MOLINA HEALTHCARE OF FLORIDA, INC.
SINGLE CASE AGREEMENT

SIGNATURE PAGE

In consideration of the promises and representations stated, the Parties agree as set forth in this Single Case Agreement ("Agreement"). The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party.

The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Effective Date of Agreement ("Effective Date"):

Provider Signature and Information:

Provider's Legal Name ("Provider") – Matching the applicable tax form (i.e. W-9, Line 1):	
Authorized Representative's Signature:	Authorized Representative's Name – Printed:
Authorized Representative's Title:	Authorized Representative's Signature Date:
Telephone Number:	Fax Number
Mailing Address – Official Correspondence:	Payment Address – If different than Mailing Address:
IRS 1099 Address – If different than Mailing Address:	Tax ID Number – As listed on corresponding tax form:
NPI – That corresponds to the above Tax ID Number:	Email Address

Health Plan Signature and Information:

Molina Healthcare of Florida, a Florida Corporation ("Health Plan")	
Authorized Representative's Signature:	Authorized Representative's Name – Printed:
Authorized Representative's Title:	Authorized Representative's Countersignature Date:
Mailing Address – Official Correspondence:	

SINGLE CASE AGREEMENT

Health Plan and Provider enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a "Party" and collectively as the "Parties".

1.1 **Definitions.** Capitalized words or phrases in this Agreement have the meaning set forth below.

   a. **Covered Service** means medically necessary services prior authorized by Health Plan and set forth in this Agreement.

1.2 **Understanding of Parties.** By executing this Agreement, the Parties establish a limited financial agreement which enables Provider to provide Covered Services to the individual identified immediately below ("Member").

Member's Name: [ ]
Member's ID: [ ]

1.3 **Provision of Covered Services.** Provider represents it has the appropriate approvals, including, but not limited to, applicable licenses, certifications, registrations, and permits to provide Covered Services in accordance with state and federal laws. Provider agrees to provide Covered Services to the Member within the scope of Provider's business, practice, and license. For the purpose of this Agreement, Covered Services are specifically set forth below.

Authorization ID: [ ]
Authorized Date of Service:
Description:

1.4 **Compensation.** Health Plan will pay Provider for clean claims for Covered Services provided to the Member in accordance with state and federal law and this Agreement. Provider agrees to accept such payments and, when applicable, co-payments, co-insurances, deductibles, and coordination of benefits collections as payment in full for Covered Services. Provider agrees in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration, or reimbursement from or have any recourse against a Member, or person acting on Member's behalf, for services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided or fees for non-Covered Services in accordance with applicable law.

1.5 **Claims.** Claims must be submitted promptly by mail or in an electronic format to:

   a. **Mailing Address:** PO Box 22812, Long Beach, CA 90801; or,

   b. **Electronic Data Interchange (EDI) Number:** 51062.

1.6 **Claims Review.** Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, federal and state billing and payment rules.

1.7 **Authorization.** If Provider believes it is medically necessary for Member to obtain services beyond those Covered Services described or beyond the dates of service authorized in this Agreement, Provider must obtain an additional authorization from Health Plan in order to be eligible to receive reimbursement.

1.8 **Utilization Review.** Provider agrees to cooperate with Health Plan's medical director, utilization review staff and other representatives of the Health Plan by timely and comprehensively responding to Health Plan requests for concurrent/retrospective review of the care rendered to Member.

1.9 **Laws and Government Program Requirements.** The Parties will comply with all state and federal laws that are applicable to this Agreement, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act. Provider acknowledges that Health Plan has entered into government contracts and Provider will comply with the applicable government program requirements that must be satisfied under this Agreement and will comply with Health Plan's Provider Manual. (available at: www.molinahealthcare.com)

1.10 **Termination.** This Agreement will terminate upon the sooner of: (i) the termination of Member's coverage with Health Plan; (ii) the last Authorized Date of Service; or (iii) the conclusion of the provision of Covered Services.

