UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA and STATES OF FLORIDA, GEORGIA, ILLINOIS, and NEW YORK ex rel. KIRK CIANCIOLO, KAREN ROSS, CIRCE LOPEZ, SANDRA BROWER, KRISTI KING and ALYSON SCOTT f/k/a ALYSON BROXTON,

Plaintiffs

v.

WELLCARE HEALTH PLANS, INC.

Defendants

_____/

CASE NO.

8:13 CV 1377 T 30 EAJ

FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2) DO NOT PLACE IN PRESS BOX OR ENTER ON PACER

FALSE CLAIMS ACT COMPLAINT AND DEMAND FOR JURY TRIAL

INTRODUCTION

1. Relators Kirk Cianciolo, Karen Ross, Circe Lopez, Sandra Brower, Kristi King and Alyson Scott f/k/a Alyson Broxton bring this action on behalf of the United States of America and the States of Florida, Georgia, Illinois and New York against Defendants WellCare Health Plans, Inc. for treble damages and civil penalties for the Defendant's violations of the False Claims Act, 31 U.S.C. § 3729 *et seq.*, and State False Claims Acts and for the Defendant's retaliatory discharges of Relators in violation of 31 U.S.C. § 3730(h).

2. Prior to filing this Complaint, pursuant to 31 U.S.C. § 3730(b)(2) and § 3730(c)(4)(B), Relators have provided to the Attorney General of the United States, to the United States Attorney for the Middle District of Florida and to the Attorney Generals of the Plaintiff States and the Chief Financial Officer of the State of Florida a written disclosure of substantially all material evidence and information they possess. Because the disclosure statement includes

NRA 17553
$ 400

attorney-client communications and work product of Relators' attorneys, and is submitted to the Attorney General, to the United States Attorney, and the Plaintiff States in their capacity as potential co-counsel in this litigation, Relators understand this disclosure to be confidential.

JURISDICTION AND VENUE

3. This action arises under the False Claims Act, 31 U.S.C. §3729 *et seq.* This Court has jurisdiction over this case pursuant to 31 U.S.C. §3732(a) and § 3730(b), as well as 28 U.S.C. §1345 and §1331.

4. Venue is proper in this district pursuant to 31 U.S.C. §3732(a), because some of the acts proscribed by 31 U.S.C. §3729 *et seq.* and complained of herein took place in this district, and is also proper pursuant to 28 U.S.C. §1391(b) and (c) because at all relevant times Defendant transacted business in this district.

PARTIES

5. Relator Kirk Cianciolo, D.O. was Vice President of Care Management from April 18, 2011 until he was fired on December 3, 2012.

6. Relator Karen Ross was Vice President of Clinical Management from July 18, 2011 until she was fired on December 3, 2012. Ms. Ross reported to Dr. Cianciolo.

7. Relator Circe Lopez was Director of Utilization Management from October 31, 2011 until she was fired on December 3, 2012. Ms. Lopez reported to Karen Ross.

8. Relator Sandra Brower was Senior Director of Training/Compliance from January 16, 2012 until she was fired on December 3, 2012. Ms. Brower reported to Dr. Cianciolo.

9. Relator Kristi King was Senior Manager of Analytics from November 28, 2011 until she was fired on December 3, 2012. Ms. King reported to Karen Ross.

10. Relator Alyson Scott f/k/a Alyson Broxton was Project Analyst from August 14, 2006 until she was fired on December 3, 2012. Ms. Scott reported to Circe Lopez.

11. Relators are "original sources" under 31 U.S.C. § 3730(e)(4)(B), but state that to their knowledge the information contained herein concerning Defendant's False Claims Act violation has not been publicly disclosed.

12. WellCare Health Plans, Inc. is a Tampa-based health maintenance organization (HMO) which operates Medicare and Medicaid HMO plans in various states around the nation. This means that WellCare is paid a capitated rate per member per month by CMS to provide for the health care needs of its Medicare beneficiaries who are enrolled as members of WellCare Medicare Advantage HMO plans. WellCare is also paid capitated rates per member per month by state Medicaid programs to provide for the health care needs of their Medicaid recipients who are enrolled as members of WellCare Medicaid HMO plans. Similarly, WellCare is paid capitated rates per member per month by the Florida Healthy Kids program to provide for the health care needs of eligible beneficiaries.

WELLCARE'S CONTRACTUAL OBLIGATIONS UNDER ITS MEDICARE ADVANTAGE CONTRACTS, ITS MEDICAID CONTRACTS AND ITS FLORIDA HEALTHY KIDS CONTRACT

13. As a Medicare Advantage (MA) organization, WellCare is bound by 42 CFR 422.504, which lists "the following provisions" that "[t]he contract between the MA [Medicare Advantage] organization and CMS must contain." **Exhibit 1**. Section 522.504(a) provides that "t]he MA organization agrees to comply with all the applicable requirements and conditions set forth in this part." It further provides that "[a]n MA organization's compliance with paragraphs (a)(1) through (a)(13) of this section is material to performance of the contract."

14. Section 522.504(a)(3)(iii) requires Medicare Advantage organizations "[t]o provide -- [i]n a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare." This means that WellCare was contractually required to provide Medicare covered services to its Medicare Advantage members "in a manner consistent with professionally recognized standards of health care." Moreover, this requirement is deemed by Section 522.504(a) to be "material to performance of the contract." In order to implement this material contractual requirement, WellCare requires that providers must "provide Covered Services in a manner consistent with professionally recognized standards of health care." WellCare's 2012 Medicare Advantage Provider Manual, at 4 (citing 42 CFR § 422.504(a)(3)(iii), attached as **Exhibit 2**.

15. Similarly, state Medicaid programs reimburse WellCare for providing "medically necessary" services. State laws require WellCare to provide Medicaid recipients which medically necessary services which are "consistent with generally accepted professional medical standards as determined by the Medicaid program." Florida Administrative Code Rule 59G-1.010(166), attached as **Exhibit 3**. State Medicaid programs incorporated this requirement into their Medicaid HMO contracts with WellCare. For example, WellCare's Staywell Medicaid contract with the Florida Agency for Health Care Administration (Contract FA971) limited WellCare's obligation to provide "covered services" to its members to medically necessary services. Contract FA971, Section VA (Covered Services), attached as **Exhibit 4**. In turn, that contract defines medically necessary services as those "consistent with the generally accepted professional medical standards as determined by the Medicaid program." Contract FA971, Section I (Definitions). *Id.* WellCare in turn requires the providers who agree to provide medical services to its members to agree to provide "medically necessary" services, which are

further defined as "services that are ... compatible with the standards of acceptable medical practice in the community." 2013 WellCare Georgia Medicaid Provider Handbook at 43, 120 attached as **Exhibit 5**.

