RICK SCOTT
GOVERNOR

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

September 12, 2013

Ms. Heather Hostetler
Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Hostetler:

The Agency for Health Care Administration is submitting the enclosed Medicaid managed care policies as required by Special Term and Condition #17 of Florida's 1115 Managed Medical Assistance (MMA) Waiver. The following is a brief description of Attachments I and II.

- **Attachment I STC 17.a.** – Florida Medicaid managed care policies to ensure increased stability among capitated managed care plans and fee-for-service provider service networks and minimize plan turnover. The policies include: (a) a limit on the number of participating plans in all areas of the state when implemented the MMA program; and (b) plan selection and oversight criteria that contains: policies regarding confirmation that plan solvency requirements are being met; an evaluation of the plan's prior business operations in the state; and the plan's financial penalties for not completing a contract term.

- **Attachment II STC 17.b.** – Florida Medicaid managed care policies to ensure provider network adequacy and access requirements which address travel time and distance, as well as the availability of routine, urgent and emergent appointments which are appropriate for the enrolled population. The policies include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The policies are consistent with the requirements of 42 CFR 438 and demonstrate a thorough and consistent oversight review for determining plan compliance with these requirements.

We appreciate your efforts in working with our staff on waiver. Should you have any questions, please contact Linda Macdonald of my staff by phone at (850) 412-4031 or by email at Linda.Macdonald@ahca.myflorida.com.

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lam
Enclosures

Attachment I

STC 17a: Managed Care Policies

Special Term and Condition #17a: requires the state to have the following: Policies to ensure an increased stability among capitated managed care plans and FFS PSNs and minimize plan turnover. This could include a limit on the number of participating plans in the five Medicaid Reform demonstration counties and, when implemented, in the Managed Medical Assistance (MMA) program. Plan selection and oversight criteria should include: confirmation that solvency requirements are being met; an evaluation of prior business operations in the state; and financial penalties for not completing a contract term. The state must report quarterly on the plans entering and leaving demonstration counties, including the reasons for plans leaving. The state must provide these policies to the Centers for Medicare and Medicaid Services (Federal CMS) within 90 days of the award of the MMA program demonstration amendment.

The following is provided in response to this requirement.

Florida Medicaid's Managed Care Policy – Stability Among Plans

The following are key provisions established in the Invitation to Negotiate (ITN) and the draft contract that address stability among plans including a limit on the number of plans per region, solvency requirements are being met, evaluation of prior business operations in Florida; and financial penalties for not completing a contract term.

A. Overview of the Managed Care Plan Procurement Process

Managed Care Plan Procurement Process

- Part IV of Chapter 409, Florida Statutes (F.S.), established 11 regions for the MMA program in the state of Florida. The following table provides the list of the counties by the 11 regions.

Managed Medical Assistance Regions		
Region	**Counties**	**Anticipated Implementation Date**
Region 1:	Escambia, Okaloosa, Santa Rosa and Walton	TBD June 2013- October 2014
Region 2:	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington	
Region 3:	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union	
Region 4:	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia	
Region 5:	Pasco and Pinellas	
Region 6:	Hardee, Highlands, Hillsborough, Manatee and Polk	
Region 7:	Brevard, Orange, Osceola and Seminole	
Region 8:	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	
Region 9:	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie	
Region 10:	Broward	
Region 11:	Miami-Dade and Monroe	

- The Agency for Health Care Administration (Agency) utilized a competitive bid process to select the MMA plans in each of the 11 designated regions and released an ITN on December 28, 2012. The Agency anticipates posting the Intent to Award September 16, 2013. Only capitated managed care organizations responded to the ITN. Therefore, no Fee-for-Service Provider Service Networks will be awarded a contract as an MMA plan.

- The Agency is required by state law to enter into five-year health plan contracts with selected vendors. The Agency may not renew the contracts, and may extend the term of the contact only in order to cover any delays in transitioning to a new plan, but the contract may not be renewed.

B. Plan Stability Process with Severe Penalties for Early Withdrawal or Termination

1. Limited Number of Plans Per Region

- The Agency is required by state law to competitively procure a specified minimum and maximum number of MMA plans per region. As noted in the following table, there will be a minimum of two plans choices in each of the 11 regions.