1.11 **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

1.12 **Meet and Confer.** Any claim or controversy arising out of or in connection with this Agreement will first be resolved, to the extent possible, via "Meet and Confer". The Meet and Confer will begin when one Party delivers written notice to the other that it intends initiate a dispute and the basis for its belief that it will prevail. After providing notice, the Meet and Confer will be held as an informal face-to-face meeting held in good faith between appropriate representatives of the Parties and at least one (1) person authorized to settle outstanding matters. The Parties will commence the face-to-face portion of the Meet and Confer within forty-five (45) days of receiving notice. Such face-to-face Meet and Confer discussion will occur at a time and location agreed to by the Parties (within the forty-five (45) days) and if both Parties agree that more face-to-face discussions would be beneficial, the Parties can agree to have more than one (1) in person settlement discussion or a combination of in person, phone meetings and exchange of correspondence.

1.13 **Governing Law.** The laws of the state of Florida will govern this Agreement.

1.14 **Relationship of Parties.** The Parties agree they are independent Parties contracting for the purpose of effectuating this Agreement. The execution of this Agreement does not make Provider a participating provider with Health Plan and does not create a relationship beyond that defined by this Agreement.

1.15 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.

1.16 **Notice.** All notices required or permitted by this Agreement will be in writing and delivered by U.S. Postal Service ("USPS") certified mail with return receipt requested. Notice is deemed given on the date of delivery. The name and mailing address set forth under the Signature Page will be the particular Party's information for delivery of notice.

1.17 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

1.18 **Confidentiality.** Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential.

ATTACHMENT A

Compensation Schedule

Fee for Service Payments

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with products/programs as specified in Attachment C, on a fee-for-service basis, at the allowable amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

- **Medicaid:**

  Covered Services shall be paid at an amount equivalent to the payable rate under the State of Florida, one hundred percent (100%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

  Notwithstanding the above, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the State of Florida Medicaid Fee-For-Service Program fee schedule as of the date(s) of service, shall not exceed an amount equivalent to the allowable payment rate of eighty percent (80%) of the prevailing Medicare Fee-For-Service, as of the date of service.

ATTACHMENT B

State of Florida Required Provisions

State Laws

The following provisions are required to be included in contracts between health maintenance organizations and providers of health care services pursuant to Florida statutes and regulations that apply to health maintenance organizations. To the extent not otherwise prohibited by law, these provisions shall be automatically modified to conform to subsequent amendments to such statutes and regulations. Any purported modifications to these provisions inconsistent with such statutes and regulations shall be null and void.

1. Provider agrees that the Member is not liable to the Provider for any services for which the Health Plan is liable as specified in F.S. 641.3154. (F.S. 641.315(1).)

2. Provider acknowledges and agrees that it must give sixty (60) days' advance written notice to the Health Plan and the Office of Insurance Regulation of the Financial Services Commission before canceling this Agreement with the Health Plan for any reason. Provider also acknowledges and agrees that nonpayment for goods or services rendered by the Provider to the Health Plan is not a valid reason for avoiding the sixty (60) day advance notice of cancellation. (F.S. 641.315(2)(a).)

3. Health Plan will provide sixty (60) days' advance written notice to Provider and the Office of Insurance Regulation of the Financial Services Commission before canceling, without cause, this Agreement with Provider, except in a case in which a patient'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. (F.S. 641.315(2)(b).)

4. Provider acknowledges that upon receipt by the Health Plan of a sixty (60)-day cancellation notice, the Health Plan may, if requested by Provider, terminate this Agreement in less than sixty (60) days if the Health Plan is not financially impaired or insolvent. (F.S. 641.315(3).)

5. Provider acknowledges and agrees that Health Plan and Provider may not terminate this Agreement unless the party terminating this Agreement provides the terminated party with a written reason for terminating this Agreement, which may include termination for business reasons of the terminating party. The reason provided in the notice required 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. (F.S. 641.315(7).)