16. WellCare also provides comprehensive medical services to eligible beneficiaries of the Florida Healthy Kids Program, which is funded by the State of Florida. Under this contract, the length of inpatient hospital stays "shall be determined based on the medical condition of the Enrollee in relation to the necessary and appropriate level of care." October 1, 2012 WellCare-Florida Healthy Kids contract at 64, attached as **Exhibit 6**.

WELLCARE'S INTENTIONAL VIOLATIONS OF ITS REGULATORY AND CONTRACTUAL OBLIGATIONS

17. In WellCare, only a medical director (who is a doctor) can deny services to a member for reasons of lack of medical necessity.

18. In 2010, WellCare changed its accreditation from URAC to NCQA. Under the NCQA system, WellCare was required to make hospital admission decisions on medical necessity within 24 hours of getting clinical information, which includes the patient's diagnosis. Under the prior URAC system, WellCare did not have to make hospital admission decisions on medical necessity for up to 72 hours and did not consider diagnosis code sufficient clinical information on which to make an admission decision.

19. WellCare's inpatient hospital denial rate was 11-14 percent in 2011. However, as the Relators began implementing the NCQA changes in 2011-12, the inpatient hospital denial rate began decreasing to approximately 2 percent, the industry average, in November 2012. This was because admissions that historically had been denied because the provider had supplied only the diagnosis code were now no longer being denied.

20. The Relators' implementation of the NCQA changes caused friction within WellCare. In January 2012, Dr. Amy Tunidias, one of four medical directors who worked under Relator Dr. Kirk Cianciolo, told Relator Circe Lopez that the NCQA driven changes were going to "ruin WellCare financially." Dr. Tunidias added that the medical directors "are in charge of financial goals related to utilization management and the changes will impact bonuses." Relator Lopez replied that "UM [utilization management] decisions are based on medical appropriateness, not driven by financial goals."

21. In September 2012, Tom Tran, WellCare's CFO, and VP Finance Don Zang, instructed VP Finance Larry Smart to begin generating a daily denial rate report.

22. At a meeting in October-November 2012, Relator Dr. Kirk Cianciolo presented the results of a literature search that supported an expected inpatient denial rate of 2 percent to Tom Tran and Don Zang. Tran replied "I don't give a damn about national statistics; we are losing too much money and must increase our denial rates to rates seen in 2011."

23. On October 1, 2012, Medical Director Dr. Milo Jaminez confronted Non-Clinical Supervisor Amie Concepcion to ask "how can we get those three amigos?", referring to Relators Dr. Cianciolo, Circe Lopez, and Karen Ross. Dr. Jaminez wanted to know if there were any memos or emails that would implicate "them."

24. On November 5, 2012, Relators Dr. Cianciolo, Circe Lopez, Sandra Brower, and Kristi King met with Larry Smart, Diane Norcross (Senior Manager of Compliance), Dr. Tracy Ferguson (Medical Director), Michelle Mock (VP Non-Clinical Health Services), and Faustino Mayo (Senior Director of Appeals and Grievances). Larry Smart said "We have do something, we are bleeding everywhere."

25. In a meeting in mid-November 2012, Tom Tran directly told Relator Dr. Kirk Cianciolo that Dr. Cianciolo needed to be "Dr. No" and increase inpatient denial rates in the second half of November. Dr. Cianciolo replied that Tran had the wrong guy if that was what he expected. Dr. Cianciolo explained that he would do what was medically and clinically appropriate. Chief Administrative Officer Walt Cooper and Dan Paquin (President of National Sales) were present for this discussion.

26. Subsequent to this meeting, Tran, Cooper and CEO Alec Cunningham assigned Al Smith, medical director for pharmacy, to review the inpatient authorization process. On November 27, 2012, Al Smith met with Relator Karen Ross. Smith asked "how the denial rate got so low." Ms. Ross told Smith that the utilization management team does not "manage by denial rate."

27. On November 12, 2012, Walt Cooper met with Dr. Cianciolo to review the inpatient authorization process and discuss how denial rates could be increased. Cooper requested daily denial rate reports. After this, Dr. Cianciolo sent daily denial rate reports to both Cooper and Paquin. Both Cooper and Paquin asked Dr. Cianciolo how denial rates can be increased faster. Cooper and Paquin also said that CEO Alec Cunningham had asked how to deal with the denial rate problem.

28. At a meeting just prior to Thanksgiving 2012, Larry Smart stated that the good news with increasing the inpatient denial rate was that although a percentage of these denials would be overturned on appeal, a percentage of them also would not because providers would determine that it was not worth appealing the denial of care.

29. On November 30, 2012, during a Florida and Georgia cost of care meeting, Larry Smart said inpatient denial rates are increasing and this is what we want. Smart noted that some hospitals would not appeal such denials.

30. Medical directors Tracy Ferguson MD, Milo Jaminez MD, and Amy Tunidias DO rejected instructions from Relator Karen Ross, VP of Clinical Management, and from Relator Dr. Kirk Cianciolo, VP of Care Management, to follow Medicaid guidelines for medical necessity determinations. Ms. Ross and Dr. Cianciolo brought these refusals to the attention of WellCare Compliance Officer Blair Todt.

31. Based on pressure from WellCare management, the inpatient denial rate began to rise in the fall of 2012 until it reached approximately 8 percent in the last half of November 2012. Tom Tran, Larry Smart, Walt Cooper and Don Zhang were elated by this increase. WellCare's illegal scheme to raise inpatient denial rates without regard to medical necessity affected its Medicare and Medicaid members in Florida, Georgia, Kentucky, Missouri, Illinois, New York and Ohio.

32. During 2012, all Relators resisted directions from WellCare management to artificially restrict and limit inpatient hospital admissions based on criteria other than medical necessity.

