29-000

For FBCC Office Use Only

Region: West Central

County: Hillsborough

Label #: 29-000

MEMORANDUM OF AGREEMENT BETWEEN FLORIDA DEPARTMENT OF HEALTH, HILLSBOROUGH COUNTY HEALTH DEPARTMENT AND

_____

The Florida Department of Health, Hillsborough County Health Department providing breast and cervical cancer early detection services in the West Central Florida Region of Florida, ("Department") and _____ (Provider), "parties" to this Memorandum of Agreement (MOA), in consideration of the mutual promises hereinafter expressed in this MOA and intending to be legally bound, agree as follows:

The Provider acknowledges that this MOA is funded in whole or in part by a grant awarded by Centers for Disease Control under the National Breast and Cervical Cancer Early Detection Program grant, grant award number 1 NU58DP007161-01-00, and CFDA number 93.898. This MOA requires the Provider to provide products and/or services that are funded in whole or in part under said grant.

1. The Provider agrees:

   a. To participate as a clinical service provider in The Florida Breast and Cervical Cancer Early Detection Project (the "FBCC") under the terms, requirements, and conditions specified in 42 U.S.C. 300k (1990) and the FBCC Guidelines (guidelines available upon request).

      1) To comply with the Department's eligibility criteria for FBCC and provide screening and diagnostic services to a **maximum** of **150 unduplicated clients** during July 1, 2023 thru June 30, 2024 timeframe, with the exception of periods of suspended services/enrollment as provided in section 1.a.(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, will be accepted into the screening program.

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

      4) To 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 FBCC 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.

6) Assess the smoking status of every woman screened using FBCC funds and refer those who smoke to the Tobacco Quit Line 1-877-U-CAN-NOW. 1-877-822-6669.

b. To provide reports of any breast and/or cervical cancer screening and diagnostic procedures to the FBCC regional coordinator within sixty (60) days of the date of service. The FBCC regional coordinator will review timely submitted claims and if required eligibility and other program factors are met will authorize payment of claims by the third-party administrator. Claims for services will not be authorized for third-party payment if the said reports are not received by the FBCC regional coordinator pursuant to this section.

c. The Provider agrees to bill at their usual, customary, and reasonable (UCR) rate for services but shall accept reimbursement by the third-party administrator for authorized services using the current Medicare Part B reimbursement schedule, as modified by the National Breast & Cervical Cancer Early Detection Program (NBCCEDP) periodically, (As determined in Attachment A, incorporated by reference herein).

d. To submit claim(s) to the FBCC regional coordinator for authorization within sixty (60) days of the date of service for individuals to whom the Provider provides services under the FBCC. The FBCC regional coordinator will authorize and submit the claim for reimbursement to the third-party administrator once the screening and/or diagnostic report is received and approved. Claims submitted after ninety (90) days will not be considered for reimbursement.

1) Reimbursement will be made by the third-party administrator under the FBCC only for services which are authorized by the Department (see Attachment A, hereby incorporated into this MOA).

2) The Provider understands and agrees that reimbursement for Provider's services does not include fees for the use of a facility and Provider will not seek reimbursement from the third-party administrator, Department, FBCC or the patient for such facility fees.

3) The Provider also agrees not to seek additional reimbursement (e.g., balance-billing) for any services for which the Department's designated third-party administrator has paid the Provider.

4) If the Provider has not received payment for services from the third-party administrator within seventy-five (75) days after the claim was sent to the FBCC regional coordinator, the Provider may submit a duplicate claim to the appropriate FBCC regional coordinator. *If mailed, the duplicate claim must have "Breast and Cervical Cancer Project Duplicate Claim" written in the lower left corner of the envelope.* If the BCCP regional coordinator receives this duplicate claim 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.

5) The Provider agrees not to seek payment from the patient for FBCC authorized services if the third-party administrator has not paid the provider for the authorized services. Any requests for such third party payments must be sought through the Department through the FBCC regional coordinator.

e. To provide his/her/its Federal Tax Identification Number on all claims submitted to the FBCC regional coordinator.

f. To list the Current Procedural Terminology (CPT) codes, patient name, and date of service on all claims.

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 maintain complete records concerning the goods and/or services furnished by the Provider under the FBCC for seven (7) years after they were provided or until any audit is completed and every exception resolved, whichever is longer. The Provider agrees to give copies of these records to the Department, regional FBCC, and/or other appropriate local, state and federal officials upon written request, subject to the limitations specified above.

i. To keep all information strictly confidential concerning the identity of the participants of the FBCC program and to comply with all applicable provisions of state and federal law, including those requirements covered by 45 Code of Federal Regulations (CFR) 164.504(e)(2)(ii)(A) and (B) of the Health Insurance Portability and Accountability Act (HIPAA), regarding confidentiality of information about individuals receiving screening services.

