shall coordinate benefits with any insurer under contract with FHKC to provide comprehensive dental care benefits to Enrollees, including the provision of prescription coverage for prescriptions prescribed by the Enrollee’s dental Provider.

## Medical Loss Ratio

The minimum medical loss ratio (MLR) for each rating period is eighty-five percent (85%). {Insurer shall calculate the MLR for Insurer’s Title XXI Enrollees and Insurer’s Full-pay Enrollees separately. The eighty-five percent (85%) minimum MLR applies to each population. *(Full-pay and subsidized)*}

Likewise, the maximum non-benefit premium component for each rating period shall not exceed fifteen percent (15%). {Insurer shall calculate the maximum non-benefit premium component for Insurer’s Title XXI Enrollees and Insurer’s Full-pay Enrollees separately. The fifteen percent (15%) maximum non-benefit premium component applies to each population. *(Full-pay and subsidized)*} Insurer shall identify what components and subcomponents have been included in its non-benefit expenses, as required by FHKC.

The MLR shall be calculated in accordance with 42 CFR 457.1203, which incorporates 42 CFR 438.8.

FHKC may issue additional written guidance on the definition of medical expense or non-benefit expense to Insurer. Federal and state regulations impacting the calculation of MLRs or non-benefit expense requirements may also be applicable. To the extent permissible by law, FHKC may choose to adopt such regulations early or adopt such regulations that would not otherwise be applicable. Should such guidelines be applied, FHKC shall notify Insurer in writing.

In the event Insurer achieves an MLR less than eighty-five percent (85%) for the rating period, Insurer shall return one hundred percent (100%) of the difference between the actual MLR and the minimum MLR to FHKC. {Insurer’s MLR rebate shall include both Insurer’s Title XXI Enrollees and Insurer’s Full-pay Enrollees in the Service Area; however, Insurer shall report the portion of the rebate attributable to the Title XXI Enrollees and the Full-pay Enrollees based on the respective proportion of Enrollee member months for the rating period. *(Full-pay and subsidized; reblend)*}

### MLR Reporting Requirements

Insurer shall provide a quarterly MLR report to FHKC in the format established by FHKC. The format established by FHKC shall include claims runout periods. The quarterly MLR report is an ongoing report. As such, Insurer shall update the report each quarter to include any additional claims information received since the prior report.

The quarterly MLR report is due as follows:

|  |  |
| --- | --- |
| **Reporting Quarter** | **Due Date** |
| January 1 – March 30 | May 31 |
| April 1 – June 30 | August 31 |
| July 1 – September 30 | November 30 |
| October 1 – December 31 | February 28 |

Insurer shall provide an updated annual MLR report with Insurer’s premium rate adjustment request. Insurer shall also identify all non-benefit and medical expense payments to affiliate and subsidiary companies, including an explanation of the relationship.

### Experience Adjustment Report

In addition to the quarterly and annual MLR report, Insurer shall provide an experience adjustment report for each Contract Year following twelve (12) months of runout. The experience adjustment report due date is February 1st.

The MLR rebate, if any, shall be calculated and provided based on the data included in this report. If any MLR rebate is owed to FHKC, Insurer shall remit such payment to FHKC no later than March 1st.

The experience adjustment report shall be in a format established by FHKC and include sufficient documentation, as determined by FHKC, to support Insurer’s MLR calculation and to allow FHKC to evaluate the component and subcomponent expenses included. FHKC shall determine the adequacy of the information supplied and whether the MLR calculation is accurate.

# Record Retention

Insurer shall retain all records associated with this Contract for at least ten (10) years following the term of this Contract, from the final date of the Contract period, or from the date of completion of any audit, whichever is later. Such records include Enrollee Grievance and Appeal records described in 42 CFR 438.416, base data described in 42 CFR 438.5(c), medical loss ratio reports and data, and information and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608 and 42 CFR 438.610, as referenced in 42 CFR 438.3(u) incorporated by 42 CFR 457.1201(q).

Insurer shall maintain records and documentation in accordance with generally acceptable accounting principles sufficient to substantiate all administrative and Medical Services expenditures under this Contract.

Insurer shall securely store such records as appropriate for the contents of the record. Insurer is responsible for all storage costs associated with record maintenance under this Contract. Destruction of records is Insurer’s responsibility.

Failure to comply with this provision may constitute a material breach and may render this Contract subject to unilateral cancellation by FHKC as determined by FHKC in its sole discretion.

# Audit Rights

Insurer and Insurer’s Subcontractors shall have all books, records, contracts, computers and other electronic systems that pertain to any aspect of services and activities performed, or determination of amounts payable, under this Contract available at any time for inspection, review, audit or copying to FHKC, any vendor contracted with FHKC or any state or federal regulatory agency as authorized by law or FHKC. Additionally, FHKC, AHCA, HHS, CMS, HHS’ Office of the Inspector General, the Comptroller General of the United States and their designees may, at any time, inspect the premises, physical facilities and equipment where work related to this Contract is conducted.

It is FHKC’s intention to provide Insurer with reasonable notice of any audit of Insurer by FHKC and to conduct any such audits at reasonable times. This statement of intention shall not limit FHKC’s rights as provided under this Contract and does not extend to any other entity in possession of audit rights under this Contract.

Insurer agrees to cooperate in any evaluative efforts conducted by FHKC, FHKC’s subcontractors, or authorized state or federal agency during the Contract term and for a period of at least ten (10) years following the term of this Contract. These efforts may include a post-Contract audit. In the event records must be sent to FHKC, Insurer is responsible for production, delivery and associated costs.

Insurer shall require any Subcontracts associated with this Contract to include this provision.

Failure to with this provision may constitute a material breach and may render this Contract subject to unilateral cancellation by FHKC as determined by FHKC in its sole discretion.

## Audit Reports

At a minimum, FHKC shall conduct periodic audits of the accuracy, truthfulness and completeness of encounter data and financial data submitted by, or on behalf of, Insurer. The results of such audits will be made available on FHKC’s public website in accordance with 42 CFR 457.1285 which incorporates 42 CFR 438.602(g).

Insurer shall ensure an annual SOC 2 Type II audit is performed on its application hosting center. Insurer shall provide a copy of the most recent audit report to FHKC by the date established in the approved implementation plan and annually thereafter by the date required by FHKC.

# Contract Management; Monitoring

Insurer shall comply with all provisions of this Contract and its amendments, if any, and shall act in good faith in the performance of the Contract’s provisions. FHKC, in its sole discretion, may assess Insurer financial consequences up to five hundred dollars ($500) per incident of noncompliance. Such financial consequences shall not be assessed if other applicable financial consequences are assessed for the incident.

Insurer shall utilize written policies and procedures to implement all provisions of this Contract.

Insurer shall provide education and training to its staff, as appropriate and applicable to the staff members’ duties, including education and training regarding advance directive policies and procedures. Insurer shall allow FHKC to participate in its formal training modules or sessions upon request.

## Implementation; Readiness Assessment

Insurer shall ensure all resources needed for a timely and complete implementation are available.

Insurer shall provide a final implementation plan for approval to FHKC within five (5) Business Days of Contract execution.

At a minimum, the implementation plan shall include:

1. Each task necessary to fully implement this Contract;
2. The start and end dates for each task;
3. Any task dependencies;
4. Identification of key milestones; and
5. The responsible Party for each task.

Insurer may submit the implementation plan in Microsoft Excel or Microsoft Project. Insurer shall submit an updated implementation plan on a weekly basis until implementation is complete. The required frequency of updated implementation plan submission may be changed with approval or direction from FHKC. Changes to task due dates require written approval from FHKC.

If the submitted implementation plan is not subsequently approved by FHKC, Insurer shall have three (3) Business Days from notification of disapproval to submit a revised implementation plan for approval.

Insurer shall be liable for financial consequences equal to one thousand dollars ($1,000) per Calendar Day the implementation plan is late, limited to a total of fifteen thousand dollars ($15,000) per incident. Financial consequences apply to each Calendar Day beyond the due date until provided to FHKC, inclusive of the date provided to FHKC. Financial consequences apply to the initial due date and to subsequent due dates should the implementation plan require revisions prior to FHKC approval.

Prior to the Effective Date, FHKC may conduct a readiness assessment to ensure Insurer’s readiness and ability to perform its obligations under this Contract. The readiness assessment may include, but is not limited to:

1. Desk and onsite reviews of policies and procedures and related documents;
2. Process demonstrations;
3. System demonstrations; and
4. Interviews with Insurer staff.

Insurer shall participate and cooperate in any readiness assessment, including making documents and appropriate staff available.

Insurer shall pass any readiness assessment to FHKC’s satisfaction by the dates established during the readiness assessment. Insurer shall be liable for financial consequences equal to three thousand dollars ($3,000) per Calendar Day, limited to a total of sixty thousand dollars ($60,000), for failure to pass. Financial Consequences apply to each Calendar Day beyond the date Insurer failed to meet readiness assessment goals until Insurer is able to meet all readiness assessment goals and provide all services required under the Contract.

## Account Management Team

Insurer shall assign an account management team to act as primary contacts for FHKC. The account management team shall include:

1. An executive sponsor;
   1. The executive sponsor must have decision-making authority for Insurer.
   2. The executive sponsor shall not be the same individual as the contract manager.
2. A contract manager;
   1. The contract manager is subject to the terms of Section 12-3 Contract Managers.
3. A member services manager;
   1. Insurer shall provide FHKC with a designated contact for escalated Enrollee issues. If Insurer chooses to designate an individual other than the member service manager as the designated contact, such individual shall be considered part of the account management team.
4. A clinical specialist, clinical manager or medical director;
   1. In addition to having medical expertise, the clinical specialist must be generally knowledgeable about pharmaceutical-related information. Alternatively, Insurer may provide a pharmacy specialist contact in addition to the clinical specialist contact.
5. A compliance manager;
6. A finance senior manager, director or officer; and
7. Other individuals identified as necessary by the Parties.

Insurer shall provide the name, email address, office telephone number and business mailing address for each person on the account management team to FHKC at the time of Contract execution.

Insurer shall provide written notice to FHKC of any changes to the account management team designations or contact information no later than one (1) Business Day for the executive sponsor and contract manager and five (5) Business Days for any other individual.

Each member of the account management team shall:

1. Be knowledgeable about Insurer’s operations relating, directly or indirectly, to Insurer’s obligations under this Contract, insofar as such operations relate to his or her job duties.
2. Be knowledgeable about and able to coordinate with other Insurer contacts for work that falls outside of his or her responsibilities or scope of expertise;
3. Dedicate the time and resources necessary to manage FHKC’s account, including reasonable availability for and responsiveness to telephonic and email communication and onsite meetings.

At a minimum, Insurer’s contract manager, member services manager, and designated contact for escalated Enrollee issues, shall provide a secondary contact and the secondary contact’s information, including name, email address and phone number, when the aforementioned primary contact is out of the office or unavailable for extended periods.

This section is intended to provide FHKC with primary contacts for key Contract functions and shall not limit either Party from working with, directly or indirectly, additional individuals.

## Contract Managers

Each Party shall designate a contract manager who will oversee the Party’s performance of its obligations during the term of this Contract.

Each Party shall provide the name, email address, direct office telephone number and business mailing address to the other Party and maintain such information with the Contract. The Parties shall provide this information at the time of Contract execution.

Each Party shall provide written notice to the other Party of any changes to the contract manager designation or the contract manager’s contact information no later than one (1) Business Day of the change. The Parties shall maintain the revised contract manager information with the Contract.

## Monitoring

FHKC shall monitor, directly and indirectly, Insurer for compliance with this Contract and applicable federal and state laws and regulations. FHKC may also monitor, directly or indirectly, the performance of the Program in relation to Insurer.

In addition to the data, documentation and information specified in this Contract, Insurer must submit any other data, documentation or information relating to the performance of Insurer’s obligations under this Contract required by FHKC or the secretary of HHS.

Insurer shall regularly monitor its own performance under this Contract and the performance of any of its Subcontractors and Providers. Insurer’s monitoring shall include:

1. Compliance with Insurer’s obligations under this Contract; and
2. Insurer’s performance, distinct from compliance, under this Contract related to:
   1. Financial management;
   2. Management of care, including health outcomes, quality of care, case and disease management programs, and utilization review;
   3. Satisfaction, including Enrollees and Providers;
   4. Administrative processes, including claims processing and call center performance; and
   5. Quality improvement, including cultural competency, performance improvement projects, performance measures, and training provided to employees and, if applicable, Providers.

Insurer shall provide a quarterly report that includes cost and utilization information for key metrics identified by FHKC and performance guarantee results. Insurer and FHKC shall conduct quarterly meetings, via conference calls unless otherwise required by FHKC, to discuss the key metrics and performance guarantees. Insurer shall make staff with the appropriate knowledge and expertise available during these meetings and shall be prepared to discuss the report in detail as well as discuss any other relevant topics such as barriers to care, emerging trends and anticipated legislative actions.

## Corrective Action Plans

FHKC may require Insurer to propose and implement a Corrective Action Plan (CAP) to address and correct the cause of deficiencies in Insurer’s performance under this Contract, including failure to meet the performance guarantees in Attachment C and findings from the EQRO compliance validation.

Insurer shall submit a CAP to FHKC for approval within seven (7) Business Days of such request from FHKC, unless FHKC requests another timeframe. The timeframe to provide the corrective action plan is inclusive of the date of request.

If the CAP is not subsequently approved by FHKC, Insurer shall submit a revised CAP within three (3) Business Days from the notification of FHKC’s disapproval.

At a minimum, CAPs shall include a description of the problem being corrected, a description of the solution, and an implementation plan detailing the implementation of the solution with anticipated completion dates.

Insurer shall be liable for financial consequences of five hundred dollars ($500) per Calendar Day, limited to fifteen thousand dollars ($15,000) per incident for CAP-submission timeliness failures. Financial Consequences apply to each Calendar Day beyond the due date until provided to FHKC, inclusive of the day provided to FHKC. Financial Consequences apply to the initial due date and to subsequent due dates should the CAP require revisions prior to FHKC approval.

Insurer shall submit CAP updates on a routine basis. The schedule for such updates shall be established individually for each CAP. Unless otherwise required by FHKC, Insurer shall recommend an update schedule for the CAP to FHKC for approval. Insurer shall be liable for financial consequences of one thousand dollars ($1,000) per Calendar Day, limited to thirty thousand dollars ($30,000) per incident, for failure to complete implementation of the approved CAP by the date established in the CAP schedule. Financial Consequences apply to each Calendar Day beyond the due date until the CAP is implemented, inclusive of the day implementation is complete.

## Contract Termination Transition Plan

Upon the termination of this Contract for any reason, including expiration, Insurer shall ensure a smooth transition to any other insurer or contract FHKC awards for each Region in Insurer’s Service Area under this Contract.

Insurer shall provide a transition plan to FHKC for approval within ninety (90) Calendar Days of the termination date of this Contract. In the event the Contract terminates prior to the expiration date and Insurer is not given more than ninety (90) Calendar Days’ notice, Insurer shall provide a transition plan by the date specified by FHKC or within five (5) Business Days of termination notice receipt if no date is specified.

