

ATTACHMENT I

SCOPE OF SERVICES

A. Service(s) to be Provided

1. Overview

The Medicare Advantage Dual Eligible Special Needs Plan (MA D-SNP) (Vendor) has entered into a contract with the Centers for Medicare and Medicaid Services (CMS) to provide an MA D-SNP Plan. Under the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) and resulting regulations, CMS requires the MA D-SNP to enter into a contract with the State Medicaid Agency to provide or arrange for benefits to be provided, which a dually eligible individual is entitled to receive. Medicare reimbursement for MA D-SNPs is provided in the same manner as for any other type of MA Plan, also known as Medicare Part C.

The Vendor is responsible for providing services in accordance with the terms and conditions set forth in this Contract and all applicable federal and state laws, rules and regulations including but not limited to the following:

- a. 42 Code of Federal Regulations Part 422;
- b. Health Insurance Portability and Accountability Act (HIPAA) of 1996;
- c. Chapter 409, Florida Statutes (FS);
- d. Chapter 624, FS;
- e. Chapter 636, FS;
- f. Chapter 641, FS; and
- g. 59G-8.100, Florida Administrative Code.

The Vendor is responsible for complying with any applicable changes in federal and state law, rules or regulations.

The provisions of this Contract apply to qualified Medicare and Medicaid dual eligible beneficiaries. This Contract may encompass only the following Medicaid eligibility categories: QMB, QMB Plus, SLMB, SLMB Plus, QI, QDWI, and FBDE. These beneficiaries are herein referred to as enrolled dual eligibles. This includes full duals but excludes Institutional Care Program (ICP) eligible recipients during the enrollment month.

B. Manner of Service Provision(s)

1. Services to be Provided by the Agency:

- a. The Agency will maintain continuing and regular oversight of the requirements of this Contract.

b. Agency expenditures and active oversight shall be subject to authorization and funding by the state legislature.

c. Provider Participation File Exchange

1) On a quarterly basis, the Agency will provide the Vendor a listing of all providers with whom the Agency has active Medicaid agreements on file in order to ensure network adequacy and promote continuity of care. The Vendor shall electronically transmit provider participation files to the Agency upon request, in a manner determined by the Agency. The Vendor shall include in the provider participation files all network providers contracted by the Vendor to serve its members who are dual eligible beneficiaries.

d. Eligibility Verification

1) Initial Eligibility Verification. The Agency shall provide the Vendor access to information verifying the eligibility of dual eligibles through the use of the Medicaid Fiscal Agent's Provider Secured Web Portal. The Vendor shall ensure individuals enrolled in the D-SNP are eligible for both Medicare and Medicaid.

2) Ongoing Eligibility Verification. The Parties agree to exchange Medicare and Medicaid eligibility and enrollment data to facilitate the Parties' performance under this Contract. The Agency shall transmit to the Vendor the Agency's eligibility data that shall verify the active or inactive status of dual eligible beneficiaries and identify the dual eligibility beneficiary categories of members. The Parties agree that the Vendor will reconcile the data and the Parties shall work in good faith to resolve any discrepancies that the Vendor or Agency may identify.

e. Cost-Sharing Obligations

1) Cost-Sharing Obligations by Plan Design. The Agency acknowledges and agrees that based on the Vendor's benefit package design and its bid to CMS, the Vendor determines varying levels of cost-sharing obligations for certain dual eligible beneficiary members. The Agency further acknowledges and agrees that as a result of these benefit package designs, the Vendor's actual cost-sharing obligations for such members may be reduced or equal zero, as provided for in Chapter 16b of the Medicaid Managed Care Manual.

2. Services to be Provided by the Vendor

a. The Vendor shall ensure individuals enrolled in the MA D-SNP are eligible for both Medicare and Medicaid. The Vendor shall ensure individuals enrolled in the MA D-SNP are eligible for both Medicare and Medicaid. The Vendor shall facilitate eligibility redeterminations, by providing assistance with applications for medical assistance on behalf of its members, conducting member

education regarding maintaining Medicaid eligibility, or other activities designed to facilitate the process.