1) 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.

2) 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.

3) 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.

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

5) 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.

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

7) 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.

8) 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.

9) 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 provider to perform employment duties within Florida; and (b) all persons (including subcontractors) assigned by the provider to perform work pursuant to the contract with the state agency.

j. To notify the Department, or designee in writing of any changes in corporate name, tax identification number, address, or status of license to provide services thirty (30) days that such changes occur.

2. The Department agrees to:

   a. Authorize its designated third-party administrator to reimburse the Provider for services rendered to participants in accordance with the rules governing the FBCC. **No funds are directly transmitted by the Department as a result of this MOA.** The Department's role is to assure programmatic compliance and eligibility pursuant to grant terms and applicable laws.

   b. Send the Provider a claims report from the third-party administrator within ten (10) days from the regional coordinator's date of receipt.

   c. Provide technical expertise and support and to assist the Provider in care coordination tracking of program screened women screened through the program with abnormal results.

3. The Department and Provider mutually agree to:

   a. 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 managers or the participants. The State of Florida performance and obligation to pay under this Agreement is subject to an annual appropriation of the legislation.

   b. The term of this MOA is July 1, 2023, or upon execution of both parties, whichever is later, through June 30, 2024, subject to the termination provisions contained in paragraph 3.c of this MOA. At that time the parties may enter into another agreement by renewal agreement the same with terms and conditions not to exceed the term of three (3) years beyond the initial MOA. (June 30, 2024, total period = 3 yrs.) The parties understand and agree that the payment terms agreed in Paragraph 1. c, referencing the current Medicare Part B Reimbursement Schedule, shall be considered the "same terms and conditions," so long as the rate paid shall be Medicare Part B rate in effect at the time of service. The parties may amend Attachment A to reflect changes in current Medicare part B rates at any time that these rates may be changed by Medicare.

   c. This MOA may be terminated by the Department at any time upon at least fifteen (15) days' advance written notice. The Provider may terminate this MOA at any time upon at least thirty (30) days' advance written notice. Notice of termination shall be transmitted by certified mail or personal delivery to the other party and considered effective upon delivery. The Department may terminate this MOA immediately, notwithstanding the advance-notice provisions specified above, if: 1) Section 287.58 of the Florida Statutes is not complied with whereas the Provider refuses to allow public access to all documents, papers, letters, or other material made or received by the Provider in conjunction with the MOA, unless the records are exempt from section 24(a) of Article 1 of the State Constitution and section 119.07(1). 2) The Provider breaches any of the terms or conditions of this MOA; or 3) there is a failure of funding under which the Department funds the FBCC. In no event will the Department be obligated to authorize or pay for any services performed by the Provider after the effective date of termination. Notice to the Department shall be sent to the Regional Coordinator, Breast and Cervical Cancer Program, Department of Health - Hillsborough County, 4704-B West Montgomery Avenue, Tampa, FL 33616. Notice to the Provider will be sent to the Provider's below-referenced address. After sending or receiving notice of termination, the Provider agrees to continue to provide services up to 12:01 a.m. on the effective date of termination.

4. The Provider will not assign any of its rights nor delegate any of its duties and responsibilities under this MOA without prior written consent of the Department. Any assignment or delegation not consented to may be deemed void by the Department.

5. The Provider agrees to maintain a current appropriate license to provide services performed under this MOA.

6. The Department and the Provider agree that in the performance of this MOA, 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 FBCC program pursuant to BCCP 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.

7. If any provision, or portions thereof, of this MOA is invalid under any applicable statute or rule of law, it (or such portions) is to that extent deemed omitted.

8. The Provider also affirms, understands, and agrees to immediately notify the Department of any change or shift in the location(s) of services performed by the Provider or its subcontractors under this MOA.

9. The terms and conditions set forth in this MOA constitute the entire understanding between the parties with respect to the matters contained herein and supersede all prior agreements and representations whether written or oral. This MOA may not be modified except in writing signed by authorized parties.

IN WITNESS WHEREOF, the parties hereto have caused this MOA to be executed by their duly authorized officials.

FLORIDA DEPARTMENT OF HEALTH, HILLSBOROUGH COUNTY HEALTH DEPARTMENT

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Douglas A. Holt, M.D.
Director_____

Title Date

Title Date

To Be Completed By Provider

Signature of Participating Provider or Authorized Agent:	Date:
Print/Type Name of Participating Provider or Authorized Agent: _____ Doing Business As (DBA):	Billing Contact Person: _____ Billing Contact Person Phone/FAX Numbers: ( ) / Fax: ( )
Street Address	Billing Street Address
City, State, Zip / County	City, State, Zip
Provider Phone Number: ( )	Provider Fax Number: ( )
Federal Tax ID Number:	
Provider E-mail Address:	

Services Provided for BCCP 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_____