COUNT I

PRESENTING FALSE AND FRAUDULENT CLAIMS IN VIOLATION OF 31 U.S.C. § 3729(a)(1)(A); FLORIDA STATUTE 68.082(2)(a); GEORGIA CODE ANN. § 49-4-168.1(a)(1); 740 ILLINOIS COMPILED STATUTES ANNOTATED 175/3 § 3(a)(1)(A); MCKINNEY'S NEW YORK STATE FINANCE LAW § 189(1)(a)

33. Relators reallege and incorporate by reference paragraphs 1 through 32.

34. From at least 2012 to the present, and continuing on an ongoing basis, Defendant knowingly presented, and caused to be presented, false and fraudulent claims for payment or

approval to the Medicare program and to Medicaid programs for the states of Florida, Georgia, Illinois, New York, Ohio, Kentucky and Missouri by submitting claims for per member/per month capitated payments while WellCare was not providing medical services to its members based on the contractually required and statutorily required medical necessity standard. By submitting these claims, WellCare made implied certifications that it was in compliance with a material condition of payment -- that is, that WellCare was in fact providing medical services to its Medicare and Medicaid members based on the contractually required and statutorily required medical necessity standard -- when in fact WellCare knew that was not the case.

35. From at least 2012 to the present, and continuing on an ongoing basis, Defendant knowingly presented, and caused to be presented, false and fraudulent claims for payment or approval to the Medicare program and to Medicaid programs for the states of Florida, Georgia, Illinois, New York, Ohio, Kentucky, and Missouri because those claims were the result of fraudulently induced Medicare Advantage contracts, state Medicaid contracts and a Florida Healthy Kids contract which WellCare obtained by promising to provide medical services based on the contractually required and statutorily required medical necessity standard while having no intention of complying with that standard.

COUNT II

CONCEALING AND AVOIDING OBLIGATIONS TO PAY OR TRANSMIT MONEY TO THE MEDICARE PROGRAM AND MEDICAID PROGRAMS IN VIOLATION OF 31 U.S.C. § 3729(a)(1)(G); FLORIDA STATUTE 68.082(2)(g); GEORGIA CODE ANN. § 49-4-168.1(a)(7); 740 ILLINOIS COMPILED STATUTES ANNOTATED 175/3 § 3(a)(1)(G); MCKINNEY'S NEW YORK STATE FINANCE LAW § 189(1)(g)

36. Relators reallege and incorporate by reference paragraphs 1 through 32.

37. From at least 2012 to the present, and continuing on an ongoing basis, Defendant knowingly concealed and knowingly and improperly avoided obligations to pay overpayments

back to the Medicare program and to state Medicaid programs for the states of Florida, Georgia, Illinois, New York, Ohio, Kentucky, and Missouri. Specifically, WellCare knew it was being paid per member/per month capitated payments to provide medically necessary services to its members, but also knew that it was not in fact providing all medically necessary inpatient hospital services.

COUNT III

RETALIATORY DISCHARGE IN VIOLATION OF 31 U.S.C. § 3730(h)

38. Relators reallege and incorporate by reference paragraphs 1 through 32.

39. Relators' actions alleged in paragraphs 17-32 are sufficient to support a reasonable conclusion that Defendant could have feared being reported to the government for fraud or sued in a False Claims Act qui tam action by Relators.

40. On December 3, 2012, all Relators were fired summarily because of lawful acts done by the Relators or associated others in furtherance of a False Claims Act action or other efforts to stop one or more False Claims Act violations.

PRAYER FOR RELIEF

WHEREFORE, Relators respectfully request this Court enter judgment against Defendant and order:

(a) That the United States and the Plaintiff States be awarded damages in the amount of three times the damages sustained by the United States because of the false and fraudulent claims alleged within this Complaint, as the False Claims Act, 31 U.S.C. § 3729, and the False Claims Acts of the Plaintiff States provide;

(b) That maximum civil penalties be imposed for each and every false and fraudulent claim that Defendant presented to the United States and the Plaintiff States;

(c) That pre and post-judgment interest be awarded, along with reasonable attorneys' fees, costs and expenses which Relators necessarily incurred in bringing and pressing this case;

(d) That the Court grant permanent injunctive relief to prevent any recurrence of the False Claims Act violations for which redress is sought in this Complaint;

(e) That the Relators be awarded the maximum relator share allowed pursuant to the False Claims Act and the False Claims Acts of the Plaintiff States;

(f) That the Relators be awarded two times the amount of back pay, interest on the back pay, reinstatement with the same seniority status Relators would have had, and compensation for any special damages sustained, including litigation costs and reasonable attorneys' fees; and

(g) That the Court award such other and further relief as it deems proper.

DEMAND FOR JURY TRIAL

Relators, on behalf of themselves, the United States and the Plaintiff States, demand a jury trial on all claims alleged herein.

Respectfully submitted,

Kevin J. Darken
Florida Bar No. 0090956
kdarken@tampalawfirm.com
THE COHEN LAW GROUP
201 East Kennedy Boulevard, Ste 1000
Tampa, Florida 33602
Telephone: (813) 225-1655
Facsimile: (813) 225-1921
Counsel for *Qui Tam* Relators

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing *False Claims Act Complaint* has been furnished by hand delivery to: **Robert O'Neill**, United States Attorney, United States Attorney's Office, 400 N. Tampa Street, Ste 3200, Tampa, FL 33602; and by Federal Express to **Eric Holder**, United States Attorney General, Dept. of Justice, 950 Pennsylvania Ave., N.W., Washington, D.C. 20530-001, Florida Attorney General **Pam Bondi**, Office of Attorney General, State of Florida, The Capitol PL-01, Tallahassee, FL 32399-1050, Georgia Attorney General **Sam Olens**, Office of the Attorney General, 40 Capitol Square, SW, Atlanta, GA 30334, Illinois Attorney General **Lisa Madigan**, Chicago Main Office, 100 West Randolph Street, Chicago, IL 60601, New York Attorney General **Eric Schneiderman**, Office of the Attorney General, The Capitol, Albany, NY 12224-0341 and Florida Chief Financial Officer **Jeff Atwater**, 200 East Gaines Street, Tallahassee FL 32399 on this 23rd day of May 2013.

Kevin J. Darken

Exhibit 1

42 CFR 422.504 - Contract provisions.

There are 2 Updates appearing in the Federal Register for 42 CFR 422. Select the tab below to view.

CFR Updates Authorities (U.S. Code) Rulemaking

prev | next

Medicare Advantage regulations

§ 422.504
Contract provisions.

The contract between the MA organization and CMS must contain the following provisions:

(a) **Agreement to comply with regulations and instructions.** The MA organization agrees to comply with all the applicable requirements and conditions set forth in this part and in general instructions. An MA organization's compliance with paragraphs (a)(1) through (a)(13) of this section is material to performance of the contract. The MA organization agrees—

(1) To accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of this part.