- b. The Vendor shall ensure the provision of Medicaid covered services specified in **Exhibit A, Medicare Advantage Dual Eligible Special Needs Plan Covered Services**, in sufficient amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished.
- c. The Vendor shall cover all costs of the Medicaid State Plan benefits listed in **Exhibit A** which are incurred by enrolled dual eligibles who meet the eligibility criteria for full Medicaid benefits as outlined in the Medicare Managed Care Manual Chapter 16b and applicable laws and regulations.
- d. The Vendor shall comply with all current Florida Medicaid Handbooks ("Handbooks") as noticed in the Florida Administrative Register ("FAR"). In addition, the Vendor shall comply with the limitations and exclusions in the Handbooks, unless otherwise specified by this Contract. In no instance may the limitations or exclusions imposed by the Vendor be more stringent than those specified in the Handbooks including the definition of medical necessity. The Vendor shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness, or condition.
- e. The Vendor Member Protections
 - 1) Limitation on Cost-Sharing Obligations. In the case of a dual eligible beneficiary who is enrolled in the Vendor's MA D-SNP, the Vendor agrees that it may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to such individual pursuant to Medicaid if the individual were not a member of the Vendor's MA D-SNP.
 - 2) Hold Harmless Member Cost-Sharing. With respect to its members for whom the State Medicaid Agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Plan to cover cost-sharing obligations, the Vendor agrees that it shall include in its written communication with providers that providers acknowledge and agree that they shall not bill or charge such members the balance of ("balance bill"), and that such members are not liable for, those cost-sharing obligations. The Vendor further agrees that in accordance with 42 C.F.R. §422.504(g)(1)(iii), it will include in its provider agreements that the provider will accept the Vendor's payment as payment in full or will bill the appropriate Agency source if the Vendor has not assumed the Agency's financial responsibility under an agreement between the Vendor and the Agency.
 - 3) Member Held Harmless from Vendor and Agency Financial Responsibility. Notwithstanding any provision in this Contract to the contrary, the Vendor shall prohibit providers, under any circumstance including but not limited to non-payment by the Vendor, insolvency of

the Vendor or breach of the Vendor's agreement with provider, from billing, charging, collecting a deposit from, seeking compensation or remuneration from or having any recourse against any member for fees that are the responsibility of the Vendor or Agency.

- f. The Vendor shall maintain a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients as specified in s. 1932(b)(7) of the Social Security Act, as enacted by s.4704(a) of the Balanced Budget Act of 1997 to provide the covered services described in **Exhibit A**.
- g. The Vendor shall have sufficient facilities, service locations and personnel within its provider network to provide the covered services described in **Exhibit A** for the population being served.
- h. The Vendor shall track and pay all eligible providers the cost-sharing obligations incurred on behalf of enrolled dual eligibles with applicable Medicaid eligibility categories covered under this Contract.
- i. The Vendor is not precluded from entering into agreements with network providers that vary the amount or method of payment for the cost-sharing and Medicaid State Plan benefits or from using the Vendor's coordination of benefits procedures.
- j. The Vendor shall ensure that all providers, service and product standards specified in the Agency's Medicaid Services Coverage and Limitations Handbooks, and the Vendor's own provider handbooks are incorporated in the Vendor's participation agreements, including professional licensure and certification standards for all service providers.
- k. The Vendor shall provide coordination of care for its enrolled dual eligibles. Coordination of care shall include, but not be limited to the following:
 - 1) Assist its enrolled dual eligibles in obtaining required services;
 - 2) Coordinate the delivery of benefits and services to its enrolled dual eligibles;
 - 3) Inform network providers of benefits and services which are to be provided to its enrolled dual eligibles;
 - 4) Train network providers on available benefits and services in order to ensure its enrolled dual eligibles receive benefits and services;
 - 5) Cover all costs incurred for benefits by its enrolled dual eligibles as indicated in **Exhibit B**.
- l. The Vendor shall submit all requests to subcontract to the Agency for review and approval at least ninety (90) calendar days before the effective date of the subcontract or change.

