For FBCCEDP Office Use Only
Region:
County:
Label #:

MEMORANDUM OF UNDERSTANDING
BETWEEN
STATE OF FLORIDA DEPARTMENT OF HEALTH
HILLSBOROUGH COUNTY HEALTH DEPARTMENT
AND

_____
(Provider/Clinic/Laboratory)

The State of Florida, Department of Health, Hillsborough County Health Department ("**Department**"), and _____, (**Provider**), "parties" to this Provider Agreement (PA), in consideration of the mutual promises hereinafter expressed in this PA and intending to be legally bound, agree as follows:

1. The Provider agrees to the following:

   a. To participate as a clinical service provider in the Florida Breast and Cervical Cancer Early Detection Program (the "FBCCEDP") under the terms, requirements, and conditions specified in 42 U.S.C. 300k (1990) and under section 381.93, Florida Statutes.

   b. To comply with the Department's eligibility criteria for FBCCEDP and provide screening and diagnostic mammography services during July 1, 2012 thru June 30, 2013 timeframe, with the exception of periods of suspended services/enrollment as provided in section 1.b.(5). Clients may be referred by the Department or by another authorized screening provider. In addition, the Provider may request approval for additional screening services in writing from the Regional Coordinator if funding is available. Only program-eligible women, as identified below, are to be accepted into the screening program.

      1) Only program-eligible women, as identified below, are to be accepted into the screening program as funding allows. A client is eligible for the FBCCEDP if:

         a) The client is a woman (1501-A-1 Public Law 101-354) **and**

         b) The client is 50-64 years of age **and**

         c) The client's household income is less than or equal to 200% or less of the Federal Poverty Guidelines as determined for the year in which the client is enrolled **and**

         d) The client does not have health insurance that will cover the cost of a mammogram, clinical breast exam (CBE), and/or Pap test exam.

      2) Eligible clients with implants will receive the same services as all other program clients and are subject to the same program protocols for diagnostics.

      3) Provide notification to clients of Mammogram results as per Mammography Quality Standards Act (MQSA) guidelines using Breast Imaging Reporting and Data System (BIRADS).

4) Provider must be in full compliance with the Mammography Quality Standards Act (MSQA) (As amended by MQSRA of 1998 and 2004), 42 USC 263b, which is hereby incorporated by reference. If the Provider does not meet requirements in the MQSA, then provider shall notify the Department immediately and cease providing services to clients until full compliance is achieved.

5) The **Provider** understands that screening services/enrollment during the months of November, December, May and June is suspended for data clean-up purposes.

c. The **Provider** agrees to bill at their usual rate for services but shall accept reimbursement for authorized services using the current Medicare Part B reimbursement schedule as modified by the Breast & Cervical Cancer Early Detection Program (FBCCEDP) periodically. (See Attachment A).

d. To submit invoices to the **FBCCEDP** regional coordinator within forty-five (45) days of the date of service for individuals to whom the **Provider** provides services under the **FBCCEDP**. Once approved, the **FBCCEDP** regional coordinator will forward the invoices to the third-party administrator for reimbursement. Bills submitted after sixty (60) days from the date of service may not be considered for reimbursement.

1) If the **Provider** has not received payment for services from the third-party administrator within seventy-five (75) days after the bill was sent to the **FBCCEDP** regional coordinator, the **Provider** may submit a duplicate bill to the **FBCCEDP** regional coordinator. *If mailed, the duplicate bill must have "Breast and Cervical Cancer Program Duplicate Bill" written in the lower left corner of the envelope.* If the **FBCCEDP** regional coordinator receives this duplicate bill more than a total of ninety (90) days after the services were provided, it will not be submitted to the third-party administrator for reimbursement and will not be reimbursed.