If the transition plan is not subsequently approved by FHKC, Insurer shall submit a revised transition plan within five (5) Business Days from the notification of FHKC’s disapproval.

Insurer’s failure to provide a timely transition plan acceptable to FHKC or failure to timely implement such transition plan, in whole or in part, shall be considered an event of default and failure to perform.

In such event Insurer shall be responsible for financial consequences in the amount of $1,000.00 (one thousand dollars) per day, as determined by FHKC. FHKC may also withhold payment to Insurer for nonperformance or unsatisfactory performance of the terms of this Contract.

In the event any transition requires additional work from Insurer after the termination date of the Contract, Insurer shall provide staff, services and other resources for consultation and the complete transition of this Contract, as requested by FHKC.

In the event any post-contract transition period is required, FHKC shall pay Insurer for services provided during this timeframe as agreed upon by the Parties in writing. Neither Party shall unreasonably withhold agreement to any post-Contract transition period payment arrangements. Payment shall only be made to the extent any such post-Contract transition period is at the active choice of FHKC and not caused by any fault or delay by Insurer, as determined by FHKC.

## Performance Guarantees

Insurer’s performance under this Contract is subject to the performance guarantees and associated financial consequences established in Attachment C.

## Financial Consequences

Insurer agrees the services provided under this Contract are critical to the success of FHKC’s provision of quality services to Enrollees and the administration of the Program as part of Florida’s CHIP. Likewise, Insurer’s performance of its obligations under this Contract in a timely and reliable manner and to a high-quality standard is significant to FHKC and FHKC’s mission.

Insurer may be subject to financial consequences as described in this Contract for failure to perform its obligations as required. Financial consequences shall be assessed at FHKC’s sole discretion. FHKC shall inform Insurer in writing of any financial consequences incurred.

Insurer may dispute or request a waiver of any financial consequences assessed by submitting such request in writing to FHKC’s contract manager within five (5) Business Days of receipt of the financial consequences assessment. Requests shall clearly identify the financial consequences being assessed, provide a narrative describing Insurer’s reasoning for the dispute or waiver request and include any supporting documentation. FHKC shall review and respond to the request in writing. FHKC’s decision shall be the final determination.

Insurer shall pay any financial consequences within forty-five (45) Calendar Days of notice of assessment. FHKC reserves the right to offset any financial consequences owed by Insurer from any payments owed to Insurer in the event Insurer fails to make timely payment.

# Intermediate Sanctions

FHKC may impose intermediate sanctions in accordance with 42 CFR 457.1270. In the event FHKC makes any of the following determinations based on findings from onsite surveys, complaints by Enrollees and others, financial status or any other source, sanction may be imposed as listed. FHKC may impose any or all of the potential sanctions listed for a determination.

1. Insurer fails substantially to provide Medically Necessary services that Insurer is required to provide, under law or under this Contract, to a covered Enrollee.
   1. Potential Sanctions:
      1. Civil money penalties limited to $25,000 for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
   2. FHKC may recommend that CMS impose denial of payment to the state for new enrollees of Insurer. Such denial of payment from CMS automatically results in a denial of payment for those same enrollees from FHKC.
2. Insurer imposes on Enrollees premiums or charges in excess of the premiums or charges permitted under the Program.
   1. Potential Sanctions
      1. Civil money penalties limited to the greater of $25,000 or double the amount of the excess charges.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
3. Insurer acts to discriminate among Enrollees on the basis of their health status or need for health care services, including termination of the enrollment or refusal to reenroll an Enrollee, except as permitted under this Contract, or any practice that would reasonably be expected to discourage enrollment by potentially Enrollees whose medical condition or history indicates probably need for substantial future Medical Services.
   1. Potential Sanctions:
      1. Civil money penalties limited to $15,000 for each Enrollee FHKC determines was not enrolled because of a discriminatory practice subject to an overall limit of $100,000 for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
4. Insurer misrepresents or falsifies information that it furnishes to FHKC, the State or CMS.
   1. Potential Sanctions:
      1. Civil money penalties limited to $100,000 for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
5. Insurer misrepresents or falsifies information that it furnishes to an Enrollee, potential Enrollee or health care provider.
   1. Potential Sanctions:
      1. Civil money penalties limited to $25,000 for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
6. Insurer fails to comply with the requirements for physician incentive plans as required by law.
   1. Potential Sanctions:
      1. Civil money penalties limited to $25,000 for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
7. Insurer has distributed directly, or indirectly through any agent or independent contractor, Marketing materials that have not been approved by FHKC or that contain false or misleading information.
   1. Potential Sanctions:
      1. Civil money penalties limited to $25,000 for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
8. Insurer has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.
   1. Potential Sanctions:
      1. Granting and notifying Enrollees the right to terminate enrollment with Insurer without cause.
      2. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      3. Suspension of payment for Enrollees enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

# Force Majeure

Neither Party shall be responsible for delays or failure to perform its obligations under this Contract resulting from acts beyond the control of the Party. Such acts include blackouts, riots, acts of war, terrorism, epidemics, fire, communication line failure, power failure or shortage, fuel shortages, hurricanes or other natural disasters.

Insurer remains responsible for delays or failures caused or contributed to by the fault or negligence of Insurer or its employees, agents or Subcontractors even when such delay occurred during or because of an act beyond the control of Insurer, to the extent the delay was under the control of Insurer, its employees, agents or Subcontractors.

In the event Insurer has reason to believe a delay or failure could occur and that such delay or failure is excusable under this provision, Insurer shall promptly notify FHKC in writing. FHKC shall be the sole determiner of whether such failure is excusable under this provision.

# Waiver

A Party’s delay or failure to exercise or enforce any of its rights under this Contract shall not constitute or be deemed a waiver of the Party’s right thereafter to enforce those rights. Any single or partial exercise or enforcement of a right shall not preclude any other or further exercise or enforcement of such right or the exercise or enforcement of any other right.

FHKC maintains the right to waive, in whole or in part, any of Insurer’s obligations under this Contract unless such waiver would result in unapproved noncompliance with any state or federal law or regulation or FHKC’s contract with AHCA.

# Indemnification

Insurer shall indemnify, defend and hold FHKC and its officers, directors, employees and agents harmless from any and all claims, suits, judgments, liabilities, losses, damages, or costs of any kind, including court costs and attorney fees, arising out of or resulting from the acts or omissions of Insurer and its officers, directors, employees agents, partners, Subcontractors or network Providers, whether acting alone or in collusion with others, in connection with the performance of this Contract, to the extent permitted by law.

The Parties agree to provide timely written notice of any loss or claim and the opportunity to mitigate, defend and settle such loss or claim as a condition of indemnification by Insurer.

# Marketing

Insurer shall not engage in Marketing Insurer’s Florida Healthy Kids plan without prior written approval from FHKC.

Insurer shall ensure Marketing materials meet the requirements of 42 CFR 457.1207 which incorporates 42 CFR 438.10.

Retention efforts directed at Insurer’s Enrollees are subject to all the requirements of this section. Retention efforts do not include activities conducted in the normal course of business, to maintain or improve health outcomes, to maintain or improve quality of care, or to measure Enrollee satisfaction.

## Florida KidCare Marketing

Insurer consents to the use of its name in any Marketing and advertising or media presentations describing Florida KidCare which are developed and disseminated by FHKC. Section 624.91(7)(a), Florida Statutes, applies to this Contract.

Insurer shall not utilize the Marketing materials, logos, trade names, service marks or other materials belonging to FHKC without FHKC’s written consent. Written authorization must be received for each individual use or activity prior to use.

Insurer shall not utilize any Marketing materials, logos, trade names, service marks or other materials identifying Florida KidCare without obtaining prior written authorization from the state agency holding the rights to such names or marks.

## Prohibited Statements

Insurer shall not make any written or oral statements suggesting that Florida Healthy Kids enrollees or potential enrollees must enroll with Insurer to obtain or retain Florida KidCare benefits.

Insurer shall not make any written or oral statements suggesting that Insurer is endorsed by FHKC, AHCA, CMS, or any other similar entity, including city or county governments.

Insurer shall not use superlatives (e.g., “the best,” “highest ranked,” rated number 1”) in Marketing materials unless such use is substantiated with supporting data provided to FHKC as a part of the Marketing activities review process.

Insurer shall not use superlatives in its logos or product tag lines (e.g., “XYZ Plan means the first in quality care,” “XYZ Plan means the best in managed care”). This requirement does not prevent Insurer from using other statements in its logos or product tag lines (e.g., “Your health is our major concern,” “Quality care is our pledge to you”).

Insurer shall not compare itself to another insurer or health plan unless:

1. An independent study makes the comparison;
2. Insurer has received written agreement from all other insurers or health plans being compared; and
3. Insurer provides a complete copy of the independent study and written agreements.

## Professional Integrity

At a minimum, Insurer shall maintain industry standards of professional integrity in conducting Marketing activities.

Insurer shall not distribute inaccurate, false or misleading Marketing materials.

Insurer shall not use Marketing materials with negative statements about any other Florida Healthy Kids insurer.

Insurer may not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

Insurer shall not require network Providers or facilities to distribute Marketing materials nor shall Insurer require or allow network Providers or facilities to distribute Marketing materials for Insurer at the exclusion of any other Florida Healthy Kids insurer with which the Provider or facility participates. Insurer shall not compensate any network Provider or facility for distributing Marketing materials.

## Cold-call Marketing

Insurer shall not directly or indirectly engage in cold-call Marketing activities, including door-to-door contact, telephonic contact, email or text message. This provision does not prohibit Insurer from communicating with Enrollees via these mediums in the course of business activities that are not cold-call Marketing activities.

If Insurer receives permission to contact the Enrollee from the Enrollee, Insurer shall not interpret such permission as open-ended permission to contact the Enrollee:

1. After the initial inquiry has been resolved;
2. About topics outside the scope of the original inquiry; or
3. In a manner outside the scope of the original permission.

## Geographic Distribution

Insurer shall not advertise outside its Service Area unless such advertising is unavoidable. For situations in which this is unavoidable, Insurer shall clearly disclose its Service Area.

Insurer shall distribute any approved Marketing materials to its entire Service Area. In the event Insurer’s responsibility to provide culturally competent services and communications necessitates variations in Marketing materials among Regions in Insurer’s Service Area, Insurer may make those changes necessary for a particular Marketing material to fulfill its cultural competency obligations without being considered noncompliant with this requirement.

## Endorsements and Testimonials

Insurer may use product endorsements and testimonials, subject to the following limitations:

1. The speaker must identify Insurer by name;
2. If an individual is paid to portray a real or fictitious situation, the Marketing material must clearly state, “Paid endorsement”;
3. Insurer shall not use quotes from Providers;
4. Insurer shall not use negative testimonials about other Florida Healthy Kids insurers;
5. Insurer shall not compensate potential enrollees for endorsement or promotion; and
6. Enrollees may endorse Insurer only if the Enrollee is currently enrolled with Insurer and voluntarily chooses to provide the endorsement.

Republication of a user’s social media or other electronic media content or comment promoting is considered an endorsement or testimonial and is subject to the terms of this provision.

## Events

Marketing events are subject to the approval of FHKC. Unless otherwise required by FHKC, prior approval from FHKC is waived for the following types of events:

1. Public events sponsored by a city or county government or the state government;
   1. This includes events held primarily for participants of a city, county or state-run program, such as sports clubs, art programs and school-sponsored events.
2. Events held by non-profit youth organizations;
   1. Such organizations shall be approved for this waiver on an individual basis and may be approved at the national level.
   2. Insurer shall submit a written request for approval for each youth organization Insurer would like to include in this waiver. Approval of a waiver for another Florida Healthy Kids insurer does not provide automatic waiver of the same organization for Insurer.
3. Events held by Providers in Insurer’s network so long as Insurer ensures the Provider has extended the same invitation to all other Florida Healthy Kids insurers for which the Provider is a network Provider.
4. Other organizations approved by FHKC.
   1. Such organizations shall be approved for this waiver on an individual basis;
   2. Insurer shall submit a written request for approval for each organization Insurer would like to include in this waiver. Approval of a waiver for another Florida Healthy Kids insurer does not provide automatic waiver of the same organization for Insurer.
   3. Insurer shall submit the name, location and a description of the organization and their activities, whether such organization is non-profit or for-profit, a description of the events Insurer expects to attend, whether the events are open to the public or limited in any way, and any other information FHKC deems necessary.

Insurer shall only distribute FHKC-approved Marketing materials at events.

Insurer shall provide a quarterly report listing all events attended and events Insurer intended to attend, but which were cancelled or Insurer otherwise did not attend. At a minimum, such reports shall include:

1. Event name;
2. Date of event;
3. Location of event;
4. Host organization;
5. Anticipated participant attendance;
6. Actual participant attendance, if available;
7. Indication that Insurer did not attend, as applicable, and the reason for non-attendance.

Insurer shall provide an annual report assessing Insurer’s Marketing events. The annual Marketing events assessment shall include:

1. A summary breakdown of the types of events attended by:
   1. Organization type;
   2. Region;
   3. Overall event purpose; and
   4. Seasonal trends, if any.
2. An assessment of the Marketing events contribution to enrollment growth or maintenance;
3. A high-level summary of lessons learned; and
4. Any other information required by FHKC.

## Nominal Gifts

Insurer may distribute nominal gifts so long as such gifts are:

1. Provided regardless of enrollment;
2. Valued at no more than fifteen dollars ($15) per item;
3. Valued at no more than seventy-five dollars ($75) in the aggregate per enrollee on an annual basis; and
4. Not in the form of cash, gift cards, gift certificates, or other monetary rebates.

Nominal gifts require approval from FHKC prior to distribution.

## Marketing Review Process

### Marketing Materials

Insurer shall submit Marketing materials to FHKC for approval no less than thirty (30) Calendar Days prior to Insurer’s intended utilization date, unless otherwise approved by FHKC. The total Marketing material review time from initial submission to final determination is dependent on multiple factors, including the condition of the original submission, the time Insurer takes to make any requested changes and the size and complexity of the materials. This provision in no way guarantees a final determination within the thirty (30) Calendar Days.

For Marketing materials with multiple versions, Insurer shall submit a copy of each version with the request.

Insurer shall be responsive to FHKC’s comments, questions, requests for more information and other such requests. Failure to be responsive to such requests or failure to provide sufficient information or appropriate changes may result in denial of Insurer’s Marketing materials.

Insurer shall provide Marketing materials in the intended final format, including quality of images used and removal of watermarks from stock photos. Insurer may submit Marketing materials that include such marks as stock photo watermarks during the review period but must provide a copy of the final Marketing material with all such marks removed. Such Marketing materials are not considered approved until the submission of the unmarked form to FHKC regardless of any approval of the draft, marked material.

Insurer shall provide Marketing materials electronically and in a format in which FHKC may use standard software functionality to create redlines or insert comments. FHKC may require Insurer to submit any Marketing materials in a different format than the original submission if needed to effectively and efficiently review and provide feedback on the material.

### Marketing Events

Insurer shall submit all events subject to prior approval to FHKC for review at least seven (7) Calendar Days prior to the event. If Insurer is invited to attend the event fewer than seven (7) Calendar Days in advance, Insurer shall submit the event to FHKC for approval as soon as reasonably possible.