Table 2

Managed Medical Assistance: Plans Per Region

	Min # of Plans	Max # of Plans	# of PSNs	Children's Medical Services Network
Region 1	2	2	1	The CMS Network will operate statewide[1]
Region 2	2	2	1	
Region 3	3	5	1	
Region 4	3	5	1	
Region 5	2	4	1	
Region 6	4	7	1	
Region 7	3	6	1	
Region 8	2	4	1	
Region 9	2	4	1	
Region 10	2	4	1	
Region 11	5	10	1	

Please note that for all regions the maximum plan numbers above will reduce the number of plans currently operating in each region including the Medicaid Reform areas. This will give each plan access to more potential members allowing them to more effectively spread/share risk.

[1] Please note: participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the Agency that is not subject to the procurement requirements or regional plan number limits.

- The ITN and draft contract also contains clear disincentives for withdrawal including substantial financial penalties and the termination of all plan contracts in other regions if a plan withdraws from a region before the end of the contract period.

  - Financial penalties include payment to the Agency for the cost of enrollment changes and other transition activities, and departing Managed Care Plans must pay a penalty of twenty-five percent (25%) of that portion of the minimum surplus maintained pursuant to s. 641.225(1), F.S., which is attributable to the provision of coverage to Medicaid enrollees
  - If the Managed Care Plan leaves a region before the end of the contract term, the Agency shall terminate all contracts with the Managed Care Plan in other regions.

See Appendix A draft MMA contract, Section XI. Sanctions, for the penalties and sanctions requirements for a plan not completing the contract term.

2. Financial Requirements

- The ITN and draft contract contains significant financial surplus requirements. These measures are statutorily required and designed to ensure that contracts are awarded to plans with sufficient financial resources to remain operational.
- The ITN and draft contract required all potential vendors responding as a Standard Plan to submit a proposal guarantee in the amount of $948,360.00 and potential vendors responding as a Specialty Plan were required to submit a proposal guarantee of $94,836.00. ITN Respondents were required to submit audited financial statements for the past two (2) years, a pro forma financial statement, a description of how the respondent will fund the surplus start-up account, the surplus account and the insolvency protection account (see below). Additionally, ITN respondents who are awarded Standard contracts must furnish a performance bond in the amount of $5,000,000.00 for each region in which the ITN respondent is awarded a Contract. Vendors awarded a Contract as a Specialty Plan must furnish a performance bond in the amount of $1,000,000.00 for each region the ITN respondent is awarded a Contract.
- The plan contract includes requirements for an insolvency protection account in which the plan must deposit five percent (5%) of the capitation payments made by the Agency each month until a maximum total of two percent (2%) of the annualized total current contract amount is reached and maintained.
- The ITN and draft contract also includes a requirement for the surplus start up account in which the plan shall submit to the Agency proof of working capital in the form of cash or liquid assets excluding revenues from Medicaid payments equal to at least the first three (3) months of operating expenses or $200,000, whichever is greater.
- The ITN and draft contract also includes a requirement that the plan maintain at all times in the form of cash, investments that mature in less than one-hundred eighty (180) calendar days and allowable as admitted assets by the Florida Department of Financial Services, and restricted funds of deposits controlled by the Agency (including the Managed Care Plan's insolvency protection account) or the Department of Financial Services, a surplus amount equal to the greater of $1.5 million, ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the Managed Care Plan's prepaid revenues

See Appendix B Draft MMA contract, Section X. Financial Requirements, for the financial requirements.

3. Past Terminations

- The ITN and draft contract specifies the potential ITN respondents were required to submit documentation as to whether, in the past seven (7) years, they have voluntarily terminated all or part of a contract (other than a provider contract) to provide services, have had such a contract partially or fully terminated before the contract end date (with or without cause); have withdrawn form a contracted service area; or have requested a reduction of enrollment levels. If so, ITN respondents were asked to describe the contract, the month and year of the contract action, the reason(s) for the termination, withdrawal, or enrollment level reduction, the parties involved; and to provide the address and telephone number of the client/other party. If the contract was terminated based on the respondent's performance, the ITN respondents were required to describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. The ITN respondents were directed to include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization and those organizations' affiliates and subsidiaries. ITN respondents received the most points if they had no voluntary or involuntary terminations to report.

4. Qualifications and Experience

- The ITN respondent were required to provide a list of all current and/or recent (within five (5) years of the issue date of the ITN) Contracts for managed care (medical care and/or integrated medical and behavioral health services) for each Medicaid population served (Temporary Assistance for Needy Families (TANF), Aged, Blind and Disabled (ABD), dual eligibles). If the ITN respondent did not have experience with managed care, they were instructed to include any relevant Contract. For each identified contract the ITN respondent was required to provide the following information.