- m. The Vendor shall ensure that issues involving third party liability are referred to the Agency's Third Party Liability (TPL) Vendor. The Vendor shall provide the Agency TPL Vendor with TPL information as it becomes available to the Vendor. The Agency will provide the Vendor with TPL Vendor contact information and methods of reporting TPL.
- n. The Vendor shall have written policies and procedures in place to ensure an adequate provider network for its enrolled dual eligibles that complies with federal rules regarding network adequacy, including, but not limited to access standards to determine effectiveness. Copies of these policies and procedures shall be provided to the Agency upon request.
- o. All agreements between the Vendor and providers must include all MA D-SNP Plan Benefit Package services and procedures including all Medicaid State Plan Services listed in **Exhibit A**. Copies of these agreements may be required to be submitted to the Agency Contract Manager for review prior to any payment being made to the Vendor. The Agency shall complete its review within forty-five (45) days of receipt.
- p. The Vendor shall ensure that claims are processed and comply with the federal and state requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S.
- q. The Vendor shall require in its credentialing with network providers an agreement that network providers will not file additional claims for Medicaid deductibles or co-payment reimbursement and that the network providers will not balance bill their enrolled dual eligibles covered under this Contract as identified in the Medicare Managed Care Manual Chapter 16b and applicable laws and regulations. Copies of these agreements may be required to be submitted to the Agency Contract Manager for review prior to any payment being made to the Vendor. The Agency shall complete its review within forty-five (45) days of receipt.
- r. The Vendor agrees to ensure that network providers serving its enrolled dual eligibles will be required in their written provider agreements to not file claims for Medicaid reimbursement to the Medicaid Fiscal Agent for its enrolled dual eligibles covered under this Contract as identified in the Medicare Managed Care Manual Chapter 16b and applicable laws and regulations. The Vendor may be required to submit copies of its provider agreements and training information to the Agency Contract Manager for review prior to any payment being made to the Vendor. The Agency shall complete its review within forty-five (45) days of receipt.

3. Internal Audits

The Vendor shall conduct quarterly internal audits in order to ensure compliance with this Contract. The audit shall be conducted on a calendar quarter basis and shall be submitted to the Agency no later than forty-five (45) calendar days after the end of each calendar quarter in a format prescribed by the Agency. Failure to conduct required internal audits to the satisfaction of the Agency may result in

suspension of payment, corrective action plan, liquidated damages or termination, at the sole discretion of the Agency.

4. Inspection of Records and Work Performed

- a. The state and its authorized representatives shall, at all reasonable times, have the right to enter the Vendor's premises, or other places where duties under this Contract are performed. All inspections and evaluations shall be performed in such a manner as not to unduly delay work.
- b. The Vendor shall retain all financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of five (5) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings.
- c. Refusal by the Vendor to allow access to all records, documents, papers, letters, other materials or on-site activities related to Contract performance shall constitute a breach of this Contract. The right of the state and its authorized representatives to perform inspections shall continue for as long as the Vendor is required to maintain records. The Vendor will be responsible for all storage fees associated with the medical records maintained under this Contract. The Vendor is also responsible for the shredding of medical records that meet the retention schedule noted above.
- d. Failure to retain records as required may result in termination of this Contract. The Agency shall give the Vendor advance notice of termination in accordance with the termination for breach requirements of the Standard Contract, and shall pay the Vendor only those amounts that are earned prior to the date of termination in accordance with the terms and conditions of this Contract.

5. Audits/Monitoring

- a. The Agency may conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency may conduct a review of a sample of analyses performed by the Vendor to verify the quality of the Vendor's analyses. Reasonable notice shall be provided for reviews conducted at the Vendor's place of business.
- b. Reviews may include, but shall not be limited to, reviews of procedures, computer systems, enrolled dual eligible records, accounting records, and internal quality control reviews. The Vendor shall work with any reviewing entity selected by the state.
- c. During the Contract period these records shall be available at the Vendor's office at all reasonable times. After the Contract period and for five (5) years following, the records shall be available at the Vendor's chosen location subject to the approval of the Agency. If the records need to be sent to the

Agency, the Vendor shall bear the expense of delivery. Prior approval of the disposition of Vendor and subcontractor records must be requested and approved by the Agency if this Contract or subcontract is continuous. Vendor's obligations under this paragraph survive the termination of this Contract.

