PROVIDER HANDBOOK
2026

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I. INTRODUCTION

Mission

"Helping people"

Access Behavioral Health (ABH) is an operating division of Lakeview Center, which is a 501 (c) (3) not-for-profit organization, incorporated Chapter 617, F.S. As not-for-profit organizations, Lakeview Center does not have shareholders who benefit financially from the performance of the organization. Rather, the organization is 'owned' by the community and any financial gains are retained by the organization and reinvested into furthering the mission of helping people.

Company History

Lakeview Center, Inc., (Lakeview Center) the corporate entity of which Access Behavioral Health is a division, was initially established in 1954 as the Escambia County Child Guidance Clinic, the result of the vision and effort of many community leaders and the Pensacola Junior Women's Club. In 1959, the Clinic's charter was amended to include services for adults, and the center was renamed the Escambia County Guidance Clinic. In 1963, with the passing of the federal Mental Retardation Facility/Community Mental Health Center Construction Act, the Clinic became one of the first comprehensive community mental health centers (CMHCs) in southeastern United States, and was renamed the Community Mental Health Center of Escambia County, Inc.

In the 1970's and 1980's the Center expanded its service offerings to include crisis stabilization, residential, day treatment, emergency services, outpatient, case management, and prevention services and began offering a full range of substance abuse services, as well as vocational services. In 1982, the center was renamed as Lakeview Center, Inc., a change made in recognition of the wide array of services that Lakeview was providing. In 1996, Lakeview Center and Baptist Health Care Corporation (also a 501(c) (3) organization that operates numerous healthcare facilities in northwest Florida) entered into an affiliation agreement.

During the 1990s, Lakeview Center operated numerous at-risk managed care behavioral health contracts for commercial health insurers. As a result, Lakeview Center was able to significantly expand its managed care administrative services including utilization management services, provider credentialing, network management, claims adjudication, and quality management and improvement services. This experience set the foundation for future growth in the managed behavioral healthcare arena, culminating in being awarded a Prepaid Limited Health Service Organization license (PLHSO) in February 2001 by the State of Florida Department of Insurance.

Access Behavioral Health (ABH), a separate division of Lakeview Center, was established in February 2001 to manage the Region 1 Prepaid Mental Health Plan (PMHP) contract. Lakeview Center organized ABH to manage risk-bearing contracts and in August 2001, was awarded a three-year contract with the Agency for Health Care Administration (AHCA) to operate the PMHP in Region 1. ABH's organizational, governance, and administrative structure ensures that there is no conflict of interest between Lakeview Center, which serves as one of the many contracted provider agencies under the PMHP contract, and ABH, which manages the PMHP contract.

ABH managed the contract with integrity and efficiency since it began operations on November 1, 2001 and this has been recognized by AHCA by having the contract renewed in October 2004 and in October 2007 as well as yearly renewals.

In 2014, Access Behavioral Health contracted with Statewide Medicaid Managed Care (SMMC) health plans in Region 1 to serve as the Managed Behavioral Health Organization (MBHO) for Florida Medicaid members enrolled in the plans.

In 2018 and 2024 AHCA reprocured the Statewide Medicaid Managed Care contracts for all Regions in Florida. ABH contracts with Medicaid MMA health plans in Regions 1 and 2 and began operations in February 2019 and continues operations in 2026. ABH now manages the mental health and substance use services for Medicaid members in 18 counties in northwest Florida, currently described as Region A.

In late 2021, Lakeview Center disaffiliated with Baptist Health Care to enable continued focus on Lakeview's non-healthcare (human services) business lines. As a result, in 2022, Lakeview Center rebranded the parent organization LifeView Group. Lakeview Center remains an operating division within the newly branded parent company, and Access Behavioral Health remains an operating division of Lakeview Center.

As of January 1, 2025, all ABH staff in positions to include: Claims Resolution Staff, Provider Relations Staff, Recipient Relations Staff, Utilization and Authorization Staff, and Quality Initiative Staff are located in the State of Florida.

Accreditation

Access Behavioral Health maintained full accreditation status under the Health Utilization Management (HUM) module with URAC from 2005 – 2017.

In 2017, ABH attained full accreditation status as a Managed Behavioral Healthcare Organization (MBHO) with the National Committee for Quality Assurance (NCQA). ABH has been awarded full reaccreditation status as a Managed Behavioral Healthcare Organization (MBHO) in January 2020 and again in February 2023. As of 2026, NCQA retired the use of the term Managed Behavioral Healthcare Organization and replaced it with Behavioral Health Accreditation (BHA). ABH was awarded full reaccreditation status in 2026.

II. ACCESS BEHAVIORAL HEALTH CONTACT INFORMATION

Access Behavioral Health may be contacted through our toll-free phone number, (866) 477-6725, or through our general email address: abhinfo@lifeviewgroup.org. Contact information for Access Behavioral Health staff is available on our website, www.abhfl.org.

III. ACCESS STANDARDS

Emergency mental health services are defined as those services that are required to meet the needs of an individual who is experiencing an acute crisis, resulting from mental illness, which is at the level of severity that would meet the requirements for involuntary hospitalization pursuant to Chapter 394.463, F.S., and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization. Members with emergencies have access to behavioral healthcare immediately and/or 24 hours per day 7 days per week.

ABH standards for access to care are defined below:

- Life threatening emergency: Seen immediately
- Non-life-threatening emergency: Seen within 6 hours of the request
- Urgent care within 48 hours
- Within 10 business days (fourteen calendar days) of the request for initial routine outpatient behavioral health treatment
- Follow up routine care is available with prescribers within 30 days
- Follow up routine care is available non-prescribers within 20 days
- At least 40% of prescribers have after-hours appointments available (defined as appointments between 5pm and 8am)
- At least 50% of non-prescribers have after-hours appointments available (defined as appointments between 5pm and 8am).
- Within 7 (seven) days post discharge from an inpatient behavioral health admission for follow up behavioral health treatment

IV. ABH COMMUNICATIONS

Toll-free information Line

Access Behavioral Health operates a toll-free information line for members and providers through the ABH Call Center. This information line, 1-888-477-6725, is available 24 hours per day, 7 days per week and is staffed by experienced, qualified member services representatives and backed up by the ABH Care Management team. Representatives assist members with finding a network provider and scheduling appointments and assist providers with eligibility and benefit inquiries.

Fax

ABH operates a fax line for sending and receiving communication: (850) 353-6041

Email

ABH receives communication via email using the address: abhinfo@lifeviewgroup.org. This email address is a group email delivered to several ABH staff.

Non-English Speaking Members

A telephonic translation service is available for non-English speaking members through Language Line Solutions, a telecommunications company equipped to interpret many different languages. Language Line Solutions interpreters are medically certified.

Hearing Impaired

ABH offers interpreter services for the deaf, hard of hearing, or speech-impaired members when needed at no charge to the member. Telephone services for the hearing impaired are provided through the Florida Relay Center and include both TTY ASCII and TTY Baudot phone numbers.

In addition, our Community Behavioral Health Providers operate TTY lines in their emergency services departments, 24 hours/day, and seven days per week. These centers also have staff “language banks” where staff may turn for help when a member who does not speak English presents for services.

V. NETWORK MANAGEMENT

Provider Network

The diversity and breadth of our network ensures that members have the flexibility to choose a provider that meets their behavioral health, social, and cultural needs. Our focus on evidence based practice, recovery and resiliency approach, and member rights ensures that members actively participate in the treatment process and contribute to the treatment plan and their short and long term treatment goals. Over the past two decades, we have expanded and further refined this network to provide members with a variety of needed services, ranging from basic inpatient and outpatient services, including infant mental health services, to psycho-educational groups and aftercare services. We have invested resources to provide optimal care while also giving members broader discretion in how treatment decisions are made. The treatment process requires that members be involved in making treatment decisions and ABH provides training on this important concept to providers and reviews for this type of inclusion as part of our quality management activities. Our wide range of services coupled with our focus on member empowerment and recovery and resiliency has allowed us to transform the system of care and provider network in Region A from one focused on alleviating and reducing symptoms to one that focuses on increasing a member's ability to overcome life's challenges by being an active participant in their treatment and self-management process.

Provider Quality Enhancement Program – The Medicaid Community Behavioral Health Home

ABH contracts with the large community behavioral health systems in the region on a capitated basis. Each of these behavioral health systems serves as a Medicaid Community Behavioral Health Home (BHH). Under the capitated financial system, ABH and a participating Community Behavioral Health Home enters into a contract to provide the full range of Medicaid benefits to members in the capitated geographic area. Community Behavioral Health Homes receive a per-member-per-month payment for all the required Medicaid services and they bear the financial risk for their patients for the specified services. The capitation rate reflects the behavioral health services required by Florida Medicaid and provides incentive for a fully integrated, outcomes based delivery of Medicaid services. This approach incentivizes investments in care coordination, quality improvement efforts, and efficiency across the full continuum of care, including coordination of care with hospitals and multi-specialty provider groups. The value-based model establishes a reimbursement system designed to manage the needs of Medicaid members who have persistent complex behavioral health conditions. ABH requires by contract that the Medicaid Community Behavioral Health Home be accountable for the full range of behavioral health services based on clinical outcome oriented services, rather than simply on utilization of services.

Overall, this capitation model payment methodology offers the following:

- Alignment of incentives;

- Flexibility for providing behavioral health services;
- Improved quality of and access to behavioral health care services for members; and
- Controls costs

With value-based contracts, ABH demonstrates that it has the capacity to serve the expected enrollment in its service Regions in accordance with the State's standards for access to care and quality performance outcomes. ABH maintains a network of providers, with Community Behavioral Health Homes as the cornerstones, that is sufficient in number, specialty mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

Availability and Accessibility Standards

Access Behavioral Health conducts network analyses on an ongoing basis. Availability standards are analyzed throughout the year utilizing a variety of means to include secret shopper calls, utilization review, and medical record audits.

In addition, a network analysis is conducted prior to making any new credentialing recommendations, to determine if there is a need in the network. Geospatial availability is also calculated periodically to ensure that members have access to care within the required timeframes. Additions to the network may include new specialties, location, language(s) spoken, and cultural/ethnic background. Geospatial access standards are reviewed to assure that members can access services in the required typical travel times.

ABH Network

The ABH network is reviewed on an ongoing basis to assure the network meets the health plans' requirements of the MMA programs and meets and provides members a choice of qualified behavioral health care providers.

Provider Training

The ABH Quality Department conducts training with providers and practitioners bi-annually. Behavioral Health network providers, organizational providers, individual providers, and individual members of provider groups must regularly participate in training offered by ABH. The Provider Handbook is made accessible to all newly credentialed providers via the ABH website.

Annual Provider Training may include, but is not limited to, the following topics:

- ABH Operational Updates
- Quality Management and Improvement
- Medicaid Documentation and Medical Records Requirements
- HEDIS, Clinical Improvement Activities, and other Contract Performance Measures
- Authorizations and Claims Payment
- Critical Incident Reporting
- Provider Complaints
- Eligibility

- Benefit Plan Limitations
- Timely Access to Services
- Transportation Services for Members
- Member Rights and Responsibilities
- Coordination of Care of BH and BH Services
- Cultural Competence
- Health, Safety, and Welfare Education
- Fraud, Waste and Abuse/Corporate Compliance

VI. CREDENTIALING AND RECREDENTIALNG

The ABH credentialing process ensures that providers of behavioral health services meet minimum standards of practice and can meet the quality of care required by Access Behavioral Health. The credentialing process ensures adequate member choice, adequate capacity within the ABH network, timely access to services, and prevents discrimination in the ABH provider Network. To participate as a Behavioral Health network provider, organizational providers, individual providers, and individual members of provider groups must meet established criteria as set forth by ABH and outlined in the policies and procedures, and successfully complete the credentialing review process. Recredentialing occurs every 36 months and includes a quality review of adverse incidents reported during the recredentialing cycle. Additionally, for provider organizations who are not accredited, an on-site quality review will be completed as part of the recredentialing process. ABH requires that all applicants meet all state standards and requirements regarding background screenings. ABH will not credential any individual or organization that is excluded from participation in Federal health care programs. ABH provider organizations and individual practitioners must maintain an active Medicaid ID to become and remain credentialed with ABH.

Practitioners must post the following in a prominent location that is visible to members: their liability insurance, the AHCA Consumer Help Line number (888-419-3456), consumer notice, office hours, and FL Patient Bill of Rights and Responsibilities.

Provider and Practitioner Rights

Applicants may review their credentialing application by contacting the ABH Quality Department via email (ABHQualityDepartment@lifeviewgroup.org). Requests must include the applicant's name, Medicaid ID, and valid contact information. Applicants can correct erroneous information prior to Committee review and decision by contacting the ABH Quality Department via email (ABHQualityDepartment@lifeviewgroup.org). Email requests must include the applicant's name, Medicaid ID, valid contact information, the name of the application document being corrected and a corrected document for review. Applicants may inquire as to the status of their application by contacting the ABH Quality Specialist via email

(ABHQualityDepartment@lifeviewgroup.org). Requests must include the applicant's name, Medicaid ID, and valid contact information. All requests will be responded to via email within three (3) business days. Credentialing applicants are notified of the credentialing decision within 30 calendar days of the ABH Credentialing Committee decision.

If a provider or practitioner chooses to appeal the credentialing action, the appeal must be in writing and the following steps are taken to respond to the appeal:

1. Appeals must be received by the Director of Quality Management and Improvement within 30 calendar days of notification of an adverse decision;
2. The request should include a detailed explanation of the reasons for reconsideration review and provide new, supporting documentation
3. The provider is able to request a hearing within 30 days and the Director of Quality Management and Improvement will review the appeal and make a recommendation to the Quality Management Committee's appropriate subcommittee (i.e. Quality, Credentialing, etc.);
4. If the ensuing decision is again adverse the individual may request, in writing, a review of the decision by the Lakeview Center CFO, containing detailed and specific reasons for the decision;
5. The Lakeview Center CFO will review the documentation and render a final decision which shall be binding;
6. The Director of Quality Management and Improvement will send the individual written notification, containing specific reasons for the outcome of the appeal decision within 30 days.

If a provider or practitioner chooses to utilize the appeals process, that individual or organization may be represented by an attorney, or another person of their choosing.

Medical Records Standards

All providers and practitioners are required to understand and adhere to the medical documentation standards set forth by the Agency for Healthcare Administration (AHCA)'s Community Behavioral Health Services Coverage and Limitations Handbook dated March 2014 and any other relevant AHCA handbook that governs service delivery and medical necessity. Providers are also required to participate in medical record audits to ensure documentation follows Medicaid guidelines, that documentation matches services billed, and to monitor for fraud, waste, and/or abuse.

VIII. QUALITY MANAGEMENT

The Quality Improvement (QI) Program at Access Behavioral Health provides a formal mechanism whereby ABH can systematically and objectively monitor, evaluate, improve, and impact the quality, efficiency, safety, and effectiveness of care to members. Through this process ABH can identify and focus on opportunities for improving the quality of clinical service delivery by network providers. The Quality Improvement program approach enables ABH to focus on opportunities for improving clinical care to members, service quality,

member safety, and customer satisfaction. The Quality Improvement plan helps ensure accountability of staff and network providers for the quality of care and services provided to ABH members.

Access Behavioral Health maintains a network of contracted behavioral healthcare providers. The Quality Improvement Department governs the quality assessment and improvement activities of network providers and spans the system to any function that impacts the quality of service delivered to members. The ABH QI Department accomplishes this governance via internal and external monitoring of care management, utilization management, the development and maintenance of a provider network, member safety, and monitoring of clinical services to ensure that all members receive the highest quality care and service.

Program Structure

The Quality Improvement (QI) Program provides a means whereby all functions of ABH, both clinical and non-clinical, can be tracked, trended, and reviewed by the oversight body, opportunities for improvement identified, and interventions to address those opportunities applied.

The Quality Improvement program is designed to monitor, evaluate, and continually improve the care and services to all ABH members and encompasses services delivered in both outpatient and inpatient settings. ABH integrates quality improvement into all functional areas.

Participation in the Quality Improvement (QI) Program is required for all contracted network providers. ABH in-network providers are expected to fully support and engage in QI activities designed to enhance the quality of care, service delivery, and overall member experience. Participation includes the collection and evaluation of relevant data, as well as active involvement in ABH's QI initiatives which may include but are not limited to:

- Outcomes of care
- Social Determinants of Health (SDOH)
- Utilization of services
- Selected Healthcare Effectiveness Data Information Set (HEDIS) indicators
- Access to care
- Patient Safety
- Compliance with government regulations

In network practitioners and providers agree to allow ABH to use performance data relating to the practitioner/provider's provision of services, including without limitation data relating to Quality Improvement activities, publicly reported data, as ABH deems necessary to comply with NCQA requirements and applicable laws.

