Attachment VIII

- Provider Subcontract Review Worksheet

PLAN NAME:		DATE WORSHEET COMPLETED:	
CONTRACT TYPE: PCP; SPECIALIST; ANCILLARY; HOSPITAL; OTHER			
VII		**Location in the subcontract**	**Comments**
D.	**Provider Contract Requirements**		
1	The Health Plan shall comply with all Agency procedures for provider contract review and approval submission.		
a.	All provider contracts must comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.		
	CAPITATED PLAN		
b.	If the Health Plan is capitated, it shall ensure that all providers are eligible for participation in the Medicaid program. If a provider was involuntarily terminated from the Florida Medicaid program, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider.		
	FEE FOR SERVICE PLAN		
	If the Health Plan is not capitated, its providers shall be enrolled as Florida Medicaid providers.		
c.	The Health Plan shall not employ or contract with individuals on the state or federal exclusions list.		
d.	No provider contract that the Health Plan enters into with respect to performance under this Contract shall in any way relieve the Health Plan of any responsibility for the provision of services or duties under this Contract. The Health Plan shall assure that all services and tasks related to the provider contract are performed in accordance with the terms of this Contract. **The Health Plan shall identify in its provider contract any aspect of service that may be subcontracted by the provider.**		
2	All provider contracts and amendments executed by the Health Plan shall be in writing, signed, and dated by the Health Plan and the provider, and shall meet the following requirements:		
a.	Prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of the Contract;		

b.	Require the provider to look solely to the following for compensation for services rendered, with the exception of nominal cost sharing, pursuant to the Medicaid State Plan and the Florida Coverage and Limitations Handbooks:		
-1	If a capitated Health Plan, then to the capitated Health Plan for compensation;		
-2	If a FFS Health Plan, then to the Agency or its Agent, unless the service is one for which the Health Plan receives a capitation payment from the Agency. For such capitated services, the Health Plan shall require providers to look solely to the Health Plan;		
c.	If there is a Health Plan physician incentive plan, include a statement that the Health Plan shall make no specific payment directly or indirectly under a physician incentive plan to a provider as an inducement to reduce or limit, medically necessary services to an enrollee, and that incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care;		
d.	Specify that any contracts, agreements, or subcontracts entered into by the provider for purposes of carrying out any aspect of this Contract shall include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of this Contract;		
e.	Require the provider to cooperate with the Health Plan's peer review, grievance, QIP and UM activities, and provide for monitoring and oversight, including monitoring of services rendered to enrollees, by the Health Plan (or its subcontractor). If the Health Plan has delegated the credentialing to a subcontractor, the agreement must ensure that all licensed providers are credentialed in accordance with the Health Plan's and the Agency's credentialing requirements as found in Attachment II, Section VII, Provider Network, Item H., Credentialing and Recredentialing;		

f.	Include provisions for the immediate transfer to another PCP or health plan if the enrollee's health or safety is in jeopardy;		
g.	Not prohibit a provider from discussing treatment or non-treatment options with enrollees that may not reflect the Health Plan's position or may not be covered by the Health Plan;		
h.	Not prohibit a provider from acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee for the enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;		
i.	Not prohibit a provider from advocating on behalf of the enrollee in any grievance system or UM process, or individual authorization process to obtain necessary services;		
j.	Require providers to meet appointment waiting time standards pursuant to this Contract;		
k.	Provide for continuity of treatment in the event a provider contract terminates during the course of an enrollee's treatment by that provider;		
l.	Prohibit discrimination with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of such license or certification. This provision shall not be construed as a willing provider law, as it does not prohibit the Health Plan from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision does not interfere with measures established by the Health Plan that are designed to maintain quality and control costs;		
m.	Prohibit discrimination against providers serving high-risk populations or those that specialize in conditions requiring costly treatments;		

n.	Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Health Plan;		
o.	Require that records be maintained for a period not less than five (5) years from the close of the Contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the Health Plan if the provider contract is continuous;		
p.	Specify that DHHS, the Agency, MPI and MFCU shall have the right to inspect, evaluate, and audit all of the following related to this Contract:		
-1	Pertinent books,		
-2	Financial records,		
-3	Medical records, and		
-4	Documents, papers, and records of any provider involving financial transactions;		
q.	Specify covered services and populations to be served under the provider contract;		
r.	Require that providers comply with the Health Plan's cultural competency plan;		
s.	Require that any community outreach materials related to this Contract that are displayed by the provider be submitted to the BMHC for written approval before use;		
t.	Provide for submission of all reports and clinical information required by the Health Plan, including Child Health Check-Up reporting (if applicable);		
u.	Require providers of transitioning enrollees to cooperate in all respects with providers of other health plans to assure maximum health outcomes for enrollees;		
v.	Require providers to submit notice of withdrawal from the network at least ninety (90) calendar days before the effective date of such withdrawal;		
w.	Require that all providers agreeing to participate in the network as PCPs fully accept and agree to responsibilities and duties associated with the PCP designation;		

x.	Require all providers to notify the Health Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida statutes;		
y.	Require providers to offer hours of operation that are no less than the hours of operation offered to commercial Health Plan members or comparable non-Reform Medicaid recipients if the provider serves only Medicaid recipients;		
z.	Require safeguarding of information about enrollees according to 42 CFR 438.224;		
aa.	Require compliance with HIPAA privacy and security provisions;		
bb.	Require an exculpatory clause, which survives provider agreement termination, including breach of provider contract due to insolvency, which assures that neither Medicaid recipients nor the Agency shall be held liable for any debts of the provider;		
cc.	Require that the provider secure and maintain during the life of the provider contract worker compensation insurance (complying with the Florida worker compensation law) for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Health Plan;		
dd.	Make provisions for a waiver of those terms of the provider contract that, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract;		
ee.	Contain no provision that in any way prohibits or restricts the provider from entering into a commercial contract with any other health plan (see s. 641.315, F.S.);		
ff.	Contain no provision requiring the provider to contract for more than one (1) Health Plan product or otherwise be excluded (see s. 641.315, F.S.);		
gg.	Contain no provision that prohibits the provider from providing inpatient services in a contracted hospital to an enrollee if such services are determined to be medically necessary and covered services under this Contract;		