- d. The Vendor shall comply with 45 CFR, Part 74, with respect to audit requirements of federal contracts administered through state and local public agencies. In these instances, audit responsibilities have been delegated to the State and are subject to the ongoing audit requirements of the State of Florida and of the Agency.
- e. Refusal by the Vendor to allow access to all records, documents, papers, letters, other materials or on-site activities related to this Contract shall constitute a breach of this Contract. The right of the state and its authorized representatives to perform inspections shall continue for as long as the Vendor is required to maintain records, regardless of the termination date of this Contract.
- f. Upon discovery of any problem or Vendor error for any aspect of this Contract that may jeopardize the Vendor's ability to perform any function of this Contract, the Vendor shall notify the Agency Contract Manager in person, via telephone or electronic mail, as soon as possible but no later than the close of business if the problem or error is identified during the business day and no later than 9:00 a.m. Eastern Time, the following business day if the problem or error occurs after close of business.
- g. The Vendor shall correct all errors discovered or identified at no cost to the Agency.

6. Confidentiality of Information

- a. All personally identifiable information obtained by the Vendor shall be treated as privileged and confidential information and shall be used only as authorized for purposes directly related to the administration of this Contract. The Vendor must have a process that specifies that patient-specific information remains confidential, is used solely for the purposes of Vendor responsibilities under this Contract, and is exchanged only for the purpose of conducting the duties outlined in this Contract.
- b. Any patient-specific information received by the Vendor can be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Vendor is retained by the Agency. The Vendor must have in place written confidentiality policies and procedures to insure confidentiality and to comply with all federal and state laws (including the Health Insurance Portability and Accountability Act [HIPAA]) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail). These policies and procedures shall be provided to the Agency upon request.

- c. The Vendor's subcontracts and provider agreements must explicitly state expectations about the confidentiality of information, and the provider is held to the same confidentiality requirements as the Vendor. If provider-specific data are released to the public, the Vendor shall have policies and procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, Florida Statutes, are met. These policies and procedures shall be provided to the Agency upon request.
- d. Any releases of information pertaining to this Contract to the media, the public, or other entities require prior approval from the Agency.

7. Encryption

- a. The Vendor shall ensure all electronic mail communications that contain Protected Health Information are encrypted in accordance with HIPAA requirements, Agency policy, and Federal Information Processing Standards Publication (FIPS) 140-2.
- b. The Vendor shall encrypt all data that is submitted to the Agency in electronic format.
- c. The Vendor shall use the Agency's encryption software when corresponding with the Agency via electronic mail.
- d. Any costs associated with obtaining the Agency's encryption software shall be at the Vendor's expense and at no cost to the Agency.

8. Fraud and Abuse Prevention

The Vendor shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903 and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447 and 455; 45 CFR part 74; Chapters 409, 414, 458, 459, 460, 461, 626, 636, 641, 812 and 817, F.S., and 59A-12.0073, 59G and 69D-2, FAC.

9. Reporting Requirements

- a. The Vendor shall comply with all reporting requirements, including submission timeframes as prescribed by the Agency when requested by the Agency.
- b. The Vendor shall have at least thirty (30) calendar days to fulfill adhoc requests.
- c. The Vendor is responsible for assuring the accuracy, completeness, and timely submission of each report.

- d. The Vendor's chief executive officer (CEO), chief financial officer (CFO), or an individual who reports to the CEO or CFO and who has delegated authority to certify the Vendor's reports, must attest, based on his/her best knowledge, information, and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful, and complete (42 CFR 438.606(a) and (b)). The Vendor shall submit its certification at the same time it submits the certified data reports (42 CFR 438.606(c)). The certification page shall be scanned and submitted electronically to the Agency.

10. Deliverables

- a. The Vendor shall provide documentation of the following to the Agency Contract Manager prior to any payment being made to the Vendor. In addition, the Vendor shall maintain current documentation throughout the term of this Contract to be provided to the Agency upon request.
 - 1) Valid certificate of authority issued by the State of Florida Department of Financial Services Office of Insurance Regulation as a risk bearing entity (either a health maintenance organization or a health insurer).
 - 2) Approval from the Centers for Medicare and Medicaid Services (CMS) qualifying as a MA D-SNP for each calendar year of this Contract.
- b. The MA D-SNP's Summary of Benefits covered by the Vendor, including both Medicare and Medicaid State Plan services, shall be submitted to the Agency Contract Manager for review prior to any payment being made to the Vendor. The Agency shall complete its review within forty-five (45) days of receipt.
- c. The Vendor shall provide the Agency with the service area(s) covered by this Contract as provided in **Exhibit B, MA D-SNP Type and Applicable Service Areas**. **Exhibit B** shall be submitted to the Agency Contract Manager for review prior to any payment being made to the Vendor. The Agency shall complete its review within forty-five (45) days of receipt.
- d. The Vendor shall refer to **Exhibit C, Required Documentation** for a complete listing of deliverable requirements.

