RESOLUTION NO. 2011-115

RESOLUTION 2011-304 RESCINDS RESOLUTION 2011-115

A RESOLUTION BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, APPROVING THE TERMS, PROVISIONS, CONDITIONS, AND REQUIREMENTS OF AN AGREEMENT BETWEEN THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, AND SHANDS/UNIVERSITY OF FLORIDA HEALTHCARE NETWORK AND AUTHORIZING THE CHAIR OF THE BOARD OF COUNTY COMMISSIONERS TO EXECUTE THE AGREEMENT ON BEHALF OF THE COUNTY

WHEREAS, Section 125.01(1)(e), Florida Statutes, authorizes County to provide health welfare programs for the residents of St. Johns County to the extent not inconsistent with general or special law; and

WHEREAS, County has established a variety of program for providing healthcare services to the uninsured, underinsured and medically indigent residents of the County; and;

WHEREAS, County desires to contract with Shands and its physicians to provide health care services when such services are not available within St. Johns County; and

WHEREAS, Shands is willing to provide such services, subject to the terms and conditions set forth in the agreement.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, AS FOLLOWS:

Section 1. The above Recitals are hereby incorporated into the body of this Resolution, and are adopted as Findings of Fact.

Section 2. The Board of County Commissioners hereby approves the terms, provisions, conditions, and requirements of the Agreement between St. Johns County and Shands/University of Florida Health Care Network for the provision of medical treatment and physician services for eligible clients of the County Social Services Medical Assistance Program, and authorizes the Chair of the Board of County Commissioners of St. Johns County, Florida to execute the Agreement on behalf of the County.

Section 3. To the extent that there are typographical and/or administrative errors and/or omissions that do not change the tone, tenor, or concept of this Resolution, then this Resolution may be revised without subsequent approval of the Board of County Commissioners.

PASSED AND ADOPTED by the Board of County Commissioners of St. Johns County, Florida, this 3rd day of ~~April,~~ May 2011.

BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA

Attest:
Cheryl Strickland
Clerk of The Court

By: Pam Halterman
Deputy Clerk

By:

Chair

RENDITION DATE 5/5/11

LETTER OF AGREEMENT
Patient Specific "In-Network" Authorization

This Letter of Agreement ("LOA") is entered into effective as of ,("Effective Date") by and between Shands Teaching Hospital and Clinics, Inc. ("Shands"), d/b/a Shands and University of Florida Health Care Network ("SUFHCN") comprised of Shands' Hospitals and Facilities ("Hospital"), and specified Shands and University of Florida Physicians, Health Professionals, and Physician Extenders ("Providers"), and **ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS** ("Payor") and in consideration of the mutual covenants and conditions set forth herein, the sufficiency of which is hereby acknowledged, the parties agree as follows:

1) The parties agree that Hospital/Provider do not participate in Payor's provider network, and are "out of network" providers. However, in recognition of the special needs of the below identified patient ("Patient"), Payor and SUFHCN agree to enter into this patient specific arrangement, and Payor agrees to authorize Patient to access the services of Hospital/Provider at "in-network" coverage levels. Accordingly, Payor agrees (1) to timely compensate Hospital/Provider for such services at the rates described herein, (2) to reimburse Hospital/Provider at in-network coverage levels with respect to Benefit Plan coverages for all services provided to Patient under this LOA, and (3) to set Patient's financial responsibility to Hospital/Provider at in-network coverage levels.

2) The arrangement described herein shall be applicable only to the below Patient and Payor for authorized services covered by Patient's Benefit Plan, as described in Section 3 below, which are provided on or after the Effective Date of this LOA. Patient must initiate initial access to services prior to the Expiration Date of this LOA.

- Patient:
- SS#:
- DOB:
- MRN:
- Payor: ST. JOHNS COUNTY BOARD OF COMMISSIONERS
- Payor Product:
- Policy #:
- Insured's Name/ID #:
- Effective Date:
- Expiration Date:

(unless extended as described in Attachment 1)

