FLORIDA MEDICAID REQUIRED PROVISIONS ATTACHMENT FOR PROVIDERS

Humana Medical Plan, Inc. ("Humana") has entered into an agreement with the State of Florida, Agency for Healthcare administration ("AHCA"), for the provision of benefits to persons enrolled in Florida's Statewide Medicaid Managed Care Program (the "AHCA Contract"). The provisions in this Addendum are required by AHCA to be included in agreements between Humana or its affiliates and providers. Provider agrees to comply with the language requirements set forth in this Addendum in addition to any applicable provisions of the AHCA Contract. If any requirement in this Addendum conflicts with a provision of the Agreement, this Addendum shall prevail.

1. Definitions:

    a. Member — A person enrolled in Humana's Florida Medicaid Managed Care Plan(s).

    b. Provider(s) — As used herein, Provider(s) refer(s) to a person or entity eligible for a Medicaid provider agreement. A Provider may be a hospital, individual physician, physician group or ancillary service provider.

    c. Provider Agreement or Agreement — As used herein, Provider Agreement or Agreement is the contract between Humana and a Provider to serve Humana's Members.

    d. Public Health Provider — Providers who are qualified under Florida law as a County Health Department, Rural Health Clinic or Federally Qualified Health Center.

    e. Subcontractor — Any entity contracting with Humana to perform services or to fulfill any of the requirements set forth in the AHCA Contract or any entity that is a subsidiary of the Humana that performs services or fulfills any of the AHCA Contract requirements. For purposes of this Addendum, Subcontractor shall include provider network managers.

Note: Providers that are contracted to provide healthcare services for Members and delegated to perform functions, services or responsibilities under the AHCA Contract would be considered both a Provider and Subcontractor. Such a Provider would be required to comply with the provisions of this Addendum and the Florida Medicaid Regulatory Addendum for Subcontractors.

2. General:

    a. A copy of the AHCA Contract is available at: http://www.fdhc.state.fl.us/Medicaid/statewide_mc/plans.shtml.

    b. If AHCA determines that any requirement in this Addendum conflicts with the AHCA Contract, such requirement shall be invalid and all other provisions shall remain in full force and effect.

    c. A current version of this Addendum is available online at Humana.com/Provider. Humana reserves the right to update this Addendum to comply with Florida's Statewide Medicaid Managed Care Program ("SMMC") requirements, as necessary. Humana shall make every effort to provide ninety (90) days advance notice to Providers of any material updates.

    d. Provider agrees to comply with and abide by all applicable terms and conditions of the AHCA Contract as well as all applicable state and federal laws, rules, regulations, and guidelines related to the SMMC.

    e. Provider represents that it is eligible for participation in the Medicaid program and further represents that it and any providers or subcontractors working for Provider are not excluded from, and are eligible for, participation in the SMMC.

    f. Provider agrees that in the event of Humana's insolvency or other cessation of operations, benefits to Members will continue for the period for which premium has been paid or for the period for which capitation has been paid to Humana, whichever is longer. Benefits to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until discharge. Provider further agrees that: (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member.

g. Payments from Humana for covered services rendered by Provider shall be made in accordance with F.S. 641.3155 and the reimbursement terms of the Provider Agreement.

h. Humana agrees not to prohibit or restrict Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a SMMC Member who is the Provider's patient regarding 1) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, 2) any information the enrollee needs to decide among all relevant treatment options, 3) the risks, benefits and consequences of treatment or non-treatment options, 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 preferences about future treatment decisions (42.CFR 438.102(a)(1)). The parties further acknowledge and agree that nothing in the Agreement or this Addendum is intended to interfere with or hinder communications between Provider and SMMC Members regarding patient treatment. Humana also agrees that it shall not prohibit PCPs from providing inpatient services in a participating hospital to a Humana member, if such services are determined to be medically necessary and covered services under the AHCA Contract.

i. In addition to any other right to terminate the Agreement, and notwithstanding any other provision of the Agreement, AHCA or Humana may request immediate termination of the Agreement if, as determined by AHCA, Provider fails to abide by the terms and conditions of the Agreement, or in the sole discretion of AHCA or Humana, Provider fails to come into compliance with the Agreement within fifteen (15) calendar days after receipt of notice specifying such failure and requesting Provider abide by the terms and conditions thereof except as specifically amended hereby, the terms and conditions of the Agreement remain the same.