11. Encounter Data

- a. The Agency may issue the Vendor an Encounter Data Plan to be executed by the Vendor. The Encounter Data Plan shall establish the method of transmission of Encounter Data, the submission schedule and format, a quality validation process with assessment standards, and any other requirements which the Agency incorporates into the plan. The Encounter Data Plan will be included in this Contract by amendment, if applicable.
- b. The Vendor shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the HIPAA-compliant formats upon implementation of the Encounter Data Plan.

C. Performance Standards and Liquidated Damages

1. Liquidated Damages

- a. The Agency reserves the right to impose liquidated damages upon the Vendor for failure to perform any of the required components of this Contract. The Agency may base its determinations on liquidated damages from findings regarding onsite surveys, enrolled dual eligibles or other complaints, financial status, or any other source.
- b. The Agency's Contract Manager will monitor the Vendor's performance in accordance with the monitoring requirements of this Contract and may determine the level of liquidated damages based upon an evaluation of the severity of the deficiency, error or violation. Failure by the Vendor to meet the established minimum performance standards may result in the Agency, in its sole discretion, finding the Vendor to be out of compliance, and all remedies provided in this Contract and under law, shall become available to the Agency.
- c. Liquidated damages are due from the Vendor within twenty-one (21) calendar days from receipt of the notice of liquidated damages.
- d. The Agency reserves the right to withhold all or a portion of the Vendor's monthly enrolled dual eligible payment for any amount owed to the Agency.

Liquidated Damages		
Issue #	Program Issue	Damages
1	A nonwillful violation.	\$2,500.00 per occurrence and shall not exceed an aggregate of \$10,000.00 for all nonwillful violations arising out of the same action.
2	A willful violation.	\$20,000.00 per occurrence and shall not exceed an aggregate of \$100,000.00 for all willful violations arising out of the same action.
3	The Vendor shall comply with public records laws, in accordance with Section 119.0701, Florida Statutes	\$5,000.00 for each incident in which the Vendor does not comply with a public records request.

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D. Method of Payment

1. The Vendor shall be compensated per dual eligible per month for January 1, 2015 through December 31, 2017 as follows:
 - a. Medicaid Areas One (1), Two (2), Three (3), Four (4), Five (5), Six (6), Seven (7) and Eight (8):
 - 1) Forty-eight dollars (**\$48.00**) per dual eligible per month for QMB enrolled dual eligibles; and
 - 2) Fifty-eight dollars (**\$58.00**) per dual eligible per month for QMB Plus enrolled dual eligibles and for full duals excluding ICP eligible recipients during the enrollment month.
 - b. Medicaid Areas Nine (9), Ten (10) and Eleven (11):
 - 1) Ten dollars (**\$10.00**) per dual eligible per month for enrolled dual eligibles.
2. Any changes to the monthly per dual eligible payment for enrolled dual eligible shall be incorporated into this Contract via formal amendment.
3. There shall be no other payment to the Vendor under this Contract.
4. The Agency will establish for each calendar year, through actuarial consultation, the monthly per dual eligible payment for enrolled dual eligibles.
5. The Vendor shall provide the Agency with all necessary and pertinent information, as determined necessary by the Agency, so the Agency may consult with the actuaries in establishing payment rates for services provided to enrollees eligible under Title XIX of the Federal Social Security Act.
6. The Vendor agrees to accept the Agency's monthly per dual eligible payment for enrolled dual eligibles as payment in full for Medicaid services covered under this Contract.
7. Any claims processed by the Agency for enrolled dual eligibles shall be deducted from future per enrolled dual eligible payments. The Agency will provide a list of any such claims paid, which will identify the enrolled dual eligible, the health care provider who submitted the claim for the service provided, and the amount paid by the Agency.
8. On an annual basis, the Agency will reconcile the accounts of the Vendor based on additional information received which identifies whether individuals for which the Agency made a payment under this program had Medicaid and/or Medicare eligibility and whether such individuals were enrolled dual eligibles.
9. Payment reconciliation will include adjustments (underpayments and overpayments) to previous and future payments. Claims processed by Medicaid for the Vendor and payment calculations determined to have been calculated or paid erroneously will be included in the reconciliation.