(2) That it will comply with the prohibition in § 422.110 on discrimination in beneficiary enrollment.

(3) To provide—

(i) The basic benefits as required under § 422.101 and, to the extent applicable, supplemental benefits under § 422.102; and

(ii) Access to benefits as required under subpart C of this part;

(iii) In a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.

(4) To disclose information to beneficiaries in the manner and the form prescribed by CMS as required under § 422.111 ;

(5) To operate a quality assurance and performance improvement program and have an agreement for external quality review as required under subpart D of this part;

(6) To comply with all applicable provider requirements in subpart E of this part, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans;

(7) To comply with all requirements in subpart M of this part governing coverage determinations, grievances, and appeals;

(8) To comply with the reporting requirements in § 422.516 and the requirements in § 422.310 for submitting data to CMS;

(9) That it will be paid under the contract in accordance with the payment rules in subpart G of this part;

(10) To develop its annual bid, and submit all required information on premiums,

benefits, and cost-sharing by not later than the first Monday in June, as provided in subpart F of this part;

(11) That its contract may not be renewed or may be terminated in accordance with this subpart and subpart N of this part.

(12) To comply with all requirements that are specific to a particular type of MA plan, such as the special rules for private fee-for-service plans in §§ 422.114 and 422.216 and the MSA requirements in §§ 422.56, 422.103, and 422.262; and

(13) To comply with the confidentiality and enrollee record accuracy requirements in § 422.118.

(14) Maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities).

(15) Address complaints received by CMS against the MAO by—

(i) Addressing and resolving complaints in the CMS complaint tracking system.

(ii) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.

(16) An MA organization's compliance with paragraphs (a)(1) through (15) and (c) of this section is material to performance of the contract.

(b) Communication with CMS. The MA organization must have the capacity to communicate with CMS electronically.

(c) Prompt payment. The MA organization must comply with the prompt payment provisions of § 422.520 and with instructions issued by CMS, as they apply to each type of plan included in the contract.

(d) Maintenance of records. The MA organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that—

(1) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the bid) of MA organizations.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the organization.

(iii) Enable CMS to audit and inspect any books and records of the MA organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the bid proposal.

(v) Establish component rates of the bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(2) Include at least records of the following:

(i) Ownership and operation of the MA organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and 10 prior periods.

(iii) Federal income tax or informational returns for the current contract period and 10 prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts, and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities.

(e) **Access to facilities and records.** The MA organization agrees to the following:

(1) HHS, the Comptroller General, or their designee may evaluate, through inspection, audit, or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) Compliance with CMS requirements for maintaining the privacy and security of protected health information and other personally identifiable information of Medicare enrollees;

(iii) The facilities of the MA organization to include computer and other electronic systems; and

(iv) The enrollment and disenrollment records for the current contract period and 10 prior periods.

(2) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the MA organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(3) The MA organization agrees to make available, for the purposes specified in paragraph (d) of this section, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require.

(4) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the end of the final contract period or completion of audit, whichever is later unless—

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or allegation of fraud or similar fault by the MA organization, in which case the retention may be extended to 6 years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or

(iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit the MA organization at any time.

(f) **Disclosure of information.** The MA organization agrees to submit—

(1) To CMS, certified financial information that must include the following:

(i) Such information as CMS may require demonstrating that the organization has a fiscally sound operation.

(ii) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA organization.

(2) To CMS, all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(i) The benefits covered under an MA plan;

(ii) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the MA monthly MSA premium.

(iii) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(iv) Plan quality and performance indicators for the benefits under the plan including—

(A) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(B) Information on Medicare enrollee satisfaction;

(C) Information on health outcomes;

(D) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(E) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(v) Information about beneficiary appeals and their disposition;

(vi) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(vii) To CMS, any other information deemed necessary by CMS for the administration or evaluation of the Medicare program.

(3) To its enrollees all informational requirements under § 422.64 and, upon an enrollee's, request the financial disclosure information required under § 422.516.

(g) **Beneficiary financial protections.** The MA organization agrees to comply with the following requirements:

(1) Effective January 1, 2010, each MA organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability (for example, as a result of an organization's insolvency or other financial difficulties) for payment of any fees that are the legal obligation of the MA organization. To meet this requirement, the MA organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the organization's providers from holding any enrollee liable for payment of any such fees;

(ii) Indemnify the enrollee for payment of any fees that are the legal obligation of the MA organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA organization, to provide services to the organization's enrollees; and

(iii) For all MA organizations with enrollees eligible for both Medicare and Medicaid, specify in contracts with providers that such enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts, and inform providers of Medicare and Medicaid benefits, and rules for enrollees eligible for Medicare and Medicaid. The MA plans may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. The contracts must state that providers will—

(A) Accept the MA plan payment as payment in full, or

(B) Bill the appropriate State source.

(2) The MA organization must provide for continuation of enrollee health care benefits—

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of an insolvency, through discharge.

(3) In meeting the requirements of this paragraph, other than the provider contract requirements specified in paragraph (g)(1)(i) of this section, the MA organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS.

(h) Requirements of other laws and regulations. The MA organization agrees to comply with-

(1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and

(2) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

(i) MA organization relationship with first tier, downstream, and related entities. (1) Notwithstanding any relationship(s) that the MA organization may have with first tier, downstream, and related entities, the MA organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS.

(2) The MA organization agrees to require all first tier, downstream, and related entities to agree that—

(i) HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with the MA organization.

(ii) HHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(3) All contracts or written arrangements between MA organizations and first tier, downstream, and related entities must contain the following:

(i) Enrollee protection provisions that provide, consistent with paragraph (g)(1) of this section, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the obligation of the MA organization.

(ii) Accountability provisions that indicate that the MA organization may only delegate activities or functions to a first tier, downstream, or related entity, in a manner consistent with the requirements set forth at paragraph (i)(4) of this section.

(iii) A provision requiring that any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement are consistent and comply with the MA organization's contractual obligations.

(4) If any of the MA organizations' activities or responsibilities under its contract with CMS are delegated to other parties, the following requirements apply to any first tier, downstream and related entity:

(i) Written arrangements must specify delegated activities and reporting responsibilities.

(ii) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) Written arrangements must specify that the performance of the parties is monitored by the MA organization on an ongoing basis.

(iv) Written arrangements must specify that either—

(A) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization; or

(B) The credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

(v) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions.