hh.	Require providers to cooperate fully in any investigation by the Agency, MPI, MFCU, or other state or federal entity and in any subsequent legal action that may result from such an investigation involving this Contract; and		
ii.	Require providers to submit timely, complete and accurate encounter data to the Health Plan in accordance with the requirements of Attachment II, Section X, Administration and Management, Item D., Encounter Data;		
jj.	Contain a clause indemnifying, defending and holding the Agency and the Health Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the provider agreement. This clause must survive the termination of the agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Health Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the 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.		
kk.	Require physicians to immediately notify the Health Plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims, or otherwise.		
ll	Specify that in addition to any other right to terminate the provider contract, and notwithstanding any other provision of this Contract, the Agency or the Health Plan may request immediate termination of a provider contract if, as determined by the Agency, a provider fails to abide by the terms and conditions of the provider contract, or in the sole discretion of the Agency, the provider fails to come into compliance with the provider contract within fifteen (15) calendar days after receipt of notice from the Health Plan specifying such failure and requesting such provider abide by the terms and conditions thereof; and		

mm	Specify that any provider whose participation is terminated pursuant to the provider contract for any reason shall utilize the applicable appeals procedures outlined in the provider contract. No additional or separate right of appeal to the Agency or the Health Plan is created as a result of the Health Plan's act of terminating, or decision to terminate, any provider under this Contract. Notwithstanding the termination of the provider contract with respect to any particular provider, this Contract shall remain in full force and effect with respect to all other providers.		
Section XVI.O			
2	All model and executed subcontracts and amendments used by the Health Plan under this Contract shall be in writing, signed, and dated by the Health Plan and the subcontractor and meet the following requirements:		
a.	Identification of conditions and method of payment:		
-1	The Health Plan agrees to make payment to all subcontractors pursuant to all state and federal laws, rules and regulations, specifically, s. 641.3155, F.S., 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (d)(5) and (d)(6);		
-2	Provide for prompt submission of information needed to make payment;		
-3	Provide for full disclosure of the method and amount of compensation or other consideration to be received from the Health Plan;		
-4	Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Health Plan; and		
-5	Specify that the Health Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with Attachment II, Section XV, Financial Requirements.		
b.	Provisions for monitoring and inspections:		
-1	Provide that the Agency and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;		

-2	Provide for inspections of any records pertinent to the Contract by the Agency and DHHS;		
-3	Require that records be maintained for a period not less than five years from the close of the Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Health Plan if the subcontract is continuous.);		
-4	Provide for monitoring and oversight by the Health Plan and the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the Health Plan's and the Agency's credentialing requirements as found in Attachment II, Section VII, Provider Network, Item H., Credentialing and Recredentialing, if the Health Plan has delegated the credentialing to a subcontractor; and		
-5	Provide for monitoring of services rendered to Health Plan enrollees through the subcontractor.		
c.	Specification of functions of the subcontractor:		
-1	Identify the population covered by the subcontract;		
-2	Provide for submission of all reports and clinical information required by the Health Plan, including CHCUP reporting (if applicable); and		
-3	Provide for the participation in any internal and external quality improvement, utilization review, peer review, and grievance procedures established by the Health Plan.		
d.	Protective clauses:		
-1	Require safeguarding of information about enrollees according to 42 CFR, Part 438.224.		
-2	Require compliance with HIPAA privacy and security provisions.		
-3	Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that Medicaid recipients or the Agency will not be held liable for any debts of the subcontractor.		

-4	If there is a Health Plan physician incentive plan, include a statement that the Health Plan shall make no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care;		
-5	Require full cooperation in any investigation by the Agency, MPI, MFCU or other state or federal entity or any subsequent legal action that may result from such an investigation;		
-6	Contain a clause indemnifying, defending and holding the Agency and the Health Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency may waive this requirement for itself, but not Health Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency;		
-7	Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Health Plan. Such insurance shall comply with Florida's Workers' Compensation Law;		
-8	Specify that if the subcontractor delegates or subcontracts any functions of the Health Plan, that the subcontract or delegation includes all the requirements of this Contract;		
-9	Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract;		

-10	Provide for revoking delegation, or imposing other sanctions, if the subcontractor’s performance is inadequate;		
-11	Provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee; and		
-12	Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:		
(a)	The False Claim Act;		
(b)	The penalties for submitted false claims and statements;		
(c)	Whistleblower protections; and		
(d)	The law’s role in preventing and detecting fraud, waste and abuse, and each person’s responsibility relating to detection and prevention.		
P.	**Hospital Provider Contracts**		
	All hospital provider contracts must meet the requirements outlined in Attachment II, Section VII, Provider Network D., Provider Contract Requirements.		
	In addition, hospital provider contracts shall require that the hospitals notify the Health Plan of enrollee pregnancies and births where the mother is a Health Plan enrollee.		
	The hospital provider contract must also specify which entity (Health Plan or hospital) is responsible for completing the DCF Excel spreadsheet and submitting it to the appropriate DCF Customer Call Center.		
	The hospital provider contract must also indicate that the Health Plan’s name shall be indicated as the referring agency when the DCF Excel spreadsheet is completed. (See Attachment II, Section III, Eligibility and Enrollment)		