3) Payor requests and authorizes Hospital/Provider to provide to Patient the services described in Attachment 1, and Payor shall compensate Hospital/Provider for such services as specified therein, subject to Patient's continued eligibility under, and any benefit and/or coverage limitations described in Patient's Benefit Plan, as described in Attachment 2. All changes in eligibility and benefits and/or coverage limitations shall be identified and disclosed by Payor prior to the initiation of services hereunder. Payor shall provide an initial claims authorization number for Hospital/Provider to include when filing claims (or shall provide SUFHCN with an alternative verification mechanism), and will work with SUFHCN in coordinating Patient's care. Except in the case of an emergency or urgently needed services, if Patient requires services in addition to those described in Attachment 1, Hospital/Provider will use best efforts to coordinate further authorization and/or referral for services with Payor. Hospital shall seek and obtain Payor's authorization to provide the services described herein prior to the time such services are to be provided. In conjunction with Hospital/Provider's request for such prior authorization, Payor shall verify Patient's continued eligibility and entitlement to receive such services under Patient's Benefit Plan, and shall verify and/or disclose any benefit and coverage limitations. The terms of

this LOA will continue to apply to each subsequent authorization. Payor shall be financially liable for emergency and urgently needed services in accord with applicable Florida or federal law.

4) Hospital/Provider will submit claims to Payor on standard HCFA 1500 or UB 92 claim forms, unless the parties agree otherwise. Payor shall process and pay all completed and uncontested claims or the uncontested portions of such claims within thirty five (35) days of receipt. If Payor contests a claim or requires additional information in order to process a claim, Payor shall request additional information within thirty five (35) days of receipt of Hospital/Provider's claim form, and shall pay or deny such claim within forty five (45) days of the receipt of such additional information. In any event, Payor shall pay or deny the claim no later than one hundred twenty (120) days after the date the initial claim was submitted. The discounted fee for service rates, if any, described in Attachment 1 shall revert to one hundred percent (100%) of billed charges[1] (subject to Florida or federal law to the contrary) if Payor fails to timely pay claims as described herein. In all cases, Payor shall pay simple interest on overdue claims, which shall accrue from the date the claim is declared overdue until the date paid, at the greater of twelve percent (12%) or the statutory rate in effect at the time payment is made.

5) Hospital/Provider shall accept the rates described in Attachment 1, less applicable co-payments, co-insurance and/or deductibles, as payment in full from Payor for the services described in Attachment 1 and for services subsequently authorized by Payor, and Hospital/Provider agree not to bill Patient for services addressed in this LOA which are the financial responsibility of Payor. However, Hospital/Provider shall be entitled to bill Patient for services which are not addressed in this LOA or for which Payor denies payment, provided that Hospital/Provider so advise Patient in advance, and Patient agrees in writing to be financially responsible for such services.

6) This LOA shall be governed by and construed in accordance with the laws of the State of Florida, unless pre-empted by federal law. The parties agree to comply with all Florida and federal laws, rules, and regulations applicable to this LOA, and with any applicable changes to same which may govern this LOA. If any provision of this LOA is determined to conflict with applicable Florida or federal laws, rules, and regulations, this LOA shall be automatically modified to effect compliance, or such non-complying provision shall be severed from the remainder of this LOA. The invalidity or unenforceability of any provision hereof shall in no way affect the validity or enforceability of any other provision of this LOA.

7) By signature below, each signatory represents and warrants that he/she is duly authorized to enter into this LOA on the respective party's behalf, and is duly authorized to bind such party to the terms herein applicable to each. This LOA shall not be binding on either party unless so executed. Payor, or Payor's authorized representative, may provide subsequent service authorization, as described in Section 3 herein, by mail or facsimile, or as mutually agreed upon by the parties.

8) This LOA shall be effective as of the Effective Date and shall terminate on the sooner of (a) the above Expiration Date (or as extended by mutual agreement in order to complete the course of treatment, consistent with the Patient's best interests), or (b) when the Patient is no longer eligible for coverage under the Benefit Plan. Notwithstanding (b) above, Hospital/provider will be protected for payment for services provided that they were authorized and verified by Payor as covered services for an eligible plan member. If Payor's failure to relay timely or accurate benefit eligibility status to Hospital/Provider results in Hospital/Provider not having secured financial consent of Patient and/or not having secured authorization of another payor, and this results in denial of payment to Hospital/Provider, then Hospital/Provider will bill Payor at rates set out in

[1] Billed charges are the charges Hospital/Provider customarily charge for a specified health care service; such charges are not dependent upon a governmental or payor established fee schedule.

attached fee schedule, and Payor will make timely payment for those services

9) This terms of this LOA are contingent upon Payor's execution of and SUFHCN's receipt of this LOA prior to the Effective Date, unless timely receipt is waived by SUFHCN, as evidenced by SUFHCN representative's execution of this LOA.