10. In the event of overpayment, the Vendor shall refund the full amount overpaid. An overpayment includes any amount paid by the Medicaid program as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.
11. Adjustments to funds previously paid and to be paid may be required. Funds previously paid shall be adjusted when payment calculations are determined to have been in error, or when payments have been made for individuals who are determined to be ineligible for enrollment during the period for which the payments were made. In such events, the Vendor agrees to refund any overpayment and the Agency agrees to pay any underpayment.
12. If after preparation and electronic submission, either the Vendor or the Agency discover an error, including but not limited to errors resulting in eligibility or enrollment errors, errors resulting in incorrect identification of enrollees, errors resulting in incorrect claims payments, and errors resulting in rate payments above the Vendor's authorized enrollment levels, the Vendor has thirty (30) calendar days after its discovery of the error, or from its receipt of Agency notice of the error, to correct the error and re-submit accurate reports. Failure to respond within the thirty (30) calendar day period shall result in a loss of any money due the Vendor for such errors and/or liquidated damages against the Vendor.

E. Special Provision(s)

1. Disputes

- a. The Vendor may request in writing an interpretation of the Contract from the Contract Manager.
- b. In the event the Vendor disputes the interpretation or any sanction imposed by the Agency, the Vendor shall request that the dispute be decided by the Deputy Secretary for Medicaid (Deputy Secretary). The Vendor shall submit, within twenty-one (21) calendar days of said interpretation or sanction, a written request disputing the Contract Manager's interpretation or sanction directly to the Deputy Secretary.
- c. The Deputy Secretary or Deputy Secretary's delegate shall reduce the decision to writing and serve a copy to the Vendor. The written decision of the Deputy Secretary or Deputy Secretary's delegate shall be final and can only be further challenged in a court if it is unreasonable, arbitrary or capricious. The Deputy Secretary will render the final decision based upon the written submission of the Vendor and the Agency, unless, at the sole discretion of the Deputy Secretary, the Deputy Secretary allows an oral presentation by the Vendor and the Agency. If such a presentation is allowed, the information presented will be considered in rendering the decision.
- d. In the event the Vendor challenges the decision of the Deputy Secretary, the Agency action shall not be stayed. Pending final determination of any dispute over an Agency decision, the Vendor shall proceed diligently with the

performance of the Contract and in accordance with the direction of the Agency.

- e. The exclusive venue of any legal or equitable action that arises out of or relates to the Contract, including an appeal of the final decision of the Deputy Secretary shall be the appropriate court in Leon County Florida; in any such action, Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Agency will notice the Vendor of the appropriate administrative remedy.

2. Venue

This Contract shall be delivered in the State of Florida and shall be construed in accordance with the laws of Florida. Wherever possible, each provision of this Contract shall be interpreted in such a manner as to be effective and valid under applicable law, but if any provision shall be found ineffective, then to the extent of such prohibition or invalidity, that provision shall be severed without invalidating the remainder of such provision or the remaining provisions of this Contract. Any action hereon or in connection herewith shall be brought in Leon County, Florida.

3. Minority and Certified Minority Subcontractors

The Agency for Health Care Administration encourages the Vendor to use Minority and Certified Minority businesses as subcontractors when procuring commodities or services to meet the requirements of this Contract.

A minority owned business is defined as any business enterprise owned and operated by the following ethnic groups: African American (Certified Minority Code H or Non-Certified Minority Code N), Hispanic American (Certified Minority Code I or Non-Certified Minority Code O), Asian American (Certified Minority Code J or Non-Certified Minority Code P), Native American (Certified Minority Code K or Non-Certified Minority Code Q), or American Woman (Certified Minority Code M or Non-Certified Minority Code R).