  - The Medicaid population served (TANF, ABD, duals);
  - The name and address of the client;
  - The name of the contract;
  - The time period of the contract;
  - A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
  - The annual contract amount (payment to the respondent) and annual claims payment amount;
  - The scheduled and actual completion dates for contract implementation;
  - The barriers encountered that hindered implementation (if applicable) and the resolutions;
  - Accomplishments and achievements;
  - Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
  - Whether the Contract was capitated, fee-for-service or other payment method.

- See Appendix C draft MMA contract, Exhibit E-1 Standard Submission Requirements and Evaluation Criteria, Category: Qualifications and Experience, for the evaluation criteria used in the ITN regarding respondent's qualifications and experience.

Appendix A

Section XI. Sanctions

A. Contract Violations and Non-Compliance

1. The Managed Care Plan shall comply with all requirements and performance standards set forth in this Contract.

2. In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Managed Care Plan pursuant to any of the following: s. 409.912 (21), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR part 438 subpart I (Sanctions) and s.1932 of the Social Security Act or s.1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to Section XIII.

3. For purposes of this section, violations involving individual, unrelated acts shall not be considered arising out of the same action.

4. In addition to imposing sanctions for a Contract violation or other non-compliance, the Agency may require the Managed Care Plan to submit to the Agency a performance measure action plan (PMAP) within a timeframe specified by the Agency. The Agency may also require the Managed Care Plan to submit a Corrective Action Plan (CAP) for a violation of or any other non-compliance with this Contract.

5. If the Agency imposes monetary sanctions, the Managed Care Plan must pay the monetary sanctions to the Agency within thirty (30) calendar days from receipt of the notice of sanction. If the Deputy Secretary determines that the Agency should reduce or eliminate the amount imposed, the Agency will return the appropriate amount to the Managed Care Plan within sixty (60) days from the date of a final decision rendered.

B. Performance Measure Action Plans (PMAP) and Corrective Action Plans (CAP)

1. If a PMAP or CAP is required as determined by the Agency, the Agency will either approve or disapprove a proposed PMAP or CAP from the Managed Care Plan. If the Agency disapproves the PMAP or CAP, the Managed Care Plan shall submit a new PMAP or CAP within ten (10) business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency. The Managed Care Plan shall accept and implement an Agency defined CAP if required by the Agency.

2. The Agency may impose a monetary sanction of $200 per calendar day on the Managed Care Plan for each calendar day that the Managed Care Plan does not implement, to the satisfaction of the Agency, the approved PMAP or CAP. Managed Care Plans shall receive a monetary sanction for measures for which their scores meet the thresholds reflected in Attachment D-II, Exhibit 14 for the second offense and subsequent offenses.

C. Performance Measure Sanctions

1. The Agency may sanction the Managed Care Plan for failure to achieve minimum performance scores on performance measures specified by the Agency after the first

year of poor performance, as specified in the MMA Exhibit or the LTC Exhibit, as applicable. The Agency will develop performance measures and may impose monetary sanctions for some or all of performance measures. The Agency will develop performance targets for each performance measure with a methodology for application of sanction specified by the Agency.

2. The Agency shall sanction the Managed Care Plan for failure to achieve minimum scores on performance measures after the first year of poor performance on any measure as specified in the table below. The Agency may impose monetary sanctions and Performance Measure Action Plans (PMAPs) or PMAPs alone as described above.

3. Two (2) HEDIS measures will be compared to the National Committee for Quality Assurance HEDIS National Means and Percentiles. The HEDIS Call Abandonment measure and the HEDIS Call Answer Timeliness measure have threshold rates (percentages) that may trigger a sanction, as indicated in the Performance Measure Sanction Table below.

Performance Measure Sanction Table – Effective 8/01/2014 – 8/31/2019	
HEDIS Measures	**Rate and applicable sanction**
Call Answer Timeliness	Rate < 25th percentile - immediate monetary sanction and PMAP may be imposed Rate < 50th percentile - PMAP may be required
Call Abandonment	Rate > 5% - immediate monetary sanction and PMAP may be imposed

4. The Agency shall sanction MMA Managed Care Plans for failure to achieve minimum scores on additional performance measures after the first year of poor performance on any measure as specified in the MMA Exhibit.

5. The Agency shall sanction LTC Managed Care Plans for failure to achieve minimum scores on additional performance measures after the first year of poor performance on any measure as specified in the LTC Exhibit.

6. The Agency shall sanction Comprehensive LTC Managed Care Plans for failure to achieve minimum scores on additional performance measures after the first year of poor performance on any measure as specified in both the MMA Exhibit and the LTC Exhibit.