All staff and network providers are encouraged to contribute to the quality management process through committee participation, medical record audits, and the implementation of corrective action plans. These

efforts support the broader quality plan and are initiated whenever barriers or opportunities for improvement are identified.

The primary goals of the Quality Management program are to ensure safe, quality, timely, and effective behavioral health services to members. Improvements in these areas are measured using Health Plan Effectiveness Data Information Set (HEDIS) information, internal quality studies, and other health outcomes data and utilized to improve Member Experience and System Effectiveness.

The major responsibilities of the four components of the ABH QI Program are:

1. **Quality Management and Improvement (QMI)**
   - Provider and practitioner monitoring/medical records audits;
   - Member Safety;
   - Member Rights and Responsibilities
   - HEDIS and Performance Measures;
   - Coordination of behavioral healthcare
   - Clinical Measurement Activities
   - Monthly, Quarterly, and Annual Quality Reports, and annual Committee Approval;
   - Credentialing and Re-Credentialing;
   - Quality of Care and Incident Reporting;
   - Fraud, Waste, and Abuse monitoring;
   - Self-Management Tools;
   - Screening Programs;
   - Timely access to services and
   - Facilitation of Quality Management Committee Meetings Quarterly.

2. **Utilization Management (UM)**

   - UM Authorizations and utilization review
   - Case management for inpatient and SIPP services
   - Care Coordination
   - Call Center Communication and
   - Daily, Monthly, Quarterly, and Annual UM Reports

3. **Network Management**

   - Availability of Providers and Practitioners
   - Practitioner and Provider directory

- Accessibility of Services
- Manage network provider negotiations and contracting
- Provider network analysis that meets health plan and accreditation standards
- Provider network performance management in conjunction with ABH Quality Management Department and health plan and ensure Culturally, Ethnically, Racially, and Linguistically Competent Network

4. **Data Analysis and Reporting**
   - HEDIS and Performance Measure Analysis
   - GAP Reports for Underperforming Providers
   - Population Assessments
   - Intervention Analysis and Re-Measurement

Oversight of QI Activities by the Quality Management Committee

The Quality Management Committee (QMC) is the governing body of the ABH Quality Improvement (QI) Program and is responsible for oversight of the QI program, along with its subcommittees. The QMC is responsible for ensuring the quality improvement processes outlined in the QI Program Description are implemented, measured, re-measured, reviewed on a regular basis, and updated as needed. The QMC also serves as an advisory group and communication forum for all ABH Quality Improvement components.

The QMC is the decision-making body ultimately responsible for implementation, coordination, and integration of all QI activities for ABH. The QMC reviews and approves all ABH Policies and Procedures, Program Descriptions, Work Plans, and the Annual Evaluation. The QMC is also the designated anti-fraud unit for Access Behavioral Health's Anti-Fraud Plan.

The Quality Management Committee meets quarterly, and ad hoc meetings may be called when necessary. The Director of Quality Management and Improvement is responsible for conducting the meeting.

The QMC is comprised of the ABH Vice President, Medical Director, Department Directors and Managers who work together to achieve program goals and objectives. The QMC's focus is on key quality outcome areas designed to improve overall system effectiveness of service delivery to ABH members. Although each component and subcommittee operates to achieve specific objectives and processes that are operationalized through the ABH QI Program, all components operate as a whole to create the ABH Quality Program.

Quality Management Committee Members include:

- Medical Director (designated Behavioral Health Care Practitioner)
- Vice President of Access Behavioral Health
- Director of Quality Management & Improvement
- Accreditation and Quality Improvement Manager
- Director of Care Management

- Director of Network Management and Contracting
- Senior Reporting and Data Analyst

The authority to implement the ABH Quality Improvement Program plan is held by the QMC. The ABH Medical Director is the designated behavioral health staff member and senior member staff designated to oversee all components of the QI plan. The QMC is assigned oversight responsibilities to all ABH quality improvement efforts.

Quarterly reports, pertinent reports, data analysis, and recommendations or actions are presented to the QMC for consideration. This process allows ABH to routinely monitor the activities and effectiveness of the Quality Improvement program. This monitoring includes, but is not limited to:

- Reviewing data and reports to identify trends that may require corrective action
- Ensuring practitioner participation in the QI process
- Analyzing and evaluating the results of QI activities
- Monitoring the implementation and effectiveness of corrective actions
- Identifying needed actions
- Determining the need for follow up and/or ad hoc committees
- Reporting conclusions and actions as appropriate to meet the goals of ABH QI

Subcommittees of QMC:

- Quality Improvement-Utilization Management (QI-UM)
- Network Development and Management
- Credentialing

QMC Roles

The QMC consists of the following voting members:

The Vice President of Access Behavioral Health is responsible for the overall operations of Access Behavioral Health. The Director of Access Behavioral Health ensures that the ABH network has the capacity and capability of meeting the behavioral healthcare needs of members.

The ABH Medical Director is the designated Behavioral Health Care Practitioner who provides supervision and oversight to the Quality Improvement program, the Quality Management Committee, and all subcommittees. The Medical Director reports to the Director of Access Behavioral Health. The Medical Director oversees the utilization review functions for the Care Management Department and the ABH Utilization Management Plan. The Medical Director provides support and consultation to ABH and provider staff

The Director of Quality Management and Improvement is the senior level quality staff person responsible for and with the authority to manage the Quality policies and procedures (including Credentialing and Rights and

Responsibilities). This role reports to the Director of Access Behavioral Health. The Director of Quality Management and Improvement coordinates the Quality Management Committee, compliance and quality monitoring activities, and other activities related to quality management of the ABH network. This position is also responsible for leading the QMC meetings.

Accreditation and Quality Improvement Manager reports to the Director of Quality Management and Improvement. The Accreditation and Quality Improvement Manager is responsible for designing, building and strategizing quality programs that meet NCQA, CMS, and Health Plan requirements and that improve performance and population health outcomes for ABH members. This position is also responsible for oversight of quality interventions for HEDIS and other performance measures.

The Director of Network Management and Contracting reports to the Director of Access Behavioral Health. The Director of Network Management and Contracting is responsible for provider negotiations, contracting and network management, ensuring that the provider network meets the needs of the Medicaid members for access to services, and meets contractual requirements for provider and practitioner to member ratios. The Director of Network Management and Contracting is responsible for updating contract terms that meet CMS, Florida Medicaid, and NCQA requirements.

The Director of Care Management is responsible for the functions and operations of the Care Management Department. This position reports to the Vice President of ABH. The Director of Care Management oversees the utilization review, utilization management, care coordination, and authorization processes for ABH. The Director of Care Management works closely with the Medical Director in coordination of care and outreach to primary care physicians, to medical providers, and to other behavioral health care providers.

The Senior Reporting and Data Analyst reports to the Director of Access Behavioral health, and is responsible for all phases of development, preparation, and distribution of reports. This includes all contractual reports for the monitoring of performance-based Health Plans requirements, all internal scheduled and ad hoc reports that support ABH operations, and any quantitative data analyzation and visualization. The Senior Reporting and Data Analyst also assists in the accreditation preparation and corrective action monitoring of ABH.

Minutes are recorded at each meeting using a standardized format which includes topic, discussion, recommendations, follow up, and applicable graphs or associated reports. Action items become topics for the next meeting. The minutes are reviewed and approved at the beginning of the subsequent meeting with any changes or corrections noted. All members of the QMC annually sign a confidentiality attestation.

Continuity and Coordination of Care

Continuity of Care is a key element contributing to a successful treatment outcome. Intra- and inter-agency communication of relevant clinical information is vital as ABH members move through a continuum of care or services to minimize disruption to the member and to the treatment plan. All communication is within federal and state laws, rules and regulations, contract requirements, and ABH Policy and Procedures.

Cultural Competence

ABH expects services to be provided within a framework of cultural competence. Cultural Competence is a set of congruent practice skills, behaviors, attitudes, and policies that comes together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. Cultural Competence is about adapting mental health care to meet the needs of members from diverse cultures. One key aim is to improve their access to care. Others are to build trust and to promote their engagement and retention in care.

Above all, cultural competence aims to improve the quality of care for members. Its broader societal purpose is to reduce or eliminate mental health disparities affecting disenfranchised groups.

The following steps are offered to Providers as a means of becoming Culturally Competent:

- Understand the racial, ethnic, and cultural demographics of the population served
- Become most familiar with one or two of the groups most commonly encountered
- Create a cultural competence advisory committee consisting of members, family and community organizations
- Translate your forms and brochures
- Offer to match a member with a practitioner of a similar background
- Have access to trained mental health interpreters
- Ask each client about their cultural background and identity
- Incorporate cultural awareness into the assessment and treatment of each member
- Tap into natural networks of support, such as the extended family and community groups representing the culture of a member
- Reach out to religious and spiritual organizations to encourage referrals or as another network of support
- Offer training to staff in culturally responsive communication or interviewing skills.
- Understand that some behaviors considered in one culture to be signs of psychopathology are acceptable in a different culture
- Be aware that a member from another culture may hold different beliefs about causes and treatment of illness

To request a full copy of the ABH Cultural Competence Plan at no cost, please contact the Quality Improvement Director at abhqualitydepartment@lifeviewgroup.org.

Member Safety

The Access Behavioral Health (ABH) Quality Management Committee retains the Quality subcommittee to ensure safe clinical practices across the system of care. Data reviewed and analyzed by this subcommittee includes but is not limited to:

- Critical Incidents

- Quality of Care
- Environment of Care
- HIPAA Compliance
- Confidentiality of members
- Review of clinical records and
- Review of site monitoring findings

All quality of care and/or member safety concerns are reported to the Quality Management Department. The investigation is initiated within one business day from when the concern is received. Suspension or restriction of clinical privileges may occur when a potential quality of care or member safety incident has a direct and imminent impact on the health or well-being of any Access Behavioral Health member.

Member Complaints, Grievances, and Appeals

Access Behavioral Health works at the direction of the member's Health Plan for resolution of any complaint, grievance, or appeal. Members may contact Access Behavioral Health for assistance in reaching their Health Plan to file a complaint, grievance, or appeal by calling 850.495.3072.

Members have the right to request continuation of benefits while utilizing the grievance and appeal system in accordance with 42 CFR 438.414.

Members may also contact the AHCA Consumer Help Line at 888-419-3456 to file a complaint or grievance.

The address and toll-free telephone number for Medicaid Fair Hearings is:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O Box 60127
Ft. Myers, FL 33906
(877) 254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

ABH Privacy and Security of Information

The purpose of the Privacy and Security Program is to ensure the confidentiality, integrity and availability of the information we collect and use for health care and business purposes. The program extends to all information regardless of location or storage medium and it applies to both paper and electronic based information. ABH holds itself to these standards and providers and practitioners are expected to do the same:

- Confidential information is protected by federal and state law and must receive the highest degree of protection. For our purposes, we've grouped this information into two categories:
- Confidential Personal Information – Any information that can be considered personal in nature, such as diagnosis and treatment information, individual names, social security numbers, insurance numbers, credit card numbers, drivers' license numbers, dates of birth, automobile tags and registration information.
- Sensitive Business Data – Any information that we collect and use for business purposes such as budgeting and financial data, staffing schedules and turnover statistics.

Guiding Principles of Information Security and Privacy

- We will become familiar and comply with policies and procedures relating to information security and privacy.
- We will safeguard confidential information regarding our customers and coworkers from misuse, theft or unauthorized access.
- We will share confidential information as necessary to provide prompt and effective treatment to our customers.
- When sharing confidential information for purposes other than treatment we will adhere strictly to the minimum necessary standard and only disclose the minimum information necessary to accomplish the task.
- We will use reasonable steps to ensure unauthorized persons do not overhear or see confidential information.
- We will not place any confidential information in public areas where the information can be easily seen by unauthorized persons.
- We will become familiar with the Notice of Privacy Practices and adhere to the consumer privacy rights it contains.
- We will use approved procedures for obtaining our own confidential information or that belonging to our dependents.
- We will not access any confidential information, including our own unless we are doing so as part of our official duties.
- We will not discuss any confidential information pertaining to our coworkers or others that we obtain in our official capacity unless doing so is ethical and necessary to complete our duties.
- We will promptly report any theft or loss of confidential information to our supervisor.

Principles Specific to Information in Electronic Form

- We will access computer systems that contain confidential information by using our own unique identification (user ID).
- We will not share our user IDs and passwords and will take reasonable steps to protect them from unauthorized disclosure.

- We will not allow vendors or contractors to access any ABH computer unless approved by Information Services.
- We will not load any unauthorized computer programs onto any ABH computer.
- We will not disable or try to defeat any security device or procedure utilized by ABH.
- We will not connect any unauthorized device to an ABH computer.
- We will only use approved methods for storing confidential information electronically.
- We will properly dispose of media such as floppy disks, DVDs, or CDs that contain confidential information.
- We will not allow unauthorized persons such as family members to use any ABH computer.

Principles Specific to Information in Paper Form

- We will properly dispose of confidential information by placing it in approved containers or by shredding.
- We will store confidential information in a way that prevents unauthorized access. When it is necessary to store confidential information, we will follow ABH record retention policies and we will ensure the information is properly destroyed when the retention period has expired.
- We will strictly adhere to company policy regarding the faxing of confidential information, including the verification of fax numbers and the use of approved fax cover sheets.

When You Believe There May Be a Problem

If you believe you have information about health care providers, practitioners, entities, or other persons engaging in improper types of activities or arrangements, it is your responsibility to report these concerns. Persons reporting information in good faith will not receive any kind of reprisal or retribution. This provision, however, cannot be used to absolve or clear any personal confessions of wrongdoing.

- Discuss concern with your immediate supervisor. The management structure (starting with your immediate supervisor) and existing policies and procedures should be used as the first approach.
- Contact the Human Resource Manager or the Corporate Compliance Officer at your facility.
- If you receive an unacceptable response or if you are unsuccessful using the initial reporting mechanism, the Human Resource Manager or Corporate Compliance Officer will arrange for you to meet with the area department head. If your concern is related to your treatment as an employee, you should meet directly with the Human Resources Manager or Corporate Compliance Officer. Should the settlement continue to be unsatisfactory, the Human Resources Manager or Corporate Compliance Officer will, in agreement with the employee, present the grievance to the Administrator.
- Contact the ABH Quality Department. The ABH Director of Quality Management and Improvement will be available to discuss any concerns with you and can be reached at (850) 495-3072.
- Your identity will be protected to the limit of the law. Concerns brought to the attention of the ABH Quality Department will be promptly and thoroughly evaluated and investigated for prompt resolution. Due to the nature of the concerns, detailed feedback may be difficult or impossible to provide due to confidentiality.

The Director of Quality Management and Improvement serves as the Corporate Compliance Officer for ABH. Also, each organizational provider is required to have a Compliance Liaison who can be contacted if you believe there is a problem that needs to be addressed.

Members' Rights and Responsibilities

All ABH members must receive a copy of their rights and responsibilities upon initial enrollment into services and then when requested thereafter. These are given to providers and practitioners upon initial credentialing with ABH. ABH Member Rights and Responsibilities are also located on the ABH website (www.abhfl.org). Rights and Responsibilities provided to members must include and be materially similar to the following:

1. The right to free exercise of rights, receive information about the organization, its providers and practitioners, its services, and the members' rights and responsibilities.
2. The right to be treated with respect and recognition of dignity and right to privacy.
3. The right to participate in decisions about their care, including the right to refuse treatment.
4. The right to a candid discussion of appropriate or medically necessary treatment options and alternatives for their condition, presented in a manner appropriate to the members' condition and ability to understand, regardless of cost or benefit coverage.
5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
6. The right to request and receive a copy of his or her medical records.
7. The right to voice complaints or appeals about their provider, practitioner, or organization, and/or the care provided.
8. The right to make recommendations regarding the organization's member rights and responsibilities policy

Members Have the Following Responsibilities:

1. To supply information (to the extent possible) that their chosen organization and providers and practitioners need in order to provide care.
2. To follow plans and instructions for care they have agreed upon with their Healthcare practitioners and providers.
3. To understand their health problems and participate in the development of mutually agreed-upon treatment goals, to the degree possible.