(5) If the MA organization delegates selection of the providers, contractors, or subcontractor to another organization, the MA organization's written arrangements with that organization must state that the CMS-contracting MA organization retains the right to approve, suspend, or terminate any such arrangement.

(j) **Additional contract terms.** The MA organization agrees to include in the contract such other terms and conditions as CMS may find necessary and appropriate in order to implement requirements in this part.

(k) **Severability of contracts.** The contract must provide that, upon CMS's request—

(1) The contract will be amended to exclude any MA plan or State-licensed entity specified by CMS; and

(2) A separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made.

(l) **Certification of data that determine payment.** As a condition for receiving a monthly payment under subpart G of this part, the MA organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment information, encounter data, and other information that CMS may specify.

(1) The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful.

(2) The CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the data it submits under § 422.310 are accurate, complete, and truthful.

(3) If such data are generated by a related entity, contractor, or subcontractor of an MA organization, such entity, contractor, or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

(4) The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the information in its bid submission is accurate, complete, and truthful and fully conforms to the requirements in § 422.254.

(m) (1) CMS may determine that an MA organization is out of compliance with a Part C

requirement when the organization fails to meet performance standards articulated in the Part C statutes, regulations, or guidance.

(2) If CMS has not already articulated a measure for determining noncompliance, CMS may determine that a MA organization is out of compliance when its performance in fulfilling Part C requirements represents an outlier relative to the performance of other MA organizations.

(n) Release of summary CMS payment data. The contract must provide that the MA organization acknowledges that CMS releases to the public summary reconciled CMS payment data after the reconciliation of Part C and Part D payments for the contract year as follows:

(1) For Part C, the following data—

(i) Average per member per month CMS payment amount for A/B (original Medicare) benefits for each MA plan offered, standardized to the 1.0 (average risk score) beneficiary.

(ii) Average per member per month CMS rebate payment amount for each MA plan offered (or, in the case of MSA plans, the monthly MSA deposit amount).

(iii) Average Part C risk score for each MA plan offered.

(iv) County level average per member per month CMS payment amount for each plan type in that county, weighted by enrollment and standardized to the 1.0 (average risk score) beneficiary in that county.

(2) For Part D plan sponsors, plan payment data in accordance with § 423.505(o) of this subchapter.

[63 FR 35099, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 64 FR 7980, Feb. 17, 1999; 65 FR 40327, June 29, 2000. Redesignated at 70 FR 4736, Jan. 28, 2005 as amended at 70 FR 4737, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005; 72 FR 68723, Dec. 5, 2007; 73 FR 54250, Sept. 18, 2008; 74 FR 1542, Jan. 12, 2009; 75 FR 19810, Apr. 15, 2010; 76 FR 21568, Apr. 15, 2011]

Exhibit 2

Medicare Provider Manual

https://www.wellcare.com/WCAssets/corporate/assets/WellCare_Medicare_Advantage_Provider_Manual_2012.pdf

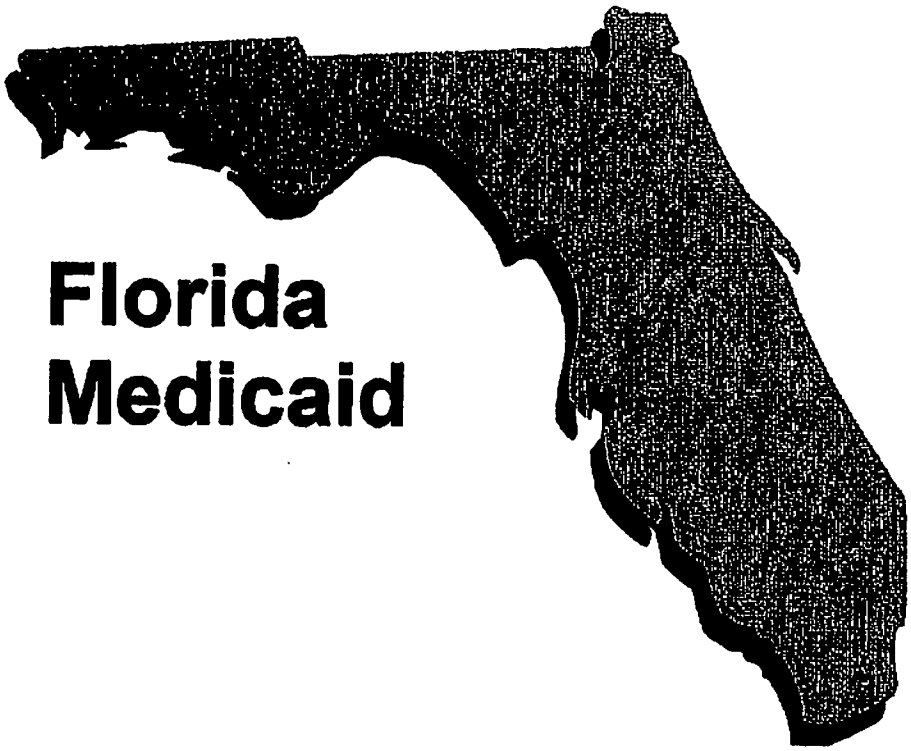
p. 4 of 77

Participating WellCare Medicare Providers, must in accordance with generally accepted professional standards:

- **Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973;**
- **Agree to cooperate with WellCare in its efforts to monitor compliance with its Medicare Advantage (MA) contract(s) and/or Medicare Advantage rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations;**
- **Retain all agreements, books, documents, papers, and medical records related to the provision of services to plan members as required by state and federal laws;**
- **Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(ii)]; .....**
- **Not deny, limit or condition the furnishing of treatment to any WellCare Medicare Advantage Plan member on the basis of any factor that is related to health status, including, but not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability;**

EXHIBIT 2

Exhibit 3



Florida Medicaid

PRACTITIONER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration
December 2012

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

EXHIBIT 3

General Services Requirements, Limitations and Exclusions, continued

Medically Necessary

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
2. 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.
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
4. Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods or services medically necessary or a covered service."

Exceptions to the Limits (Special Services) Process

As required by federal law, Florida Medicaid provides services to eligible children under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1905(a) of the Social Security Act, codified in Title 42 of the United Sates Code 1396d(a).

Services requested for children under the age of 21years in excess of limitations described within this handbook or the associated fee schedule may be approved, if medically necessary, through the prior authorization process described in the Florida Medicaid Provider General Handbook.