Insurer shall submit all events to FHKC’s public outreach calendar at least seven (7) Calendar Days prior to the event. If Insurer is invited to attend the event fewer than seven (7) Calendar Days in advance, Insurer shall submit the event to FHKC’s public outreach calendar the same day the event invitation is accepted if the event does not require prior approval, or the same date the event is approved by FHKC if prior approval is required. Insurer shall inform FHKC if such an event is cancelled or Insurer is unable to attend as expected.

# Eligibility and Enrollment

## Eligibility

FHKC is the sole authority for determining eligibility for Florida Healthy Kids.

Insurer shall accept Enrollees FHKC identifies to Insurer for coverage, without restriction. Insurer shall not refuse to provide coverage to any Enrollee on the basis of past or present health status or need for healthcare services.

Insurer shall not refuse to provide coverage to, or use any policy or practice that has the effect of discriminating against, any Enrollee on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability or whether or not an Enrollee has executed an advance directive.

Insurer shall inform FHKC of information Insurer receives about changes in an Enrollee’s circumstances that may affect the Enrollee’s eligibility, including changes in Enrollee’s residence and the death of the Enrollee within five (5) Business Days of receipt of such information.

### Requests for Eligibility Review

If Insurer has reasonable cause to believe that an Enrollee is not eligible for the Program; for example, Insurer believes an Enrollee should be placed in a different state or federal program for which eligibility would render that Enrollee ineligible for the Program. Insurer shall provide a written eligibility review request to FHKC.

Insurer’s written eligibility review request shall include:

1. The reason for the eligibility review request;
2. How the relevant considerations were discovered;
3. Confirmation that no other considerations influenced Insurer’s decision to request the review, including (specifically, but without limitation):
   1. An adverse change in the Enrollee’s health status;
   2. Utilization of services;
   3. The Enrollee’s diminished mental capacity; or
   4. Uncooperative or disruptive behavior resulting from the Enrollee’s special needs.

FHKC shall review the eligibility request and provide its findings to Insurer, to the extent permitted by law.

In the event Insurer disputes FHKC’s determination of a written eligibility request and the request is based upon the Enrollee’s eligibility for another state or federal program that would make the Enrollee ineligible for Florida Healthy Kids coverage, FHKC will seek an eligibility determination from the entity administering the federal or state insurance program for which Insurer alleges the Enrollee is eligible. The Parties shall be bound by the entity’s response to the eligibility review request. The rights and remedies provided under this section are exclusive to such eligibility disputes.

## Enrollment

FHKC is the sole authority for assigning enrollees to Florida Healthy Kids plans.

An Enrollee’s coverage is effective at 12:00 a.m. on the first day of the Enrollee’s first Coverage Month, as determined by FHKC.

### Enrollment Files

FHKC shall provide Insurer all enrollment information necessary for Insurer to provide the services under this Contract. The enrollment information shall identify Enrollees who have been identified as American Indian or Alaskan Native{,the Enrollees who are Title XXI eligible, the Enrollees who are enrolled in the Full-pay Plan and Enrollees who have met the out-of-pocket maximum of five percent (5%) of family income *(Full-pay and subsidized; reblend)*}.

FHKC shall provide enrollment information as follows:

1. FHKC shall provide Insurer a preliminary enrollment file at least seven (7) Business Days prior to the start of the Coverage Month.
2. FHKC shall provide Insurer a supplemental enrollment file on the fifth day of the Coverage Month. Coverage for Enrollees identified on the supplemental enrollment file is effective retroactive to the first day of the Coverage Month.
3. FHKC may provide manual enrollment updates for reinstatements or terminations at any time. Coverage for Enrollees identified on manual enrollment updates is effective on the first of the identified Coverage Month.
4. FHKC shall notify Insurer in advance of any planned deviations from the enrollment file timeframes listed herein. Insurer shall accept these planned deviations as well as any unplanned deviations regardless of whether FHKC provided prior notification.

Insurer shall maintain an information system capable of electronically receiving and updating enrollment information as provided by FHKC. Insurer shall accurately and timely process enrollment changes in accordance with this section and Attachment C.

Insurer shall accept enrollment files and manual enrollment updates in the format required by FHKC. The current enrollment file format is in Attachment E. The format is subject to change and shall not require a Contract amendment.

#### Enrollment File Discrepancy Reports

Insurer shall assess the preliminary and supplemental enrollment files each month and provide a discrepancy report to FHKC. Insurer shall report discrepancies on the enrollment file discrepancy report, such as duplicate records, address errors, records rejected by Insurer’s system and other errors that call the data into question. Discrepancy reports shall be provided to FHKC within five (5) Business Days of receipt of the supplemental enrollment file.

Insurer shall timely make any corrections to the data required after FHKC’s review of the discrepancy reports.

#### Enrollment Reconciliation

FHKC shall provide a monthly capitation file that includes all enrollment changes related to Insurer that have occurred in the month and the amount FHKC paid or offset for each Enrollee listed.

Insurer shall accept the monthly capitation file in the format FHKC requires. The current monthly capitation file format is in Attachment F. The format is subject to change and shall not require a Contract amendment.

Insurer shall use the monthly capitation file as the source for reconciling enrollment and premium payments. Insurer shall reconcile enrollment and premiums received and provide the results of such reconciliation to FHKC quarterly.{Insurer shall conduct and provide separate reconciliations for Title XXI Enrollees and Full-pay Enrollees. *(Full-pay and subsidized)*}

### Enrollee Assignment Process

During the first Contract Year, FHKC shall auto-assign potential enrollees to available plans on a one-to-one (1:1) basis, upon application approval. Beginning with the second Contract Year, FHKC may choose to:

1. Continue assigning potential enrollees to available plans on a one-to-one (1:1) basis; or
2. Modify the auto-assignment process to an assignment ratio other than one-to-one (1:1) to the benefit of higher performing Florida Healthy Kids insurers. FHKC may consider performance measure results, provision of obligations in compliance with this Contract, quality assessment and performance improvement execution or any other aspect or aspects, in whole or in part, of Insurer’s obligations under this Contract, subject to FHKC’s sole discretion.

At initial enrollment, enrollees are provided a Free-look Period in which the enrollee has ninety (90) Calendar Days to enroll with another available plan without cause. Enrollees are provided a Free-look Period annually. Enrollees may only request a change in plans outside of a Free-look Period as provided in this section.

FHKC is responsible for notifying enrollees of their right to request a plan enrollment change outside of the Free-look Period, if such choice is available in their Region, as follows:

1. For cause:
   1. The Enrollee has moved out of Insurer’s Service Area under this Contract;
   2. The Enrollee has an active relationship with a health care Provider who is not in Insurer’s network but is in the network of another available health plan;
   3. Insurer no longer participates in the Region in which the Enrollee resides;
   4. The Enrollee’s health plan is under a quality improvement plan or corrective action plan relating to quality of care intermediate sanctions with FHKC; or
   5. Other reasons, including poor quality of care, lack of access to services or lack of access to Providers experienced in providing care needed by Enrollee.
2. Without cause, determined on a case-by-case basis by FHKC.

### Enrollment Procedures

#### Primary Care Provider Assignment

Insurer shall offer each Enrollee a choice of Primary Care Providers (PCPs) who meet the credentialing, access and appointment standards of this Contract. In addition to offering Enrollees a choice of PCPs, Insurer shall ensure each Enrollee is assigned to a PCP who acts as an ongoing source of care appropriate and is primarily responsible for coordinating the services accessed by the Enrollee.

Insurer may auto-assign Enrollees to PCPs, but Enrollees must be permitted to select another PCP. Should Insurer choose to auto-assign Enrollees to PCPs, Insurer shall take the following into consideration when making such assignments:

1. The Enrollee’s last PCP assignment, if known;
2. The closest PCP to the Enrollee’s home address;
3. Sibling assignments; and
4. The Enrollee’s age and any age limitations with the PCP.

#### Enrollment Package

Insurer shall provide an enrollment package to new Enrollees within five (5) Business Days’ receipt of the enrollment information. The enrollment package shall include the following items:

1. Member identification card;
2. PCP assignment and contact information or PCP selection instructions;
3. Member handbook;
4. Provider directory; and
5. Plan formulary.

Insurer shall provide the enrollment package in accordance with the terms of Section 21-3, Enrollee Materials.

#### Health Risk Assessment

Insurer shall have mechanisms in place to assess Enrollees and provide those determined to have special health care needs with direct access to a specialist in a manner that is appropriate for the Enrollee’s condition and identified needs. Direct access may include a standing referral or an approved number of visits.

Insurer shall make a best effort to conduct an initial screening of each Enrollee’s needs within ninety (90) Calendar Days from the coverage effective date for all new Enrollees. Insurer shall make subsequent attempts to contact the Enrollee for an initial screening if the first attempt is unsuccessful.

To prevent duplication of work, Insurer shall accept such information as assessed by another insurer in the Program from FHKC. Likewise, Insurer shall provide such information to FHKC or another Florida Healthy Kids insurer, upon FHKC’s request.

For purposes of this provision, “special health care needs” means health care needs sufficient to meet the clinical eligibility criteria for the CMS Plan.

## Disenrollment

An Enrollee’s coverage shall terminate on the last day of the Coverage Month in which the Enrollee:

1. Ceases to be eligible to participate;
2. Establishes residence outside of the Service Area; or
3. Is determined to have acted Fraudulently.

Insurer may not request disenrollment of an Enrollee for any reason.

Termination of coverage and the effective date of such termination shall be determined solely by FHKC.

# Enrollee Rights

Insurer shall comply with all applicable state and federal laws pertaining to Enrollee rights and shall ensure that Insurer’s network Providers observe and protect those rights.

Insurer shall maintain written policies regarding Enrollee rights. Insurer shall provide a copy of such policies to FHKC during implementation of the Contract and by the date established in the approved implementation plan. Insurer shall also provide a copy of its Enrollee rights policies for review prior to the effective date of any change to such policies.

Insurer shall provide education and training on Enrollee rights to its staff.

An Enrollee’s exercise of his or her rights shall not adversely affect the way Insurer, or Insurer’s network Providers, treat the Enrollee. At a minimum, Insurer must adhere to the Enrollee rights listed in this provision.

In accordance with 42 CFR 457.1220 which incorporates 42 CFR 438.100, Enrollees have the right to:

1. Receive information in accordance with 42 CFR 438.10;
2. Be treated with respect and consideration for his or her dignity and privacy;
3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
4. Participate in decisions regarding his or her health care, including the right to refuse treatment;
5. Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
6. Request and receive a copy of his or her medical records and request that such medical records be amended or corrected; and
7. Receive health care services in accordance with 42 CFR 438.206- 438.210.

# Cultural Competency

Insurer shall provide services, including oral and written communication to Enrollees, in a culturally competent manner appropriate for the population, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Insurer shall maintain a comprehensive written cultural competency plan describing how Insurer, its Providers, employees and systems will effectively provide services to Enrollees of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the Enrollee and protects and preserves the dignity of each.

Insurer shall submit its initial cultural competency plan for approval by FHKC by the date established in the approved implementation plan and annually thereafter by November 1st.

# Enrollee Services

Insurer shall maintain an enrollee service unit to provide enrollee-related customer service. The enrollee service unit shall have the ability to answer Enrollee inquiries by telephone, electronic communication and written communication. The enrollee service unit shall be accessible by a toll-free telephone number during the hours of 7:30 a.m. to 7:30 p.m. Eastern Time, Monday through Friday, except on state-recognized holidays.

Insurer shall utilize automatic call distribution equipment and enrollee services representatives staffing sufficient to handle the expected volume of calls. Insurer shall also provide a telecommunication device for the deaf (TTY/TDD) and access to interpreter services. Insurer shall ensure enrollee services representatives are satisfactorily trained and capable of resolving Enrollee and potential Enrollee inquiries in all areas related to Florida Healthy Kids. Insurer’s enrollee services representatives shall be familiar with the basic eligibility requirements for the Florida Healthy Kids Program, but shall refer or transfer individuals with detailed questions or concerns to the Florida KidCare call center. Insurer shall monitor the enrollee services line to ensure Insurer meets certain performance standards and for quality assurance, including recording calls, conducting routine audits and other monitoring activities. Insurer shall meet the performance guarantees related to enrollee services included in Attachment C.

Insurer shall provide a publicly available website with access to Florida Healthy Kids information. The publicly available website shall include:

1. The Enrollee handbook,
2. A printable provider directory,
3. A searchable electronic provider directory,
4. Insurer’s preferred drug list (PDL),
5. A link to FHKC’s Florida Healthy Kids website, and
6. Any other information that may be needed by Enrollees or potential Enrollees.

Insurer’s publicly available website is subject to FHKC approval.

Insurer shall also provide a website with secure access for Enrollees. The non-public website access shall include:

1. The ability for Enrollees to print a temporary ID card,
2. The ability for Enrollees to request a new ID card,
3. Enrollee educational materials (unless Insurer chooses to make such materials available on the publicly-available website), and
4. Cost sharing accumulator information
   1. {Insurer shall track Full-pay Enrollees’ contributions to the Deductible and out-of-pocket maximum, as separate accumulator trackers. (*Full-pay and subsidized)*}
   2. {Insurer shall track the Title XXI Enrollees’ cost share contributions to assist families in tracking their progress towards the Title XXI out-of-pocket maximum. (*Subsidized only; Full-pay and subsidized)*}
   3. {Insurer shall track the Enrollees’ cost share contributions to assist families in tracking their progress towards the out-of-pocket maximum. (*reblend)*}

Insurer’s non-public website is subject to FHKC’s approval.

## Escalated Enrollee Issues

FHKC sometimes receives Enrollee complaints or concerns directly from Enrollees or forwarded from state agencies, legislative offices and others. FHKC may forward such issues to Insurer for research and resolution. An escalated Enrollee issue may be designated by FHKC as an urgent escalated Enrollee issue based upon factors such as the Enrollee’s health status. All other escalated Enrollee issues are considered routine escalated Enrollee issues.

Insurer shall acknowledge receipt of the escalated Enrollee issue within two (2) hours for urgent escalated Enrollee issues and by close of business for routine escalated Enrollee issues unless a different timeframe is specified by FHKC.

Insurer shall provide regular status updates to FHKC on any activities and progress underway, including when further action and progress are temporarily halted. In the event progress is temporarily halted, Insurer shall allow no more than two (2) Business Days or three (3) Calendar Days between updates, whichever is earlier. Insurer shall not wait to be prompted for status updates by FHKC to provide such updates.

To the extent reasonable and unless otherwise required by FHKC, Insurer shall resolve routine escalated Enrollee issues within five (5) Business Days and urgent escalated Enrollee issues within two (2) Business Days, unless the Enrollee’s health requires faster resolution. In the event the expected resolution timeframe is not reasonable to resolve the escalated Enrollee issue, Insurer shall inform FHKC in writing and provide an expected timeframe for resolution and the basis for the extended timeframe, subject to FHKC approval.

Escalated Enrollee issues are not intended to take the place of or circumvent any aspect of the Grievance or Appeal process. The Parties shall act in good faith in the performance of this provision.