Identifying and Reporting Abuse, Neglect and Exploitation of Members

Mandatory reporters are required to contact the Florida Abuse Hotline when they know or have reasonable cause to suspect that a child or a vulnerable adult has been abused, abandoned, neglected, or exploited, including suspected victims of human trafficking. The Abuse Hotline Counselor will determine if the information provided meets legal requirements to accept a report for investigation.

There are five ways to make a report:

1. By Telephone 1-800-96ABUSE 800-962-2873
2. By Fax 800-914-0004
3. Florida Relay 711
4. By TTY 800-955-8771
5. Web Reporting https://reportabuse.dcf.state.fl.us

Fraud, Waste and Abuse Prevention

Access Behavioral Health works with the Health Plans to prevent, detect, and correct fraud, waste, and abuse activities. The ABH Compliance Program is intended to establish methods for consistent adherence to applicable laws, regulations, and requirements governing Corporate Compliance as well as for preventing, detecting, and investigating fraud, abuse, and overpayment. ABH has established a centralized mechanism via the Corporate Compliance Program, the Anti-Fraud Unit, and the Quality Management Committee (and subcommittees), to track compliance and achieve the goal of preventing fraud and abuse. These mechanisms have created a corporate culture of strict adherence to federal, state, and local laws. The ABH Fraud, Waste and Abuse Plan is structured to demonstrate commitment to the highest standards of ethical conduct, to prevent and deter criminal activity, and to encourage employees to report potential problems that will allow for appropriate internal inquiry and corrective action.

The purpose of the ABH compliance plan is to create and maintain a corporate culture that:

- Promotes integrity and ethical behavior;
- Establishes formal standards that comply with increased governmental regulation; and
- Demonstrates the commitment of Lakeview Center, Inc. d/b/a Access Behavioral Health to act in compliance with all legal and ethical responsibilities.

The ABH Compliance Plan ensures that the organization has ethics, culture, and values which are consistent with the highest standards of business conduct and provides uniform guidance for fraud, abuse, and overpayment activities.

This plan is a broad and comprehensive strategy to ensure that:

- The risk for fraud, abuse, or overpayment is eliminated and/or reduced;
- All employees of ABH, their contracted network providers and their employees conduct themselves in accordance with the high standards of business and professional conduct established by ABH;
- Encounter data accurately reflects the documented services provided; compliance with all general regulatory matters;
- Reporting of potential violations of applicable laws, rules and regulations is encouraged; and
- Network providers take responsibility for the actions of their employees.

Providers may request a copy of the ABH Corporate Compliance Plan and Anti-Fraud, Abuse, and Overpayment Plan for more information by contacting the ABH Quality Management and Improvement Director. A copy is also available on the ABH website (www.abhfl.org).

Telemedicine/Telehealth

Telemedicine is the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.

Services must be delivered from a facility that is enrolled in Medicaid as a community behavioral health services provider for Medicaid to reimburse for services delivered through telemedicine. Services that can be provided through telemedicine are listed in the Medicaid Handbook for Community Behavioral Health Services Procedure Codes and Fee Schedule, found in the appendices.

The following interactions do not constitute reimbursable telemedicine services:

- E-mail messages
- Facsimile transmission

Providers utilizing telemedicine must implement technical written policies and procedures for telemedicine systems that comply with the Health Insurance Portability and Accountability Act privacy regulations as well as applicable state and federal laws that pertain to patient privacy. Policies and procedures must also address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.

Services provided via Telemedicine and Telehealth must adhere to the Agency for Health Care Administration's (AHCA) *Community Behavioral Health Services Coverage and Limitations Handbook* guidelines and requirements and must only be rendered by a practitioner who meets the AHCA qualifications for that service. Appropriate services codes must be used for billing.

Documentation for Telemedicine and/or Telehealth should follow standard documentation protocols and should include justification as to why the service is being provided via Telemedicine and/or Telehealth instead of in person. Telemedicine and/or Telehealth services must be provided to members in a secure office location. The member must consent in writing to service delivery via Telemedicine and/or Telehealth. The computer used to provide Telemedicine and Telehealth must not be able to access any client records or information. If the member is using an in-facility computer, staff must assist the member with computer operation to ensure proper operation and assist the member, if needed, to address any computer or other problems, or if the member has questions.

Access Behavioral Health reimburses for telehealth services at the same rate as equivalent services offered face-to-face.

UTILIZATION MANAGEMENT

Scope and Goals

The clinical philosophy at Access Behavioral Health (ABH) is to provide a care management system that offers easy and immediate access to the most appropriate, quality mental health, services for members, and a utilization management system that supports providers in delivering clinically necessary and effective care with minimal administrative barriers. The Utilization Management Plan encompasses management of care from the

point of entry into care through discharge from care. ABH believes in macro-management of care as much as possible through the use of objective, standardized, widely distributed clinical protocols and outlier management programs. Intensive utilization management is reserved for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. The Care Management team bases its reviews on clear and concise criteria developed specifically to guide level of care, treatment and length of stay determinations. Care Management staff are trained to match the needs of patients to appropriate services, levels of care, and community supports. This requires careful consideration of the intensity and severity of clinical data presented with the goal of quality treatment in the least restrictive environment. The clinical integrity of the Utilization Management Program ensures that members who present for care are appropriately monitored. Those cases that appear to be outside of best practice guidelines are referred for specialized reviews. These may include peer clinical review, peer-to-peer conversation, or more frequent care manager review.

Access Behavioral Health has designed a system of care that is not only based on principles of quality care, but also one that is flexible in meeting the needs of diverse populations, communities and customers.

Access Behavioral Health:

- Provides easy and early access to appropriate treatment;
- Works collaboratively with providers in delivering quality care according to accepted best-practice standards;
- Addresses the special needs of children in the mental health system;
- Identifies common illnesses or trends of illness;
- Targets high risk cases for intensive care management; and
- Emphasizes prevention, education and outreach.

Principles

ABH Clinical Management staff adheres to the following principles:

- All persons shall be treated with respect and dignity;
- The person directs the recovery process; therefore, the individual's input is essential throughout the process;
- Individuals are able to recover more quickly when their hope is encouraged, enhanced, and/or maintained; life roles with respect to work and meaningful activities are defined; spirituality is considered; culture is understood; educational needs as well as those of their family/significant others are identified; and socialization needs are identified;
- Individual differences are considered and valued across the life span;

- Recovery from mental illness is most effective when a holistic approach is considered;
- To the maximum extent possible, members shall be offered a choice of direct service providers;
- Services to members shall be tailored to the individual and provided in the least restrictive and most natural setting environment as possible, preferably in the member's own community;
- For children, services and treatments must be family centered, geared to give families real and meaningful choices about treatment options and providers; care must focus on increasing the child's ability to successfully cope with life's challenges and on building resilience, not just on managing symptoms;
- Services to members are built on the strengths of the member and the member's family and foster independence;
- Utilization review shall follow established best-practice guidelines and industry standards;
- Grievance procedures shall be developed for the member or provider to resolve issues according to established timeframes;
- The confidentiality and privacy of the member shall be protected at all times.
- Information shall be collected, analyzed, and disseminated to foster system accountability and quality improvement;
- Patient rights and other member information shall be communicated in a manner understood by the ABH member; and
- Access Behavioral Health does not discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and does not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

Staff Qualifications

Access Behavioral Health places high value on the selection, training, and performance evaluation of clinical staff performing utilization management services. All staff involved in utilization management activities possess terminal degrees and licensure in their field. The ABH Medical Director and Physician Advisors are experienced, senior level clinicians, many of whom remain active in private practice. They are board certified in their specialty areas and are required to maintain a current knowledge of behavioral health research findings and nationally recognized practice guidelines.

Care Management staff are multidisciplinary and are able to manage care in all general psychiatric, psychiatric subspecialty, and substance abuse areas. ABH requires that all Care Management staff be fully licensed mental health professionals with a minimum of three years' prior clinical experience in a mental health/substance abuse setting providing direct patient care. First-level review staff are licensed nurses with experience in psychiatric nursing (RN) or Licensed Mental Health Counselors (LMHC). These reviewers complete all types of reviews, including precertification, concurrent review, discharge planning, and care

coordination. The status of current licensure is maintained within the Lakeview Center, Inc. Human Resources Department for all actively employed clinical staff.

ABH ensures 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 member.

The ABH Quality Management Committee is responsible for the development of clinical policy and standards for the Utilization Management department, the standardization of operational systems, and the assurance of clinical integrity throughout all lines of business.

UM Staff Responsibilities

The overall clinical responsibility within ABH rests with the Medical Director. The Medical Director reports to the ABH Director of Access Behavioral Health. The Medical Director provides medical and clinical leadership for the day-to-day clinical operations, oversees the UM Program implementation and ensures the application of policies and procedures and participates in training of clinical staff. The Medical Director participates in the continuous quality improvement program, which includes the ongoing development and monitoring of key indicators, outcome studies, provider quality profiling, and best practices. The Medical Director routinely reviews utilization and quality improvement reports to help identify quality practices that can be shared with other providers, and to identify aberrant practices and participate in corrective actions. The Medical Director helps design, monitor and control utilization targets. The Medical Director assists in the development and implementation of necessary corrective action plans related to utilization. In addition, the Medical Director oversees the certification process and appeals decisions and serves as a Physician Advisor in the peer review/appeals process.

Physician Advisors are independently contracted employees and perform their reviews as designees of the Medical Director, but are not subordinate to the ABH Medical Director.

The Director of Care Management collaborates with the Medical Director to identify and resolve clinical issues related to referral, care management, and peer review processes. The Director of Care Management manages the day-to-day operations of the Care Management Department and provides direct clinical and administrative supervision to the Care Management staff. Additionally, the Director of Care Management monitors departmental productivity and utilization statistics. This position works closely with the ABH Director of Quality Management and Improvement to ensure that care management and referral processes are performed at or above established performance benchmarks. The Director of Care Management reports to the ABH Director of Managed Care.

ABH Clinical Care Coordinators provide clinical assessment and referral services as well as concurrent inpatient, alternative levels of care, and outpatient reviews. The primary function of the Clinical Care Coordinator is to ensure that members receive quality services in the most appropriate level of care. Clinical Care Coordinators inform clinical management of problem cases and resolve these issues in consultation with the Director of Care Management and the Medical Director. Clinical Care Coordinators receive clinical supervision from the Medical Director and the Director of Care Management and report directly to the ABH Director of Care Management.

Conflicts of Interest

No person may participate in the review and evaluation of any case or clinical activities in which he or she has been professionally involved or where judgment may be compromised. Utilization Management decision-making is based solely on the clinical appropriateness of the care and services needed. Access Behavioral Health does not offer incentives to individuals engaged in utilization review for issuing denials of coverage or service, or for rendering decisions that result in underutilization. Psychiatrists and other mental health professionals who carry out care management or peer review activity must be free from conflict of interest when reviewing the work of providers. Among other things, this means that clinical staff, including peer reviewers, must not review the work of any health care facility or entity where they have active staff privileges and treat patients or from which they derive any income.

Access to UM Services

A member or provider has access to a toll-free number for referral to a network provider for assessment, 24 hours per day, 7 days per week, and 365 days per year through the ABH Call Center. ABH Care Management staff are available for consultation for urgent as well as non-urgent circumstances 24 hours per day, 7 days per week, 365 days per year via the ABH Call Center. After normal business hours, 8am to 5pm CST, non-urgent messages may be left on the confidential voice mail of the Care Management staff or may be submitted electronically to ABH CM staff at abhreferral@lifeviewgroup.org. Response to telephonic and electronic general administrative communications to ABH Care Management staff will occur immediately in most cases, but in no less than one business day.

Clinical Criteria

The clinical criteria used by ABH to make admission, level of care, and continuing treatment decisions reflect ABH's philosophy and clinical values. These criteria are assessed and revised at least annually by the ABH Quality Management Committee. Prior to a criterion set being approved for use it is reviewed to ensure adherence to clinical best practices guidelines and overall core criteria standards. Clinical criteria are reviewed and approved by the ABH Quality Management Committee.

Sources for various criteria include:

- Florida Medicaid Coverage and limitations Handbooks for Behavioral Health:
    - Community Behavioral Health

  - Specialized Therapeutic Services
  - Targeted Case Management
  - Statewide Inpatient Psychiatric Services
- Florida Medicaid Statewide Inpatient Psychiatric Program Coverage Policy (Dec 2015)
- American Society of Addiction Medicine (ASAM) criteria
- Florida Medicaid Drug Therapy Management Program for Behavioral Health
- Diagnosis-based treatment guidelines for adults
  - American Psychiatric Association
- Diagnosis-based treatment guidelines for Children and adolescents
  - American Academy of Child and Adolescent Psychiatry

Clinical criteria are routinely disseminated to ABH providers via provider forums, the ABH website, and at individual or group training sessions. The criteria are accompanied by the following statement, “The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

To determine the appropriate level of care, Care Management staff evaluates the clinical information relative to the levels of care clinical criteria.

A hard copy of UM decision-making criteria may be requested by contacting Access Behavioral Health.

Medical Necessity

It is the policy of ABH to authorize payment only for services that are medically necessary and provided for the identification and/or treatment of a member's illness. ABH considers medically necessary treatment as that which is:

- Necessary to protect life, to prevent significant relapse of a mental illness or significant disability, or to alleviate severe pain;
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member’s needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
- Furnished in a manner not primarily intended for the convenience of the member, the member’s caretaker, or the provider.

Authorization and Notification for Behavioral Health Services

Access Behavioral Health manages authorization requests for the following services:

- Inpatient behavioral health services in a psychiatric bed (both in- and out-of-network; notification is requested by the first business day after the admission)
- Statewide Inpatient Psychiatric Programs (SIPP)
- Psychological and psychiatric testing (both in- and out-of-network)
- Electroconvulsive therapy (ECT) treatments (Note: ECT treatments rendered while a member is in an inpatient setting are included as part of the DRG payment to the facility.)

In-network non-emergent outpatient services

- All non-emergent outpatient services rendered within the regions where ABH operates are to be provided by in-network providers.
- No prior authorization is required for in-network providers.

Out-of-network non-emergent outpatient services

- No prior authorization is required for out-of-network providers outside the regions where ABH operates who participate in the Florida Medicaid program and provide transition benefit services to ABH members.
- A single case agreement may be requested for out-of-network non-emergent outpatient services by contacting ABHContracting@lifeviewgroup.org Mike Potters at (850) 495-2623.

Submitting Authorization Requests for Inpatient Psychiatric Hospitalization

Authorization requests can be made by Access Behavioral Health or by faxing clinical information directly to ABH at (850) 353-6041, or by secure email to abhreferral@lifeviewgroup.org. All information and documentation noted below should be included in the authorization request.

Information needed when requesting preauthorization

To obtain authorization through ABH, supporting clinical documentation, containing the following information, needs to be faxed to ABH or be available when calling ABH:

- Member name, date of birth, Medicaid identification number
- Member diagnosis
- Clinical information relevant to the admission, such as:
    - Significant clinical history, including mental status exam and history of present illness, Baker Act status, significant comorbidities, current medications and adherence
    - Current relevant laboratory reports
    - Treatment plan, including inpatient days requested and expected discharge placement and outpatient follow-up

Please note: Screening intake and physician history and physical forms are usually sufficient.

Additional information

Following Access Behavioral Health's review of the submitted information, the health care provider will be given an authorization number, the number of approved days, and the date of the next review. If the request is incomplete or does not meet evidence-based criteria for the level of care requested, the health care provider will be asked for additional information.

Continued stay reviews are not required for hospitals paid by DRG (Diagnosis Related Groups).

If Access Behavioral Health requests medical records as a result of an authorization request, prompt return of the information will facilitate the timely processing of the authorization request.

Questions

Questions about this program may be directed to Access Behavioral Health from 8 a.m. to 5 p.m. CST, Monday through Friday.

Peer Clinical Review

Physician Advisors provide clinical case review of those cases that do not meet medical necessity or that present quality of care issues. For after hour's coverage, a clinical supervisor, and Medical Director are on-call to deal with any emergencies. ABH's Medical Director, who is responsible for the clinical decisions, is a board certified psychiatrist and provides case consultation in general adult psychiatry at all levels of care. Physician Advisors utilize Access Behavioral Health's clinical criteria for determining medical necessity decisions. Specialists are available for adult and child/adolescent to assist in the determination of clinical appropriateness.