ATTACHMENT C

Required Provisions
(Medicaid/AHCA)

The State of Florida, Agency for Health Care Administration (AHCA) requires health maintenance organizations that participate in the Florida Medicaid program to include the following provisions in all contracts between such health maintenance organizations and hospitals that provide Medicaid services. Unless otherwise indicated, all citations are to the contract between the Health Plan and AHCA (the "Model Contract"). To the extent not otherwise prohibited by law, these provisions shall be automatically modified to conform to subsequent amendments to the Model Contract.

1. Health Plan agrees to make payments to Provider in accordance with Section 2.8 of the Provider Services Agreement (Claims Payment) and all State and federal laws, rules and regulations, including F.S. 641.3155, F.S., 42 C.F.R. 447.46, and 42 C.F.R. 447.45(d)(2), (3), (d)(5), and (d)(6). Health Plan and Provider agree to the terms of Section 2.8(d) (Coordination of Benefits) with respect to recovery of resources from third parties.

2. When presenting a claim for payment to the Health Plan, Provider is indicating an understanding that the Provider has an affirmative duty to supervise the provision of, and the responsible for, the covered services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for Health Plan -covered services:

   (1) Have actually been furnished to the Member by the Provider prior to submitting the claim; and
   (2) are medically necessary

3. If there is a physician incentive plan, Health Plan shall make no specific payment directly or indirectly to Provider as an inducement to reduce or limit Medically Necessary services to an Member, and any such incentive plan does not contain provisions which provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

4. Provider shall ensure timely access to physician appointments as follows: (i) appointments for urgent care shall be available no later than one (1) day of a request for such an appointment; (ii) appointments for routine sick care shall be available no later than one (1) week of a request for such an appointment; and (iii) appointments for well care visits shall be available no later than one (1) month of a request for such an appointment.

5. Evidence that the Health Plan has determined that the following documents are posted in the provider's waiting room/reception area: the Agency's statewide consumer call center telephone number, including hours of operation, and a copy of the summary of Florida's Patient's Bill of Rights and Responsibilities, in accordance with s. 381.026, F.S. The provider must have a complete copy of the Florida Patient's Bill of Rights and Responsibilities, available upon request by an enrollee, at each of the provider's offices.

6. In addition to any other right to terminate this Agreement, and not withstanding any other provision of the Model Contract, AHCA or Health Plan may request immediate termination of this Agreement if, as determined by AHCA, Provider fails to abide by the terms and conditions of this Agreement, or in the sole discretion of AHCA, Provider fails to come into compliance with this Agreement within fifteen (15)

calendar days after receipt of notice from Health Plan specifying such failure and requesting Provider abide by the terms and conditions thereof.

7. In the event Health Plan delegates responsibility for any administrative function(s) to Provider, the following shall apply: (1) Health Plan oversees and is accountable for any delegated functions and responsibilities. (2) Prior to any delegation, Health Plan will evaluate the Provider's ability to perform the delegated function(s). (3) The parties shall provide in writing (i) the specific activities and report responsibilities delegated to Provider; and (ii) in the event Provider's performance of such delegated functions does not meet or exceed the performance requirements imposed by Health Plan and/or AHCA, Health Plan may revoke responsibility for such functions or require Provider to undertake a written corrective action plan that is subject to Health Plan's approval. (4) Health Plan shall monitor Provider's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. (5) If Health Plan identifies deficiencies or areas for improvement, Health Plan and Provider shall take corrective action.

8. Any Provider whose participation is terminated pursuant to this Agreement for any reason shall utilize the applicable appeals procedures outlined in the Provider Agreement. No additional or separate right of appeal to AHCA or Health Plan is created as a result of the Health Plan's act of terminating, or decision to terminate any Provider under the Model Contract. Notwithstanding the termination of this Agreement, the Model Contract shall remain in full force and effect with respect to all other Providers.

9. Provider must be eligible to participate in the Florida Medicaid program. Any Provider who has involuntarily terminated from the Florida Medicaid program, other than those terminated for inactivity, is not considered to be an eligible Medicaid provider.