## Translation Services; Alternative Formats

Insurer shall provide oral translation services to any Enrollee who speaks any non-English language. Insurer shall notify Enrollees of the availability of oral interpretation services and inform Enrollees how to access such services.

Insurer shall make all written materials available in English, Spanish and all other prevalent non-English languages. Prevalent non-English languages means any language in Insurer’s Service Area spoken by approximately five percent (5%) or more of Insurer’s Florida Healthy Kids population.

Insurer shall provide translation services to Enrollees at no cost.

## Enrollee Materials

Insurer is responsible for all preparation, cost and distribution of Enrollee materials.

Insurer shall provide all materials to Enrollees and potential Enrollees in a manner and format that may be easily understood and is readily accessible in accordance with 42 CFR 457.1207 which incorporates 42 CFR 438.10. Insurer agrees to follow best practices related to accessibility of materials insofar as such best practices are reasonable and practicable.

Insurer shall use a font size no smaller than 12-point in all written materials.

Insurer shall make all written materials available in alternative formats and in a manner that takes into consideration the Enrollees’ special needs, including those who are visually impaired or have limited reading proficiency. Such alternative formats shall include auxiliary aids and services, oral interpretation in any language and written interpretation in the language(s) prevalent in the Service Area. Insurer shall notify all Enrollees that information is available in alternative formats upon request at no cost. Insurer shall also inform Enrollees how to access such services.

Written materials shall include a notice of nondiscrimination and taglines explaining the availability of written or oral translation in the prevalent non-English languages in the Service Area, as required by Section 1557 of the Affordable Care Act, as well as in large print, which means printed in a font size no smaller than 18-point. Insurer shall use the top fifteen (15) prevalent non-English languages determined by HHS unless otherwise approved by FHKC to use another source Insurer believes is more accurate.

Insurer shall inform FHKC of the intended methodology(ies) Insurer will use to distribute Enrollee materials. FHKC may require Insurer use or refrain from using certain methodologies.

Insurer shall make good faith efforts to contact or provide materials through alternate, allowable, methods to Enrollees when mail or other communication is returned undeliverable.

### Specified Enrollee Materials

At a minimum, Insurer must provide the Enrollee materials specified in this section.

1. Enrollee Identification (ID) Card.

Insurer shall mail each Enrollee a hardcopy of his or her Enrollee ID card without requiring that the Enrollee first request such hardcopy. The Enrollee ID card shall include Insurer’s name, the Enrollee’s name, ID number, effective date of coverage and Insurer’s contact information. The Enrollee ID card shall identify the Enrollee as a Florida Healthy Kids member and shall not contain any potentially misleading information, such as references to non-Florida Healthy Kids Programs.

1. Enrollee Handbook.

Insurer shall provide an Enrollee handbook based on the model Enrollee handbook provided by FHKC. Insurer shall customize such material to the extent permitted or required by FHKC. {Insurer shall provide separate Enrollee handbooks for the Title XXI population and the Full-pay population *(full-pay and subsidized)*} The handbook shall include the following elements:

1. A description of benefits and any associated cost sharing sufficient to ensure that Enrollees understand the benefits covered by this Contract, including the scope, amount, duration and limitations associated with a benefit.
2. A description of how to access services, including any requirements for prior authorization of any services, referrals for specialty care or any other restrictions on choice among network Providers.
3. The extent to which, and how, Enrollees may obtain benefits, including family planning services and supplies from out-of-network Providers and an explanation that Insurer cannot require an Enrollee to obtain a referral before choosing a family planning Provider.
4. A description of Emergency Medical Conditions and services, including post-stabilization services, including what constitutes an emergency, the fact that prior authorization is not required, and that Enrollee has a right to use any hospital or setting for emergency care.
5. The process for selecting and changing the Enrollee’s PCP;
6. A description of the Grievance and Appeal process, including the right to file and the availability of assistance in the filing process;
7. A description of the Enrollee’s rights and responsibilities;
8. An explanation about how to exercise an advance directive;
9. How to access auxiliary aids and services, including accessing information in alternative formats or languages;
10. The toll-free telephone number for Enrollee Services and any other unit providing services directly to Enrollees;
11. How to report suspected Fraud or Abuse; and
12. Any other information required by FHKC.
13. Provider directory.

Insurer shall make a Provider directory available on Insurer’s website in a machine-readable file and format, as specified by the Secretary of HHS, as well as in paper form upon request. Insurer shall also make a searchable electronic Provider Directory available on Insurer’s website.

Information included in a hardcopy Provider directory or a printable electronic Provider directory must be updated at least monthly. Searchable electronic Provider directories must be updated no later than thirty (30) Calendar Days after Insurer receives updated Provider information.

At a minimum, the Provider directory must contain the following information for each PCP, specialist (including behavioral health Providers), hospital and pharmacy:

1. Provider name;
2. Provider group affiliation, if any;
3. Specialty, as appropriate;
4. Street Address(es);
5. Telephone number(s);
6. Website URL, if any;
7. Office hours;
8. Age limitations, if any;
9. Non-English languages, including American Sign Language, spoken by the Provider or a skilled medical interpreter at the Provider’s office;
10. Whether Provider has completed cultural competency training;
11. Whether Provider’s office or facility has accommodations for people with physical disabilities, including offices, exam rooms and equipment; and
12. Whether the Provider is accepting new patients.
13. Preferred Drug List (PDL).

Insurer shall make information about which generic and brand name medications are covered in Insurer’s formulary available in print and electronic formats. Insurer’s PDL must be available on Insurer’s website in a machine-readable file and format, in accordance with state and federal regulations.

Insurer shall notify Enrollees who have filled a prescription in the last twelve (12) months for a medication that is being removed from the PDL or for which additional utilization management requirements will apply sixty (60) Calendar Days prior to the effective date of the change.

1. Enrollee Handbook Notice of Change.

Insurer shall provide Enrollees with a notice of change for any significant changes, as determined by FHKC, made to the Enrollee handbook. Any such notices must be provided to Enrollees at least thirty (30) Calendar Days prior to the effective date of such change.

1. Notice of Network Provider Termination.

Insurer shall notify Enrollees who received services from a terminating provider within the past six (6) months of such termination at least sixty (60) Calendar Days before the effective date of the termination. When such notice is not possible, Insurer shall make a good faith effort to provide written notice to Enrollees who received primary or regular care from a terminating network Provider within fifteen (15) Calendar Days of receipt or issuance of the Provider termination notice.

1. Advance Directives.

Insurer shall provide adult Enrollees with written information on advance directive policies, including a description of applicable Florida law, within five (5) Business Days of the Enrollee’s eighteenth birthday or enrollment in the event an Enrollee enrolls in coverage at age eighteen (18). Such information must be updated to reflect changes in State law within ninety (90) Calendar Days of the effective date of such change.

1. Certificates of Creditable Coverage.

Insurer is responsible for issuing certificates of creditable coverage to Enrollees upon the Enrollee’s request.

### Enrollee Material Review Process

All Enrollee materials must be approved by FHKC prior to distribution.

Insurer shall submit Enrollee materials to FHKC for approval no less than thirty (30) Calendar Days prior to Insurer’s intended publication or utilization date, unless otherwise approved or required by FHKC. The total Enrollee material review time from initial submission to final determination is dependent on multiple factors, including the condition of the original submission, the time Insurer takes to make any requested changes and the length and complexity of the materials. This provision in no way guarantees a final determination within the thirty (30) Calendar Days.

For Enrollee materials with multiple versions, Insurer shall submit a copy of each version with the request.

Insurer shall be responsive to FHKC’s comments, questions, requests for more information and other such requests. Failure to be responsive to such requests or failure to provide sufficient information or appropriate changes may result in denial of Insurer’s Enrollee materials.

Insurer shall provide Enrollee materials in the intended final format, including quality of images used and removal of watermarks from stock photos. Insurer may submit Enrollee materials that include marks such as stock photo watermarks during the review period, but must subsequently provide a copy of the final Enrollee material with all such marks removed. Such Enrollee materials are not considered approved until the submission of the unmarked form to FHKC, regardless of any approval of the draft, marked material.

Insurer shall provide Enrollee materials electronically and in a format in which FHKC may use standard software functionality to create redlines or insert comments. FHKC may require Insurer to submit any Enrollee materials in a different format than the original submission if needed to effectively and efficiently review and provide feedback on the material.

# Benefits

Insurer shall provide the Covered Services described in Attachment A. In the event Insurer requires clarification about any coverage or cost-sharing requirement, Insurer shall consult with FHKC. Insurer shall have mechanisms in place to help Enrollees and potential Enrollees understand the requirements and benefits of the Plan.

In the event an Enrollee meets the out-of-pocket maximum, Insurer shall be responsible for informing its Providers and ensuring that such Enrollees incur no further out-of-pocket costs for Covered Services. FHKC shall provide {Title XXI *(Full-pay and subsidized)*} Enrollees who have met the out-of-pocket maximum a letter stating that the Enrollee shall not incur any cost-sharing responsibilities for the remainder of the Contract Year.

Insurer shall not avoid costs for services covered under this Contract, including immunization requirements, by referring Enrollees to publicly supported health care resources and requiring the Enrollee to utilize those resources.

Insurer shall not object or otherwise refuse to provide a benefit or service covered under this Contract on moral or religious grounds.

Insurer shall ensure that services provided are sufficient in amount, duration and scope to reasonably achieve the purpose for which the services are furnished. Insurer shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or Enrollee condition. This provision does not prohibit Insurer from placing appropriate limits on services or implementing utilization management controls.

## Utilization Management

Insurer shall establish utilization management controls to ensure Enrollees receive appropriate care. Insurer’s utilization management controls shall allow for consideration of factors specific to individual Enrollees such as age and medical history.

Insurer shall not compensate individuals or entities conducting utilization management activities in a way that provides incentives for the individual or entity to deny, limit or discontinue Medically Necessary services to an Enrollee.

Utilization management activities, including prior authorization reviews, shall be conducted by individuals with clinically appropriate backgrounds in a manner that results in interrater reliability sufficient to indicate the appropriateness and validity of the process, including the training given to the reviewers.

## Behavioral Health; Substance Use Disorder Benefits

Insurer shall adopt Section 394.491 and Chapter 397, Florida Statutes, as guiding principles in the delivery of services and supports to Enrollees with behavioral health care needs, including substance use disorder services.

Insurer shall maintain policies and procedures that support:

1. Early identification of behavioral health care needs through the use of valid assessments;
2. The use of services that enhance the Enrollee’s likelihood of positive outcomes, improved ability to function at home, school and in the community, and to live drug-free;
3. Enrollees’ ability to receive services in the least restrictive and most normal environment that is clinically appropriate;
4. The use of care or case management and coordination of services; and
5. A smooth transition to adult behavioral health care, for older Enrollees.

Insurer shall also make educational materials about recognizing child and adolescent behavioral health care needs and how to obtain access to treatment and support services available to Enrollees.

## Parity

Insurer shall comply with the requirements of 42 CFR 457.496. Insurer shall conduct parity assessments using the Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children’s Health Insurance Programs published by CMS on January 17, 2017, as amended or replaced, unless such toolkit becomes outdated and not revised or replaced. Insurer shall provide an initial parity assessment during implementation of the Contract by the date established in the approved implementation plan.

Prior to making significant changes to the administration of benefits, including implementing or changing any utilization management policies, whether quantitative or non-quantitative in nature, Insurer shall conduct a parity assessment on the change in question and provide such assessment to FHKC. This requirement does not require Insurer to conduct a full parity assessment.

Insurer shall also conduct parity assessments upon FHKC’s request. Insurer shall provide supporting documentation to FHKC, including documentation required by CMS for inclusion in the parity-related provisions of the state plan amendment.

If Insurer utilizes a Subcontractor for behavioral health services, Insurer may allow the Subcontractor to assist in conducting the parity assessment, but Insurer must validate any such work.

All parity assessments must be satisfactory to FHKC. Insurer shall revise any unacceptable parity assessments to FHKC’s satisfaction.

In the event Insurer is not at parity in any aspect, Insurer shall implement appropriate, timely changes to become compliant. FHKC shall reserve the right to approve or disapprove Insurer’s approach to become compliant.

## Lifetime Limit

Florida Healthy Kids coverage {for Title XXI Enrollees *(Full-pay and subsidized)*} is limited to a lifetime maximum of one million dollars ($1,000,000) per Enrollee. Insurer shall submit a monthly report listing all Enrollees with claims costs exceeding seven hundred thousand dollars ($700,000).

Insurer shall include sufficient information to identify the Enrollee, the amount of Enrollee’s accumulated claims, whether the Enrollee is eligible for case management, and if so, the Enrollee’s case management enrollment status, whether the Enrollee has active coverage with Insurer, the termination date of Enrollee’s coverage with Insurer and any notes about the record relevant to FHKC. Insurer shall continue to report inactive Enrollees until such Enrollees have been inactive for twelve (12) months.

FHKC may choose to implement a different methodology for monitoring Enrollees nearing the lifetime maximum. Insurer agrees to cooperate with any such changes.

In the event Insurer becomes aware of an Enrollee who experiences a potentially catastrophic event likely to cause the Enrollee to meet and/or exceed the lifetime limit for which Insurer has not yet received significant claims, Insurer shall report the event to FHKC within five (5) Business Days of Insurer’s receipt of sufficient information to make such determination. Insurer’s awareness of the potentially catastrophic event shall not be based solely upon the claims’ staff awareness and shall include any department or business unit within Insurer’s organization, including clinical staff and enrollee service representatives. Insurer’s report to FHKC shall include, at a minimum, the Enrollee’s name, ID number and a summary narrative sufficient to allow FHKC to determine potential next steps needed.

## Telehealth

FHKC considers telehealth to be a modality of care and not a separate form of health care practice. As such, all requirements applicable to Providers delivering in-person services apply to Providers delivering telehealth services, including standards of care and medical record requirements. Insurer shall not apply any policies or procedures to telehealth services that are significantly more restrictive or stringent than those applied to in-person services unless such differences are required to maintain the intent and functionality of a policy or procedure that applies to in-person services.

Insurer shall cover benefits for services provided by telehealth to the extent the same services are provided in-person, when possible and appropriate. Insurer shall cover store-and-forward and remote patient monitoring services telehealth modalities, as appropriate.

Telephone conversations (without two-way, real-time audio and visual components), chart review, email, and facsimile transmissions are not considered telehealth.

## Benefit Determinations; Practice Guidelines

Insurer shall consult with the requesting Provider when making benefit determinations, as appropriate.

Insurer shall follow written policies and procedures and practice guidelines, for making benefit determinations, including processing requests for initial and continuing authorization for services.

Insurer shall adopt practice guidelines:

1. That are based on valid, reliable clinical evidence of Providers in the relevant field;
2. Consider the needs of Enrollees; and
3. In consultation with contracting health care professionals.

Insurer shall review and periodically update its practice guidelines, as appropriate.

Decisions related to utilization management, Enrollee education, coverage of services and other relevant areas shall be consistent with Insurer’s adopted practice guidelines. Insurer shall provide any practice guidelines used for the Plan to Enrollees, potential Enrollees and network Providers, upon request.