D. Other Sanctions

1. Pursuant to s. 409.967(2)(h)2., F.S., if the Managed Care Plan fails to comply with the encounter data reporting requirements as specified in this Contract for thirty (30) calendar days, the Agency shall assess the Managed Care Plan a fine of five thousand dollars ($5,000) per day for each day of noncompliance beginning on the thirty-first (31st) calendar day. On the thirty-first (31st) calendar day, the Agency must notify the Managed Care Plan that the Agency will initiate Contract termination procedures on the

ninetieth (90th) calendar day unless the Managed Care Plan comes into compliance before that date.

2. Fraud and Abuse – See Section VIII.F.

3. Pursuant to s. 409.967(2)(a), F.S, after two (2) years of continuous operation under this Contract, the Managed Care Plan's physician payment rates shall equal or exceed Medicare rates for similar services. The Agency may impose fines or other sanctions if the Managed Care Plan fails to meet this performance standard.

4. Pursuant to s. 409.967(2)(h)1., F.S., if the Managed Care Plan reduces its enrollment level or leaves a region before the end of the Contract term, the Managed Care Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities. If more than one MMA or LTC Managed Care Plan leaves a region at the same time, the exiting Managed Care Plans will share the costs in a manner proportionate to their enrollments. In addition to the payment of costs, departing PSNs shall pay a per-enrollee penalty of up to three (3) months' payment and continue to provide services to enrollees for ninety (90) calendar days or until the enrollee is enrolled in another Managed Care Plan, whichever occurs first. In addition to payment of costs, all other departing Managed Care Plans must pay a penalty of twenty-five percent (25%) of that portion of the minimum surplus maintained pursuant to s. 641.225(1), F.S., which is attributable to the provision of coverage to Medicaid enrollees. The Managed Care Plan will provide at least one hundred eighty (180) calendar days' notice to the Agency before withdrawing from a region. If the Managed Care Plan leaves a region before the end of the Contract term, the Agency shall terminate all Contracts with the Managed Care Plan in other regions.

E. Notice of Sanctions

1. Except as noted in 42 CFR part 438, subpart I (Sanctions), before imposing any of the sanctions specified in this section, the Agency will give the Managed Care Plan written notice that explains the basis and nature of the sanction, cites the specific contract section(s) and/or provision of law and the methodology for calculation of any fine.

2. If the Agency decides to terminate the Managed Care Plan's Contract for cause, the Agency will provide advance written notice of intent to terminate including the reason for termination and the effective date of termination. The Agency will also notify Managed Care Plan enrollees of the termination along with information on their options for receiving services following Contract termination.

3. Unless the Agency specifies the duration of a sanction, a sanction will remain in effect until the Agency is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

4. For non-risk Managed Care Plans, the Agency reserves the right to withhold all or a portion of the Managed Care Plan's monthly administrative allocation for any amount owed pursuant to this section.

F. Dispute of Sanctions

1. To dispute an Agency's Sanction under the Contract, the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute. The Managed Care Plan must submit, within twenty-one (21) calendar days after the issuance of a Sanction, a written dispute of the Sanction directly to the Deputy Secretary or designee; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation and exhibits). The Managed Care Plan waives any dispute not raised within twenty-one (21) calendar days of receiving the Sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) calendar days of receiving a Contract Interpretation, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission submitted within the twenty-one (21) calendar days following its receipt of the Sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

2. The Deputy Secretary or his/her designee will decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Managed Care Plan. This written decision will be final.

3. The exclusive venue of any legal or equitable action that arises out of or relating to the Contract, including an appeal of the final decision of the Deputy Secretary or his/her designee, will be Circuit Court in Leon County, Florida; in any such action, the Managed Care Plan agrees that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Agency will notice the Managed Care Plan of the appropriate administrative remedy.

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Appendix B

ATTACHMENT D
SCOPE OF SERVICES – CORE PROVISIONS

Section X. Financial Requirements

A. Insolvency Protection

1. Insolvency Protection Requirements

a. The Managed Care Plan shall establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997), and s. 409.912, F.S. The Managed Care Plan shall deposit into that account five percent (5%) of the capitation payments made by the Agency each month until a maximum total of two percent (2%) of the annualized total current Contract amount is reached and maintained. No interest may be withdrawn from this account until the maximum Contract amount is reached and withdrawal of the interest will not cause the balance to fall below the required maximum amount. This provision shall remain in effect as long as the Managed Care Plan continues to contract with the Agency.

b. The restricted insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by the Managed Care Plan and two (2) representatives of the Agency. The Multiple Signature Agreement Form shall be resubmitted to the Agency within thirty (30) calendar days of Contract execution and resubmitted within thirty (30) calendar days after a change in authorized Managed Care Plan personnel occurs. If the authorized persons remain the same, the Managed Care Plan shall submit an attestation to this effect annually by April 1 of each Contract year to the Agency along with a copy of the latest bank statement. The Managed Care Plan may obtain a sample Multiple Signature Verification Agreement form from the Agency or its agent or download from the Agency website at:

   http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml.