10. Health Plan shall not employ or contract with individuals on the State or Federal exclusions list.

11. This Agreement does not in any way relieve Health Plan of any responsibility for the provision of services duties under the Model Contract. Health Plan ensures that all services and tasks related to this Agreement are performed in accordance with the terms of the Model Contract. Health Plan shall identify in this Agreement any aspect of service that may be subcontracted by the Provider, if any.

12. Provider shall not seek payment from Members for any Covered Services provided to the Member within the terms of the Model Contract.

13. Provider shall look solely to Health Plan for compensation for services rendered, with the exception of nominal cost sharing, pursuant to the Florida State Medicaid Plan and the Florida Coverages and Limitations Handbooks.

14. If there is a physician incentive plan, Health Plan shall 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 Members, and incentive plans shall not contain provisions which provide incentives, monetary or otherwise, for the withholding of Medically Necessary services.

15. Any contracts, agreements, or subcontracts entered into by Provider for the purposes of carrying out any aspect of this Agreement must include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of the Model Contract.

16. Provider shall cooperate with Health Plan's peer review, grievance, QI and UM activities, provide for monitoring and oversight, including monitoring of services rendered to Members, by the Plan (or its subcontractors), and identify the measures that will be used by the Plan to monitor the quality and performance of the Provider. If the Plan has delegated the credentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Plan's and the Agency's credentialing requirements as found in the Model Contract.

17. If a Member's health or safety is in jeopardy, Provider shall immediately contact Health Plan to arrange for the immediate transfer of Member to another primary care physician or Health Plan as necessary.

18. Nothing in this Agreement prohibits Provider from discussing treatment or non-treatment options with Members that may not reflect Health Plan's position or may not be covered by Health Plan.

19. Nothing in this Agreement prohibits Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered.

20. Nothing in this Agreement prohibits Provider from advocating on behalf of the Member in any grievance system or UM process, or individual authorization process to obtain necessary health care services.

21. Provider shall meet all appointment waiting time standards pursuant to the Model Contract.

22. Provider shall provide for continuity of treatment in the event this Agreement terminates during the course of a Member's treatment by Provider. Provider shall allow enrollees in active treatment to continue care when such care is medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or during the next open enrollment period. None of the above may exceed six (6) months after the termination of the provider's contract.

23. Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as a willing Provider law, as it does not prohibit the Health Plan from limiting provider participation to the extent necessary to meet the needs of the Members. This provision does not interfere with measures established by the Health Plan that are designed to maintain quality and control costs.

24. Health Plan shall not discriminate against Providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

25. Provider shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Health Plan.

26. Provider shall maintain records for a period not less than six (6) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if this Agreement is continuous.)

27. Department of Health and Human Services (DHHS), AHCA, including Medicaid Program Integrity (MPI) and Medicaid Fraud Control Unit (MFCU), shall have the right to inspect, evaluate, and audit all of the following related to the contract: (i) pertinent books, (ii) financial records, (iii) medical records, and (iv) documents, papers, and records of any Provider involving transactions, financial or otherwise, related to the Model Contract.

28. This Agreement specifies Covered Services and populations to be served under this Agreement which are outlined in Health Plan's Provider Manual.

29. Providers shall comply with the Health Plan's cultural competency plan.

30. Any community outreach materials related to the Model Contract that are displayed by Provider shall be submitted to AHCA for written approval before use.

31. Provider shall submit all reports and clinical information required by Health Plan, including Child Health Check-Up reporting (if applicable). The "Child Health Check-Up Program" (CHCUP) is a comprehensive and preventative set of health examinations which are provided on a periodic basis and are aimed at identifying and correcting medical conditions in Children/Adolescents. Policies and procedures are described in the Child Health Check-Up Services Coverage and Limitations Handbook set forth by AHCA.

32. Providers of transitioning Members shall cooperate in all respects with providers of other health plans to assure maximum health outcomes for Members.