### Adverse Benefit Determinations

Insurer shall provide timely and adequate written notice of an Adverse Benefit Determination. The benefit determination and any notice of Adverse Benefit Determination must be provided within the following timeframes in accordance with 42 CFR 457.1260 and to the extent it incorporates 42 CFR part 438 subpart F:

1. For termination, suspension or reduction of previously approved services, the notice must be provided at least ten (10) Calendar Days before the date of action except when:
   1. Insurer has information confirming the death of the Enrollee;
   2. Insurer receives a clear signed written statement from the Enrollee stating that the Enrollee no longer wishes to receive services, or the Enrollee gives information that requires termination or reduction of services and the Enrollee indicates understanding that termination or reduction of services must be the outcome of providing such information;
   3. The Enrollee has been admitted to an institution which causes ineligibility under the plan for further services;
   4. The Enrollee’s whereabouts are unknown and the United States Postal Service returns Insurer’s mail to the Enrollee with no forwarding address;
   5. Insurer establishes that the Enrollee is enrolled in Florida Healthy Kids with another insurer;
   6. A change in the level of medical care is prescribed by the Enrollee’s physician;
   7. The notice involves an Adverse Benefit Determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;
   8. In accordance with 42 CFR 431.213(h); and
   9. Insurer has facts, verified through secondary sources when possible, indicating that action should be taken because of probable Fraud by the Enrollee. In such instances the notice must be provided at least five (5) Calendar Days before the date of action.
2. For denial of payment, the notice must be provided at the time of any action affecting the claim;
3. For standard service authorization decisions that deny or limit services, within fourteen (14) Calendar Days following receipt of request for service, except that Insurer may extend the timeframe up to an additional fourteen (14) Calendar Days if the Enrollee or Provider requests extension or Insurer is able to justify to FHKC a need for additional information and that the extension is in the Enrollee’s interests so long as:
   1. Insurer gives the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance; and
   2. Insurer issues and carries out the determination as expeditiously as the Enrollee’s health condition requires, but no later than the date the extension expires.
4. For service authorization decisions not reached within the timeframes required by 42 CFR 438.210(d), which constitutes a denial and thus is an Adverse Benefit Determination, Insurer must provide the notice on the date the timeframe expires;
5. For expedited service authorization decisions, Insurer must provide notice as expeditiously as the Enrollee’s health condition requires, but no later than seventy-two (72) hours after receipt of the request, except that Insurer may extend the timeframe up to an additional fourteen (14) Calendar Days if the Enrollee or Provider requests extension or Insurer is able to justify to FHKC a need for additional information and that the extension is in the Enrollee’s interests.
6. Insurer shall provide notice of a decision in response to a request for authorization of outpatient drugs by telephone or other telecommunication device within twenty-four (24) hours of the request, in accordance with section 1927(d)(5)(A).

A notice of Adverse Benefit Determination must include:

1. The Adverse Benefit Determination Insurer has made;
2. The reason for the Adverse Benefit Determination;
3. The Enrollee’s right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Adverse Benefit Determination, including Medical Necessity criteria and processes, strategies or evidentiary standards used in setting coverage limits;
4. The Enrollee’s right to request an Appeal, including information on exhausting the Appeal process and the right to request an independent review;
5. The procedures for exercising these rights; and
6. The circumstances under which an Appeal can be expedited and how the Enrollee can request an expedited Appeal.

## Value-add Benefits

Insurer may offer value-add benefits at no cost to FHKC or the Enrollees. Insurer shall offer any value-add benefits proposed during the ITN and listed in Attachment A.

Insurer shall submit any proposed value-add benefits, including a description of the eligible population and any limitations, to FHKC for approval.

Insurer must request and receive FHKC approval to discontinue any value-add benefits. Value-add benefits are anticipated to be offered for at least one (1) complete Contract Year unless otherwise stated in the approval request. Any value-add benefits proposed during the ITN and included in this Contract are considered material to the competitive ITN process. As such, Insurer shall not discontinue these value-add benefits without replacing the value-add benefit with an equivalent value-add benefit, subject to FHKC approval. An equivalent value-add benefit must be relevant to the Florida Healthy Kids population and must be expected to fulfill similar needs for Enrollees regarding the number of Enrollees potentially impacted and the level of care.

If a value-added service is provided in lieu of a covered service or setting required in this Contract:

1. Such service is subject to FHKC’s determination that the alternative service or setting is medically appropriate and cost effective;
2. Enrollees are not required to use the alternative service or setting;
3. The alternative services or setting are authorized and identified in this Contract; and
4. The utilization and actual cost of the alternative services or setting are taken into account when developing the premium rates in accordance with 42 CFR 457.1201(e) which incorporates 42 CFR 438.3(e)(2)(iv).

Insurer shall include all value-add benefits in Insurer’s Enrollee handbook.

## Disease and Case Management

Insurer shall provide disease and case management services. Insurer shall provide FHKC a list of disease and case management programs, to the extent any case management is condition-specific, by the date established in the approved implementation plan. Insurer shall inform FHKC of any addition or removal of such programs sixty (60) Calendar Days prior to the change.

Insurer shall have policies and procedures in place for identifying and enrolling Enrollees likely to benefit from such services.

Insurer shall provide a quarterly disease and case management report that includes the number of Enrollees identified as eligible for disease or case management, the number of Enrollees enrolled in the quarter, the percentage of eligible Enrollees engaged in disease or case management, Insurer’s definition of “engagement” and a breakdown of such information by program.

## Coordination; Transition of Care

Insurer shall coordinate, or provide for the coordination of, services between settings of care, including appropriate discharge planning for short and long-term hospital and institutional stays, with services Enrollees receive from other health care coverage or liable third-parties and with services Enrollees receive from community and social support Providers.

Insurer shall implement a transition of care policy consistent with the transition of care policy adopted by FHKC. FHKC’s transition of care policy shall be made publicly available. Insurer will provide a copy of Insurer’s transition of care policy to FHKC during implementation of the Contract, by the date established in the approved implementation plan, and prior to any proposed changes. Changes to Insurer’s transition of care policy are subject to FHKC’s approval. Summaries of the transition of care policy shall be included in the Enrollee handbook and relevant notices.

Notwithstanding any other provision of this Contract, as of the Effective Date of this Contract, Insurer shall be liable for the cost of any previously authorized, ongoing course of treatment provided to an Enrollee by any provider, regardless of whether such provider has a contract with Insurer, without any further authorizations, for an additional sixty (60) Calendar Days after termination or expiration of any prior insurer’s contract covering such Enrollees.

# Grievances and Appeals

Insurer shall have a Grievance and Appeal system in place for Enrollees in compliance with 42 CFR 457.1260. {The Grievance and Appeal system shall be the same for Title XXI Enrollees and Full-pay Enrollees. *(Full-pay and subsidized; reblend)}*. Insurer shall establish and maintain policies and procedures for the Grievance and Appeal system, including procedures for expedited Appeals.

Insurer shall provide its Grievance and Appeal policies and procedures to FHKC by the date established in the approved implementation plan and at least sixty (60) Calendar Days prior to any proposed changes. The initial policy and procedures and any subsequent changes are subject to approval by FHKC. Insurer shall provide its Grievance and Appeal policies and procedures to Providers and Subcontractors when Insurer enters into a written agreement with such entities or individuals and after any approved changes.

Insurer shall ensure individuals making decisions about Grievances and Appeals:

1. Were not involved in any previous level of review or decision-making and are not the subordinate of any such individual;
2. Have the appropriate clinical expertise in treating the Enrollee’s condition or disease when:
   1. An Appeal is based on lack of Medical Necessity;
   2. A Grievance is about the denial of an expedited resolution of an Appeal; and
   3. A Grievance or Appeal involves clinical issues.
3. Take all comments, documents, records and other information submitted by the Enrollee or Enrollee’s representative into account without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

Insurer shall maintain a record of all Grievances and Appeals that includes the following information for each Grievance and Appeal:

1. Date received;
2. Date of each review or review meeting, as applicable;
3. Enrollee name;
4. Nature or general description of the reason for the Grievance or Appeal;
5. Disposition of each level of the Grievance and Appeal process, as applicable;
6. Date of resolution at each level, as applicable; and
7. Documents relevant to each Grievance and Appeal.

Insurer shall accurately maintain these records in a manner accessible to FHKC and, upon request, CMS.

Insurer shall provide FHKC with a quarterly Grievances and Appeals report. The Grievances and Appeals report shall include:

1. A summary analysis of the Grievances and Appeals that includes:
   1. Appeal response timeliness as a percentage of Appeals in the reporting quarter that were closed timely. Appeals closed in the quarter includes Appeals that were received in a different quarter and closed in the reporting quarter.
   2. Grievance response timeliness as a percentage of Grievances in the reporting quarter that were closed timely. Grievances closed in the quarter includes Grievances that were received in a different quarter and closed in the reporting quarter.
2. Line item records of Grievances and Appeals received in the quarter that includes:
   1. The date received;
   2. Identification as a Grievance or an Appeal;
   3. Nature or general description of the reason for the Grievance or Appeal;
   4. The disposition, as applicable;
   5. The date of the disposition, as applicable; and
   6. If a Subcontractor handles the Grievance or Appeal, the name of the Subcontractor responsible.
   7. {An indicator showing whether the Grievance or Appeal is for a Title XXI Enrollee or a Full-pay Enrollee *(Full-pay and subsidized; reblend)}*
3. Line item records of Grievances and Appeals closed in the quarter that includes:
   1. The date received;
   2. Identification as a Grievance or an Appeal;
   3. Nature or general description of the reason for the Grievance or Appeal;
   4. The disposition;
   5. The date of the disposition; and
   6. If a Subcontractor handles the Grievance or Appeal, the name of the Subcontractor responsible.
   7. {An indicator showing whether the Grievance or Appeal is for a Title XXI Enrollee or a Full-pay Enrollee *(Full-pay and subsidized; reblend)}*

Insurer shall provide an annual summary analysis Grievance and Appeals report that includes:

1. Appeal response timeliness as a percentage of Appeals in the reporting Contract Year that were closed timely. Appeals closed in the Contract Year includes Appeals that were received in a different Contract Year for this Contract and closed in the reporting Contract Year.
2. Grievance response timeliness as a percentage of Grievances in the reporting Contract Year that were closed timely. Grievances closed in the Contract Year includes Grievances that were received in a different Contract Year for this Contract and closed in the reporting Contract Year.
3. Summary of any Appeal trends. At a minimum Insurer shall consider whether any trends may be found regarding benefits appealed, Provider specialty types involved (as a function of the benefit, not related to Provider involvement in the Appeal process), and similarities in overturned Appeals.
4. A description of activities Insurer has taken to address avoidable Appeals as well as any planned activities.
5. Summary of any Grievance trends. At a minimum Insurer shall consider whether any trends may be found regarding Grievance topic and Providers involved (as a component of the Grievance, not related to Provider involvement in the Grievance process).
6. A description of activities Insurer has taken to address avoidable Grievances as well as any planned activities.

Insurer shall provide this information in the aggregate and broken out in the manner requested by FHKC. Insurer’s performance in this subject to the performance guarantees established in Attachment C.

Insurer shall provide Enrollees with reasonable assistance completing forms and taking other procedural steps related to Grievances and Appeals, upon request. Such assistance shall include providing auxiliary aids and services, interpretation services and toll-free numbers with TTY/TTD and interpreter capability. Insurer shall follow the requirements of 42 CFR 457.1207 which incorporates 42 CFR 438.10 and any method(s) established by FHKC when notifying Enrollees about any aspect of the Grievance and Appeal process.

An Enrollee’s authorized representative, including Providers, may file Grievances and Appeals on the Enrollee’s behalf with the written consent of the Enrollee. Insurer shall not take punitive action against any Provider for filing an Appeal, requesting an expedited Appeal, or supporting an Enrollee’s request for an expedited Appeal.

## Grievances

Enrollees may file a Grievance with Insurer orally or in writing at any time. Insurer shall acknowledge receipt of the Grievance in writing within five (5) Business Days.

Insurer shall provide Enrollees a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

Insurer shall resolve each Grievance, and provide notice of the resolution, as expeditiously as the Enrollee’s health condition requires within the timeframes required in this Contract and 42 CFR 457.1260. Standard resolution and notice of Grievances shall not exceed ninety (90) Calendar Days from the date of Grievance receipt, unless extended appropriately.

The standard resolution timeframe for a Grievance may be extended by up to fourteen (14) Calendar Days if:

1. The Enrollee requests the extension; or
2. Insurer shows that there is need for additional information and that such an extension is in the Enrollee’s interest. FHKC may choose to request the basis for Insurer’s decision to extend the timeframe. In such instances, the basis for Insurer’s decision is subject to FHKC’s satisfaction.

If a Grievance timeframe has been extended other than at the request of an Enrollee, Insurer shall make reasonable efforts to give the Enrollee:

1. Prompt oral notice of the delay;
2. Written notice of the decision to extend the timeframe within two (2) Calendar Days; and
3. Notice of the Enrollee’s right to file a Grievance regarding this decision.

Insurer shall resolve the Grievance as expeditiously as the Enrollee’s health condition requires, but no later than the date the extension expires.

## Appeals

Enrollees may file an Appeal orally or in writing within sixty (60) Calendar Days of the date of notification of an Adverse Benefit Determination. Oral requests for Appeal must be followed by a signed, written Appeal unless the request is for an expedited Appeal. Such oral requests shall be used to establish the earliest possible filing date for the Appeal. Insurer shall acknowledge receipt of the Appeal in writing within five (5) Business Days. Appeals are limited to a single level. Enrollees wishing to further appeal Insurer’s decision to uphold an Appealed decision may proceed to the independent external review process.

Insurer shall provide Enrollees a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Such reasonable opportunity includes informing the Enrollee of the limited time available for these actions sufficiently in advance of the resolution timeframes for Appeals. Insurer shall also provide Enrollees with the Enrollee’s case file, including medical records, other documents and records and any new or additional evidence considered, relied upon or generated by Insurer in connection with the Appeal of the Adverse Benefit Determination, free of charge and sufficiently in advance of the resolution timeframe for Appeals.

Insurer shall resolve each Appeal, and provide notice, as expeditiously as the Enrollee’s health condition requires within the timeframes required in this Contract and 42 CFR 457.1260.

1. Standard resolution and notice of Appeals shall not exceed thirty (30) Calendar Days from the date of Appeal receipt, unless extended appropriately.
2. Expedited resolution and notice of Appeals shall not exceed seventy-two (72) hours from the Appeal receipt, unless extended appropriately.

When an Enrollee requests an expedited Appeal, Insurer shall determine whether taking the time for a standard resolution could seriously jeopardize the Enrollee’s life, physical or mental health, or ability to attain, maintain or regain maximum function. Providers may also request, or support an Enrollee’s request for, an expedited Appeal.

The standard resolution timeframe for an Appeal may be extended by up to fourteen (14) Calendar Days if:

1. The Enrollee requests the extension; or
2. Insurer shows that there is need for additional information and that such an extension is in the Enrollee’s interest. FHKC may choose to request the basis for Insurer’s decision to extend the timeframe. In such instances, the basis for Insurer’s decision is subject to FHKC’s satisfaction.