j. Humana does not prohibit a Provider from advocating on behalf of the enrollee in any part of the grievance and appeal system or UM process, or individual authorization process to obtain necessary services pursuant to 42 CFR 438.402(c)(1)(i)-(ii); and 42 CFR 438.408.

k. No Provider Agreement shall in any way relieve Humana of any responsibility for the provision of services or duties under the AHCA Contract. Humana shall assure that all services and tasks related to the Provider Agreement are performed in accordance with the terms of the AHCA Contract. Humana shall identify in its Provider Agreement any aspect of service that may be delegated by the Provider.

l. For hospital contracts, rates shall be in accordance with s. 409.975(6), F.S.

m. Humana shall identify the measures, metrics, and frequency of measurement that shall be used by the Humana to monitor the quality and performance of the provider.

n. Humana shall include the specific reports and clinical information required by Humana for QI or other administrative purposes out of claims processing.

3. Provider Requirements:

a. Provider acknowledges that the Provider Agreement must comply with Chapter 641.315, F.S.,42 CFR 438.230, 42 CFR 455.104, 42 CFR 438.3(k), 42 CFR 455.105 and 42 CFR 455.106 and all applicable Medicaid laws and regulations including applicable sub-regulatory guidance and AHCA Contract provisions, and any other applicable state or federal law.

b. If the Agency determines, at any time, that the Agreement is non-compliant with the AHCA Contract requirement, Humana shall promptly revise the Agreement to bring it into compliance.

c. Provider must offer hours of operation that are no less than the hours of operation offered to commercial Managed Care Plan members or comparable Medicaid FFS recipients if the provider serves only Medicaid recipients (42 CFR 438.206(c)(1)).

d. Provider must immediately notify Humana of a Member’s pregnancy, whether identified through medical history, examination, testing, claims, or otherwise. Provider shall fill out the Notification of Pregnancy Form, located in the provider portal at Humana.com, and submit to Humana’s Case Management Department, pursuant to the instructions on the form.

e. Provider must meet timely access standards in accordance with the AHCA Contract.

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

g. Providers must ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Humana's Members with special health care needs, including physical or mental disabilities in accordance with 42 CFR 438.206(c)(3).

h. Provider shall ensure immediate transfer to another Provider if the Member's health or safety is in jeopardy.

i. Provider must cooperate in all respects with providers of other Managed Care Plans to assure maximum health outcomes for Members who are transferring.

j. Provider must ensure continuity of care for the course of treatment in the event the Provider Agreement terminates during the course of an enrollee's treatment.

k. Provider must accept Humana's compensation for services rendered as payment in full, with the exception of cost sharing and patient responsibility (if applicable).

l. Institutional Care Program, Hospice and Assisted Living Facility Providers are responsible for the collection of any monies owed due to patient responsibility. The assessment of late fees against the Member for patient responsibility are prohibited.

m. Provider must participate with Humana's peer review, grievance, quality improvement and utilization management activities, as directed by Humana.

n. Provider shall be subject to monitoring and oversight activities by Humana, consistent with the Agreement and Humana Policies and Procedures, including the monitoring of services rendered to enrollees, by Humana.

o. Any marketing materials related to the AHCA Contract displayed by the Provider must be submitted to Humana for written approval from AHCA before use.

p. Provider must maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Humana's Members.

q. Provider agrees to maintain records for a period not less than ten (10) years from the close of the AHCA Contract and retained further if the records are under review or audit until the review or audit is complete. (42 CFR 438.3(u)).

r. Provider must obtain prior approval from Humana for the disposition of records if the Provider Agreement is continuous.

s. Provider must cooperate fully with AHCA (or its designee), CMS, the OIG, the Comptroller General, and Attorney General's Office for the inspection, evaluation, and auditing of any records or documents (medical or financial) of Humana or its subcontractors at any time, related to the AHCA Contract (42 CFR 438.3(h)).

t. Provider must cooperate fully in any investigation by AHCA, Medicaid Program Integrity Bureau, Medicaid Fraud Control Unit or other State or federal entity and in any subsequent legal action that may result from such an investigation involving the AHCA Contract.