Exhibit 4

Exhibit 10.1

Contract No. EA971

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
STANDARD CONTRACT

THIS CONTRACT is entered into between the State of Florida, AGENCY FOR HEALTH CARE ADMINISTRATION, hereinafter referred to as the "Agency", whose address is 2727 Mahan Drive, Tallahassee, Florida 32308, and WELLCARE OF FLORIDA, INC., D/B/A STAYWELL HEALTH PLAN OF FLORIDA hereinafter referred to as the "Vendor", whose address is 8735 Henderson Road, Renaissance 2, Tampa, Florida 33634, a Florida For Profit Corporation, to provide health care services to eligible Medicaid recipients.

I. THE VENDOR HEREBY AGREES:

A. General Provisions

1. To provide services according to the terms and conditions set forth in this Contract, Attachment I, Scope of Services, and Attachment II, Core Contract Provisions and all other attachments named herein which are attached hereto and incorporated by reference (collectively referred to herein as the "Contract").

2. To perform as an independent vendor and not as an agent, representative, or employee of the Agency.

3. To recognize that the State of Florida, by virtue of its sovereignty, is not required to pay any taxes on the services or goods purchased under the terms of this Contract.

B. Federal Laws and Regulations

1. This Contract contains federal funds, therefore, the Vendor shall comply with the provisions of 45 CFR, Part 74, and/or 45 CFR, Part 92, and other applicable regulations.

2. This Contract contains federal funding in excess of $100,000, therefore, the Vendor must, upon Contract execution, complete the Certification Regarding Lobbying form, Attachment IV. If a Disclosure of Lobbying Activities form, Standard Form LLL, is required, it may be obtained from the Agency's Contract Manager. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the Agency's Procurement Office.

3. Pursuant to 45 CFR, Part 76, the Vendor must, upon Contract execution, complete the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts, Attachment V.

C. Audits and Records

1. To maintain books, records, and documents (including electronic storage media) pertinent to performance under this Contract in accordance with generally accepted accounting procedures and practices which sufficiently and properly

EXHIBIT 4

Medicaid Reform — The program resulting from s. 409.91211, F.S.

Medical Foster Care Services — Services provided to enable medically-complex children under the age of 21, whose parents cannot care for them in their own home, to live and receive care in foster homes rather than in hospitals or other institutional settings. Medical foster care services are authorized by Title XIX of the Social Security Act and s. 409.903, F.S., and Chapter 59G, F.A.C.

Medical Record — Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR 456.111 and 42 CFR 456.211.

Medically Necessary or Medical Necessity — Services that include medical or allied care, goods or services furnished or ordered to:

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 confirm 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 be experimental or investigational;
   d. Be reflective of the level of service that can be furnished safely 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 enrollee, the enrollee's caretaker or the provider.
2. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
3. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Medicare — The medical assistance program authorized by Title XVIII of the Social Security Act.

Medicare Advantage Special Needs Plan — A Medicare plan defined by Section 1859(b)(6) of the Social Security Act and 42 CFR Section 422.2 that exclusively enrolls or enrolls a disproportionate percentage of special needs individuals as set forth in 42 CFR Section 422.4(a)(1)(iv).

Section V

Covered Services

(See Attachment I and Attachment II, Exhibit 5)

A. Covered Services

1. The Health Plan shall ensure the provision of services in sufficient amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services defined and specified in this Contract. The Health Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the enrollee's diagnosis, type of illness or condition. The Health Plan may place appropriate limits on a service on the basis of such criteria as medical necessity or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.

2. The Health Plan is responsible for ensuring that all providers, service and product standards specified in the Agency's Medicaid Services Coverage & Limitations Handbooks and the Health Plan's own provider handbooks are incorporated into the Health Plan's participation agreements. This includes professional licensure and certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in this Contract.

3. The Health Plan shall require out-of-network providers to coordinate with respect to payment and must ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network.

4. In addition to this section, the Health Plan shall ensure the provision of the covered services specified in Attachment I and Attachment II, Exhibit 5.

B. Optional Services

(Non-Reform Only, See Attachment I and Attachment II, Exhibit 5)

C. Expanded Services

(See Attachment I)

1. The following services are defined as expanded services that may be offered by the Health Plan. The Health Plan shall define the services specifically in writing and submit them to HSD for approval before implementation.

   a. Services in excess of the amount, duration and scope of those listed in Attachment II, Section V, Covered Services, and Section VI, Behavioral Health Care;

   b. Services and benefits not listed in Attachment II, Section V, Covered Services, or Section VI, Behavioral Health Care;

Health Plan shall direct providers to maintain documentation in the enrollee's medical records to reflect this provision. See s. 409.912, F.S.

f. The provisions of this subsection shall not be interpreted so as to prevent a health care provider or other person from refusing to furnish any contraceptive or family planning service, supplies or information for medical or religious reasons. A health care provider or other person shall not be held liable for such refusal.

10. Hospital Services - Inpatient

a. Inpatient services are medically necessary services ordinarily furnished by a state-licensed acute care hospital for the medical care and treatment of inpatients provided under the direction of a physician or dentist in a hospital maintained primarily for the care and treatment of patients with disorders other than mental diseases.

(1) Inpatient services include, but are not limited to, rehabilitation hospital care (which are counted as inpatient hospital days), medical supplies, diagnostic and therapeutic services, use of facilities, drugs and biologicals, room and board, nursing care and all supplies and equipment necessary to provide adequate care. See the Medicaid Hospital Services Coverage & Limitations Handbook.

(2) Inpatient services also include inpatient care for any diagnosis including tuberculosis and renal failure when provided by general acute care hospitals in both emergent and non-emergent conditions.

(3) The Health Plan shall cover physical therapy services when medically necessary and when provided during an enrollee's inpatient stay.

(4) The Health Plan shall provide up to twenty-eight (28) inpatient hospital days in an inpatient hospital substance abuse treatment program for pregnant substance abusers who meet ISD Criteria with Florida Medicaid modifications, as specified in InterQual Level of Care Acute Criteria-Pediatric and/or InterQual Level of Care Acute Criteria-Adult (McKesson Health Solutions, LLC, "McKesson"), the most current edition, for use in screening cases admitted to rehabilitative hospitals and CON-approved rehabilitative units in acute care hospitals.

(5) In addition, the Health Plan shall provide inpatient hospital treatment for severe withdrawal cases exhibiting medical complications that meet the severity of illness criteria under the alcohol/substance abuse system-specific set which generally requires treatment on a medical unit where complex medical equipment is available. Withdrawal cases (not meeting the severity of illness criteria under the alcohol/substance abuse criteria) and substance abuse rehabilitation (other than for pregnant women), including court ordered services, are not covered in the inpatient hospital setting.