If an Appeal timeframe has been extended other than at the request of an Enrollee, Insurer shall make reasonable efforts to give the Enrollee:

1. Prompt oral notice of the delay;
2. Written notice of the decision to extend the timeframe within two (2) Calendar Days; and
3. Notice of the Enrollee’s right to file a Grievance regarding this decision.

Insurer shall resolve the Appeal as expeditiously as the Enrollee’s health condition requires, but no later than the date the extension expires.

Insurer shall provide written notice of resolution for Appeals and shall additionally make reasonable efforts to provide oral notice of resolution of an expedited Appeal. Appeal determination notices must include:

1. The result of the Appeal process;
2. The date the Appeal was resolved;
3. For Appeal determinations not wholly in the Enrollee’s favor, the right to request an independent external review, and instructions on how to make such a request.

In the event Insurer fails to adhere to the Appeal decision or notice requirements, the Enrollee shall be deemed to have exhausted the Appeal process and may request an independent external review.

In the event Insurer overturns an Adverse Benefit Determination, Insurer shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee’s health condition requires, but no later than seventy-two (72) hours from the Appeal resolution date.

## Independent External Review

Enrollees may request an independent external review within one hundred twenty (120) Calendar Days of notification that an appealed Adverse Benefit Determination has been upheld or when the Appeal process has been deemed exhausted by way of Insurer’s failure to adhere to the notification and timing requirements of 42 CFR 457.1260 which incorporates 42 CFR 438.408.

Insurer shall maintain a contract with an Independent Review Organization (IRO) for the provision of Enrollees’ option to have a post-appeal independent review. Such contract shall specify and meet all state and federal laws, regulations and guidance applicable to CHIP Grievance and Appeal process requirements and subcontractor requirements, including FHKC’s audit rights.

Insurer and Insurer’s IRO shall enter into a memorandum of understanding with FHKC. FHKC shall have full insight into the IRO’s performance.

Insurer shall provide a quarterly report listing all independent reviews the IRO handled in the quarter, including the date the independent review was requested, the date the IRO made a final decision, the outcome of the review, whether Insurer has since received any Grievances related to the independent review and any other information requested by FHKC.

Enrollees and the Enrollee’s representative or the legal representative of a deceased Enrollee’s estate shall be included as parties to the review.

In the event the independent external review overturns an Adverse Benefit Determination, Insurer shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee’s health condition requires, but no later than seventy-two (72) hours from the independent external review determination date.

Insurer is responsible for the full cost of all independent reviews.

# Access to Care

## General network Requirements

Insurer shall maintain a network of Providers sufficient to meet the requirements of this Contract and to adequately serve the needs of the Enrollees. Insurer shall allow Enrollee choice of network Providers to the extent possible and appropriate.

Insurer’s Provider network shall be supported by written agreements.

Insurer shall establish mechanisms to:

1. Ensure network Provider compliance with required terms;
2. Monitor Providers regularly to determine compliance;
3. Take corrective action should a network Provider fail to comply; and
4. Handle Provider complaints.

Insurer shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification, including Providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision does not:

1. Require Insurer to contract with Providers beyond the number necessary to meet the needs of the Enrollees;
2. Preclude Insurer from using different reimbursement amounts for different specialties or different Providers of the same specialty; or
3. Preclude Insurer from establishing measures designed to maintain quality of services or control costs and are consistent with Insurer’s responsibilities to Enrollees.

Insurer shall promptly notify FHKC when Insurer receives information about a change in a network Provider’s information that may affect the Provider’s eligibility to participate in the Program.

Insurer shall provide FHKC with a monthly list of Providers leaving and entering the network the previous month. The monthly network change report shall include each Provider’s NPI, name, address(es), specialty type, telephone number, whether the Provider is entering or leaving the network, an indicator showing whether the Provider should appear in the Provider director or be suppressed, and indicators for any Providers removed from the network for ineligibility to participate in Medicare, Medicaid or CHIP or for Fraud or Abuse.

Insurer shall provide FHKC with 90 Calendar Days’ advance written notice of any anticipated termination of large Provider groups, hospitals, or any independently practicing Provider if the independently practicing Provider has at least fifty (50) Enrollees on its patient panel.

## Provider Credentialing

Insurer shall establish and follow policies and procedures for credentialing and recredentialing Providers. Such policies and procedures shall, at a minimum, comply with the uniform credentialing and recredentialing policy adopted by FHKC. Insurer may adopt credentialing and recredentialing policies and procedures that are more robust than FHKC’s uniform credentialing and recredentialing policy requires.

In the event Insurer declines to contract with a Provider or Provider group, Insurer shall provide affected Providers with written notice of the reason for Insurer’s decision.

## Participating Provider Requirements

Insurer shall require each network Provider to have a National Provider Identifier (NPI).

Insurer shall ensure all network Providers have an active Medicaid ID.

Insurer’s network shall not include any Providers excluded for participation by Medicare, Medicaid or CHIP. Insurer shall not enter into or authorize any agreements with such excluded Providers that would otherwise require Insurer to pay for out-of-network services, except for Emergency Services.

Insurer shall ensure that all network Providers are enrolled in Medicaid or CHIP consistent with the Provider disclosure, screening and enrollment requirement of 42 CFR part 455, subparts B and E as incorporated in 42 CFR 438.608(b). Insurers may execute temporary Provider Contracts pending the outcome of the Medicaid or CHIP provider enrollment process of up to one hundred twenty (120) Calendar Days but must terminate a Network Provider Immediately upon notification that the Network Provider cannot be enrolled, or the expiration of one (1) 120 Calendar Day period without enrollment of the Provider. Insurer shall provide assistance to AHCA, FHKC and any other agency as requested to facilitate the enrollment process.

### Medical Records

Insurer shall require Providers to maintain and share, as appropriate, medical records for each Enrollee under this Contract in accordance with professional standards and applicable federal and state law.

### Health Information Technology Participation

### Florida SHOTS

Insurer’s shall require and ensure that network PCPs provide all covered immunizations to Enrollees, are enrolled with Florida’s statewide online immunization registry, the Florida State Health Online Tracking System (SHOTS), and continue to keep the Enrollee’s immunization record updated in the SHOTS database. Insurer may allow immunizations to be administered at locations other than a PCP’s office so long as Insurer ensures the treating Provider submits the information to SHOTS or notifies the Enrollee’s PCP of the immunization administration. This provision shall not allow a PCP to refuse to proactively offer or administer immunizations at the PCP’s office.

Insurer shall confirm to FHKC annually that Insurer is in compliance with these provisions.

### Electronic Health Records

Insurer shall promote and support the use of electronic health records (EHRs) among its network Providers.

By the end of the second Contract Year and annually thereafter, Insurer shall provide evidence to FHKC that:

1. At least fifty percent (50%) of eligible professionals and eligible hospitals, as defined under the HITECH Act, use certified EHRs in a meaningful manner, as described in the Florida Medicaid EHR Incentive Program; and
2. At least sixty-five percent (65%) of Enrollees are assigned to PCPs using certified EHRs in a meaningful manner, as described in the Florida Medicaid EHR Incentive Program; or
3. PCPs are able to receive notifications of hospital encounters, including inpatient discharges and emergency department visits through Insurer’s participation in the Event Notification System of the Florida Health Information Exchange.

This provision does not require Insurer’s Providers meeting EHR use standards to participate in or receive incentives from the Florida Medicaid EHR Incentive Program.

### Primary Care Providers

PCPs are limited to:

1. Board-certified pediatricians;
2. Board-certified family physicians;
3. Providers who have recently completed a residency program in pediatrics or family practice approved by the National Board for Certification of Training Administrators of Graduate Medical Education Programs and who are eligible for board certification but have not yet achieved board certification;
   1. If the Provider does not achieve board certification within three (3) years of initial credentialing for the Florida Healthy Kids program, Insurer shall remove the Provider from its Florida Healthy Kids network or request a board-certification exemption for the provider.
4. Physician extenders working under the direct supervision of a board-certified pediatrician or board-certified family physician; and
5. Exempt Providers, as described in this Contract.

#### Board-certified PCP Exemptions

Insurer may request an exemption to the board-certification requirement for individual pediatricians and family physicians in writing. Insurer shall provide the reason for such request and include the proposed Provider’s curriculum vitae and other information required by FHKC. Insurer shall not make board-certification exemption requests for the sole or primary purpose of avoiding normal business costs associated with board-certified PCPs. FHKC shall review the exemption requests on a case-by-case basis provide a written response to Insurer. Board-certification exemptions are provided on a per Insurer basis for any specific Provider. Insurer must submit an exemption request to FHKC for a Provider even if that Provider has an active exemption with another Florida Healthy Kids insurer. Exemptions expire after two (2) years unless a Renewal is approved by FHKC.

### Facility Standards

Network facilities shall meet applicable accreditation, licensure requirements and facility regulations specified by AHCA.

### Behavioral Health and Substance Use Disorder Providers

Behavioral health, including substance use disorder, Providers shall be limited to those Providers delivering behavioral health services within the scope of their licensure and Insurer’s credentialing and recredentialing requirements.

In addition to qualified, licensed behavioral health Providers, Insurer may allow services to be provided by provider agencies eligible to provide Florida Medicaid behavioral health overlay services in the manner described in Rule 59G-4.027, Florida Administrative Code. This allowance is limited to the provider and staff qualifications and does not allow Insurer to adopt Florida Medicaid’s behavioral health overlay services as Covered Services under this Contract.

Behavioral health Provider qualifications and requirements for entry into the network are subject to mental health/substance use disorder parity requirements.

### Federally Qualified Health Centers; Rural Health Centers

A Federally Qualified Health Center (FQHC) is an entity that is receiving a grant under Section 330 of the Public Health Service Act and Section 1905(1)(2)(B) of the Social Security Act.

A Rural Health Clinic (RHC) is a facility meeting the requirements of section 1861(aa)(2) of the Social Security Act, 42 CFR 405.2401 and 42 CFR 491.2.

Insurer shall reimburse FCHCs and RHCs at or above the reimbursement amounts provided under the Medicaid Prospective Payment System for such entities.

No supplemental payments from FHKC will be provided for these payments under any circumstances. Insurer is responsible for the entire amount.

Insurer shall provide a quarterly report identifying all network FQHCs and RHCs and attesting to Insurer’s compliance with these reimbursement requirements.

This provision does not require Insurer to contract with FQHCs or RHCs.

### Indian Health Care Providers

Insurer shall maintain sufficient numbers of Indian Health Care Providers (IHCPs) in Insurer’s Provider network to ensure timely access to services from such Providers to Enrollees eligible to receive such services. Insurer shall provide a quarterly attestation and supporting documentation to FHKC demonstrating compliance with this requirement.

Insurer shall allow any Enrollee who is eligible to receive services from a network IHCP to choose the IHCP as his or her PCP so long as the IHCP has the capacity to provide the services. Insurer must also allow any Enrollee who is eligible to receive services from an IHCP to obtain services covered under the Contract from an out-of-network IHCP. Insurer shall allow out-of-network IHCPs to refer Enrollees to a network Provider.

Should there be too few IHCPs in the State to ensure timely access to Covered Services, Enrollees who are eligible to receive such services shall be permitted to access out-of-state IHCPs.

Insurer shall pay for Covered Services provided to eligible Enrollees by IHCPs, whether participating in the network or not, at either the rate negotiated between Insurer and the IHCP or at a rate not less than the level and amount of payment Insurer would make for services to a non-IHCP network Provider. Insurer shall make all payments to network IHCP’s in a timely manner, as required by 42 CFR 447.45 and 447.46.

When an IHCP is also an FQHC, but is not a network Provider, Insurer shall pay the IHCP an amount equal to the amount Insurer would pay a participating FQHC that is not an IHCP.

When an IHCP is not an FQHC, regardless of network participation status, the IHCP has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of such published encounter rate, the amount it would receive if the services were provided by the State’s Medicaid fee for service payment methodology.

Insurer shall pay IHCPs the full amount an IHCP is eligible to be paid. No supplemental payments from FHKC will be provided for these payments under any circumstances. Insurer is responsible for the entire amount.

## Network Adequacy

Insurer shall maintain and monitor a Provider network sufficient to meet Enrollee needs and the requirements of this Contract. Insurer shall take into consideration Enrollees with limited English proficiency , physical and mental disabilities, or other barriers to care and Insurer’s ability to meet such needs through the Provider network when determining network adequacy.

Insurer shall provide a certification attesting to, and documentation supporting, Insurer’s capacity to serve the expected enrollment in its service area in accordance with the terms of this Contract. Supporting documentation must demonstrate that Insurer offers an appropriate range of preventive, primary care and specialty services for the anticipated number of Enrollees in the Service Area and that Insurer maintains a network of Providers sufficient in number, mix and geographic distribution to meet the needs of the anticipated Enrollees. Insurer shall submit this documentation in the format specified by FHKC. {Insurer shall provide separate certifications and supporting documentation for Title XXI Enrollees and Full-pay Enrollees. *(Full-pay and subsidized; reblend)*}

Documentation shall be submitted when:

1. Insurer enters into this Contract with FHKC;
2. On an annual basis, when submitting the annual premium report; and
3. Any time there has been a significant change in Insurer’s operations that may affect the adequacy of capacity and services, including changes in:
   1. Services;
   2. Benefits;
   3. Geographic service area;
   4. Composition of Provider network;
   5. Payments to Provider network; or
   6. Enrollment of a new population in plan.

Insurer understands and agrees that such documentation may be posted on FHKC’s website in accordance with 42 CFR 457.1285.

Insurer shall also provide any documentation needed by FHKC’s EQRO to conduct an annual network adequacy validation or any other activity required by FHKC.

Failure to provide access as required in this Contract may constitute a material breach, as determined by FHKC in its sole discretion. Such material breach shall entitle FHKC to unilaterally terminate this Contract pursuant to Section 34-4 Termination for Lack of Performance or Breach.

### Access to Family Planning Providers; Women’s Health Specialists

Insurer shall demonstrate that the Provider network includes sufficient access to family planning Providers to ensure timely access to Covered Services.

Insurer shall provide female Enrollees with direct access to a network women’s health specialist. Such direct access is in addition to the Enrollee’s PCP if the PCP is not a women’s health specialist.

### Geographical Access

Insurer shall maintain a network that meets the following standards:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provider Type** | **Time (in minutes)** | | **Distance (in miles)** | |
|  | **Rural** | **Urban** | **Rural** | **Urban** |
| **PCP – Pediatrician** | 30 | 20 | 30 | 20 |
| **PCP – Family Physician** | 20 | 20 | 20 | 20 |
| **OB/GYN** | 30 | 30 | 30 | 30 |
| **Behavioral Health – Pediatric** | 60 | 30 | 45 | 30 |
| **Behavioral Health – Other** | 60 | 30 | 45 | 30 |
| **Allergy/immunology** | 60 | 30 | 45 | 30 |
| **Dermatology** | 60 | 30 | 45 | 30 |
| **Optometry** | 60 | 30 | 45 | 30 |
| **Otolaryngology (ENT)** | 60 | 30 | 45 | 30 |
| **Specialist – Pediatric** | 40 | 20 | 30 | 20 |
| **Specialist – Other** | 20 | 20 | 20 | 20 |
| **Hospital** | 30 | 30 | 30 | 20 |
| **Pharmacy** | 15 | 15 | 10 | 10 |
| **Urgent Care Center** | Report | Report | Report | Report |

“Other” means providers in the specified provider type who do not hold a pediatric subspecialty.