u. Providers must submit timely, complete, and accurate claims to Humana in accordance with the requirements of AHCA Contract Section X.D., Information Management and Systems, at a minimum.

v. Provider must comply with the background screening requirements of the AHCA Contract.

w. Provider must comply with HIPAA privacy and security provisions (42 CFR 438.224).

x. Provider must submit notice of withdrawal from the network at least ninety (90) days before the date of such withdrawal.

y. If Provider's participation is terminated pursuant to the Agreement for any reason, it shall utilize the applicable appeals procedures outlined in the Agreement. No additional or separate right of appeal to AHCA or Humana is created as a result of Humana's act of terminating, or decision to terminate, any provider under the AHCA Contract.

z. Provider agrees that neither Humana's Members nor AHCA shall be liable for any debts of the Provider. This provision shall survive the Provider Agreement termination for any cause, including insolvency.

aa. Provider must secure and maintain, during the life of the Provider Agreement, workers' compensation insurance (complying with the Florida workers' compensation law) for its employees connected with the work under the AHCA Contract unless such employees are covered by the protection afforded by Humana.

bb. Providers must notify Humana in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida Statutes.

cc. Provider agrees to indemnify, defend, and hold AHCA and Humana's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause survives the termination of the Provider Agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Managed Care Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers shall be approved in writing by the Agency.

dd. Provider shall cooperate with recovery efforts, including participating in audits and repaying overpayments.

ee. Provider shall report to Humana when it has received an overpayment and repay such overpayment within sixty (60) days after the date on which the overpayment was identified and must notify Humana in writing the reason for the overpayment as required by 42 CFR 438.608(d)(2). Notice shall be mailed to:

Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655

ff. Provider must ensure that that any contracts or agreements entered into by Provider for purposes of carrying out any aspect of the AHCA Contract shall include assurances that the individuals who are signing are so authorized and that it includes all the requirements of the AHCA Contract.

gg. If copayments are waived as an expanded benefit, Provider must not charge co-payments to Members for covered services. If copayments are not waived as an expanded benefit, the amount paid to Providers shall be the contracted amount, less any applicable copayments.

hh. Humana reserves the right to immediately terminate a Provider Agreement immediately upon notification from AHCA that the provider cannot be enrolled, or upon expiration of the sixty (60) day enrollment/on-boarding period. Upon such termination, Humana will notify affected Members in accordance with 42 CFR 438.602(b)(2).

ii. Humana shall make no specific payment directly or indirectly under a physician incentive plan to Provider as an inducement to withhold, reduce or limit, medically necessary services to a Member, and said incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care.

jj. Providers participating in the network as Primary Care Providers ("PCP") accept and agree to responsibilities and duties associated with the PCP designation. PCP Providers must arrange for coverage of primary care services during PCP absences due to vacation, illness or other situations that require the PCP to be unable to provide services.

kk. Provider hospital is responsible for completing the Department of Children and Families ("DCF") Excel Spreadsheet and submitting it to the appropriate DCF Customer Call Center for unborn activation. Such completed spreadsheet will indicate Humana as the referring agency. In the event Provider hospital fails to do the above, Humana will complete and submit the Excel Spreadsheet.

ll. Provider Hospitals agree to include Provider Preventable Conditions information in all encounter data submissions in order to meet the Provider Preventable Conditions identification requirements in the AHCA Contract.

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

(a) Authentication and authorization of users;
(b) Authentication of the origin of the information;
(c) The prevention of unauthorized access to the system or information;
(d) System security, including the integrity of information that is collected, program integrity and system integrity; and
(e) Maintenance of documentation about system and information usage.

nn. Public Health Providers shall contact Humana before providing health care services to enrollees and provide Humana with the results of the office visit, including test results.

oo. Long Term Care ("LTC") Providers shall develop and maintain policies and procedures for back-up plans in the event of absent employees, and that each provider maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees.

pp. Assisted Living Facilities ("ALF") and Adult Family Care Homes ("AFCH") will support the Member's community inclusion and integration by working with the case manager and Member to facilitate the Member's personal goals and community activities.

qq. Members residing in ALFs or AFCHs shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

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

Ability to have:
- Unrestricted visitation; and
- Snacks as desired.