   All such agreements or other signature cards shall be approved in advance by the Agency.

c. In the event that a determination is made by the Agency that the Managed Care Plan is insolvent, as defined in Section I, Definitions and Acronyms, the Agency may draw upon the amount solely with the two (2) authorized signatures of representatives of the Agency and funds may be disbursed to meet financial obligations incurred by the Managed Care Plan under this Contract. A statement of account balance shall be provided by the Managed Care Plan within fifteen (15) calendar days of request of the Agency.

d. If the Contract is terminated, expired, or not continued, the account balance shall be released by the Agency to the Managed Care Plan upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.

e. In the event the Contract is terminated or not renewed and the Managed Care Plan is insolvent, the Agency may draw upon the insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency including, but not limited to, overpayments made to the Managed Care Plan, and fines imposed under the Contract or, for HMOs, s. 641.52, F.S., for EPOs, s. 627, F.S., and for health insurers, s. 624, F.S., for which a final order has been issued. In addition, if the Contract is terminated or not renewed and the Managed Care Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Managed Care Plan agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

f. In the event the Contract is terminated or not renewed and the Managed Care Plan is insolvent, the Agency may draw upon the insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency including, but not limited to, overpayments made to the Managed Care Plan, and fines imposed under the Contract, for which a final order has been issued. In addition, if the Contract is terminated or not renewed and the Managed Care Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Managed Care Plan agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

2. Insolvency Protection Requirements for FFS PSNs

a. For its enrollees, the FFS Managed Care Plan shall submit to the Agency for approval a comprehensive plan for transitioning from a FFS Managed Care Plan to a capitated Managed Care Plan. Such transition plan shall be in accordance with Agency guidelines and shall be designed to ensure that the Managed Care Plan is capable of meeting all solvency, reserves and working capital requirements of Chapter 641 F.S. Although the Managed Care Plan shall not be required to be licensed in accordance with Chapter 641 F.S., the Managed Care Plan shall be required to comply with all solvency requirements of Medicaid HMOs, at such time as the Managed Care Plan transitions from a FFS Managed Care Plan to a capitated Managed Care Plan.

b. In the twentieth (20^{th}) month after operations begin, the FFS Managed Care Plan shall begin funding the insolvency protection account in accordance with insolvency protection requirements specified for capitated Managed Care Plans (five [5] percent of the estimated monthly capitation amount that would be paid to the Managed Care Plan by the Agency each month until a maximum total of two [2] percent of the annualized total Contract amount). The insolvency protection account shall be fully funded no later than one hundred-twenty (120) days prior to the Managed Care Plan becoming capitated.

c. In accordance with s. 409.968(2). F.S., the FFS Managed Care Plan shall submit to the Agency a PSN conversion application to support its conversion to a capitated

Managed Care Plan Contract by the first day of its second Contract year. The Managed Care Plan must transition to a capitated plan by the last day of its second year of operation in order to continue this Contract. The Agency will provide guidelines for developing a comprehensive plan for conversion to capitation.

3. Insolvency Protection Account Waiver

Pursuant to s. 409.912, F.S., the Agency may waive the insolvency protection account in writing when evidence of adequate insolvency insurance and reinsurance are on file with the Agency to protect enrollees in the event the Managed Care Plan is unable to meet its obligations.

B. Surplus

1. Surplus Start Up Account

All new Managed Care Plans (excluding public entities that are organized as political subdivisions) at Contract execution, shall submit to the Agency proof of working capital in the form of cash or liquid assets excluding revenues from Medicaid payments equal to at least the first three (3) months of operating expenses or $200,000, whichever is greater. This provision shall not apply to Managed Care Plans that have been providing services to enrollees for a period exceeding three (3) continuous months.