For urgent care centers, Insurer shall report enrollees’ access to such facilities. FHKC may choose to use such reports and other information available to create minimum geographic access standards for urgent care centers.

Insurer shall provide FHKC with a quarterly geographic access report demonstrating Insurer’s compliance with these requirements and the performance guarantees in Attachment C. {Insurer shall provide separate geographic access reports for Title XXI Enrollees and Full-pay Enrollees. *(Full-pay and subsidized; reblend)*}

#### Geographic Access Exemptions

Insurer may request a service area exemption to waive time and/or distance network adequacy standards for a given geographical area. To request a service area exemption, Insurer must submit a written request for an exemption accompanied by supporting documentation. These requests shall include:

1. Identification of the service area, provider type(s), and specific standard(s) the request for exemption covers;
2. The reason for the request, which may include:
   1. No providers exist in the area.
   2. No providers exist in the area that are able to pass Insurer’s credentialing or recredentialing standards.
   3. Limited providers exist in the area and all refuse to contract with Insurer despite Insurer’s documented good faith efforts to contract.
3. The number of providers in the area;
4. The distance to the nearest network provider;
5. Documentation of Insurer’s efforts to find providers in the area as well as proof of existing providers’ inability to be credentialed/recredentialed or proof of Insurer’s failed good faith efforts to contract, as appropriate. Insurer must provide the practice address and phone number of any provider refusing to contract;
6. Certification attesting that documentation is complete and accurate;
7. Insurer’s plan to monitor the area and take action should any change occur;
8. Explanation of how Insurer will provide timely services to enrollees in the area; and
9. Any other information FHKC deems necessary to make a determination.

Once a service area exemption has been granted, Insurer must monitor and report on enrollee access to the relevant provider type as well as activity relating to Insurer’s monitoring plan on a quarterly basis.

Exemptions expire and must be re-approved every two years unless withdrawn by Insurer or revoked by FHKC. Exemptions may be revoked for the following reasons:

1. The situation in the area has changed and Insurer can reasonably be expected to meet access requirements;
2. Failure to provide continuing evidence that the exemption is appropriate; and
3. Failure to adequately monitor, take action or report as required by Insurer’s documented plan, the contract or state or federal law.

Information regarding service area exemptions may be reported to CMS as required by federal law.

### Appointment Access

Insurer shall require network Providers to offer hours of operation and appointment times that are no less than the hours of operation and appointment times offered to commercial enrollees.

Insurer shall provide timely treatment for Enrollees in accordance with the following standards:

1. Emergency care shall be provided immediately.
2. Urgently needed care shall be provided within twenty-four (24) hours.
3. Routine care shall be provided within seven (7) Calendar Days of the Enrollee’s request for services.
4. Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four (4) weeks of the Enrollee’s request.
5. Follow-up care shall be provided as medically appropriate.

### Out-of-Network Access

In the event an Enrollee requires access to Covered Services and Insurer has failed to provide adequate access to such Covered Services, as determined by FHKC or Insurer, Insurer shall provide access to the relevant Covered Services outside the network. In the event Insurer has materially failed to provide adequate access for an Enrollee’s ongoing health care needs, including access to an out-of-network Provider, FHKC may direct Enrollees to seek related Covered Services from an out-of-network Provider. Should FHKC direct such action, Insurer shall be financially responsible for such services to the extent Insurer would be responsible if the services had been provided by a network Provider.

## Physician Incentive Plans

Insurer shall comply with 42 CFR 457.1201(h) incorporating through 42 CFR 438.3(i) references to 42 CFR 422.208 and 42 CFR 422.210, as well as any other applicable federal or state laws and regulations related to physician incentive plans.

Insurer shall not make specific payment(s), directly or indirectly (including offerings of monetary value measured in the present or future), to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

If a physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, Insurer shall ensure that all physicians and physician groups at financial risk have sufficient aggregate or per-patient stop-loss protection.

Substantial financial risk is determined as defined in 42 CFR 422.208 and this Contract. Substantial financial risk is when risk is based on the use or costs of referral services and that risk exceeds the risk threshold of twenty-five percent (25%) of potential payments. Payments based on other factors are not considered in determining whether substantial financial risk exists.

The following arrangements cause substantial financial risk to exist for physicians or physician groups with patient panel sizes not greater than twenty-five thousand (25,000) patients:

1. Withholds greater than twenty-five percent (25%) of potential payments;
2. Withholds less than twenty-five percent (25%) of potential payments if the physician or physician group is potentially liable for amounts exceeding twenty-five percent (25%) of potential payments;
3. Bonuses that are greater than thirty-three percent (33%) of potential payments minus the bonus;
4. Withholds plus bonuses if the withholds plus bonuses equal more than twenty-five percent (25%) of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula described in 42 CFR 422.208(d)(3)(iv);
5. Capitation arrangements if the difference between the maximum potential payments and the minimum potential payments is more than twenty-five percent (25%) of the maximum potential payments or the maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group; and
6. Any other incentive arrangements that have the potential to hold the physician or physician group liable for more than twenty-five percent (25%) of potential payments.

Stop-loss protection required for physicians and physician groups at substantial financial risk must cover ninety percent (90%) if aggregate stop-loss protection is used. If per-patient stop-loss protection is used, the stop-loss limit per patient must be determined based on the size of the patient panel in accordance with 42 CFR 422.208(g) and must cover ninety percent (90%) of the costs of referral services that exceed the per patient Deductible limit in accordance with 42 CFR 422.208(f)(2)(iii).

Insurer shall provide Enrollees with a disclosure that includes whether the Insurer uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement and whether stop-loss protection is provided, upon request.

Insurer shall notify FHKC of any physician incentive plans used for Healthy Kids Enrollees and provide documentation to FHKC assuring that insurer is meeting contractual and regulatory requirements. Such documentation shall also include a copy of the Enrollee disclosure notice Insurer intends to provide to Enrollees.

## Integrity of Professional Advice to Enrollees

Insurer shall comply with 42 CFR 457.985 prohibiting Insurer from interfering with the advice of health care professionals to Enrollees and requiring that professionals engaged in the performance of Insurer’s duties under this Contract give information about treatments to Enrollees as provided by law.

Insurer shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice from advising or advocating on behalf of an Enrollee who is his or her patient regarding:

1. The Enrollee’s health status, medical care or treatment options, including any alternative treatment that may be self-administered;
2. Any treatment the Enrollee needs to decide among all relevant treatment options;
3. The risks, benefits and consequences of treatment or non-treatment; and
4. The Enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preference about future treatment decisions.

Insurer shall be subject to intermediate sanctions, as described in 42 CFR Part 457, Subpart I, for any violations of this prohibition.

## Provider Payments

### Claims

Insurer shall provide FHKC with the address from which claims are paid.

Insurer shall receive and process claims in accordance with the terms of this Contract and industry best practices and nationally recognized standards, including the use of electronic transmission of claims, payments and related documents.

Insurer shall pay clean claims submitted electronically within fifteen (15) Calendar Days of receipt. For all other claims submitted electronically, Insurer shall deny or request any additional information needed to process the claim within fifteen (15) Calendar Days and deny or pay within ninety (90) Calendar Days of claim receipt.

Insurer shall pay clean claims not submitted electronically within twenty (20) Calendar Days of receipt. For all other claims submitted electronically, Insurer shall deny or request any additional information needed to process the claim within fifteen (15) Calendar Days and ultimately deny or pay within ninety (90) Calendar Days of receipt.

Insurer shall also process and pay claims in accordance with the performance guarantees required in Attachment C.

A clean claim is a claim completed in accordance with Insurer’s guidelines, accompanied by all documentation required for payment and that may be processed and adjudicated without obtaining additional information from the Provider or a third party or Medical Necessity review. Claims from Providers under investigation for Fraud, Abuse or violation of state or federal laws or regulations are not considered clean claims.

Information pertaining to claims and payment data provided to FHKC shall be accompanied by an attestation attesting to the accuracy, completeness and truthfulness of the data under penalty of perjury.

### Capitated Arrangements

Insurer shall monitor and assess any capitated arrangements in place on a routine basis to ensure that such arrangements continue to provide appropriate value in cost savings or avoidance.

Annually, or upon request, Insurer shall provide FHKC with a report listing the types of services provided under capitated arrangements, the percent of encounters that are capitated, the total amount paid for capitated services broken out as required by FHKC and, for those services provided by a mix of capitated and other payment arrangements, the percentage of providers under a capitated agreement.

### Provider Overpayments

Insurer shall provide an annual report listing all overpayments to Providers, including overpayments made related to Fraud, Waste and Abuse and all other overpayments.

1. Such policies and procedures must include:
   1. A mechanism for a network Provider to report in writing to Insurer that an overpayment has been received and the reason why the overpayment was received; and
   2. Require Provider to return the overpayment to Insurer within sixty (60) Calendar Days after the date on which the overpayment was identified.

# Fraud and Abuse

Insurer shall have administrative and management arrangements and procedures to detect and prevent Fraud, Waste and Abuse that comply with all state and federal laws and regulations, including 42 CFR 457.1285.

Insurer’s arrangements and procedures shall include:

1. A compliance program that includes:
   1. Written policies, procedures and standards of conduct detailing Insurer’s commitment to comply with all applicable requirements and standards;
   2. A compliance officer responsible for developing and implementing the policies, procedures and practices designed to ensure compliance with the Contract. The compliance officer shall have sufficient experience in healthcare and shall report directly to the CEO and Insurer’s board of directors;
   3. A regulatory compliance committee on the board of directors and at the senior management level charged with overseeing Insurer’s compliance program and its compliance with the Contract;
   4. A system for training and educating the compliance officer, senior management and Insurer’s employees about state, federal and contractual requirements;
   5. Effective lines of communication between the compliance officer and Insurer’s employees, as evidenced by some formal policy;
   6. Enforcement of standards through well-publicized disciplinary guidelines;
   7. Non-retaliation policies against any individual that reports violations of Insurer’s Fraud and Abuse policies and procedures or suspected Fraud and Abuse; and
   8. A system, and related procedures, with dedicated staff for routine internal monitoring, auditing of compliance risks, prompt response to, investigation of, and correction of compliance issues, actions to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements of the Contract.
2. A method used to verify services that were represented to have been delivered by network Providers were received by Enrollees. Such verification process shall be conducted on a regular basis;
3. The distribution of written policies to Insurer’s employees, and of any Subcontractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about the rights of employees to be protected as whistleblowers;
4. Prompt reporting to FHKC of information Insurer obtains indicating Fraud or potential Fraud by a Provider, Subcontractors, Applicant or Enrollee;
5. Suspension of payments to a network Provider when FHKC or AHCA determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23; and
6. Policies and procedures to maintain adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist Insurer with preventing and detecting potential Fraud and Abuse activities.

Insurer shall provide its Fraud, Waste and Abuse policies to FHKC for approval during implementation of this Contract, by the date established in the approved implementation plan, and prior to any changes. Changes to Insurer’s Fraud, Waste and Abuse policies are subject to FHKC approval.

Insurer shall provide FHKC with a quarterly Fraud, Waste and Abuse report detailing prevention activities conducted by Insurer, potential offenses being investigated and any confirmed instances of Fraud or Abuse. Insurer may report information on violations of law by Subcontractors, Providers, Enrollees or other relevant individuals to FHKC and/or to CMS, as appropriate. Insurer may only report such information regarding Enrollees when the information pertains to enrollment in the plan or Covered Services.

Insurer shall cooperate in any investigation by FHKC or any state or federal entities and any subsequent legal action that may result from such an investigation.

# Quality Management

## Accreditation

Insurer shall inform FHKC of any accreditations received by a private independent accrediting entity. Insurer shall authorize the private independent accrediting entity to provide FHKC with a copy of its most recent accreditation review. Such review includes the following information:

1. Accreditation status;
2. Accreditation survey type;
3. Accreditation level, as applicable;
4. Accreditation results, including
   1. Recommended actions or improvements
   2. Corrective action plans; and
   3. Summaries of findings
5. Expiration date of the accreditation

In accordance with the requirements of 42 CFR 457.1240(c), FHKC will make Insurer’s accreditation status available on the Florida Healthy Kids website. Such accreditation status will include the name of the accrediting entity, accreditation program and accreditation level, as applicable.

Insurer shall provide FHKC with a report listing the accrediting entity, accreditation program and accreditation level of all accreditations during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by December 15th. Insurer shall inform FHKC of any change in accreditation status within thirty (30) Calendar Days of such change.

## Quality Assessment and Performance Improvement

Insurer shall maintain a quality assessment and performance improvement (QAPI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes.

At a minimum, the QAPI program shall include:

1. Performance improvement projects (PIPs) focusing on clinical and non-clinical areas;
2. Collection and submission of performance measurement data;
3. Mechanisms to detect underutilization and overutilization of services;
4. Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs;
5. Written policies and procedures that address components of effective health care management including anticipation, identification, monitoring, measurement, evaluation of Enrollees’ health care needs, and effective action to promote quality of care; and
6. Any performance measures and PIPs that are required by CMS during the term of this Contract.

Insurer’s QAPI shall incorporate an annual quality improvement plan (QIP). Insurer’s QIP shall:

1. Include an executive summary describing the structure of Insurer’s QAPI, Insurer’s approach to quality improvement and how Insurer evaluates the QIP and QAPI to determine new or improved quality improvement activities;
2. Define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest-level of success;
3. Implement specific interventions to better manage Enrollee care and promote improved health outcomes; and
4. Identify performance goals supporting the QAPI program.

Insurer shall submit its QIP to FHKC during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by July 1st. Insurer’s QIP is subject to FHKC approval. Insurer shall use the results of the QIP to assess and report on the overall QAPI program to FHKC annually.

Insurer shall have a quality improvement committee that develops and is responsible for the oversight of the QIP. The quality improvement committee shall be chaired or co-chaired by Insurer’s medical director, meet at least quarterly and include provider representation.

## External Quality Review

FHKC shall contract with an EQRO to conduct annual external quality review activities during the Contract term.

Insurer shall cooperate in all such activities. Cooperation with EQR-activities includes, but is not limited to:

1. Responsiveness to requests for discussion and feedback, including requests for PIP-topic preferences;
2. Provision of data, documentation and other information in an accurate and timely manner;
3. Reviews and evaluation of Insurer’s PIPs, whether such review is a review of the format and initial methodology, progress review or the EQRO’s validation review;
4. Participation in any EQR-related training made available to Insurer by FHKC;
5. Monitoring of activities by FHKC; and
6. Corrective action plans or quality improvement activities required of Insurer by FHKC as a result of EQR-activity findings.

Insurer shall calculate results for and report the performance measures identified by FHKC on an annual basis as part of FHKC’s external quality review activities. Insurer shall also provide FHKC with data, as specified by FHKC, which enables FHKC to validate or calculate Insurer’s performance using the standard measures. FHKC may choose to independently calculate, or have calculated, the performance measures. Insurer remains responsible for calculating the performance measures regardless of whether FHKC is independently calculating these performance measures.