Resources available through the Utilization Management Program and utilized by ABH Care Management staff include the following:

- Informal discussions with the Medical Director or the Access Behavioral Health Physician Advisors on a daily basis.
- Weekly case rounds for case review and monthly in-service training.
- Review of "outlier" cases on every level of care.

Determination of No Medical Necessity

If the Care Management staff questions the medical necessity and/or appropriateness of the treatment as outlined in Access Behavioral Health's clinical criteria, or if there are quality of care concerns, the case is referred to the ABH Medical Director or a Physician Advisor (PA). The ABH Medical Director or Physician Advisor reviews the available information, and may offer to speak directly with the attending or primary provider to discuss the case. Through this communication, the ABH Medical Director or Physician Advisor may obtain clinical data that was not available to the care management staff at the time of the review. This collegial clinical

discussion allows the ABH Medical Director or Physician Advisor the opportunity to explore alternative treatment plans with the provider and to gain insight into the attending providers anticipated goals, interventions and time frames. The ABH Medical Director or Physician Advisor may request more information from the provider to support specific treatment protocols and ask about treatment alternatives. Determinations of no medical necessity are rendered only by the ABH Medical Director or a Physician Advisor and only if the ABH Medical Director or Physician Advisor and the attending provider are unable to reach an agreement. It is always possible for the treating provider to provide additional written or verbal information prior to the peer review decision. This additional information may alter the medical necessity determination.

Disagreement may be a result of anyone or a combination of the following:

- the current level of care;
- the frequency of a specific treatment modality;
- the duration of care; and/or
- the treatment modality being utilized

ABH sends notices of adverse determination when delegated by the health plan. When a determination of no medical necessity is made in a case, the treating provider (and hospital, if applicable) is notified telephonically of the decision. Written notification of a determination of no medical necessity is provided to the member and the member's treating practitioner. The notification letter specifies the level of care for which a determination of no medical necessity has been made, the reason(s) why the determination has occurred and instructions on how to initiate an appeal. Access Behavioral Health Care Management staff always work with providers in finding alternatives when a given level or type of care is not determined to be medically necessary, and this is documented in the case review notes.

Peer-to-Peer Conversation

Based on criteria for medical necessity, Care Management staff concludes that the proposed treatment of a member does not appear to meet the clinical criteria. The Care Management staff reviews these concerns with the facility UR staff or treating provider on the same business day. If the Care Management staff and the treating provider are not able to resolve these concerns, the process for referral of the case for peer-to-peer review is initiated, if not already completed as described above.

The peer review process follows core policies and procedures which are established by the Access Behavioral Health QI/UM Committee. The procedure is as follows:

An appointment is scheduled for the Physician Advisor and the treating provider by an ABH Care Management Department staff member. If the treating provider cannot be reached, a message is left, indicating that the call pertains to a question of medical necessity determination, and unless a call is received within (24) hours, a non-certification decision is issued unless special circumstances are identified that prevent the treating

physician from returning the call. After reviewing the information with the treating provider, the Physician Advisor determines whether the treatment services the provider intends to render (or has already rendered) are medically necessary. If so, the case is referred back to the ABH Care Management staff for continued review. If not, the provider is informed of the determination of no medical necessity and of the appeal process. Peer review decisions are usually rendered immediately, but in all cases within 24 hours of the review. Note: It is always possible for the treating provider to provide additional written or verbal information prior to the peer review decision. This additional information may alter the medical necessity determination. However, once Access Behavioral Health has sent a no medical necessity determination letter according to contractual standards, the case is governed by the protocols established for an appeal. The determination remains valid until and/or unless it is overturned by an appeal.

Appeal Process

Access Behavioral Health is not delegated member or provider Grievances, Complaints and Appeals. Provider Complaints and all aspects of the grievance and appeal process are handled by the member's MMA Health Plan. In the event an appeal or complaint is received by Access Behavioral health, it will be forwarded immediately to the member's MMA plan.

Practitioner Satisfaction with Access Behavioral Health UM Processes

Satisfaction surveys are sent, on an annual basis, to those providers who regularly use the ABH Care Management services. Data are aggregated, trended and used to identify improvement opportunities including areas in which our administrative and clinical practices need revision. Results are presented to the Quality Management Committee and are shared with providers.

IX. CLAIMS

Member Eligibility

Member eligibility within a designated health plan is determined by the Agency for Health Care Administration (AHCA). Access Behavioral Health's contracted health plans bear the responsibility of providing daily member eligibility files to ABH. ABH is required to attest to the health plans that eligibility files are uploaded exactly as they are received. ABH is not permitted to determine or change member eligibility.

Members may request assistance with eligibility questions by contacting Choice Counseling at 877-711-3662.

Reporting Member Demographic Information changes to Florida Medicaid

The Department of Children and Families (DCF) needs to know when a member's name, address, county, or telephone number change.

The member may:

- Call DCF toll-free at 1-866-762-2237 (TTY 1-800-955-8771) Monday through Friday from 8 a.m. to 5:30 p.m.
- Go online and make the changes in their Automated Community Connection to Economic Self Sufficiency (ACCESS) account.
- Contact the Social Security Administration (SSA) to report changes. Call SSA toll-free at 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 7 a.m. to 7 p.m.
- Contact their local Social Security office or go online and make changes in their Social Security account.

Claims Processing

Access Behavioral Health is committed to processing all claims accurately and in a timely manner by following all rules and regulations set forth by federal and state requirements. ABH claims processing payment occurs twice weekly (every Tuesday and Thursday). A detailed remittance advice report is mailed to providers, generally on the same day, but always within two business days of each claims payment day. When a claim is denied, the remittance advice includes the reason for the denial. Claims adjudication is not final until the date the check run occurs.

Claims Submission

Per provider contracts, all claims must be submitted to Access Behavioral Health within ninety (90) days from the date of service. Non-contracted providers have 6 months or 180 days from the date of service in which to submit claims. Claims are not denied for late file unless received beyond 1 year (365 days) of the date of service.

Paper Claims

Outpatient services must be billed on a CMS-1500. Inpatient services are billed on a UB-04.

All fee-for-service claims must be submitted on paper claims to:
Access Behavioral Health

ATTN: Claims
1221 W. Lakeview Avenue
Pensacola, FL 32501

Electronic Claims

Providers should contact Access Behavioral Health for questions regarding filing claims electronically. Electronic claims must be submitted with a single type procedure code per claim. Secondary claims may not be submitted electronically. Secondary claims must be submitted via paper claim with the completed explanation of benefits/remittance advice from the primary payer attached

Clean Claims

A clean claim form means a standard, original and legible claims form UB04, CMS 1500, 837 or successor forms which has been accurately completed by inserting all the correct information required to answer each data element needed to immediately process claims within the time period stated for services rendered and to promptly approve or deny payment.

Covered Diagnosis Codes

ABH covers both mental health and substance abuse diagnosis codes with the following exceptions:

ABH does not authorize community behavioral health services for the treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation. Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

ICD-10 Reimbursable behavioral health diagnosis codes: F01.50 – F53.1; F55.0 – F63.9; F68.10 – F69; F80.82, F88 – F99; Z03.89

Authorization Numbers

Authorization numbers are not required to be on the claim for claims payment.

Claims Payment

Electronic claims are processed within 15 days. Paper claims (fee-for service claims) are processed within 20 days.

Claims Remittance

Claims payments to providers is accompanied by an itemized accounting of the individual claims included in the payment including but not limited to, the member's name, the date of service, the procedure code, service units, the amount of reimbursement and the identification of the managed care plan.

Medicaid Benefit Limits

The ABH claims payment system does not allow payment beyond the limitations set forth in the Florida Medicaid Provider handbooks. Medicaid recipients may not be billed for services rendered that are denied by ABH for plan benefit limits.

Member Responsibility

Florida Medicaid does not require any co-payments or cost sharing for covered services to plan members. Members may not be billed for services rendered by out of network providers unless the member agrees in writing prior to the delivery of the services. Members may not be billed for missed appointments.

Disaster Planning

In the event of a disruption in the ability of service providers to contact ABH for authorizations due to an emergency, providers are instructed to provide medically necessary services. ABH will conduct retrospective reviews on these cases and authorize appropriate claims. ABH will pay claims and not hold members responsible for any medically necessary services that incurred during a time of disaster regardless of whether or not prior authorization was obtained. Consumer health and safety is of utmost concern and is not to be jeopardized by an inability of providers to communicate with ABH.

Claims Questions

Providers are encouraged to contact Access Behavioral Health with any questions regarding claims payment. Telephone: (850) 469-3631; email: abhbilling@lifeviewgroup.org

Corrected Claims

For handling and addressing corrections concerning claims issues, a provider has 35 days after receipt of notification to resubmit a claim to:

Access Behavioral Health
Attention: Claims Corrections
1221 W. Lakeview Avenue
Pensacola, FL 32501

Provider Complaints

Provider complaints (including overpayment disputes) must be issued in writing to:
Access Behavioral Health
1221 West Lakeview Avenue
Pensacola, FL 32501

Provider Claims Related Complaints

Providers are allowed ninety (90) calendar days from the date of final determination of the primary payer to file a written complaint for claims issues. Within three (3) business days of receipt of a claim complaint, the provider is notified (verbally or in writing) that the complaint has been received and the expected date of

resolution. Within thirty(30) calendar days of receipt of a claim complaint, the provider is given written notice of the status of the complaint, and again every thirty (30) calendar days thereafter until the complaint is resolved. Complaints related to claims are resolved within sixty (60) calendar days of receipt and written notice of the disposition and the basis of the resolution is sent to the provider within three (3) business days of resolution.

Provider Non-Claim Related Complaints

Providers may file a complaint regarding any aspect of their experience as a provider of service to ABH members. Providers have forty-five (45) days to file a written complaint for issues that are not related to claims.

The member's Health Plan will

- Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
- Document why a complaint is unresolved after thirty (30) calendar days of receipt and provide written notice of the status to the provider every thirty (30) calendar days thereafter; and
- Resolve all complaints within ninety (90) calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

Provider Change Notifications

Prompt notification of Access Behavioral Health in the event of any demographic change such as provider name or address by calling the ABH claims department at (850) 469-3631 or emailing abhinfo@lifeviewgroup.org will facilitate timely claims payment.

X. PROVIDER CONTRACTS

It is the responsibility of each contracted provider to familiarize themselves with the requirements in his/her signed contract with Access Behavioral Health. Contract questions will be addressed promptly by contacting the ABH Director of Network Management and Contracting directly listed in the staff directory.

XI. Appendix 1: Medicaid Product Attachment

Effective 2/1/2025

MEDICAID PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered between Lakeview Center, Inc. dba Access Behavioral Health ("***ABH***" or "***Company***") and all ABH Network Providers (in this Product Attachment referred to as "***Provider***").

WHEREAS, ABH and Provider entered into that certain provider agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by, available from or through a Company;

WHEREAS, Contracted Providers will be designated and participate as Participating Providers in the Product described in this Product Attachment; and

WHEREAS, ABH has contracted with Florida Medicaid Health Plans ("***Health Plans***") to be a Managed Care Organization to provide Covered Services to Covered Persons in the Statewide Medicaid Managed Care program (sometimes "***SMMC***") which includes the subprograms Managed Medical Assistance ("***MMA***") Program and Long-Term Care ("***LTC***") Program and such other subprograms (combined, hereafter referred to as "***Medicaid Program***") as may be awarded to ABH by Health Plans. The term "***Medicaid Product***" refers collectively to those programs, subprograms and health benefit arrangements offered by ABH or another Company (each such program, subprogram or arrangement a "***Medicaid Product Type***") that is administered, sponsored or regulated by the federal government (or any agency, department or division thereof), on its own or jointly with a State that administers or regulates such program or plan, and which for the purposes of Provider and Contracted Provider may include one or more of the following: MMA; a Child Welfare Specialty Product ("***Child Welfare Product***"); a Serious Mental Illness Specialty Product ("***SMI Product***"); the Children's Medical Services Health Plan, contracted through the Department of Health ("***CMS Plan***"); Long-Term Care Program ("***Long-Term Care***"); HIV/AIDS Specialty Product ("***HIV/AIDS Product***") and/or other Medicaid Product Types.

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement and/or State Contract (defined below). Citations to the State Contract or other State or federal requirements are being provided herein for convenience only and shall not affect the meaning or interpretation of the terms of this Product Attachment. Such citations may become outdated as these requirements are amended from time to time.

2. Product Participation.

2.1 SMMC. This Product Attachment addresses the participation of Provider and the applicable Contracted Providers in the Medicaid Product. The Medicaid Product includes those programs, subprograms, and health benefit arrangements offered by Health Plan or other Company pursuant to a contract with AHCA (a "***State Contract***"), or any successor thereto, to provide specified services and goods to covered beneficiaries under SMMC programs (or additional, ancillary or successor State Medicaid programs thereto), and to meet certain performance standards while doing so. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product's attachment to the Agreement. This Product Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

Where Company is not the Payor, the rights and responsibilities assigned under this Product Attachment to Company, Payor or "Company or Payor" shall be understood to apply to either Company or Payor, as applicable, under the circumstances and as determined by the terms of the Payor Contract, Regulatory Requirements and/or Company policies and procedures. The phrase "Company or Payor" is not intended to nor shall result in the expansion of any rights on the part of Provider or Contracted Providers or any liabilities on the part of Company or Payor. Nothing in this Product Attachment shall be construed as conferring any financial or legal liabilities of Payor under any Regulatory Requirements or the Payor Contract to Company or Health Plan. Nothing in this Product Attachment shall be construed as altering the terms of the Payor Contract, or in a manner that is inconsistent with Regulatory Requirements. The rights and responsibilities that arise under a Payor Contract (including a Governmental Contract) and that are assigned under this Product Attachment to Health Plan are understood to be assigned to Company (and references to "Health Plan" will be understood to be references to Company) where Company is a party to the Payor Contract.

2.2 Participation. Unless otherwise specified in this Product Attachment, all Contracted Providers under the Agreement will participate in one or more Medicaid Product Types as "Providers" and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This attachment constitutes the Product Attachment for the Medicaid Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company. To the extent any provision of this Product Attachment, or any provision of the Agreement as it relates to this Product Attachment, (including any exhibit, attachment or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Product Attachment will be coterminous with the Agreement unless a Party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicaid Product in accordance with the applicable provisions of the Agreement or this Product Attachment. Notwithstanding the above, Health Plan may immediately terminate this Product Attachment upon notice to Provider if the State Contract is terminated or the SMMC program (or any aspect thereof)

is no longer authorized by law (i.e., has been vacated by a court of law, CMS has withdrawn federal authority for the program or the program is the subject of a legislative repeal).

4. Governmental Contract/Regulatory Requirements. The "Governmental Contract Requirements" schedule herein and incorporated by this reference, sets forth special provisions applicable to the Medicaid Product under the State Contract, including Long-Term Care provisions when applicable, and the provisions that are required by the State Contract to be included in the Agreement with respect to the Medicaid Product. The "Regulatory Requirements" schedule herein and incorporated by this reference, sets forth the terms applicable to the Medicaid Product under State laws and regulations, and that are required under such laws and regulations to be included in the Agreement with respect to the Medicaid Product. To the extent that a Coverage Agreement is subject to the law cited in Regulatory Requirements, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement. Provider shall expressly impose these terms and obligations, in writing, on each of its Contracted Providers, as such term is defined in the Agreement. Health Plan is and shall be a third-party beneficiary of any agreement between Provider and its Contracted Providers with the right to directly enforce these terms and condition upon Contracted Providers. Applicable State agencies have the right to modify, supplement amend and add to the terms, conditions and obligations set forth in Governmental Contract Requirements and Regulatory Requirements, and Provider shall be bound by such changes. Provider shall be bound by all obligations of the State Contract and Regulatory Requirements applicable to Provider and the services it provides whether or not summarized, quoted or referenced herein and Provider warrants and represents to Health Plan it is familiar with such obligations and has the financial, legal and resources necessary to so comply.

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL CONTRACT REQUIREMENTS

This schedule sets forth the special provisions that are specific to the Florida SMMC Program under the applicable State Contract.

1. Definitions. For purposes of this Product Attachment, capitalized terms shall have the meaning set forth in the Agreement or, if not defined there, in the State Contract. Terms used in this Product Attachment that are not otherwise explicitly defined shall be understood to have the definition set forth in applicable State and federal rules and regulations including, but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

2. AHCA Approval. The Agreement shall in no way relieve Health Plan of any responsibility for the provision of services or duties under the State Contract. Provider may not delegate any aspect of service under the Agreement unless approved to do so by Health Plan. The Agreement and material changes hereto are subject to prior approval by AHCA. If AHCA determines at any time that the Agreement is not in compliance with the State Contract, Health Plan will promptly revise the Agreement to bring it into compliance and Provider accedes to such revision(s).