(6) The Health Plan shall coordinate hospital and institutional discharge planning for substance abuse detoxification to ensure inclusion of appropriate post-discharge care.

(7) The Health Plan shall adhere to the provisions of the Newborns and Mothers Health Protection Act (NMHPA) of 1996 regarding postpartum coverage for

C. Service Requirements

1. Inpatient Hospital Services

a. Inpatient hospital services are medically necessary behavioral health services provided in a hospital setting. (See Section V, Covered Services, Item H., Coverage Provisions, sub-item 10., Hospital Services -- Inpatient.) The inpatient care and treatment services that an enrollee receives must be under the direction of a licensed physician with the appropriate medical specialty requirements. Capitated Health Plans may provide inpatient hospital services in a general hospital psychiatric unit or in a specialty hospital.

b. A hospital's per diem (daily rate) for inpatient mental health hospital care and treatment covers all services and items furnished during a twenty-four (24) hour period. The facilities, supplies, appliances, and equipment furnished by the hospital during the inpatient stay are included in the per diem as well as the related nursing, social, and other services furnished by the hospital during the inpatient stay.

c. For all child/adolescent enrollees (up to age 21) and pregnant adults in Reform, the Health Plan shall be responsible for the provision of up to three-hundred sixty-five (365) days of behavioral health-related hospital inpatient care for each state fiscal year. For all non-pregnant adults in Reform, the Health Plan shall be responsible for up to forty-five (45) days of behavioral health-related inpatient coverage and up to three-hundred sixty-five (365) days of behavioral health-related emergency inpatient care, for each state fiscal year. For non-reform, the Health Plan shall be responsible for providing up to forty-five (45) days of behavioral health-related hospital inpatient care for each state fiscal year for all enrollees.

d. For all enrollees, the Health Plan shall pay for inpatient mental health-related hospital days determined medically necessary by the Health Plan's medical director or designee, up to the maximum number of days required under the Contract.

e. If an enrollee is admitted to a hospital for a non-psychiatric diagnosis and during the same hospitalization transfers to a psychiatric unit or receives treatment for a psychiatric diagnosis, the Health Plan is at risk for the medically necessary behavioral health treatment inpatient days up to the maximum number of days required under this Contract.

f. The Health Plan shall cover the cost of all enrollees' medically necessary stays resulting from a mental health emergency, until such time as the Health Plan can safely transport the enrollee to a designated facility.

g. Capitated Health Plans only -- Crisis stabilization units (CSU) may be used as a downward substitution for inpatient psychiatric hospital care when determined medically appropriate. These bed days are calculated on a two-for-one basis. Beds funded by DCF cannot be used for enrollees if there are non-funded clients in need of the beds. If CSU beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Health Plan shall demonstrate adequate capacity for inpatient hospital care in anticipation of such transfers.

Exhibit 5

2013

Georgia Medicaid Provider Handbook

WellCare®

EXHIBIT 5

WellCare

Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM)

Utilization Management

Overview

WellCare's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and DCH while providing members access to high quality, cost-effective, medically necessary care. For purposes of this section, terms and definitions may be contained in this section, in *Section 13: Definitions* of this Handbook, or both.

The goal of the UM Program is to achieve the best outcomes while providing quality health care at the most appropriate setting and the most appropriate time for the members. The UM Program:

- Ensures culturally sensitive delivery of services that are medically necessary, appropriate, and are consistent with the member's diagnosis and level of care required.
- Provides access to the most appropriate and cost efficient health care services. Ongoing monitoring, tracking and trending of care rendered to WellCare's members in order to ensure that quality health care is provided.
- Works collaboratively with the Case Management, Disease Management, and Quality Improvement Department by identifying and referring potential quality of care issues for review and implementation of intervention plans, as indicated.
- Monitors over- and underutilization, continuity and coordination of care and implements corrective action intervention plans, as needed.
- Works collaboratively with the Provider Services Department and the Appeals and Grievance Committees with timely review and response to member or provider grievances/appeals relating to utilization management decisions.
- Facilitates communication and partnerships among participants, physician providers, facility providers, delegated entities, and WellCare in an effort to enhance cooperation and appropriate utilization of health care services.
- Monitors, implements and maintains systems to enable compliance with government and legislative requirements of utilization management processes

Medically Necessary Services

The determination of whether a covered benefit or service is medically necessary complies with the requirements established in WellCare's contract with the DCH. Please refer to *Section 13: Definitions* for the definition of medical necessity.

WellCare provides to members medically necessary services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services provided to beneficiaries under fee-for-service Medicaid. WellCare will ensure that services provided to each member are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are provided.

WellCare's utilization management program includes components of prior authorization, prospective, concurrent, and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on WellCare

Management Organizations to manage the care of eligible Members and P4HB℠ Participants.

"Grievance" means an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to:

- the quality of care or services provided,
- aspects of interpersonal relationships such as rudeness of a provider or employee; or
- failure to respect the enrollee's rights.

"Health Care" means care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:

- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

"Ineligible Person" means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration; (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs; or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State Governmental Authority.

"Long-Term Acute Care (LTAC) Hospital" means care facilities include nursing homes, skilled nursing facilities, psychiatric residential treatment facilities and other facilities that provide long-term non-acute care.

"Medical Necessity" or **"Medically Necessary"** means services that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Compatible with the standards of acceptable medical practice in the community;
- Not provided solely for the convenience of the member or the convenience of the health care provider or hospital;
- Not primarily custodial care unless custodial care is a Covered Service or benefit under the member's evidence of coverage; and
- No other effective, more conservative, or substantially less costly treatment, service, or setting is available.

Exhibit 6

Form 8-K for WELLCARE HEALTH PLANS, INC.

1-Oct-2012

Entry into a Material Definitive Agreement, Financial Statements and

Item 1.01 Entry into a Material Definitive Agreement

On September 28, 2012, WellCare of Florida, Inc. ("WellCare of Florida"), a wholly-owned subsidiary of WellCare Health Plans, Inc. ("WellCare"), received a countersigned Contract to Provide Comprehensive Medical Services (the "Healthy Kids Contract") between WellCare of Florida and the Florida Healthy Kids Corporation ("FHKC").

The Healthy Kids Contract replaces in its entirety the Contract to Provide Comprehensive Medical Services between WellCare of Florida and FHKC dated as of October 1, 2010 (the "Prior Contract"), which expired pursuant to its terms on September 30, 2012.