Insurer shall conduct PIPs as part of the QAPI program in accordance with the written guidance for PIPs released by CMS. Each PIP must be designed to:

1. Achieve significant improvement, sustained over time, in health outcomes and/or Enrollee satisfaction; and
2. Must include measurement of performance using:
   1. Objective quality indicators;
   2. Implementation of interventions to achieve improvement in access and quality of care;
   3. Evaluate the effectiveness of the interventions; and
   4. Planning and initiation of activities for increasing or sustaining improvement.

PIPs specific to Insurer and/or to the overall Program resulting from FHKC’s monitoring, the EQR-activities or industry trends or emerging issues may also be required from Insurer. FHKC may choose to either dictate any or all of the PIP topics or allow Insurer to choose any or all of its PIP topics, subject to FHKC approval.

## Managed Care Quality Rating System

FHKC may adopt the quality rating system developed by CMS or may adopt an alternative quality rating system as allowed in 42 CFR 457.1240 which incorporates 42 CFR 438.334. FHKC will notify Insurer of any such quality rating system.

Insurer shall cooperate with FHKC in the implementation and maintenance, including data submission, of such quality rating system.

## FHKC Quality Initiatives

FHKC may implement quality initiatives other than those types of quality activities considered in this Contract and may require Insurer to participate in such initiatives. In the event a quality initiative requires substantial and material efforts by Insurer beyond the scope of the Contract, FHKC shall amend the Contract to include the quality initiative. The Parties agree to negotiate such amendments in good faith.

Insurer shall engage in preliminary discussions, research assistance, basic consultation and other activities of a similar nature and such activities shall not require a Contract amendment.

# Reporting Requirements

Insurer shall comply with all reporting requirements under this Contract in the manner and timeframes specified in the Contract, as listed under Attachment D or as otherwise required by FHKC. For this section, the term “reports” encompasses reports, documents, deliverables and other information provided to FHKC.

Insurer shall provide reports to FHKC electronically with physical copies provided upon request.

Reports submitted to FHKC must be clearly named and must include, at a minimum, Insurer’s name and a short descriptive document title. Such descriptive document titles should be intelligible by an individual familiar with CHIP and general health insurance, but unfamiliar with Insurer and Insurer’s internal document management system and processes. FHKC may occasionally dictate a specific naming convention for certain documents. Insurer shall adhere to any prescribed naming convention.

In the event a routine report is required for which Insurer has no data to report for the reporting period, Insurer shall populate relevant fields in the report with a statement indicating the lack of reportable information. Insurer shall not fail to submit any report because of lack of reportable data.

Insurer may be required to provide FHKC information or data that is not specified under this Contract. Insurer shall have at least thirty (30) Calendar Days to fulfill such ad hoc reporting requests unless otherwise required by FHKC.

Insurer shall provide supporting evidentiary documentation with all reports unless otherwise required by FHKC.

Insurer shall provide reports in accordance with the requirements described in this Contract or requested by FHKC. Insurer shall be liable for financial consequences in the amount of five hundred dollars ($500) per Calendar Day, limited to fifteen thousand dollars ($15,000) per incident, for failure to provide reports in an acceptable format by the required due date. Financial Consequences apply to each Calendar Day beyond the due date until provided to FHKC, inclusive of the day provided to FHKC. Financial Consequences apply to the initial due date and to subsequent due dates should the report require revisions prior to FHKC approval.

Insurer shall be liable for financial consequences in the amount of five hundred dollars ($500) per incident for failure to adhere to any reporting requirement other than timeliness.

FHKC shall not assess both Calendar Day and per incident financial consequences for the same instance of noncompliance nor shall FHKC assess such financial consequences when FHKC has assessed other financial consequences for an equivalent reason for the instance of noncompliance.

# Encounter Data

Insurer shall provide a quarterly encounter and claims data for all services rendered under this Contract. Insurer shall submit the encounter and claims data using a format and following a process established by FHKC. The quarterly encounter and claims data shall include the level of detail specified by FHKC using standardized ASC X12N 837, NCPDP formats and the ASC X12N 835 or another standardized format, as required by FHKC. Encounter data reports must comply with HIPAA security and privacy standards and shall be submitted in a format required by the Medicaid Statistical Information System or successor system.

FHKC anticipates requiring Insurer to submit the quarterly encounter and claims data to FHKC’s contracted EQRO and AHCA’s contracted vendor responsible for the annual Florida KidCare Evaluation Report.

Insurer shall provide the quarterly Encounter and Claims Data by the due dates listed below:

|  |  |
| --- | --- |
| **Encounters and Claims Processed During:** | **Data Due to FHKC by:** |
| January 1st – March 31st | April 15th |
| April 1st – June 30th | July 15th |
| July 1st – September 30th | October 15th |
| October 1st – December 31st | January 15th |

FHKC may amend the process, format or other requirements during the Contract term without amending this Contract. Insurer shall implement such changes by the date required by FHKC.

Insurer shall be liable for financial consequences in the amount of one thousand dollars ($1,000) per Calendar Day for failure to provide a complete file of all claims/encounter data to FHKC’s contracted EQRO and/or AHCA’s contracted vendor on a quarterly basis in the format and timeframe specified by FHKC. Financial Consequences apply to each Calendar Day beyond the due date until such complete file is submitted to FHKC’s EQRO and/or AHCA’s contracted vendor in the format specified, inclusive of the date Insurer provides the file.

Insurer shall assist FHKC in complying with any state or federal encounter data reporting requirements, including correcting accuracy, completeness or other compliance issues.

Access to Enrollee claims data by FHKC, the State of Florida, the federal Centers for Medicare and Medicaid Services and the Department of Health and Human Services Inspector General shall be allowed to the extent permitted by law.

# Attestations

Insurer shall provide a written attestation signed by Insurer’s Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual reporting directly to the CEO or CFO with delegated authority to sign for the aforementioned individual, certifying that based on best information, knowledge and belief, the data, documentation or information provided is accurate, complete and truthful when submitting the information listed in this provision.

The CEO or CFO is ultimately responsible for attestations provided by an individual with delegated authority. Insurer shall provide an organizational chart upon execution of this Contract and within one (1) week of any changes.

This provision is applicable to the following specified data, documentation and information:

1. Encounter Data;
2. Data FHKC may use to determine Insurer’s compliance with MLR requirements;
3. Data FHKC may use to determine Insurer has made adequate provision against the risk of insolvency;
4. Documentation related to Insurer’s compliance with requirements for availability and accessibility of services, including Provider network adequacy;
5. Information on ownership and control of Insurer and Insurer’s Subcontractors;
6. Annual overpayment recoveries report; and
7. Any other data, documentation or information for which FHKC requests an attestation.

Attestations must be submitted concurrently with the submission of data, documentation or information.

Insurer shall attest to the accuracy, completeness and truthfulness of claims and payment data submitted to FHKC under penalty of perjury.

# Governing Law

Insurer shall comply with all applicable federal and state laws and regulations, including:

1. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq.;
2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794;
3. Title IX of the Education Amendments of 1972, as amended 20, U.S.C. 1681 et seq.;
4. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq.;
5. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849;
6. The American Disabilities Act of 1990, P.L. 101-336;
7. Section 274A (e) of the Immigration and Nationalization Act;
8. Title XXI of the federal Social Security Act;
9. HIPAA, and any other federal or state laws regarding disclosure of protected health information as specified in Attachment B.
10. The Immigration Reform and Control Act of 1986
11. All applicable federal and state laws regarding advertising, marketing and promotional activities of health care services or otherwise related to the offering of health care services and items and services including: (i) the Federal Anti-Kickback Law, 42 U.S.C. § 1320a-7b; (ii) the Civil Monetary Penalty Law, 42 U.S.C. § 1320a-7a; (iii) the Civil and Criminal False Claims Acts, 31 U.S.C. §§ 3729-3733; (iv) the Stark Law, 42 U.S.C. §1395nn; (v) the Health Care Fraud Statute, 18 U.S.C. § 1347, Federal; and (f) to the extent applicable, the respective state law counterparts of any of the federal laws described in (i) through (v) above.

Insurer further agrees that all contractors, Subcontractors, sub-grantees or others with whom it arranges to provide goods, services or benefits in connection with any of its programs and activities are not discriminating against either those whom they employ nor those to whom they provide goods, services or benefits in violation of the above statutes, regulations, guidelines and standards.

It is expressly understood that evidence of Insurer’s refusal or failure to substantially comply with this section or such failure by Insurer’s subcontractors or anyone with whom Insurer affiliates in performing under this Contract shall constitute a material breach and renders this Contract subject to unilateral cancellation by FHKC.

# Notice

All Notices required under this Contract shall be in writing and shall be delivered by any of the following methods:

1. Certified mail with return receipt requested;
2. Facsimile with proof of receipt;
3. Email with proof of receipt; or
4. In person with proof of delivery.

Notices shall be directed to:

For FHKC:

[Name]

[Address]

For Insurer:

[Name]

[Address]

In the event that different contact persons are designated by either Party after execution of this Contract, Notice of the name and address of the new contact will be sent to the other Party. A change in contact for this section does not require an amendment to the Contract.

### Notification Requirements

Insurer shall notify FHKC in writing within one (1) Business Day, of:

1. Any judgment, decree or order rendered by any court of any jurisdiction or Florida administrative agency enjoining Insurer from the sale or provision of services under Chapter 641, Part II, Florida Statutes.
2. Any petition by Insurer in bankruptcy or for approval of a plan of reorganization or arrangement under the Bankruptcy Act or Chapter 631, Part I, Florida Statutes or an admission seeking relief provided therein.
3. Any petition or order of rehabilitation or liquidation as provided in Chapter 631 or 641, Florida Statutes.
4. Any order revoking Insurer’s Certificate of Authority.
5. Any administrative action taken by the Department of Financial Services, Office of Insurance Regulation or the Agency for Health Care Administration in regard to Insurer, including the initiation of any Subscriber Assistance Panel or other administrative proceedings.
6. Any medical malpractice action filed in a court of law in which an Enrollee is a party (or in which Enrollee’s allegations are to be litigated).
7. The filing of an application for merger or other change in structure or ownership.

Any pending litigation or commencement of legal action involving Insurer in which liability for or Insurer’s obligation to pay could exceed five hundred thousand dollars ($500,000.00) or ten percent (10%) of Insurer’s surplus, whichever is lower.

# Administrative and Legal Proceedings

“Legal actions” are defined to include administrative proceedings.

### Venue

In the event of any legal action in relation to this Contract, Insurer consents that hearings and depositions for any administrative or other litigation related to this Contract shall be held in Leon County, Florida. FHKC, in its sole discretion, may waive this venue for depositions.

### Attorney Fees

In the event of any legal action, dispute, litigation or other proceeding in relation to this Contract, FHKC is entitled to recover its attorney fees and other costs incurred from Insurer, whether or not suit is filed, and if filed, at both trial and appellate levels.

The Parties agree the intent of this provision is to protect the enrollees who receive medical benefits through Florida KidCare and rely upon the continuation of FHKC’s duties authorized in section 624.91, Florida Statutes.

# Severability

If any provision of this Contract is held to be unenforceable by a court of competent jurisdiction, such provision shall be severed from the remaining provisions of the Contract, which shall remain in effect.

# Survival

The provisions of the following sections shall survive any termination of this Contract:

1. Record Retention;
2. Indemnification,
3. Attorney Fees;
4. Confidentiality; Public Records
5. Conflicts of Interest;
6. Non-Solicitation;
7. Governing Law;
8. Venue;
9. Contract Termination Transition Plan Contract Termination

## Termination for Lack of Funding

This Contract is subject to the continuation and approval of funding to FHKC from state, federal and other sources. FHKC has the right, at its sole discretion, to terminate this Contract if funding for the Program is to be changed or terminated to the extent that this Contract cannot be sustained. FHKC shall provide Insurer a notice of termination at least thirty (30) Calendar Days prior to the date of termination.

## Termination for Lack of Payment

In the event FHKC fails to make payments in accordance with the schedule included in this Contract, Insurer may suspend work and pursue the appropriate remedies for FHKC’s breach of its payment obligations. Insurershall provide FHKC at least thirty (30) Calendar Days written notice of any suspension due to lack of payment and allow FHKC an opportunity to correct the default prior to suspension of work.

## Termination for Insolvency or Bankruptcy

In the event of Insurer’s insolvency of filing a petition for bankruptcy, FHKC may immediately terminate this Contract, either in its entirety or any part herein, at its sole discretion. Insurer shall notify FHKC within one (1) Business Day of the Insolvency or the filing of a petition for bankruptcy. Consistent with section 9-1 above, in no event shall FHKC or Enrollees be held liable for Insurer’s debt.

## Termination for Lack of Performance or Breach

The continuation of this Contract is contingent upon the satisfactory performance of Insurer. If Insurer fails to adequately meet the terms of this Contract, FHKC reserves the right to terminate this Contract, or any part herein, at its discretion. Such termination shall be effective on the date determined by FHKC and provided by written notice to Insurer. FHKC, in its sole discretion, may allow Insurer to cure any performance deficiencies prior to termination of the Contract.

## Termination upon Revision of Applicable Law

In the event federal or state revisions of any applicable laws or regulations restrict FHKC’s ability to comply with the Contract, make such compliance impracticable, frustrate the purpose of the Contract or place the Contract in conflict with FHKC’s ability to adhere to its statutory purpose, FHKC may unilaterally terminate this Contract. FHKC shall provide Insurer a notice of termination at least thirty (30) Calendar Days prior to the termination date.

## Termination upon Mutual Agreement

Upon mutual agreement of the Parties, this Contract, or any part herein, may be terminated on an agreed date prior to the end of the Contract without penalty to either Party.

## Termination by FHKC

Notwithstanding any other termination provisions, FHKC may terminate this Contract or any part of this Contract, without penalty or cost to FHKC, at its convenience, and such termination will be effective at such time as is determined by FHKC.

IN WITNESS WHEREOF, the parties have caused this Contract, to be executed by their undersigned officials as duly authorized.

**FOR:**

**[Insurer]**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME:**

**TITLE:**

**DATE SIGNED:**

STATE OF

COUNTY OF

The foregoing instrument was acknowledged before me before this day of 2019, by , as on behalf of the . He/She is personally known to me or has produced as identification.

Signature

Notary Public – State of Florida

Print, Type or Stamp Name of Notary Public

My Commission Expires

**FOR**

**FLORIDA HEALTHY KIDS CORPORATION:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME: Rebecca Matthews**

**TITLE: Interim Executive Director**

**DATE SIGNED:**

STATE OF FLORIDA

COUNTY OFLEON

The foregoing instrument was acknowledged before me before this \_\_\_\_\_\_ day of \_\_\_\_\_\_, 2019, by Rebecca Matthews, as Interim Executive Director, on behalf of the Florida Healthy Kids Corporation. She is personally known to me or has produced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as identification.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

Notary Public – State of Florida

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print, Type or Stamp Name of Notary Public

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Commission Expires