33. Providers shall submit notice of withdrawal from the network at least ninety (90) calendar days prior to the effective date of such withdrawal.

34. Providers who participate in the network as primary care physicians shall perform case management responsibilities and duties associated with the primary care physician designation.

35. Provider shall notify Health Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida laws.

36. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial HMO members or comparable to Non-Reform Medicaid Recipients if the provider serves only Medicaid recipients.

37. Provider shall safeguard information about Members in accordance with 42 CFR, Part 438.224.

38. Provider shall comply with HIPAA privacy and security provisions.

39. Neither Members nor AHCA shall be held liable for any debts of Provider. This provision survives termination of this Agreement, including breach of Agreement due to insolvency.

40. AHCA and Members shall be indemnified and held harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees to the extent proximately caused by any negligent act or other wrongful conduct arising from this Agreement: (i) this clause survives termination of

this Agreement, including breach due to insolvency, and (ii) AHCA may waive this requirement for itself, but not for Members, for damages in excess of the statutory cap on damages for public entities if Provider is a public health entity with statutory immunity (all such waivers must be approved in writing by AHCA).

41. Provider shall secure and maintain during the life of this Agreement worker's compensation insurance (in compliance with the State of Florida's Workers' Compensation Law) for all of its employees connected with the services provided as part of the Model Contract, unless such employees are covered by the protection afforded by the Health Plan.

42. Provider agrees to waive any terms of this Agreement, which, as they pertain to Members, are in conflict with the specifications of the Model Contract.

43. This Agreement does not contain any provision that in any way prohibits or restricts the Provider from entering into a commercial contract with any other plan (pursuant to Section 641.315, F.S.).

44. This Agreement contains no provision requiring the Provider to contract for more than one Health Plan product or otherwise be excluded (pursuant to Section 641.315, F.S.).

45. This Agreement contains no provision that prohibits the Provider from providing inpatient services in a contracted hospital to a Member if such services are determined to be Medically Necessary and Covered Services under the Model Contract.

46. Providers must cooperate fully in any audit, investigation by AHCA, review by Health Plan, Medicaid Program Integrity (MPI), or Medicaid Fraud Control Unit (MFCU), other state or federal entity, or any subsequent legal action that may result from such an audit investigation or review involving this contract.

47. If Provider fails to fully cooperate in investigations, reviews or audits conducted by the Health Plan, Agency, MFCU or any other state or federal entity, including but not limited to allowing access to the premises, allowing access to Medicaid-related records, or furnishing copies of documentation upon request may constitute a material breach of this Agreement and render it immediately terminated.

48. Molina Healthcare requires providers to submit timely, complete and accurate encounter data to Molina in accordance with the requirements of the Model Contract.

49. Physicians shall immediately notify the Health Plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims or otherwise, of any Member presenting themselves for healthcare services. The form to be utilized for such notification can be found in the Provider Manual.

50. Provider shall comply with the terms of the Health Plan's Provider Manual.

51. All claims payment will be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of the Managed Care Plan.

52. If co-payments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if co-payments are not waived as an expanded benefit, the amount paid to providers shall be the contracted amount less any applicable co-payments.

53. Provider will report adverse incidents to Plan within twenty-four (24) hours after the incident. Provider is required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours after the incident. Reporting will include information including the Member's identity, description of the incident and outcomes including current status of the Member.

54. Provider will comply with marketing requirements specified in Section III. D. of the Model Contract. Marketing materials that are to be displayed by the Provider must be submitted to the Health Plan for approval before use. If the Health Plan approves the marketing materials, the Health Plan will forward to the Agency for written approval. No marketing materials are to be displayed until a written approval from the Agency has been received.

ATTACHMENT D

Medicare Advantage

Laws and Government Program Requirements

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ATTACHMENT E

Medicare-Medicaid Program

Laws and Government Program Requirements

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ATTACHMENT F

Molina Marketplace

Laws and Government Program Requirements

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