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

rr. ALF Providers hereby agree to accept monthly payments from Humana for Member services as full and final payment for all LTC services detailed in the Member's plan of care which are to be provided by ALFs. Members remain responsible for the separate ALF room and board costs as detailed in their resident contract. As Members age in place and require more intense or additional LTC services, ALFs may not request payment for new or additional services from a Member, their family members or personal representative. ALFs may only negotiate payment terms for services pursuant to this Provider Agreement with Humana.

ss. Adult Day Health Care ("ADHC") Providers shall conform to the Home and Community Based (HCB) Settings Requirements, as defined in 42 CFR 441.301(c)(4).

tt. ADHC Providers will support the enrollee's community inclusion and integration by working with the case manager and Member to facilitate the Member's personal goals and community activities.

uu. Members accessing adult day health services in ADHCs shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Daily activities;
- Physical environment;
- With whom to interact;
- Access to telephone and unlimited length of use;
- Eating schedule;
- Activities schedule; and
- Participation in facility and community activities.

Ability to have:

- Right to privacy;
- Right to dignity and respect;
- Freedom from coercion and restraint; and
- Opportunities to express self through individual initiative, autonomy, and independence.

vv. Home and community-based services Providers shall report critical incidents to Humana in a manner and format specified by Humana, to ensure reporting of such critical incidents to the Agency within twenty-four (24) hours of the incident. Humana does not require nursing facilities or ALFs to report critical incidents or provide incident reports to Humana. Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law, including but not limited to ss. 400.147 and 429.23, F.S., and Chapters 39 and 415, F.S.

ww. Providers shall not provide or assist in the completion of enrollment or disenrollment requests or restrict the Member's right to disenroll voluntarily in any way.

xx. Providers, upon request and as required by state and/or federal law, shall:

1) Make available to all authorized federal and state oversight agencies and their agents, including but not limited to AHCA, the Florida Attorney General, and DFS any and all administrative, financial and enrollee records and data relating to the delivery of items or services for which Medicaid monies are expended; (42 CFR 438.242(b)(4)); and

2) Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to AHCA, the Florida Attorney General, and DFS to any place of business and all enrollee records and data, as required by state and/or federal law. Access shall be during normal business hours, except under special circumstances when AHCA, the Florida Attorney General, and DFS shall have after hours admission. AHCA and the Florida Attorney General shall determine the need for special circumstances.

yy. For pharmacy contracts, pharmacy benefits managers must provide the following electronic message alerting the pharmacist to provide Medicaid recipients with the HSA notice/pamphlet when coverage is rejected due to the drug not being on the PDL:

Non-preferred drug; Contact provider for change to preferred drug or to obtain prior authorization. Give Medicaid pamphlet if not corrected.

zz. The following is applicable solely to Florida children's hospitals and only applies to health benefit plan(s) administered by Humana under Florida Medicaid program(s) available by AHCA. Hospital agrees to provide coordination of care in a multidisciplinary clinic for medically complex children with:

1) One or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently)

and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments, or

2) One life-limiting illness or rare pediatric disease (as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

aaa. The use of an electronic visit verification ("EVV") system by any Provider or Subcontractor shall offer compatibility and interoperability across EVV platforms and be compatible with AHCA's EVV system, as prescribed by the Agency.

bbb. Provider is prohibited from offering anything of value (including reduction of room and board costs) to retain enrollees or persuade potential enrollees to select them as their provider or to enroll in a particular Managed Care Plan.

ccc. Covered services, including applicable prior authorization requirements, acceptable billing codes, and populations to be served under this Agreement are outlined in the Florida Medicaid Provider Manual at https://provider.humana.com/medicaid/florida-medicaid.

ddd. The following is applicable to primary care provider agreements ONLY: Primary care providers are required to conduct screening of at least ninety-five percent (95%) of Members for health-related social needs using an AHCA-approved screening tool and record the identified ICD-10 codes Z55-Z65 in the enrollee's electronic health record.

eee. Humana shall program its claim processing systems within ninety (90) days following rule promulgation and/or publication by AHCA of revised rate methodologies with new fees being effective on the date specified by the Agency. Humana shall reprocess any claims impacted by retroactive changes included in an update back to the effective date established by the state.

fff. Participating nursing facilities are required to submit cost reports to AHCA.

ggg. Participating hospices shall submit room and board logs to AHCA.