4. MyFloridaMarketPlace Vendor Registration

Each Vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in section 287.012, Florida Statutes, shall register in MyFloridaMarketPlace, in compliance with Rule 60A-1.030, Florida Administrative Code, unless exempt under Rule 60A-1.030(3) Florida Administrative Code.

5. MyFloridaMarketPlace Transaction Fee

This Contract has been exempted by the Florida Department of Management Services from paying the 1% transaction fee per Rule 60A-1.032(2)(a & b), Florida Administrative Code.

6. Public Records Requests

In accordance with Section 119.0701, Florida Statutes, and notwithstanding Standard Contract, Section I, Item M., Requirements of Section 287.058, Florida Statutes, in addition to other contract requirements provided by law, the Vendor shall comply with public records laws, as follows:

- a. The Vendor shall keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Contract;
- b. The Vendor shall provide the public with access to public records on the same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in s. 119.0701, F.S., or as otherwise provided by law;
- c. The Vendor 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;
- d. The Vendor shall meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Vendor upon termination of the Contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the information technology systems of the Agency; and
- e. If the Vendor does not comply with a public records request, the Agency shall enforce the Contract provisions in accordance with this Contract.

7. Definitions

- a. **Dual Eligible** means a Medicare managed care recipient who is also eligible for Medicaid.
- b. **Eligible provider** means a provider that has an agreement with the Vendor to serve enrolled dual eligibles.
- c. **Encounter** means covered services or group of covered services, including but not limited to Medicare A, B and D covered services and Medicaid covered services identified in **Exhibit A**, delivered by a health care service provider to an enrolled dual eligible during a visit between the enrolled dual eligible and the health care service provider.
- d. **Encounter Data** means data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.
- e. **Enrolled Dual Eligible** means a dual eligible who is eligible to participate in, and is voluntarily enrolled in, the Vendor's MA D-SNP Plan. For purposes of this Contract, enrolled dual eligibles are QMB, QMB Plus, SLMB, SLMB

Plus, QI, QDWI, and FBDE. This includes full duals but excludes ICP eligible recipients during the enrollment month.

- f. **Full Benefit Dual Eligible (FBDE)** means an individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- g. **Full dual** means an individual who has Medicare and full Medicaid coverage.
- h. **Medicare Advantage Dual Eligible Special Needs Plan (MA D-SNP)** means a type of Medicare Advantage coordinated care plan focused on individuals with special needs created by Section 231 of the Medicare Modernization Act of 2003.
- i. **Qualified Disabled and Working Individual (QDWI)** means an individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed two hundred percent (200%) FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Part A premium only. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- j. **Qualifying Individual (QI)** means an individual entitled to Medicare Part A, with an income at least one hundred twenty percent (120%) FPL but less than one hundred thirty-five percent (135%) FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- k. **Qualified Medicare Beneficiaries (QMB)** means an individual entitled to Medicare Part A, with an income of one hundred percent (100%) Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through the State. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

- l. **Qualified Medicare Beneficiaries Plus (QMB Plus)** means an individual entitled to Medicare Part A, with income of one hundred percent (100%) FPL or less and resources that do not exceed twice the limit for SSI eligibility, and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State Plan. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level. Medicaid does not pay towards the out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- m. **Provider Agreement (agreement)** means a contract between the Vendor and a provider that is an entity authorized to do business in Florida, to provide services to enrolled dual eligibles.
- n. **Specific Low Income Medicare Beneficiary (SLMB)** means an individual entitled to Medicare Part A, with an income that exceeds one hundred percent (100%) FPL but less than one hundred twenty percent (120%) FPL, with resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- o. **Specific Low Income Medicare Beneficiary Plus (SLMB Plus)** means an individual who meets the standards for SLMB eligibility, and who also meets the criteria for full State Medicaid benefits. These individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.
- p. **State Plan** means the State of Florida's plan for the Medical Assistance Program as submitted by the Agency and approved by the Secretary of the U.S. Department of Health and Human Services under Title XIX of the Social Security Act, as modified or amended.
- q. **Subcontract** means an agreement entered into by the Vendor for provision of administrative services on its behalf related to this Contract.
- r. **Subcontractor** means any person or entity with which the Vendor has contracted or delegated some of its functions, services or responsibilities for providing services under this Contract.