2. Surplus Requirement

a. A capitated Managed Care Plan shall maintain at all times in the form of cash, investments that mature in less than one-hundred eighty (180) calendar days and allowable as admitted assets by the Department of Financial Services, and restricted funds of deposits controlled by the Agency (including the Managed Care Plan's insolvency protection account) or the Department of Financial Services, a surplus amount equal to the greater of $1.5 million, ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the Managed Care Plan's prepaid revenues. In the event that the Managed Care Plan's surplus (as defined in Section I, Definitions and Acronyms) falls below the amount specified in this paragraph, the Agency shall prohibit the Managed Care Plan from engaging in community outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Managed Care Plan's Contract statewide.

b. In lieu of the surplus requirements under Section X.B., Surplus Requirements, the Agency may consider the following:

(1) If the organization is a public entity, the Agency may take under advisement a statement from the public entity that a county supports the Managed Care Plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer or oversee the Managed Care Plan, either partly or wholly, through a county department or agency;

(2) The state guarantees the solvency of the organization;

(3) The organization is a federally qualified health center (FQHC) or is controlled by one (1) or more FQHCs and meets the solvency standards established by the state for such organization pursuant to s. 409.912(4)(c), F.S.; or

(4) The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 CFR 422.380 through 422.390 and the solvency requirements established in approved federal waivers or Florida's Medicaid State Plan.

C. Interest

Interest generated through investments made by the Managed Care Plan under this Contract shall be the property of the Managed Care Plan and shall be used at the Managed Care Plan's discretion.

D. Third Party Resources

The Managed Care Plan shall determine the legal liability of third parties to pay for services rendered to enrollees under this Contract and notify the Agency of any third party creditable coverage discovered.

1. Capitated Managed Care Plans

a. The Managed Care Plan shall specify whether it will assume full responsibility for third party collections in accordance with this section.

b. The Managed Care Plan has the same rights to recovery of the full value of services as the Agency (see s. 409.910, F.S.). The following standards govern recovery:

(1) If the Managed Care Plan has determined that third party liability exists for part or all of the services provided directly by the Managed Care Plan to an enrollee, the Managed Care Plan shall make reasonable efforts to recover from third party liable sources the value of services rendered.

(2) If the Managed Care Plan has determined that third party liability exists for part or all of the services provided to an enrollee by a subcontractor or referral provider, and the third party is reasonably expected to make payment within one-hundred twenty (120) calendar days, the Managed Care Plan may pay the subcontractor or referral provider only the amount, if any, by which the subcontractor's allowable claim exceeds the amount of the anticipated third party payment; or, the Managed Care Plan may assume full responsibility for third party collections for service provided through the subcontractor or referral provider.

c. The Managed Care Plan may not withhold payment for services provided to an enrollee if third party liability or the amount of liability cannot be determined, or if

payment shall not be available within a reasonable time, beyond one-hundred twenty (120) calendar days from the date of receipt.

d. When the Agency has a fee-for-service lien against a third party resource and the Managed Care Plan has also extended services potentially reimbursable from the same third party resource, the Agency's lien shall be entitled to priority.

e. The Agency may, at its sole discretion, offer to provide third party recovery services to the Managed Care Plan. If the Managed Care Plan elects to authorize the Agency to recover on its behalf, the Managed Care Plan shall be required to provide the necessary data for recovery in the format prescribed by the Agency. All recoveries, less the Agency's cost to recover, shall be income to the Managed Care Plan. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the Managed Care Plan elects to authorize the Agency to recover on its behalf.

f. All funds recovered from third parties shall be treated as income for the Managed Care Plan.

2. Third Party Resource Requirements for FFS PSNs

a. The Managed Care Plan shall cost avoid all services that are subject to payment from a third party health insurance carrier, and may deny a service to an enrollee if the Managed Care Plan is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below. However, if a third party health insurance carrier requires the enrollee to pay any cost sharing amounts (e.g., copayment, coinsurance, deductible), the Managed Care Plan shall authorize claims for the cost sharing amounts, even if the services are provided outside the Managed Care Plan's network. The Managed Care Plan's authorization of claims for such cost sharing amounts shall not exceed the amount the Agency would have paid under the Medicaid FFS program.

b. Further, the Managed Care Plan shall not deny claims for services provided to an enrollee if third party liability, or the amount of third party liability, cannot be determined, or if payment will not be available within sixty (60) calendar days.

c. The requirement of cost avoidance applies to all covered services except claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services the Managed Care Plan shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Managed Care Plan shall then coordinate with the Agency or its agent to enable the Agency to recover payment from the potentially liable third party.

d. If the Managed Care Plan determines that third party liability exists for part or all of the services rendered, the Managed Care Plan shall:

(1) Notify providers and supply third party liability data to a provider whose claim is denied for payment due to third party liability; and

(2) Authorize the provider's claim for only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability.