10) All requests for copies of medical/clinical or other applicable records shall be subject to compliance with applicable laws, rules, and regulations governing confidentiality of such information, and to requirements otherwise set forth in this Agreement. The requesting party shall bear the cost of making paper copies at the rate of one dollar ($1.00) per page, plus tax, and transmittal expense, and the cost of making non-paper copies (i.e., micro fiche, X-rays, etc.), plus tax, and transmittal expense.

IN WITNESS WHEREOF, the parties have executed this LOA effective as of the Effective Date.

Payor

Authorized Signature:

By:_____
Date

Shands Teaching Hospital and Clinics, Inc., d/b/a Shands and University of Florida HealthCare Network

By:_____
Michael S. Lawton Date
VP, Managed Care & Network Development

Send Notices For Payor To:
St. Johns County HHS/ Social Services
Attn: Susan MacLean
1955 US 1 South, Suite D-9
St. Augustine, FL 32086

FAX: 904-209-6141
PH: 904-209-6147
smaclean@sicfl.us

Claims Mgmt
Contact Person: Same as above
Claims Address: Same as above

Send Notices For SUFHCN To:
Dawn M. Fitch
Contract Manager
PO Box 103574
Gainesville, Florida 32610-3574

FAX: 352-265-7212
PH: 352-265-0680 ext 85999

Attachment 1 To
Letter of Agreement
Patient Specific "In-Network" Authorization
Applicable Services and Rates
Effective Date:

1) Patient Information:
   - Patient:
   - SS#:
   - DOB:
   - MRN:
   - Payor: ST. JOHNS COUNTY BOARD OF COMMISSIONERS
   - Payor Product:
   - Policy #:
   - Insured's Name/ID #:
   - Effective Date:
   - Expiration Date:

Date range under initial authorization
Subject to modification as set out below.

The duration of this LOA shall initially be co-terminus with the initial authorization. If a new authorization is given such that it authorizes a continuation of or different inpatient and/or outpatient treatments for Patient under a continued plan of treatment, then the terms and conditions of this LOA shall apply for the duration of all associated authorizations.

2) The following services shall be made available to Patient as described in the LOA, at the below specified rates. Such services shall include diagnostic and clinical laboratory services reasonably necessary to provide the specified services:

3) Payment for the above specified services and other services authorized by Payor shall be in accord with the following.

Entity	Rates	Tax ID #s
Provider University of Florida	100% of Shands MEDICAID RATE[2] College of Medicine	59-1680273
Hospital Shands at UF	To be paid under HCRA (see attached form) 100% of Shands MEDICAID RATE[3] for all services not covered by HCRA	59-1943502

AUTHORIZATION: _____ **CONTACT:** _____

[2] Shands Jacksonville Florida Medicaid rate effective for date of service.

[3] Shands Jacksonville Florida Medicaid rate effective for date of service.

Attachment 2
To Letter of Agreement
Patient Specific "In-Network" Authorization

Benefit Plan

Effective Date:

1. Patient Information:

- Patient:
- SS#:
- DOB:
- MRN:
- Payor: ST. JOHNS COUNTY BOARD OF COMMISSIONERS
- Payor Product:
- Policy #:
- Insured's Name/ID #:
- Effective Date:
- Expiration Date:

2. As of the date of execution of this Agreement, the Benefit Plan and all Benefit Limitations are set out below. Payor represents that such Benefit Plan coverages and limitations reflect in-network coverage levels.

- Percent of coverage: _____
- Deductible: _____
- Annual Maximum: _____
- Lifetime Maximum: _____
- Coverage Limitations: _____
- Coverage Exclusions: _____

3. Any subsequent changes to Benefit Plan and Benefit Limitations will be communicated to Hospital in writing prior to provision of services and/or at time of authorization of services.

SHANDS HealthCare

Managed Care
PO Box 103574
Gainesville, FL 32610
Phone: (352) 265-8046 ext 8-5999
Fax (352) 265-7212
Dawn M. Fitch
Contract Manager
Email: fitchd@shands.ufl.edu

To:	Susan MacLean	Phone:	904-209-6147
Company	St. Johns County	Fax:	904-209-6141
From:	Dawn M. Fitch	Date:	1-18-11
Re:		Pages:	6
CC:			

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Comments:

Per our conversation, please sign and return to me. Thank you!