3. Timely Access. Provider shall comply with the appointment availability/timely access standards set forth below. Health Plan shall monitor Provider's compliance with these standards and will take corrective action, with which Provider must comply, in the event of Provider's non-compliance.

3.1. If Provider is a PCP, Provider agrees to provide or arrange for coverage of services, consultation or approval for referrals 24 hours per day, 7 days per week. After-hours coverage must be accessible using the medical office's daytime telephone number and shall consist of an answering service, call forwarding, Provider call coverage or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The PCP shall 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 service. A Medicaid-eligible PCP must provide coverage.

3.2. Appointments for Urgent Medical or behavioral health care services shall be provided:

3.2.1. Within 48 hours of a request for medical or behavioral health care services that do not require Prior Authorization.

3.2.2. Within 96 hours of a request for medical or behavioral health care services that do require Prior Authorization.

3.3. Appointments for non-Urgent Care services shall be provided:

3.3.1. Within seven days post-discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.

3.3.2. Within 14 days for initial outpatient behavioral health treatment.

3.3.3. Within 14 days of a request for Ancillary Services for the diagnosis or treatment of Injury, illness or other health condition.

3.3.4. Within 30 days of a request for a primary care appointment.

3.3.5. Within regs of a request for a Specialist appointment after the appropriate referral is received by the Specialist.

3.4. Early intervention services shall be provided no later than 30 days from the date the Individualized Family Support Plan (IFSP) was completed for Children enrolled in the Early Steps Program.

4. Credentialing and Recredentialing. Provider shall comply with Health Plan's credentialing/recredentialing processes and shall at all times be eligible for participation in the Medicaid program, consistent with Provider disclosure, screening, and Enrollment requirements (42 CFR 455.100-106; 42 CFR 455.400-470). Provider represents and warrants that all licensed medical professionals are credentialed in accordance with Health Plan's and AHCA's credentialing requirements.

5. Enrollment in Medicaid. For the entire term of the Agreement, Provider shall be eligible for participation in the Medicaid program. Provider agrees that Health Plan may execute Provider Agreements pending the outcome of the Provider Enrollment process. Health Plan will terminate a Network Provider immediately upon notification from AHCA that the Network Provider cannot be enrolled, or upon expiration of the 60 Day period without Enrollment of the Provider and notify affected Covered Persons in accordance with 42 CFR 438.602(b)(2). Moreover, Provider shall have a National Provider Identifier (NPI) in accordance with Section 1173(b) of the Social Security Act which shall be submitted to Health Plan. Health Plan shall recoup any payments made in the event Provider does not successfully complete the Onboarding process within 60 days and the delay is not caused by Health Plan. Provider can obtain NPI(s) through the National Plan and Provider Enumerator System located at: https://nppes.cms.hhs.gov/NPPES/Welcome.do. Provider shall submit all NPIs for its physicians and other health care Providers to Health Plan within 15 Business Days of receipt. NPIs are not required from an entity that does not meet the definition of "health care provider" found at 45 CFR 160.103.

6. Event Notification System ("ENS"). Provider shall cooperate with and, where eligible, participate in ENS.

7. Compliance with Federal Law. Provider acknowledges and agrees the Agreement complies with Chapter 641.315, F.S., 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106 and shall agree to all revisions necessary to ensure compliance.

8. Lawful Scope of Practice & Patient Advocacy. Health Plan will not prohibit or restrict a Provider acting within the lawful scope of practice from advising or advocating on behalf of a Covered Person who is his or her patient regarding:

8.1. The Covered Person's health status, medical care or treatment options, including any alternative treatment that may be self-administered.

8.2. Any Information the Covered Person needs to decide among all relevant treatment options.

8.3. The risks, benefits and consequences of treatment or non-treatment.

8.4. The Covered Person'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.

8.5. Nothing in the Agreement shall be deemed or construed to prohibit Provider from advocating on behalf of the Covered Person in any part of the Covered Person Grievance and Appeal System or utilization management (UM) process or individual authorization process to obtain necessary services.

9. Non-Referral. Provider shall not offer anything of value (including reduction of room and board costs) to retain Covered Persons or persuade potential Covered Persons to select them as their Provider or to enroll in a particular Managed Care Plan.

10. Provider is obligated to comply with Health Plan's policies and procedures including, but not limited to, those relative to prior authorizations, claims submittal, and billing codes. The specific Covered Services, including prior authorization requirements, acceptable billing codes, and identification of populations to be served by this Provider via this Agreement are described elsewhere in the Agreement (its attachments, exhibits, and schedules) and/or Health Plan's Provider Manual.

11. Hours of Operation. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial Managed Care Plan members or comparable Medicaid fee-for-service (FFS) recipients if Provider serves only Medicaid Recipients.

12. Accessibility. Provider shall ensure physical access, reasonable accommodations, culturally competent communications and accessible equipment for Covered Persons with Special Health Care Needs, including physical or mental disabilities in accordance with 42 CFR 438.206(c)(3). Provider shall cooperate with and participate in Health Plan's Cultural Competency Plan to promote the delivery of Covered Services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender.

13. Provider Preventable Conditions. If Provider is a Hospital or CSU, pursuant to Section 2702 of the Patient Protection and Affordable Care Act (ACA), the Florida Medicaid State Plan and 42 CFR Sections 434.6(12), 438.6(f) and 447.26, Health Plan is prohibited from making payments for any amounts expended for PPCs occurring after admission in any inpatient hospital or inpatient psychiatric hospital setting including certain CSUs. Provider is required to identify and report all PPCs to Health Plan in the claims submissions as specified in the State Contract.

14. Screening and Social Needs. If Provider is a PCP, Provider shall conduct screening of at least 95% of Covered Persons for health-related social needs using an Agency-approved screening tool and record the identified ICD-10 codes (Z55-Z65) in the Covered Person's electronic health record.

15. Changes to Fee Schedules. Health Plan identifies in the Provider Manual the process and timing for updating its Claim processing system when fee schedules are updated.

16. Notification of Pregnancy. Provider shall immediately notify Health Plan of a Covered Person's pregnancy, via the mechanism as outlined in the Provider Manual, whether identified through medical history, examination, testing, claims or otherwise.

17. Abuse, Neglect and Exploitation Training. If Provider is a Direct Service Provider, Provider shall complete Abuse, Neglect and Exploitation training, including training to identify victims of human trafficking.

18. Transfer – Health & Safety. Provider shall ensure immediate transfer to another provider if the Covered Person's health or safety is in jeopardy.

19. Transitioning Covered Persons. Provider shall cooperate in all respects with providers of other managed care organizations with respect to Covered Persons who are transitioning to a different managed care organization to assure maximum health outcomes for those Covered Persons.

20. Continuity of Care. If the Agreement or Product Attachment terminates (for any reason other than "For Cause") during the course of a Covered Person's treatment by Provider, Provider shall, for a minimum of 60 days following termination, provide for continuity of care for the course of treatment of a condition for which Covered Person was receiving care at the time of termination, until the Covered Person selects another treating Provider, or during the next Open Enrollment period, provided however, such continuity of treatment shall in no event exceed six Months after the termination. If a pregnant Covered Person has initiated a course of prenatal care with Provider, regardless of the trimester in which care was initiated, Health Plan shall allow Covered Person to continue care until completion of postpartum care from a not-for-cause terminated provider. Notwithstanding the provisions hereof, Provider may refuse to continue to provide care to a Covered Person upon termination of the Agreement who is abusive or noncompliant. During continuation of care following termination, Health Plan and Provider shall continue to abide by the terms and conditions of the Agreement as existed at the time of termination.

21. Covered Persons not Liable. Provider shall look solely to Health Plan for compensation for services rendered, except for cost sharing and patient responsibility (if applicable).

22. ICP, Hospice and ALFs. Provider will meet requirements for Institutional Care Program (ICP), Hospice Services and assisted living facilities (ALF) regarding collection of patient responsibility, and shall not assess late fees.

23. Cooperation with Plan Activities. Provider shall participate with Health Plan's Peer Review, grievance, QI and UM activities, as directed by Health Plan. This includes participation in Health Plan's monitoring and oversight activities.

24. Monitoring and Oversight. Health Plan will monitor Provider's compliance with State Contract requirements including monitoring the quality, appropriateness and timeliness of Covered Services rendered to Covered Persons and will take necessary action to ensure compliance. Health Plan's monitoring activities may include site visits and audit of Provider's records. Further detail shall be set forth in the Provider Manual.

25. Performance Measurements. Health Plan identifies in its Provider Manual the measures, metrics and frequency of measurement that shall be used by Health Plan to monitor the quality and performance of Provider.

26. Provider Participation in Marketing. Any Marketing Materials related to the State Contract that are displayed by Provider shall be submitted to the Agency for written approval before use. Provider shall comply with all requirements of the State Contract relating to Marketing including, but not limited to, the following requirements: (i) Provider shall at all times remain neutral regarding competing Medicaid plans offered in the State; (ii) Provider may make available and/or distribute Health Plan Marketing Materials as long as Provider does so for all Managed Care Plans with which Provider participates; (iii) Provider may display posters or other materials in common areas, such as Provider's waiting room; (iv)

Long-Term Care facilities may provide materials in admission packets announcing all Managed Care Plan contractual relationships; (v) Provider may not (1) offer Marketing/appointment forms; (2) make phone calls or direct, urge or attempt to persuade potential Covered Persons to enroll or remain enrolled in a Managed Care Plan based on financial or any other interests of Provider; (3) mail Marketing Materials on behalf of a Managed Care Plan; (4) offer anything of value to retain Covered Persons or persuade potential Covered Persons to select them as their Provider or to enroll in a particular Managed Care Plan; or (5) Accept compensation directly or indirectly from a Managed Care Plan for Marketing activities. Additional permissible and impermissible Marketing activities are set forth in Attachment B, Section III, P. of the State Contract. Provider shall co-brand all communications with Covered Persons and other Providers and Subcontractors to ensure it is clear that Health Plan is aware of and endorses the content contained within the communication.

27. Record System & Maintenance. Provider shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for Covered Services rendered to Covered Persons. In addition, Provider shall retain the following information in accordance with 42 CFR 438.3(u): base data in 423 CFR 438.5(c); medical loss ratio (MLR) reports in 42 CFR 438.8(k); and the data Information and documentation specified in 42 CFR 438.604, .606, .608 and .610. Provider shall maintain records for a period not less than 10 years from the close of the State Contract and retained further if the records are under review or audit until the review or audit is complete (42 CFR 438.3(u)). Prior approval for the disposition of records must be requested and approved by Health Plan if the Agreement is continuous. Provider shall follow the Covered Person record standards set forth in Rule 59G-1.054, F.A.C.

28. Cooperation with Inspections, Audits and Investigations. Provider acknowledges and agrees that:

28.1. The United States Department of Health and Human Services ("US DHHS"), AHCA, including the Bureau of Medicaid Program Integrity ("MPI"), Medicaid Fraud Control Unit ("MFCU") or Department of Elder Affairs ("DOEA") shall have the right to inspect, evaluate, and audit all of the following related to the State Contract: pertinent books, financial records, medical records, documents, papers, and records of any Provider involving financial transactions or any other records determined to be pertinent to the State Contract by AHCA, DOEA or US DHHS.

28.2. Upon request, and as required by State and/or federal law, Provider shall make available to AHCA, MPI, MFCU and/or any DOEA and all administrative, contractual, financial and medical records relating to the delivery of items or services for which Medicaid monies are expended.

28.3. Upon request, and as required by State and/or federal law, Provider shall also allow AHCA, MPI and/or MFCU to have access to any place of Provider's business and all its medical records. AHCA, MPI, MFCU and/or DOEA shall have access during Normal Business Hours, except under special circumstances when AHCA, MPI, MFCU and/or DOEA shall have after-hour admission. AHCA, MPI, MFCU and/or DOEA shall determine the need for special circumstances.

28.4. Provider shall cooperate fully with the Agency (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 Health Plan or its Subcontractors, at any time, related to the State Contract.

28.5. Provider shall cooperate fully in any investigation by the Agency, MPI, MFCU, CMS, the US DHHS Inspector General, the Comptroller General, or their designees, DOEA or other State or federal entity and in any subsequent legal action that may result from such an investigation involving the State Contract.

28.6. The Agency, CMS, the US DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate or inspect Provider's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems pertaining to any aspect of services and activities performed or determination of amounts payable under the State Contract. In accordance with 42 CFR 438.230(c)(3)(iii), Provider agrees the right to audit exists through 10 years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

28.7. Provider shall make available for purposes of an audit, evaluation or inspection its premises, physical facilities, equipment, books, records, contracts, computers or other electronic systems relating to Covered Persons pertinent to the State Contract by the Agency, CMS, the US DHHS Inspector General, the Comptroller General or their designees, and DHHS (42 CFR 438.3(h), s. 1903(m)(2)(A)(iv) of the Social Security Act.

29. Required Reports and Information. The Provider Manual includes the specific reports and clinical Information required by Health Plan for QI or other administrative purposes out of claims processing including Well Child Visits (CHCUP) reporting (if applicable).

30. Claims Submittal and Payment. Provider shall submit timely, complete and accurate claims to Health Plan in accordance with the requirements of the Administration and Management provisions and Information Management and Systems, at a minimum. Provider shall make prompt submission of Health Plan within six Months of (A) the date of services of discharge from an inpatient setting; or (B) the date on which Provider is furnished with the correct name and address of Health Plan. When Health Plan is the secondary payor, Provider shall submit the Claim to Health Plan within 90 days of the final determination of the primary payor. Health Plan agrees to make payment to Provider in accordance with applicable State and federal laws, rules and regulations including, but not limited to, Section 641.315, F.S., 42 CFR 447.46 and 42 CFR 447.45(d)(2), (3), (d)(5) and (d)(6). Health Plan shall include, with any claims payment to Provider, an itemized accounting of the individual claims included in the payment including, but not limited to, the Covered Person's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of Health Plan. Provider shall submit to Payor timely, complete and accurate claims or encounters for Covered Services in accordance with the Provider Manual. Payor reserves the right to deny payment to Provider if Provider fails to submit in accordance with the Provider Manual. If applicable, based on Provider's compensation arrangement, Provider shall submit encounter data to Payor in a timely fashion, in accordance with the requirements of the State Contract including, but not limited to, Attachment B, Section IX.E. thereof and which shall contain such statistical and descriptive medical and patient data and identifying Information as specified in the Provider Manual, in accordance with the requirements of the Information Management and Systems provisions of the State Contract, at a minimum.

31. Background Screening and Excluded Individuals and Entities.

31.1. Provider shall comply with the background screening requirements of the State Contract applicable to Providers.

31.2. Upon request and as required by State and/or federal law, Provider shall:

31.2.1. Make available to all authorized federal and State oversight agencies and their agents including, but not limited to, the Agency, the Florida Attorney General and the Florida Department of Financial Services (DFS), all administrative, financial and Covered Person records and data relating to the delivery of items or services for which Medicaid monies are expended.

31.2.2. On at least a monthly basis, check current staff, subcontractors and providers against the federal List of Excluded Individuals and Entities (LEIE) and the federal System for Award Management (SAM) (includes the former Excluded Parties List System (EPLS)) or their equivalent, to identify excluded parties.

31.3 Provider warrants and represents it is not:

31.3.1 an entity that is in nonpayment status or is excluded from participation in federal health care programs under Sections 1128 and 1128A of the Social Security Act.

31.3.2 debarred or excluded from participation in any federal health care program under §§1128 and 1128A of the Social Security Act nor an individual or entity who/which is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610(a)(1) nor on the discriminatory vendor list maintained by the Department of Management Services, in accordance the Section 287.134 (Florida Statutes) (42 CFR 438.808(a) and (b)(2); 42 CFR 431.55(h); 42 CFR 438.610(b); Sections 1128(b)(8) and 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b); State Medicaid Director Letters 6/12/08 and 1/16/09; Executive Order No 12549)

31.4 Health Plan will not pay, employ or contract with individuals on State or federal exclusion lists. Provider shall, upon request of Health Plan and as required by law, make such disclosures to Health Plan regarding Provider's officers, directors, owners, managers, members, partners and affiliated entities in the form and format as requested by Health Plan and required by law and to enable Health Plan to comply with Health Plan's disclosure requirements under law and the State Contract.