3. FFS PSNs Capitated for Transportation Services

a. For transportation services for which a capitation payment is received from the Agency, the Managed Care Plan shall specify whether it will assume full responsibility for third party collections in accordance with this section.

b. For transportation services for which a capitation payment is received from the Agency, the Managed Care Plan has the same rights to recovery of the full value of services as the Agency, (see s. 409.910, F.S.) The following standards govern recovery:

(1) If the Managed Care Plan has determined that third party liability exists for part or all of the transportation services provided directly by the Managed Care Plan to an enrollee, the Managed Care Plan shall make reasonable efforts to recover from third party liable sources the value of services rendered.

(2). If the Managed Care Plan has determined that third party liability exists for part or all of the transportation services provided to an enrollee by a subcontractor or referral provider, and the third party is reasonably expected to make payment within one-hundred twenty (120) calendar days, the Managed Care Plan may pay the subcontractor or referral provider only the amount, if any, by which the allowable claim exceeds the amount of the anticipated third party payment; or, the Managed Care Plan may assume full responsibility for third party collections for service provided through the subcontractor or referral provider.

c. The Managed Care Plan may not withhold payment for transportation services provided to an enrollee if third party liability or the amount of liability cannot be determined, or if payment shall not be available within a reasonable time, beyond one-hundred twenty (120) calendar days from the date of receipt.

d. When both the Agency and the Managed Care Plan have liens against the proceeds of a third party resource, the Agency shall prorate the amount due to Medicaid to satisfy such liens under s. 409.910, F.S., between the Agency and the Managed Care Plan. This prorated amount shall satisfy both liens in full.

e. The Agency may, at its sole discretion, offer to provide third party recovery services to the Managed Care Plan. If the Managed Care Plan elects to authorize the Agency to recover on its behalf, the Managed Care Plan shall be required to provide the necessary data for recovery in the format prescribed by the Agency. All recoveries, less the Agency's cost to recover, shall be income to the Managed Care Plan. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the Managed Care Plan elects to authorize the Agency to recover on its behalf.

f. All funds recovered from third parties shall be treated as income for the Managed Care Plan.

4. Patient Responsibility

The Managed Care Plan shall have policies and procedures to ensure that, where applicable, enrollees residing in residential facilities are assessed for patient responsibility by DCF and pay their patient responsibility. Some enrollees have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility. The Managed Care Plan is responsible for collecting its enrollees' patient responsibility. The Managed Care Plan may transfer the responsibility for collecting its enrollees' patient responsibility to the residential facilities and compensate these facilities net of the patient responsibility amount. If the Managed Care Plan transfers collection of patient responsibility to the provider, the provider contract must specify complete details of both parties' obligations in collection of patient responsibility. The Managed Care Plan must either collect patient responsibility from all its providers or transfer collection to all providers. The Managed Care Plan must have a system in place to track the receipt of patient responsibility at the enrollee level. This data must be available upon request by the Agency. The Managed Care Plan or its providers shall not assess late fees for the collection of patient responsibility from enrollees.

E. Assignment

Except as provided below, or with the prior written approval of the Agency, this Contract and the monies which may become due are not to be assigned, transferred, pledged or hypothecated in any way by the Managed Care Plan, including by way of an asset or stock purchase of the Managed Care Plan, and shall not be subject to execution, attachment or similar process by the Managed Care Plan.

1. No plan subject to this procurement or any entity outside this procurement shall be allowed to be merged with or acquire all the Managed Care Plans within the region. When a merger or acquisition of a Managed Care Plan has been approved, the Agency shall approve the assignment or transfer of the appropriate Medicaid Managed Care Plan Contract upon the request of the surviving entity of the merger or acquisition if the Managed Care Plan and the surviving entity have been in good standing with the Agency for the most recent twelve (12) month period, unless the Agency determines that the assignment or transfer would be detrimental to Medicaid recipients or the Medicaid program (see s. 409.912, F.S.). The entity requesting the assignment or transfer shall notify the Agency of the request ninety (90) calendar days before the anticipated effective date.

2. Entities regulated by the Department of Financial Services, Office of Insurance Regulation (OIR), must comply with provisions of s. 628.4615, F.S., and receive OIR approval before a merger or acquisition can occur.

3. For the purposes of this section, a merger or acquisition means a change in controlling interest of a Managed Care Plan, including an asset or stock purchase.

4. To be in good standing, a Managed Care Plan shall not have failed accreditation or committed any material violation of the requirements of s. 641.52, F.S., and shall meet the Medicaid Contract requirements.