The Healthy Kids Contract is effective as of October 1, 2012. Under the Healthy Kids Contract, WellCare of Florida will offer coordinated care plans to eligible beneficiaries of the Florida Healthy Kids Program in an aggregate sixty-five Florida counties under the brand names Staywell Kids and HealthEase Kids. The term of the Healthy Kids Contract expires on September 30, 2014, but it may be extended for up to two additional one-year terms at FHKC's option. It may also be terminated earlier by FHKC at any time with cause or for convenience.

The terms and conditions of the Healthy Kids contract are equivalent to the terms and conditions of the Prior Contract in most material respects. Among other things, the Healthy Kids Contract:

- Provides for the medical benefits WellCare of Florida is required to provide to members;
- Sets the capitation rates payable by FHKC to WellCare of Florida, which range from $82.13 to $112.80 per member per month based on the member's county of residence;
- Establishes certain performance standards for WellCare of Florida relating to measures such as access to care, including minimum geographical access requirements relating to primary and specialty care and minimum standards regarding access to appointment times;
- Provides procedures for the enrollment and disenrollment of members into the coordinated care plans offered by WellCare of Florida;
- Requires WellCare of Florida to maintain a compliance program, including the adoption of measures to detect and prevent fraud and abuse, the appointment of a compliance officer and the adoption of non-retaliation policies;
- Provides for requirements relating to communications with members and potential members including required communications, such as the distribution of member handbooks and the provision of translation services; and
- Provides for reporting and record retention obligations for WellCare of Florida.

The foregoing description does not purport to be a complete description of the parties' rights and obligations under the Healthy Kids Contract. The above description is qualified in its entirety by reference to the Healthy Kids Contract, a copy of which is attached as Exhibit 10.1 to this Current Report on Form 8-K.

EXHIBIT 6

IN WITNESS WHEREOF, the parties have caused this Contract, to be executed by their undersigned officials as duly authorized.

FOR
WELLCARE OF FLORIDA, INC.

/s/ Christina C. Cooper
NAME: Christina C. Cooper
TITLE: President, Florida and Hawaii Division
DATE SIGNED: 9/10/12

STATE OF FLORIDA)

COUNTY OF HILLSBOROUGH)

The foregoing instrument was acknowledged before me before this 10 th day of September , 20 12 , by Christina C. Cooper , as President, HI & FL on behalf of the WellCare of Florida, Inc. . ~~He~~/She is personally known to me ~~or has produced as identification.~~

/s/ Emily A. Merlin
Signature
Notary Public - State of Florida

[NOTARY STAMP]
Print, Type or Stamp Name of Notary Public

4/23/2013
My Commission Expires

/s/ Billie Cruz
WITNESS #1 SIGNATURE

Billie Cruz
WITNESS #1 PRINT NAME

/s/ Season McMillian
WITNESS #2 SIGNATURE

Season McMillian
WITNESS #2 PRINT NAME

FOR
FLORIDA HEALTHY KIDS CORPORATION:

/s/ Rich Robleto
NAME: Rich Robleto
TITLE: Executive Director
DATE SIGNED: 9/18/2012

STATE OF FLORIDA)
COUNTY OF Leon)

The foregoing instrument was acknowledged before me this 18th day of Sept., 20 12, by Rich Robleto, as Executive Director on behalf of the Florida Healthy Kids Corporation. He is personally known to me or has produced _____ as identification.

/s/ Amber N. Floyd
Signature
Notary Public - State of Florida

Amber N. Floyd
Print, Type or Stamp Name of Notary Public [NOTARY STAMP]

Nov. 14, 2013
My Commission Expires

/s/ Amber N. Floyd
WITNESS #1 SIGNATURE

Amber N. Floyd
WITNESS #1 PRINT NAME

/s/ Tracy J. Achey
WITNESS #2 SIGNATURE

Tracy J. Achey
WITNESS #2 PRINT NAME

Reviewed by:
/s/ Jennifer K. Lloyd Date: 8/10/2012 /s/ Steve Malono Date: 8/14/2012
Signature of: Jennifer K. Lloyd, Chief External Affairs Officer Florida Healthy Kids Corporation
Signature of Steve Malono, Esquire Florida Healthy Kids Corporation General Counsel Fla Bar Number: 0705705

BENEFIT	LIMITATIONS	CO-PAYMENTS
A. Inpatient Services All covered services provided for the medical care and treatment of an Enrollee who is admitted as an inpatient to a hospital licensed under part I of Chapter 395. Covered services include: physician's services; room and board; general nursing care; patient meals; use of operating room and related facilities; use of intensive care unit and services; radiological, laboratory and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; special duty nursing; radiation and chemotherapy; respiratory therapy; administration of whole blood plasma; physical, speech and occupational therapy; medically necessary services of other health professionals.	All admissions must be authorized by INSURER. The length of the patient stay shall be determined based on the medical condition of the Enrollee in relation to the necessary and appropriate level of care. Room and board may be limited to semi-private accommodations, unless a private room is considered medically necessary or semi-private accommodations are not available. Private duty nursing limited to circumstances where such care is medically necessary. Admissions for rehabilitation and physical therapy are limited to fifteen (15) days per contract year. Shall not include experimental or investigational procedures defined as a drug, biological product, device, medical treatment or procedure that meets any one of the following criteria, as determined by INSURER: 1. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials; or, 2. Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the circumstances of a particular patient is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives; or, 3. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.	NONE
B. Emergency Services Covered Services include visits to an emergency room or other licensed facility if needed immediately due to an injury or illness and delay means risk of permanent damage to the Enrollee's health. Covered services also means inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under §1932(b)(2) and 42 CFR 438.114(a) and that are needed to evaluate or stabilize an emergency medical condition.	INSURER must also comply with the provisions of s. 641.513, Florida Statutes. Subject to the provisions of federal and state law, Enrollee has the right to use any hospital or other setting for emergency care. INSURER is responsible for any post-stabilization services obtained within or outside of INSURER's network that are pre-approved by INSURER or INSURER's representative or where such approval has been sought by the facility or provider and INSURER has failed to respond within one (1) hour of such request for further post-stabilization services that are administered to maintain, improve or resolve the Enrollee's stabilized position. INSURER must limit non-covered charges to Enrollees for post-stabilization care services to an amount not greater than what the facility or provider would charge the Enrollee if the Enrollee had	Ten dollars ($10.00) per visit waived if admitted or authorized by primary care physician.