32. HIPAA. Pursuant to 42 CFR 438.224 regarding confidentiality of information relative to Covered Persons, Provider shall safeguard Information about Covered Persons and comply with HIPAA privacy and security provisions.

33. Notice of Withdrawal. Provider shall submit notice to Health Plan of withdrawal from Health Plan's Network at least 90 days before the effective date of such withdrawal.

34. Appeal of Termination. If the Agreement is terminated for any reason, Provider shall utilize the applicable Appeals procedures outlined in the Agreement or the Provider Manual. No additional or separate right of Appeal to the Agency or Health Plan is created as a result of Health Plan's act of terminating, or decision to terminate, any Provider under the State Contract.

35. No Liability of Covered Persons or AHCA. Provider acknowledges and agrees that neither Covered Persons nor AHCA shall be held liable for any debts of Provider. This provision shall survive termination of the Agreement and/or this Product Attachment, including termination of the Agreement due to Insolvency.

36. Insurance.

36.1. Insurance Adequacy. In addition to any other insurance obligations set forth in the Agreement, Provider shall maintain throughout the term adequate insurance satisfactory to AHCA for the protection of Provider's employees.

36.2. Workers' Compensation Insurance. Provider shall secure and maintain, during the life of the Agreement, workers' compensation insurance (in compliance with the Florida workers' compensation law) for all its employees

connected with the work under the State Contract unless such employees are covered by the protection afforded by Health Plan.

36.3. Lapse of Insurance. Provider shall notify Health Plan in the event of a lapse in general liability or medical malpractice insurance, or if its assets fall below the amount necessary for licensure under Florida Statutes (F.S.).

37. Indemnification/Hold Harmless. Provider shall indemnify, defend, and hold the Agency and Covered Persons 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 obligation survives the termination of the Agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Covered Persons, for damages exceeding the statutory cap on damages for public entities, if 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.

38. Return of Overpayments. When Provider has received an overpayment, Provider shall immediately report same in writing to Health Plan and shall return any overpayment to Health Plan within 60 days after the date on which the overpayment was identified and shall notify Health Plan in writing of the reason for the overpayment, as outlined in the Provider Manual. Provider shall cooperate with recovery efforts, including participating in audits and repay overpayments.

39. Authorized Signer(s). Provider warrants and represents that the individuals who are signing the Agreement on its behalf are so authorized. Moreover, the Agreement contains all requirements of the agreement between the parties with respect to the subject matter hereof.

40. Copayments. If copayments are waived as an Expanded Benefit, the Provider must not charge Covered Persons copayments for Covered Services; and if copayments are not waived as an Expanded Benefit, that the amount paid to Providers shall be the contracted amount, less any applicable copayments. Provider may not assess late fees for the collection of patient responsibility.

41. Compliance with State Contract. Provider agrees that all services and tasks related to the Agreement shall be performed in accordance with the terms of the State Contract.

42. Hospital Admitting Privileges. If Provider is a physician, Provider shall maintain, in good standing, hospital privileges at the hospital designated as the primary admitting facility by Provider or, if the Provider does not have admitting privileges, there shall be good standing of privileges at the hospital by another physician with whom Provider has entered into an arrangement for hospital coverage.

43. Physician Incentive Plans. Health Plan will make no specific payment, directly or indirectly, under a physician incentive plan to Provider as an inducement to reduce or limit Medically Necessary services to a Covered Person nor shall such plans contain provisions which provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. (42 CFR 422.208(c)(1); 42 CFR 438.3(i)). If the physician incentive plan places a physician or physician group at substantial financial risk (pursuant to 42 CFR 422.208(a)(d)) for services that the physician or physician group does not furnish itself, Health Plan shall assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(c)(2).

44. PCPs. If Provider participates as a PCP, Provider fully accepts and agrees to the responsibilities and duties associated with the PCP designation. Moreover, nothing in the Agreement shall prohibit a PCP from providing inpatient services in a participating hospital to a Covered Person if such services are determined to be Medically Necessary and Covered Services under the State Contract.

45. Hospital Rates. If Provider is a Hospital, in addition to the requirements of FL ST §409.967, the rates shall be in accordance with FL ST §409.975(6).

46. DCF Form. If Provider is a hospital, Provider shall notify Health Plan of births where the mother is a Covered Person. Health Plan is responsible for completing the Florida Department of Children and Families (DCF) Excel spreadsheet, or any successor form, for Unborn Activation and submitting it to the local Florida DCF office. Health Plan shall indicate its name as the referring agency when the Excel spreadsheet, or any successor form, is completed.

47. Reporting Requirements. If Provider is a hospital, Provider shall familiarize itself with and comply with all reporting obligations relating to Provider-Preventable Conditions as such may be set forth in the State Contract. Whether a hospital, private practitioner or otherwise, Provider, shall deliver timely and accurate reporting to Health Plan and/or the State as required by law and the State Contract and shall further submit such reports as requested by Health Plan to enable Health Plan to comply with its reporting obligations under law and/or the State Contract.

48. Telemedicine. If Provider is approved by Health Plan to provide Covered Services through Telemedicine, the Provider shall have Protocols in place to prevent fraud and abuse that address at a minimum the authentication and authorization of users; the authentication of the origin of the information; the prevention of unauthorized access to the system or information; system security, including the integrity of information that is collected; program integrity and system integrity; and maintenance of documentation about system and information usage.

49. Public Health Providers. If Provider is a public health provider, Provider shall contact Health Plan before providing Covered Services to Covered Persons and provide Health Plan with the results of the office visit, including test results.

50. Urgent Care Centers. If Provider is an Urgent Care center, Provider agrees to provide all relevant clinical Information regarding a Covered Person's visit to Covered Person's Primary Care Provider within five Business Days following the Covered Person's visit. Such relevant clinical Information includes, but is not limited to, diagnosis, treatment and services provided to Covered Person during the visit.

51. Non-Discrimination Against Provider. Health Plan shall not discriminate (i) against Provider with respect to participation, reimbursement or indemnification when Provider is acting within the scope of his or her license or certification under applicable State law; (ii) against Provider if Provider serves high-risk populations or specializes in conditions requiring costly treatments; or (iii) take punitive action against Provider if and when Provider requests an expedited resolution or supports a Covered Person's Appeal. This provision should not be construed as an any willing Provider law, as it does not prohibit Health Plan from limiting Provider participation to the extent necessary to meet the needs of the Covered Persons. This provision does not interfere with measures established by Health Plan that are designed to maintain quality and control costs.

52. Additional Termination Provisions. In addition to any other right to terminate under the Agreement, and notwithstanding any other provision of the State Contract, Provider acknowledges and agrees that AHCA or Health Plan may request immediate termination of the Agreement and/or Product Attachment if, as determined by AHCA, Provider

fails, within 15 Calendar Days after receipt of notice from Health Plan specifying such failure and requesting Provider to abide by the terms and conditions thereof, to abide by the terms and conditions of the Agreement and Product Attachment, or in the sole discretion of AHCA, Provider fails to come into compliance with the Agreement and Product Attachment.

53. Cost Avoidance Obligations. Provider shall assume responsibility for cost avoidance measures for third party collections in accordance with Section XI.D, Financial Requirements, of the State Contract.

54. Utilization Management and Incentives. Provider agrees that, to the extent it or others engaged by it conduct(s) utilization management activities, compensation is not, and shall not be, structured to provide Incentives to deny, limit or discontinue Medically Necessary services to any Covered Person.

55. Bed Hold Policies and Procedures. If Provider is a nursing facility and/or hospice, the bed hold days provision shall comport with the Medicaid FFS bed hold days policies and procedures.

56. Civil Rights Requirements. Provider shall not discriminate against Covered Persons or Provider's employees in violation of the following statutes, regulations, guidelines and standards:

56.1. Title VI of the Civil Rights Act of 1964, as amended, 42 United States Code (U.S.C.) 2000d et seq., which prohibits discrimination on the basis of race, color or national origin.

56.2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.

56.3. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.

56.4. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.

56.5. The Americans with Disabilities Act of 1990, Public Law (P.L.) 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.

56.6. FL ST Chapter 409

56.7. Rule 62-730.160, F.A.C. pertaining to standards applicable to generators of hazardous waste.

56.8. All applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 United States Code (U.S.C.) 7401 et seq.

56.9. The Medicare-Medicaid Fraud and Abuse Act of 1978.

56.10. Other Federal omnibus budget reconciliation acts.

56.11. The Balanced Budget Act of 1997.

56.12. All regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

57. Confidentiality. Notwithstanding anything contained in the Agreement to the contrary, Provider is held to the same confidentiality obligations as Health Plan. Provider shall comply with the requirements of FL ST Section 501.171 and shall, in addition to the reporting requirements therein, report to Health Plan and AHCA any breach of personal information.

58. Unauthorized Aliens and E-Verify. Provider shall comply with Section 274A of the Immigration and Nationality Act. AHCA will consider the employment by Provider of unauthorized aliens a Violation of this Act. If Provider knowingly employes unauthorized aliens, such Violation shall be Cause for unilateral cancellation of the Agreement. Provider shall use the E-Verify System to verify employment eligibility of all new employees hired by Provider performing work or providing services pursuant to the State Contract.

59. Performance In United States. All services provided under the Agreement will be performed within the borders of the United States and its territories and protectorates. State-owned Data (data collected or created for or provided by AHCA) will be processed and stored in data centers that are located only in the 48 contiguous United States.

60. Certifications.

60.1. If and to the extent Provider's compensation will equal or exceed $25,000 under the Agreement, then Provider shall submit a signed copy of the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts" which such certification is incorporated herein by reference.

60.2. Provider shall certify and make such disclosures as required by the "Certification Regarding Lobbying Certification for Contracts, Grants, Loans and Cooperate Agreements" which such certification is incorporated herein by reference.

61. Advance Directives. Provider shall not, as a condition to treatment, require a Covered Person to execute or waive an Advance Directive.

62. Health Information Exchange. To the extent Provider is participating in the Value-Based Payment (VBP) program, Provider shall participate in the Florida Health Information Exchange (HIE) Encounter Notification Services (ENS).

63. Critical Incident Reporting. Provider shall report Adverse Incidents to Health Plan within 48 hours of the incident and shall comply with such required training and corrective action plans as may be imposed by Health Plan for lack of compliance.

64. Reporting Suspected Unlicensed Entities. Pursuant to FL ST 408.812, Provider shall report suspected unlicensed ALFs and Adult Family Care Homes (AFCH).

65. Provider Education and Training. Provider shall avail itself of training offered by Health Plan and shall participate in such training as may be required by the State Contract.

66. Prohibited Payments. Provider will not be paid for the following:

66.1. Home Health Care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in Section 1861(o)(7) of the Social Security Act;

66.2. Items or services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend payments;

66.3. Any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 (Section 1903(i) of the Social Security Act);

66.4. Items or services furnished by Provider during a period when the Agency has determined there is reliable evidence of circumstances giving rise the need for a withholding of payment, which involves fraud, willful misrepresentation or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid Recipients; and

66.5. Prescriptions, including refills, written by individuals that have had their Medicaid prescribing rights suspended by the Agency.

67. Peer Review. Provider shall cooperate with Health Plan's Peer Review process.

68. Emergency Management Plan. Provider shall cooperate with the implementation of Health Plan's Emergency Management Plan.

69. Subcontractor. If and to the extent Provider is deemed a "Subcontractor" under the terms and conditions of the State Contract, Provider agrees to comply with those obligations of the State Contract binding upon Subcontractors including, but not limited to, the provisions of the State Contract concerning Patents, Copyrights, Royalties, Rights to Data and Sponsorship Statement.

70. Florida Handbook and Policies. Provider acknowledges, understands, and agrees that all coverage and service requirements specified in the Florida Medicaid Services Coverage & Limitations Handbooks, Florida Medicaid Coverage Policies, are incorporated by reference into the Agreement. This includes, but is not limited to, professional licensure and certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in this Contract.

71. Management Information Systems (MIS), Information Technology (IT) and Data Security. If and where required by the State Contract, Provider shall conform its MIS/IT systems to conform to the requirements of the State Contract. Provider shall deliver immediate notice (within one hour) to Health Plan, and the AHCA Information Security Manager (ISM) in the event it becomes aware of a security breach and any unauthorized transmission or loss of all the data collected or created for or provided by the Agency (State Data).

72. Pharmacy Agreements. In the event Provider is a pharmacy or pharmacy benefit manager (PBM), Provider shall ensure the PBM provides the following electronic message alerting the pharmacist to provide Covered Persons with the Hernandez Settlement Agreement (HSA) notice/pamphlet when coverage is rejected due to not being on the Preferred Drug List (PDL): "Non-preferred drug; Contact provider for change to preferred drug or to obtain prior authorization. Give Medicaid pamphlet if not corrected.

73. False Claims Act, Fraud and Abuse, Etc.

73.1. Employees, Subcontractors, Providers and Agents of the Provider must comply with the Federal False Claims Act ("***FCA***"), which applies to claims presented to federal health care programs for payment and permits the government to bring civil actions to recover damages and penalties when healthcare Providers submit false claims, and provides, among other things, that anyone who "knowingly" presents, or causes to be presented, a "false or fraudulent Claim" is liable for damages up to three times the amount of the erroneous payment, mandatory penalties for each Claim submitted and administrative remedies such as exclusion from future participation in government health care programs (31 U.S.C. 3729 through 3733). False Claim Violations under the FCA may be punishable by civil penalties between $5,000 and $10,000, plus three times the amount of the damages sustained by the government.

73.2. Any employee who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against with respect to the terms and conditions of employment as a result of initiating a qui tam relator action under the False Claims Act, or otherwise assisting in the investigation or litigation of a False Claims Act Violation, may be entitled to certain remedies from his or her employer including reinstatement at the same seniority status that such employee would have had but for the allegedly discriminatory actions of the employer; payment of twice the amount of backpay accrued by the employee; and compensation for any special damages sustained by the employee as a result of the discrimination, including litigation costs and reasonable attorney's fees.

73.3. Provider shall cooperate and comply with Health Plan's programs related to detecting, preventing and reporting Fraud, Waste and Abuse.

73.4. Provider shall ensure that Health Plan policies related to FCA and Fraud, Waste and Abuse generally are available to all employees, including management, as well as all Subcontractors, Providers and Agents. Should any Provider employee, Subcontractor, Provider or Agent (or employee of the same) obtain Information that reasonably leads it, him or her to believe there has or may have been a Violation of the FCA or of Health Plan's compliance program by Provider or any of its employees, Subcontractors, Providers or Agents, such person must promptly report and disclose the same to the appropriate individual at the Provider, who shall report the same, along with all Information related to such belief, to Health Plan, and Provider also must cooperate in any audit or investigation related thereto.

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Attachment A: Medicaid

SCHEDULE A-1
GOVERNMENTAL CONTRACT REQUIREMENTS (CONTINUED)
LONG-TERM CARE
Florida

This schedule sets forth required provisions that, in addition to the provisions set forth in the base Agreement and the previous "Governmental Contract Requirements" schedule to this Product Attachment, are applicable to the Long-Term Care Medicaid Product Type under this Medicaid Product Attachment.

ARTICLE I
DEFINITIONS

The definitions listed below will supersede any meanings contained elsewhere in this Product Attachment regarding this Product Attachment.

1.1 ***Department*** means the Florida Department of Elder Affairs.

1.2 ***Long-Term Care Managed Care Program*** means the Medicaid long-term care managed care program established by the 2011 Florida Legislature under CS/HB 7107 and codified at section 409.978, Florida Statutes, et seq.

1.3 ***Medically Necessary*** or ***Medical Necessity*** means services provided in accordance with 42 CFR 438.210(a)(4) and as defined in s. 59G-1.010(166), F.A.C., to include that medical or allied care, goods or services furnished or ordered must:

1.3.1 Meet the following conditions: (a) be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain; (b) be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or Injury under treatment, and not in excess of the patient's needs; (c) be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; (d) be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and (e) be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the contractor.

1.3.2 Be services when furnished in a hospital on an inpatient basis which could not, consistent with the provisions of appropriate care, be effectively furnished more economically on an outpatient basis or in a facility of a different type.

The fact that a physician or other contractor has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary or a Medical Necessity or a Covered Service.

1.4 ***MPI*** means Medicaid Program Integrity.