2) The **Provider** agrees not to seek payment from the patient if the **Department** has not paid the **Provider** for authorized services.

e. Reimbursement will be made under the **FBCCEDP** only for services which are authorized by the **Department** (see Attachment A, hereby incorporated into this PA). The **Provider** understands and agrees that reimbursement for **Provider's** services may not include fees for the use of a facility and **Provider** will not seek reimbursement for such facility fees. The **Provider** also agrees not to seek additional reimbursement for any services for which the Department's designated third-party administrator has paid the Provider.

f. The **Provider** agrees to provide a Federal Tax Identification Number, the Current Procedural Terminology (CPT) codes, patient name, SSN, and date of service on all claims submitted to the **FBCCEDP** regional coordinator. The Provider **will not** submit payment invoices UB92 or HCFA 1500 forms directly to United Group Program, Inc. (UGP). This will only delay the payment process.

g. To refund to the third-party administrator any duplicate payment, overpayment, payment for services reimbursed by another third-party payer, or other incorrect payment within thirty (30) days of receipt of the payment or written notification of the incorrect payment, whichever is sooner.

h. To assign a designated contact person to serve as a liaison for the **FBCCEDP** and notify the **Department**, or designee in writing of any changes in corporate name, tax identification number, address, or status of license to provide services within thirty (30) days that such changes occur.

i. Any payment due under the terms of this agreement may be withheld until all reports due from the provider and necessary adjustments thereto have been approved by the Department. Invoices will ***not*** be considered complete until documented results have been forwarded to:

Hillsborough County Health Department
Community Health Division (FBCCEDP)
2313 East 28th Avenue
Tampa, Florida 33610
(Attn: Clarence Gyden)

j. **Electronic transmission of confidential information via Internet must be encrypted.** Unless encrypted, the provider may not send any patient, confidential or sensitive information via electronic mail.

k. Wireless Devices: Sending confidential information via a wireless device is prohibited unless the information can be encrypted in transmission and the device secured by password. In addition, the wireless device must be an approved DOH standard.

l. All external electronic data files with confidential information must be encrypted. This applies to all files to be electronically transmitted or transported in any way.

m. Other electronic transmissions of confidential/sensitive information must be safeguarded consistent with current departmental policies and protocols.

n. Confidential/sensitive information must be kept secured within the facility and while in transit to an authorized recipient by using appropriate administrative, technical, and physical safeguards.

o. Confidential/sensitive information about clients and employees must be kept private/secured when using faxing machines, telephones, and mail or courier services.

p. The provider warrants and represents that the provider has authority to enter into the agreement and any person signing it on the provider's behalf has been duly authorized to execute the agreement for the provider.

q. To provide adequate liability insurance coverage on a comprehensive basis and to hold such liability insurance at all times during the existence of this agreement and any renewal(s) and extension(s) of it. Upon execution of this agreement, unless it is a state agency or subdivision as defined by Florida Statutes 768.28, the provider accepts full

responsibility for identifying and determining the type(s) and extent of liability insurance necessary to provide reasonable financial protections for the provider and the clients to be served under this agreement.

r. The provider agrees to utilize the U.S. Department of Homeland Security's E-Verify system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of: (a) all persons employed during the contract term by the contractor to perform employment duties within Florida; and (b) all persons (including subcontractors) assigned by the contractor to perform work pursuant to the contract with the state agency.

2. The **Department** agrees to:

a. Request that its designated third-party administrator, United Group Program Inc. (UGP) reimburse the **Provider** for services rendered to participants in accordance with the rules governing the **FBCCEDP** within 30 days of UGP's receipt of the Provider's completed invoice.

b. Request that the **Provider** is sent a claims report from the third-party administrator within ten (10) days from the regional coordinators date of receipt.

c. The **Department** will provide technical expertise and support and will also assist the **Provider** in care coordination tracking of women screened through the program with abnormal results.

