Attachment XIII

- Contract Language Related to Health Plan Transitions

Attachment II – Core Contract Provisions Related to Withdrawal/Transition

Section IV: Enrollee Services, Community Outreach and Marketing

A. Enrollee Services

8. New Enrollee Procedures

c. The Health Plan shall honor any written documentation of prior authorization of ongoing covered services for a period of thirty (30) calendar days after the effective date of enrollment, or until the enrollee's PCP reviews the enrollee's treatment plan, whichever comes first.

d. For all enrollees, written documentation of prior authorization of ongoing services includes the following, provided that the services were prearranged prior to enrollment with the Health Plan:

(1) Prior existing orders;

(2) Provider appointments, e.g. dental appointments, surgeries, etc.; and

(3) Prescriptions (including prescriptions at non-participating pharmacies).

Section XVI: Terms and Conditions

C. Assignment

Except as provided below, or with the prior written approval of the Agency, this Contract and the monies which may become due are not to be assigned, transferred, pledged or hypothecated in any way by the Health Plan, including by way of an asset or stock purchase of the Health Plan, and shall not be subject to execution, attachment or similar process by the Health Plan.

1. When a merger or acquisition of a Health Plan has been approved, the Agency shall approve the assignment or transfer of the appropriate Medicaid Health Plan Contract upon the request of the surviving entity of the merger or acquisition if the Health Plan and the surviving entity have been in good standing with the Agency for the most recent twelve month (12-month) period, unless the Agency determines that the assignment or transfer would be detrimental to Medicaid recipients or the Medicaid program (see s. 409.912, F.S.). The entity requesting the assignment or transfer shall notify HSD of the request ninety (90) calendar days before the anticipated effective date.

2. Entities regulated by the Department of Financial Services, Office of Insurance Regulation (OIR), must comply with provisions of s. 628.4615, F.S., and receive OIR approval before a merger or acquisition can occur.

1. For the purposes of this section, a merger or acquisition means a change in controlling interest of a Health Plan, including an asset or stock purchase.

4. To be in good standing, a Health Plan shall not have failed accreditation or committed any material violation of the requirements of s. 641.52, F.S., and shall meet the Medicaid Contract requirements.

Q. Termination Procedures

1. In conjunction with the Standard Contract, Section III., Item B., Termination, all provider contracts and subcontracts shall contain termination procedures. The Health Plan agrees to extend the thirty (30) calendar-day notice found in the Standard Contract, Section III., Item B.1., Termination at Will, to one-hundred and twenty (120) calendar days' notice. The Health Plan will work with the Agency to create a transition plan, including the orderly and reasonable transfer of enrollee care and progress whether or not they are hospitalized. Depending on the volume of Health Plan enrollees affected, the Agency may require an extension of the termination date. The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination shall specify the nature of termination, the extent to which performance of work under the Contract is terminated, and the date on which such termination shall become effective. In accordance with s. 1932(e)(4), Social Security Act, the Agency shall provide the Health Plan with an opportunity for a hearing prior to termination for cause. This does not preclude the Agency from terminating without cause.

2. Upon receipt of final notice of termination, on the date and to the extent specified in the notice of termination, the Health Plan shall:

    a. Continue work under the Contract until the termination date unless otherwise required by the Agency;

    b. Cease enrollment of new enrollees under the Contract;

    c. Terminate all community outreach activities and subcontracts relating to community outreach;

    d. Assign to the state those subcontracts as directed by the Agency's contracting officer including all the rights, title and interest of the Health Plan for performance of those subcontracts;

    e. In the event the Agency has terminated this Contract in one or more Agency areas of the state, complete the performance of this Contract in all other areas in which the Health Plan's Contract was not terminated;

    f. Take such action as may be necessary, or as the Agency's contracting officer may direct, for the protection of property related to the Contract that is in the possession of the Health Plan and in which the Agency has been granted or may acquire an interest;

    g. Not accept any payment after the Contract ends, unless the payment is for the time period covered under the Contract. Any payments due under the terms of this Contract may be withheld until the Agency receives from the Health Plan all written and properly executed documents as required by the written instructions of the Agency;

    h. At least sixty (60) calendar days before the termination effective date, provide written notification to all enrollees of the following information: the date on

which the Health Plan will no longer participate in the state's Medicaid program and instructions on contacting the Agency's choice counselor/enrollment broker help line to obtain information on enrollment options and to request a change in health plans.

S. Withdrawing Services from a County

If the Health Plan intends to withdraw services from a county, the Health Plan shall provide the Agency with one-hundred and twenty (120) calendar days' notice and work with the Agency to develop a transition plan. The Health Plan shall provide written notice to all enrollees in that county at least sixty (60) calendar days before the last day of service. The notice shall contain the same information as required for a notice of termination according to Attachment II, Section XVI, Terms and Conditions, Item Q., Termination Procedures. The Health Plan shall also provide written notice of the withdrawal to all providers and subcontractors in the county.