1.5 ***MFCU*** means Medicaid Fraud Control Unit.

ARTICLE II
LONG-TERM CARE PLAN REQUIREMENTS

2.1. Policies and Rules. Provider shall familiarize itself with and fully comply with the Rules and Policies specific to the type of LTC Covered Services provided by Provider.

2.2. Third Party Collections. Health Plan will assume full responsibility for third party collections.

2.3. Inspections. The Department, Agency, Health Plan and Department of Health and Human Services ("***DHHS***") may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed under this Product Attachment. Provider shall permit inspections of any records pertinent to this Product Attachment by the Department, Agency, Health Plan and DHHS.

2.4. Coverage. The parties acknowledge and agree that the defined term "Covered Person" identifies the population covered by this Product Attachment. Provider acknowledges and agrees that this Product Attachment specifies the amount, duration and scope of services to be provided by Provider, including a requirement that Provider continues to provide services through the term of the capitation period for which the Agency has paid Health Plan.

2.5. Transitions/Transfers. Provider will cooperate and provide for immediate transfer to another Provider if the Covered Person's health or safety is in jeopardy. In the transitioning of Covered Persons, the Provider will cooperate in all respects with Providers of other health plans to assure maximum health outcomes for Covered Persons.

2.6. Notification. If Provider is a facility or home health Provider, Provider will provide notice to Health Plan within 24 hours when a Covered Person dies, leaves the facility or moves to a new residence.

2.7. Delegation and Waiver. If the Provider delegates or Subcontracts any functions of Health Plan, Provider agrees that the Subcontract or delegation shall include all the requirements of this Product Attachment. Provider agrees to waive those terms of the Subcontract that, as they pertain to Medicaid Recipients, conflict with the specifications of this Product Attachment.

2.8. Extension, Renegotiation and Termination. Provider acknowledges that the Agreement specifies procedures and criteria for extension, renegotiation and termination of the Agreement.

2.9. Notice of Cancellation. Health Plan shall give 60 days' advance written notice to Provider and the Agency before canceling the State Contract for any reason or such period as required under the State Contract. Should Provider terminate the Agreement with Health Plan, Provider agrees that nonpayment by Health Plan for goods and services rendered by Provider is not a valid reason for avoiding the termination provision time frames in the Agreement. The termination provisions in the Agreement will apply to any termination. Health Plan will provide advance written notice to Provider and the Department before canceling this Product Attachment. However, in a case in which a Covered Person's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency, notification must be provided to the Department immediately.

2.10. Assisted Living Facilities, Adult Family Care Homes and Hospices. If Provider is an assisted living facility, adult family care home or hospice, Provider shall maintain a copy of the current care plan in the Covered Person's record for inspection by State and federal agencies.

2.10.1. Residential facilities must maintain the Home and Community Based (HCB) Settings Requirements as defined by the Agency for Health Care Administration.

2.10.2. Providers must develop and maintain policies and procedures for back-up plans in the event of absent employees and agree to maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees.

2.10.3. Provider agrees to comply with Health Plan's cultural competency plan, as referenced in the Provider Manual.

2.11. Marketing Outreach Requirements Provider agrees to comply with all Medicaid Marketing Outreach requirements as outlined in the contract between Health Plan and the Agency.

2.12. Modification of Product Attachment. Provider acknowledges and agrees that Health Plan may, without Provider's consent, amend this Product Attachment to the extent necessary to maintain consistent and/or compliance with any of the then-applicable Long-Term Care Managed Care Program requirements, or any State or federal law, policy or directive, upon 30 Calendar Days' notice to Provider, or a shorter timeframe if necessary for compliance. In addition, the compensation methodology and rates may be amended by Health Plan depending on financial Information provided as part of the Long-Term Care Managed Care Program procurement process and/or State Contract. Any other modification, alteration or change to this Product Attachment shall be made only by a written agreement duly executed by both parties.

2.13. Provider Acknowledgements. Provider acknowledges that this Product Attachment contains no provision that:

2.13.1. Restricts the Provider's ability to communicate Information to the Provider's patient regarding medical care or treatment options for the patient when the Provider deems knowledge of such Information by the patient to be in the best interest of the health of the patient.

2.13.2. Pursuant to s. 641.315(10), F.S., requires Provider to contract for more than one long-term care product or otherwise be excluded.

2.13.3. Pursuant to s. 641.315(6), F.S., in any way prohibits or restricts the Provider from entering into a commercial contract with any other contractor.

2.13.4. Prohibits discrimination with respect to participation, reimbursement of indemnification of any Provider who is acting within the scope of his/her license or certification under applicable State law, solely based on such license or certification. This provision shall not be construed as an any willing Provider law, as it does not prohibit the Plan from limiting Provider participation to the extent necessary meet the needs of the Covered Persons. This provision does not interfere with measures established by the Plan designed to maintain quality and control cost.

2.14. Nondiscrimination. Provider will provide services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of payor, source of payment, physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991 ("***ADA***"). Provider recognizes that as a governmental contractor, Health Plan is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action,

which also may be applicable to Subcontractors. Health Plan does not discriminate against Providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

2.15. Authority. The parties whose signatures are set forth in the Agreement represent and warrant that they are duly empowered and authorized to execute the Agreement, contract or Subcontract, for purposes of carrying out any aspect of, and that it includes all the requirements of, the Agreement or Subcontract.

2.15.1. Provider is prohibited from seeking payment from the Covered Person for any Covered Services provided to the Covered Person within the terms of the contract.

2.15.2. Any Provider claims payment from Health Plan will be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the Covered Person's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of Health Plan.

ARTICLE III
SCOPE OF SERVICE

Provider confirms and attests to qualification to provide and agreement to provide described services which are applicable to Provider's license. Provider will provide only those services that are approved through Health Plan's credentialing process.

3.1 Companion Services: Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the Covered Person with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the Covered Person.

3.2 Adult Day/Adult Day Health Care Services. Adult day health services, pursuant to Chapter 429, Part III, F.S., shall include services furnished in an outpatient setting, encompassing both the health and social services needed to ensure optimal functioning of a Covered Person, including social services to help with personal and family problems, and planned group therapeutic activities. Adult day health services shall include nutritional meals which are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks, and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the Covered Person's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward Activities of Daily Living and personal hygiene, are also a component of this service. Adult Day Health Care (ADHC) Providers shall conform to the HCB Settings Requirements as required by AHCA.

ADHC Providers will support the Covered Person's community inclusion and integration by working with the case manager and Covered Person to facilitate the Covered Person's personal goals and community activities. Covered Persons accessing ADHC services in an ADHC Provider shall be offered services with the following options unless medical, physical or cognitive impairments restrict or limit exercise of these options. These options shall include choices 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. Covered Persons shall have the 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.

3.3 Attendant Care: Attendant Care services are both supportive and health-related hands-on-care services specific to the needs of the individual. Attendant Care services are those that substitute for the absence, loss, diminution or impairment of a physical or cognitive function. Attendant Care services may include Skilled Nursing Care or personal care to the extent permitted by State law. Housekeeping activities incidental to the performance of care may also be furnished as part of this activity. This service can be authorized when the recipient's mental or physical condition requires assistance with medically related needs.

3.4 Behavioral Management: This service provides behavioral health care services to address mental health or substance abuse needs of long-term care plan members. These services exceed those listed in the Community Behavioral Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations Handbook. The services are used to maximize reduction of the Covered Person's disability and restoration to the best possible functional level and may include, but are not limited to, an evaluation of the origin and trigger of the presenting behavior; development of strategies to address the behavior; implementation of an Intervention by the Provider; and assistance for the caregiver in being able to intervene and maintain the improved behavior.

3.5 Chore Services: Services needed to maintain the home as a clean, sanitary and safe living environment. This service includes heavy household chores such as washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe entry and exit; and pest control.

3.6 Caregiver Training Services: Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to Covered Persons. For purposes of this service, an individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship or support to a Covered Person. This service may not be provided to train paid caregivers. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the Covered Person at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the Covered Person. All training for individuals who provide unpaid support to the Covered Person must be included in the Covered Person's plan of care.

3.7 Home Accessibility Adaptation Services: Physical adaptations to the home required by the Covered Person's care plan which are necessary to ensure the health, welfare or safety of the Covered Person, or which enable the Covered Person to function with greater independence in the home, or without which the Covered Person would require institutionalization. Such adaptation may include the installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities or installation of plumbing systems to accommodate the medical equipment or supplies, which are necessary for the welfare of the Covered Person. Excluded are those adaptations or improvements to the home that are general utility and are not of direct medical or remedial benefit to the Covered Person, such as carpeting, roof repair or central air conditioning. Adaptations which add to the total square footage of the home are not included in this benefit. All services must be provided in accordance with State and local building codes.

3.8 Home Delivered Meals: Nutritionally sound meals to be delivered to the residence of a Covered Person who has difficulty shopping for or preparing food without assistance. Each meal is designed to provide a minimum 33.3% of the current Dietary Reference Intake (DRI). The meals shall meet the current Dietary Guidelines for Americans, the U.S. Department of Agriculture (USDA) My Plate Food Intake Pattern and reflect the predominant statewide demographic.

3.9 Intermittent and Skilled Nursing: Intermittent or part-time nursing services provided by a registered nurse or Licensed practical nurse. The scope and nature of these services do not differ from skilled nursing furnished under the Medicaid State Plan. This service includes the home health benefit available under the Medicaid State Plan as well as expanded nursing services under this waiver. Services listed in the plan of care that are within the scope of Florida's Nurse Practice Act and are provided by a registered professional nurse, or Licensed practical or vocational nurse under the supervision of a registered nurse, Licensed to practice in the State. Skilled nursing services must be listed in the Covered Person's plan of care and are provided on an intermittent basis to Covered Persons who either do not require continuous nursing supervision or whose need is predictable.

3.10 Homemaker Services: General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control, may be included in this service.

3.11 Medication Management/Administration Services: Medication administration can only be provided by Licensed nurses. Assistance with self-administered medications whether in home or in a facility, can be provided either by a Licensed nurse or, with a documented request and informed consent, an unlicensed staff member. Pursuant to 400.4256, F.S., assistance with self-administration of medications includes taking the medication from where it is stored and delivering to the Covered Person; removing a prescribed amount of medication from the container and placing it in the resident's hand or another container; helping the resident by lifting the container to his or her mouth; applying topical medications; and keeping a record of when a resident receives assistance with self-administration of his or her medications. Medication Management includes review by the Licensed nurse or pharmacist of all prescriptions and over-the-counter medications taken by the Covered Person, in conjunction with the Covered Person's physician on at least an annual or as needed basis upon a Significant Change in the Covered Person's condition. The purpose of the review is to assess whether the Covered Person's medication is accurate, valid, non-duplicative and correct for the diagnosis; that therapeutic doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications are being assessed and prevented.

3.12 Nutritional Assessment/Risk Reduction Services: An assessment, hands-on care and guidance to caregivers and Covered Persons with respect to nutrition. This service teaches caregivers and Covered Persons to follow dietary specifications that are essential to the Covered Person's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and food preparation.

3.13 Personal Emergency Response Systems (PERS): The installation and service of an electronic device that enables Covered Persons at high risk of institutionalization to secure help in an emergency. The PERS is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The Covered Person may also wear a portable "help" button to allow for mobility. PERS services are generally limited to Covered Persons who live alone or who are alone for significant parts of the Day and who would otherwise require extensive supervision.

3.14 Personal Care Services: Assistance with eating, bathing, dressing, personal hygiene and other Activities of Daily Living. This service includes assistance with preparation of meals but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the Covered Person, rather than the Covered Person's family.

3.15 Occupational Therapy: Treatment to restore, improve or maintain impaired functions aimed at increasing or maintaining the Covered Person's ability to perform tasks required for independent functioning when determined through a multi-disciplinary assessment to improve a Covered Person's capability to live safely in the home setting.

3.16 Physical Therapy: Treatment to restore, improve or maintain impaired functions by use of physical, chemical and other properties of heat, light, electricity or sound, and by massage and active, resistive or passive exercise. There shall be an explanation that the patient's condition will be improved significantly (the outcome of the therapies shall be measurable by the attending medical professional) in a reasonable (and generally predictable) period of time based on an assessment of restoration potential, or a determination that services are necessary to a safe and effective maintenance program for the Covered Person, using activities and chemicals with heat, light, electricity or sound, and by massage and active, resistive or passive exercise when determined through a multi-disciplinary assessment to improve a Covered Person's capability to live safely in the home setting.

3.17 Respiratory Therapy: Treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems and bronchopulmonary drainage, breathing exercises and chest physiotherapy.

3.18 Speech Therapy. The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism or neurological conditions that effect oral motor functions. Therapy services include the evaluation and treatment of problems related to an oral motor dysfunction when determined through a multi-disciplinary assessment to improve a Covered Person's capability to live safely in the home setting.

3.19 Assisted Living Facility (ALF) Services: A service comprising personal care services, homemaker services, chore services, attendant care, companion care services, medication oversight and therapeutic social and recreational programming, provided in a home-like environment, in an assisted living facility Licensed pursuant to Chapter 429 Part I, Florida Statutes and 58A-5 of the Florida Administrative Code, in conjunction with living in the facility.

ALF will support the Covered Person's community inclusion and integration by working with the case manager and Covered Person to facilitate the Covered Person's personal goals and community activities. Covered Persons residing in an ALF or Adult Family Care Home (AFCH) shall be offered services with the following options, unless medical, physical, or cognitive impairments restrict or limit exercise of these options. These options shall include choice of private or semi-private rooms, as available; choice of roommate for semi-private rooms; locking door to living unit; access to telephone and unlimited length of use; choice of eating schedule; choice of activities schedule; and choice of participation in facility and community activities.

ALF must ensure that Covered Persons reside in a facility offering care with the home-like environmental characteristics. HCB Settings Requirements also include the ability to have unrestricted visitation and snacks as desired. It must also include the ability to prepare snacks as desired and maintain a personal sleeping schedule. This service does not include the cost of room and board furnished in conjunction with residing in the facility.

This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Individualized care is furnished to persons who reside in their own living units (which may include dual occupied units when both occupants consent to the arrangement), which may or may not include kitchenette and/or living rooms, and which contain bedrooms

and toilet facilities. The resident has a right to privacy. Living units may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing that the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. The facility must have a central dining room, living room or parlor, and common activity areas, which may also serve as living rooms or dining rooms. The resident retains the right to assume risk, tempered only by a person's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible and treat each person with dignity and respect. Assisted living services may also include physical therapy, occupational therapy, speech therapy, medication administration and periodic nursing evaluations. Health Plan may arrange for other authorized service Providers to deliver care to residents of assisted living facilities in the same manner as those services would be delivered to a person in their own home. ALF administrators, direct service personnel and other outside service personnel such as physical therapists have a responsibility to encourage Covered Persons to take part in social, educational and recreational activities they are capable of enjoying. All services provided in an ALF shall be included in a care plan maintained at the facility with a copy provided to the Covered Person's care manager. Health Plan shall be responsible for placing Covered Persons in the appropriate ALF setting based on each Covered Person's choice and service needs.

Assisted Living Facility Inclusions:

1. 24 hour access to staff;
2. Assistance with Activities of Daily Living: bathing, dressing, toileting (including incontinence care), ambulation, eating and transferring;
3. Observe general health, safety, physical and emotional well-being of the member;
4. Documentation of any Significant Changes in the member's state of health which results in medical attention, major incidents or change that results in additional services;
5. Contacting the resident's health care Provider and other appropriate party such as family, guardian and Plan if the resident exhibits a Significant Change, or if the resident is hospitalized, discharged or moves out of facility;
6. Assistance with grooming;
7. Medication management;
8. Monitor therapeutic diet as prescribed by a physician;
9. Incontinence Supplies (diapers, wipes and any other necessary items related to incontinence);
10. Nutritional Supplements as prescribed by a physician;
11. Housekeeping;
12. Personal laundry and linen service;
13. Escort to dining room;
14. Personal services in accordance with ALF Licensure;
15. Social and recreational activities;
16. Coordination of medical appointments and services;
17. Emergency Disaster plan;
18. Secure Environment for persons with Alzheimer's disease or related disorder; and
19. Services and care for persons with Alzheimer's disease or related disorder

Note: ALF hereby agrees to accept monthly payments from Health Plan for Covered Person services as full and final payment for all long-term care services detailed in the Covered Person's plan of care, which is to be provided by ALF. Covered Persons remain responsible for the separate ALF room and board costs as detailed in their resident contract. As Covered Persons age in place and require more intense or additional long-term care services, Provider may

not request payment for new or additional services from a Covered Person, their family members or personal representative. ALF may only negotiate payment terms for services pursuant to the Agreement with Health Plan.