3. The Department and the Provider mutually agree on the following:

a. Health Insurance Portability and Accountability Act (HIPAA): Both parties agree to comply with the Standards of Privacy of Individually Identifiable Health Information ("protected health information") published by the Secretary of the United States of Health and Human Services (HHS) to amend C.F.R. Part 160 and part 64 (the Privacy Regulation") under HIPAA of 1996.

b. In the performance of this agreement, it is agreed between the parties that the provider is an independent contractor and that the provider is solely liable for the performance of all tasks contemplated by this agreement which are not the exclusive responsibility of the department.

c. The Provider will maintain all records documenting activities of this agreement and shall assure that all records pertaining to activities under this agreement shall be subject to inspection or review by the Department or other personnel duly authorized by the Department.

d. Any patient medical records created as a result of this agreement shall be kept in the physical custody of the Provider. The records shall be kept confidential and for a period of up to 7 years following the termination of this agreement. The records shall be available for review and copying by the Department.

e. To renegotiate and amend this memorandum for services to be rendered by the provider should it become necessary due to a reduction in the amount of available state or federal funds.

f. The Provider Agreement (PA) may be renewed on a yearly basis for no more than three (3) years beyond the initial PA. Such renewals shall be made by mutual agreement and shall be contingent upon sufficient funds being made available by the Legislature or being obtained from other sources. Each renewal shall be confirmed in writing and shall be subject to the same terms and conditions set forth in the initial PA.

g. The **Department** and the **Provider** agree that neither party is responsible to the other party for nonperformance or delay in performance due to acts of God, wars, riots, strikes, or other causes beyond the control of the parties. The **Department** is not responsible to the **Provider** for nonperformance or delay in performance by the third-party administrator for the aforementioned reasons. In addition, the **Department** is not responsible to the **Provider** for nonperformance or delay in performance due to the acts or omissions of the regional case manager or the participants.

h. The **Department** and the **Provider** agree that in the performance of this PA, there will be no discrimination against any person because of race, color, sex, sexual orientation, religion, national origin, ancestry, age, veteran status, disability, handicap (except that services are to be provided solely to participants of the **FBCCEDP** program pursuant to **FBCCEDP** eligibility guidelines) or any other factor specified in the Civil Rights Act of 1964, as amended, in Section 504 of the Rehabilitation Act of 1973, as amended, and in any subsequent legislation pertaining to civil rights.

i. The term of this PA is July 1, 2012, or upon execution of both parties, whichever is later, through June 30, 2013, subject to the cancellation provisions contained in paragraph 3.j of this PA.

j. This PA may be canceled by the **Department** at any time upon at least fifteen (15) days' advance written notice. The **Provider** may cancel this PA at any time upon at least thirty (30) days' advance written notice. Notice of cancellation shall be transmitted by certified mail or personal delivery to the other party and considered effective upon delivery. The **Department** may cancel this PA immediately, notwithstanding the advance-notice provisions specified above, if: 1) the **Provider** breaches any of the terms or conditions of this PA; or 2) there is a failure of funding under which the **Department** funds the **FBCCEDP**. In no event will the **Department** be obligated to pay for any services performed by the **Provider** after the effective date of cancellation. Notice to the **Department** shall be sent to the Regional Coordinator, Breast and Cervical Cancer Early Detection Screening Program, Hillsborough County Health Department, 2313 East 28th Avenue, Tampa, FL 33605. Notice to the **Provider** will be sent to the **Provider**'s below-referenced address. After sending or receiving notice of cancellation, the **Provider** agrees to continue to provide services up to 12:01 a.m. on the effective date of cancellation.

In witness thereof, the parties have caused this Memorandum of Understanding to be executed by the undersigned officials as duly authorized.

HILLSBOROUGH COUNTY HEALTH DEPARTMENT

_____ _____

Douglas A. Holt, M.D.

_____ Director_____

Title Date Title Date

To Be Completed By Provider

Provider Contact Person:		**Billing** Contact Person:
Provider Contact Person Phone Number:		**Billing** Contact Person Phone Number:
Provider Street Address		**Billing** Street Address
City, State, Zip (Print/Type)	County (Print/Type)	City, State, Zip
Provider Phone Number: ( )		Provider Fax Number: ( )
Federal Tax ID Number (Print/Type)		
Provider E-mail Address		
Services Provided for FBCCEDP Clients (check all that apply) □ Clinical Breast Exam □ Mammography □ Ultrasound (Breast) □ FNA □ Breast Biopsy □ Surgical Consultation (Breast) □ Pelvic Exam □ Pap Test □ Colposcopy □ Cervical Biopsy □ Endocervical Curettage □ Gynecologic Consultation □ Cytology □ Pathology □ Other		