The Provider shall maintain active Medicaid Enrollment and submit required cost reports to the Agency for the duration of the Agreement and shall be compliant with the Assisted Care Communities Resident Bill of Rights per s.429.28, F.S. Assistive Care Services cannot be billed separately by the ALF when billing Health Plan for Assisted Living Services for a Covered Person.

3.20 Assistive Care Services: Provided to Medicaid eligible recipients requiring an integrated set of services on a 24 hour per Day basis provided by an AFCH or ALF. Requires a Health Assessment by a Licensed practitioner establishing Medical Necessity for at least two of the four service components and the need for at least one specific service each day. Components are health support; assistance with Activities of Daily Living (ADLs); assistance with instrumental Activities of Daily Living (IADLs); and assistance with self-administration of medication.

ALF or AFCH will support the Covered Person's community inclusion and integration by working with the case manager and Covered Person to facilitate the Covered Person's personal goals and community activities. Covered Persons residing in an ALF or AFCH shall be offered services with the following options, unless medical, physical or cognitive impairments restrict or limit exercise of these options. These options shall include choice of private or semi-private rooms as available; choice of roommate for semi-private rooms; locking door to living unit; access to telephone and unlimited length of use; choice of eating schedule; choice of activities schedule; and choice of participation in facility and community activities.

AFCH or ALF must ensure that Covered Persons reside in a facility offering care with the home-like environmental characteristics. HCB Settings Requirements include the ability to have unrestricted visitation and snacks as desired. It must also include the ability to prepare snacks as desired and maintain a personal sleeping schedule.

3.21 Respite Care Services: Services provided to Covered Persons unable to care for themselves, furnished on a short-term basis, due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a Licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid Licensed hospital, nursing facility or ALF.

3.22 Skilled Nursing Facility: Services furnished in a health care facility Licensed under Chapter 395 or Chapter 400 F.S. per the Nursing Facility Coverage and Limitation Handbook. Bed-hold days will comport with Medicaid fee for service applicable policies and procedures. The Provider shall maintain active Medicaid Enrollment and submit required cost reports to the Agency for the duration of the Agreement.

3.23 Hospice Services: Services provided by an eligible Hospice Provider as Licensed in accordance with Chapter 400, Part IV, Florida Statutes, and Chapter 58A-2 of the Florida Administrative Code. Services include forms of palliative medical care and services designed to meet the physical, social, psychosocial, emotional and spiritual needs of terminally ill recipients and their families. Hospice care focuses on palliative care rather than curative care. An individual is considered terminally ill if he/she has a medical diagnosis with a life expectancy of six Months or less if the disease runs its normal course. The hospice Provider shall maintain active Medicaid Enrollment and submit required room and board cost logs/reports to the Agency for the duration of the Agreement.

3.24 Adult Family Care Home (AFCH): Assistive Care Services provided to Medicaid eligible recipients requiring an integrated set of services on a 24 hour per Day basis provided by an AFCH. Requires a Health Assessment by a Licensed practitioner establishing Medical Necessity for at least two of the four service components and the need for at least one specific service each day. Components are health support; assistance with ADLs; assistance with IADLs; and assistance with self-administration of medication.

AFCH will support the Covered Person's community inclusion and integration by working with the case manager and Covered Person to facilitate the Covered Person's personal goals and community activities. Covered Persons residing in an AFCH shall be offered services with the following options, unless medical, physical or cognitive impairments restrict or limit exercise of these options. These options shall include choice of private or semi-private rooms as available; choice of roommate for semi-private rooms; locking door to living unit; access to telephone and unlimited length of use; choice of eating schedule; choice of activities schedule; and choice of participation in facility and community activities.

AFCH must ensure that Covered Persons reside in a facility offering care with the home-like environmental characteristics. HCB Settings Requirements also include the ability to have unrestricted visitation and snacks as desired. It must also include the ability to prepare snacks as desired and maintain a personal sleeping schedule. This service does not include the cost of room and board furnished in conjunction with residing in the facility.

3.25 Case Management Services: Coordination of care between health care and social Service Delivery Systems, particularly physicians, hospitals, nursing homes and home health agencies, including initial assessment of service needs, development of a comprehensive, individualized service plan, coordination of services required to implement the plan, client monitoring to assess the efficacy of the plan and periodic re-evaluation and adaptation of the plan as necessary over the life of the client. These services require Prior Authorization by the Plan and include all types of Case Management including face-to-face, phone contact and other forms of communication which may be classified as Case Management services and includes all additional requirements as defined by Health Plan.

3.26 Case Management (Transition): Transition Case Management services are provided to Covered Persons who currently reside in a nursing facility and wish to transition into a less restrictive environment within the community. This service can be used to assess, evaluate, plan and coordinate the services needed by a potential nursing home transition candidate.

3.27 Community Transition Service (CTS): The CTS is a one-time payment to assist institutionalized Covered Persons to reintegrate into the community by providing financial assistance to move from a nursing facility institutional setting to their own home, apartment, ALF or AFCH. This payment is not dispersed directly to the Covered Person.

3.28 Pest Control: Pest Control services aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the recipient's residence. Services must be provided at the recipient's residence. Services will not be provided if other parties, such as landlords, are responsible for providing this service.

3.29 Transportation: Non-emergent transportation services shall be offered in accordance with the Covered Person's plan of care and coordinated with other Service Delivery Systems. This non-emergency transportation service includes trips to and from services offered by Health Plan and includes trips to and from Health Plan's Expanded Benefits.

3.30 Critical Incidents. Providers shall report Critical Incidents to Health Plan as outlined in the Provider Manual to ensure reporting of such Critical Incidents to AHCA within 24 hours of the incident. Nursing facilities and ALFs are not required to report Critical Incidents or provide incident reports to Health Plan. Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law including, but not limited to, Sections 400.147 and 429.23, F.S., and Chapters 39 and 415, F.S.

Attachment A: Medicaid

SCHEDULE B
REGULATORY REQUIREMENTS
Florida

This schedule sets forth provisions required by State law to be included in the Agreement with respect to the Medicaid Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual, another Attachment or elsewhere in the Florida statutes and regulations. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this schedule, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable. The following are summaries and/or paraphrasing of the referenced statutes/regulation; the actual text shall take precedence and govern in the event of an inaccurate summary/paraphrase.

FL-1 Regulatory Review and Approval.

a. The Florida Department of Financial Services (the "***Department***") may require a Health Maintenance Organization to submit any contract for administrative services, contract with a Provider other than an individual physician, contract for management services and contract with an affiliated entity to the Department.

b. After review of a contract, the Department may order the Health Maintenance Organization to cancel the contract in accordance with the terms of the contract and applicable law if it determines:

(i) That the fees to be paid by the Health Maintenance Organization under the contract are so unreasonably high as compared with similar contracts entered into by the Health Maintenance Organization or as compared with similar contracts entered into by other Health Maintenance Organizations in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors or creditors of the Health Maintenance Organization; or

(ii) That the contract is with an entity that is not Licensed under State statutes, if such license is required, or is not in good standing with the applicable regulatory agency.

c. All contracts for administrative services, management services, Provider services other than individual physician contracts, and with affiliated entities entered into or renewed by a Health Maintenance Organization on or after October 1, 1988, shall contain a provision that the contract shall be canceled upon issuance of an order by the Department pursuant to this section.

d. If a Health Maintenance Organization, through a health care risk contract, transfers to any entity the obligations to pay any Provider for any claims arising from services provided to or for the benefit of any subscriber of the organization, the Health Maintenance Organization shall remain responsible for any Violations of Florida statutory sections 641.3155, 641.3156 and 641.51(4). The provisions of Florida statutory sections 624.418-624.4211 and 641.52 shall apply to any such Violations.

FL-2 Covered Persons Not Liable.

a. A Covered Person is not liable to the Provider for any services for which Health Plan is liable as specified in Florida statutory section 641.3154.

b. Provider or any representative of Provider, regardless of whether Provider is under contract with Health Plan, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a Covered Person for payment of services for which Health Plan is liable, if Provider in good faith knows, or should know, that Health Plan is liable. This prohibition applies during the pendency of any Claim for payment made by Provider to Health Plan for payment of the services and any legal proceedings or dispute resolution process to determine whether Health Plan is liable for the services if Provider is informed that such proceedings are taking place. It is presumed that Provider does not know and should not know that Health Plan is liable unless (a) Provider is informed by Health Plan that it accepts liability; (b) a court of competent jurisdiction determines that Health Plan is liable; or (c) the Agency issues a final order that Health Plan is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to Florida statutory section 408.7057.

FL-3 Notice of Termination. Provider shall give 60 days' advance written notice to Health Plan and the office before canceling the contract with Health Plan for any reason, and nonpayment for goods or services rendered by Provider to Health Plan is not a valid reason for avoiding the 60-day advance notice of cancellation. Upon receipt by Health Plan of a 60-day cancellation notice, Health Plan may, if requested by Provider, terminate the Agreement in less than 60 days if Health Plan is not financially impaired or insolvent.

FL-4 Cancellation Without Cause. Health Plan will provide 60 days' advance written notice to Provider and the office before canceling, without Cause, the Agreement, except in a case in which a Covered Person's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

FL-5 Anti-Gag Clause. Nothing in the Agreement shall be deemed or construed to restrict Provider's ability to communicate Information to Covered Persons regarding medical care or treatment options when Provider deems knowledge of such Information to be in the best interest of the health of the Covered Person.

FL-6 No Anti-Competition. Nothing in the Agreement shall be deemed or construed to prohibit or restrict Provider from entering into a commercial contract with any other Health Maintenance Organization or Health Plan from entering into a commercial contract with any other health care Provider.

FL-7 Reasons for Termination. Neither Health Plan nor Provider may terminate the Agreement unless the party terminating the Agreement provides the terminated party with a written reason for the termination, which may include termination for business reasons of the terminating party. The reason provided in the notice required in this section or any other Information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. As used in this section, the term "health care Provider" means a physician Licensed under Chapter 458, Chapter 459, Chapter 460 or Chapter 461, or a dentist Licensed under Chapter 466.

FL-8 Prior-Authorization for Services. Health Plan will give written notice to the contracted Provider prior to any change in prior-authorization procedures.

FL-9 Medically Necessary Services in Hospital. If Provider is a contracted primary care or admitting physician, nothing in the Agreement shall be deemed or construed to prohibit Provider from providing inpatient services in a contracted hospital to a Covered Person, if such services are determined by Health Plan to be Medically Necessary and Covered Services under Health Plan's contract with the Covered Person.

FL-10 Acceptance of Other Terms and Conditions. Nothing in the Agreement shall be deemed or construed to require a contracted health care practitioner as defined in Florida statutory section 456.001(4) to accept the terms of other health care practitioner contracts with Health Plan or any Insurer, or other Health Maintenance Organization, under common management and control with Health Plan, including Medicare and Medicaid practitioner contracts and those authorized by Florida statutory Sections 627.6471, 627.6472 and 636.035, or this section, except for a practitioner in a group practice as defined in Florida statutory Section 456.053, who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any Agreement provision that violates this section is void. A Violation of this section is not subject to the criminal penalty specified in Florida statutory Section 624.15.

FL-11 Dentists.

a. If Provider is a dentist Licensed under Chapter 466 for the provision of services to a Covered Person, nothing in the Agreement shall be deemed or construed to require Provider to provide services to the Covered Person at a fee set by Health Plan, unless such services are Covered Services under the applicable benefit package. As used in this subsection, the term "Covered Services" means dental care services for which a reimbursement is available under the Covered Person's contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

b. In the event Provider is a dentist Licensed under Chapter 466 for the provision of services to a Covered Person, nothing in the Agreement shall be deemed or construed to require Provider accept credit card payment as the only acceptable method of payment from Health Plan to Provider.

c. If Health Plan pays dental claims through electronic funds transfer (EFT) including, but not limited to, virtual credit card payment, Health Plan shall notify Provider as provided herein and obtain Provider's consent before employing EFT. Provider's consent applies to the Provider's entire practice. Such consent, which may be given through electronic mail, must bear Provider's signature, which may include electronic or digital signature, provided the form of signature is recognized as a valid signature under applicable federal or State contract law or an act that demonstrates express consent including, but not limited to, checking a box indicating consent. Neither Health Plan nor Provider shall require that a dentist's consent, as described herein, be made on a patient-by-patient basis. The notification provided by Health Plan to the dentist must include all the following: (i) the fees, if any, associated with EFT; and (ii) the available methods of payment of claims by Health Plan, with clear instructions to the dentist on how to select an alternative payment method.

d. If Health Plan pays dental claims through Automated Clearing House (ACH) transfers, there shall not be a fee solely to transmit the payment unless the Provider has consented to the fee.

e. Health Plan may not deny any Claim subsequently submitted by a dentist Licensed under Chapter 466 for procedures specifically included in a Prior Authorization, unless at least one of the following circumstances applies for each procedure denied: (i) benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the Prior Authorization, are reached subsequent to issuance of the Prior Authorization; (ii) the documentation provided by

the person submitting the Claim fails to support the Claim as originally authorized; (iii) subsequent to the issuance of the Prior Authorization, new procedures are provided to the Covered Person or a change in the condition of the Covered Person occurs such that the prior authorized procedure would no longer be considered Medically Necessary, based on the prevailing standard of care; (iv) subsequent to the issuance of the Prior Authorization, new procedures are provided to the Covered Person or a change in the Covered Person's condition occurs such that the prior authorized procedure would at that time have required disapproval, pursuant to the terms and conditions for coverage under the Covered Person's plan in effect at the time the Prior Authorization was issued; (v) the denial of the Claim was due to: (A) another payor is responsible for payment; (B) the dentist has already been paid for the procedures identified in the Claim; (C) the Claim was submitted fraudulently or the Prior Authorization was based in whole or material part on erroneous Information provided to Health Plan by the dentist, Covered Person or other person not related to Health Plan; (D) the Covered Person receiving the procedure was not eligible to receive the procedure on the date of service; or (E) the Covered Services were provided during the grace period established under Florida statutory Section 627.608, or applicable federal regulations, and Health Plan notified Provider that the Covered Person was in the grace period when Provider requested eligibility or Enrollment verification from Health Plan, if such request was made.

f. The provisions of FL-11(b) through (e) above shall apply if the Agreement was delivered, issued or renewed on or after January 1, 2025.

FL-12 Ophthalmologists. If Provider is an ophthalmologist Licensed pursuant to Chapter 458 or Chapter 459, or an optometrist Licensed pursuant to Chapter 463, nothing in the Agreement shall be deemed or construed to (i) require Provider to join a Network solely for the purpose of credentialing the licensee for another organization's vision Network. This paragraph does not prevent Health Plan from entering into a contract with another organization's vision care plan to use the vision Network; nor (ii) restrict an ophthalmologist Licensed pursuant to Chapter 458 or Chapter 459, an optometrist Licensed pursuant to Chapter 463 or an optician Licensed pursuant to Part I of Chapter 484, to utilize specific suppliers of materials or optical laboratories. This paragraph does not restrict Health Plan in determining specific amounts of coverage or reimbursement for the use of Network or out-of-network suppliers or laboratories.

FL-13 Financial Statements. If Provider provides comprehensive health care services and has assumed, through capitation or other means, more than 10 percent of the health care risks of Health Plan, Providers shall, upon Health Plan's request, deliver to Health Plan true, accurate and complete copies of Provider's financial statements for submittal to the State. This shall not apply to individual physicians.

XII. Appendix 2: Humana Healthy Horizons

Access Behavioral Health is contracted with Humana Healthy Horizons in Florida's Regions 1 and 2.

SMMC Plan Contact:
Email: LTCProviderrelations@humana.com
Phone: 561-860-8660

MMA Provider contact:
Email: FLMedicaidProviderRelations@humana.com
Phone: 305-626-5006

Address:
Humana Healthy Horizons
PO Box 14546
Lexington, KY 40512-4546

XIII. Appendix 3: Sunshine Health

Access Behavioral Health is contracted with Sunshine Health in Florida Region 1.

Address:
Sunshine Health
P.O. Box 459087
Fort Lauderdale, FL 33345-9087
Provider Services: 1-844-477-8313