5. The Managed Care Plan requesting the assignment or transfer of its enrollees and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, as required by the Agency and to ensure a seamless transition for enrollees, particularly those hospitalized, those requiring care coordination/case management and those with complex medication needs. The Managed Care Plan requesting assignment or transfer of its enrollees shall perform as follows:

   a. Notice its enrollees, providers and subcontractors of the change in accordance with this Contract; and

   b. Provide to the Agency the data needed, including encounter data, by the Agency to maintain existing case relationships.

6. The notice to enrollees shall contain the same information as required for a notice of termination according to Section XII.F.

F. Financial Reporting

1. Financial Statements

a. The Managed Care Plan shall submit to the Agency an annual audited financial report and quarterly unaudited financial statements in accordance with Section XIV, Reporting Requirements, and the Managed Care Report Guide, as applicable.

b. The Managed Care Plan shall submit to the Agency the audited financial statements no later than three (3) calendar months after the end of the calendar year, and submit the quarterly statements no later than forty-five (45) calendar days after each calendar quarter and shall use generally accepted accounting principles in preparing the statements.

c. The Managed Care Plan shall submit annual and quarterly financial statements that are specific to the operations of the Managed Care Plan rather than to a parent or umbrella organization.

2. Medical Loss Ratio (MLR)

MMA Managed Care Plans shall comply with Medical Loss Ratio requirements as specified in the MMA Exhibit.

G. Inspection and Audit of Financial Records

The state, CMS and DHHS may inspect and audit any financial records of the Managed Care Plan or its subcontractors. Pursuant to s. 1903(m)(4)(A) of the Social Security Act and state Medicaid Manual 2087.6(A-B), non-federally qualified Managed Care Plans shall report to the state, upon request, and to the Secretary and the Inspector General of DHHS, a description of certain transactions with parties of interest as defined in s. 1318(b) of the Social Security Act.

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Appendix C

EXHIBIT E-1
STANDARD SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

Vendor's Name:

Category: Qualifications and Experience

SRC #1 [CORE]: The respondent shall provide a list of all current and/or recent (within five (5) years of the issue date of this ITN) Contracts for managed care (medical care and/or integrated medical and behavioral health services) for each Medicaid population served (Temporary Assistance for Needy Families (TANF), Aged, Blind and Disabled (ABD), dual eligibles). If the respondent does not have experience with managed care, please include any relevant Contracts. The respondent shall provide the following information for each identified Contract:

a. The Medicaid population served (TANF, ABD, duals);
b. The name and address of the client;
c. The name of the Contract;
d. The time period of the Contract;
e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
f. The annual Contract amount (payment to the respondent) and annual claims payment amount;
g. The scheduled and actual completion dates for Contract implementation;
h. The barriers encountered that hindered implementation (if applicable) and the resolutions;
i. Accomplishments and achievements;
j. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
k. Whether the Contract was capitated, fee-for-service or other payment method.

Vendor Response:

SRC #1 Evaluation Criteria:

1. *The Medicaid population served by the managed care Contracts.*

2. *The number and size of managed care Contracts active in the last five (5) years.*

3. *The extent to which managed care Contracts, or other Contracts, active in the last five years, provided relevant experience.*

4. *The extent to which listed accomplishments and achievements are significant and relevant to this ITN.*

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

SRC #2 [CORE]: The respondent (including respondents' parent, affiliate(s) or subsidiary(ies) shall describe its experience (i.e., number of years, number of enrollees, and number of Contracts) in delivering managed care services (i.e., medical and integrated medical and behavioral health, dental, and/or transportation services), to Medicaid populations similar to the target population (TANF, ABD, dual eligibles) of this ITN. The respondent shall describe all relevant experience it has gained prior to responding to this ITN by each relevant Medicaid population. The respondent may include experience regarding services provided by subcontractors for which the respondent was contractually responsible.

Vendor Response:

SRC #2 Evaluation Criteria:

1. *The extent to which the respondent identifies experience in delivering services to populations similar to the target population.*

2. *The extent to which the respondent describes its experience managing or delivering services to populations similar to the target population through medical and behavioral health services.*

3. *The extent to which the respondent describes its experience managing or delivering services to the TANF population.*

4. *The extent to which the respondent describes its experience managing or delivering services to the ABD population.*

5. *The extent to which the respondent describes its experience managing or delivering services to the dual eligible population.*

Score: This section is worth a maximum of 25 raw points with the above components being worth a maximum of 5 points each.

SRC #3 [CORE]: The respondent (including respondents' parent, affiliate(s) or sudsidiary(ies)) shall describe any lessons learned from its managed care or other relevant experience and how the lessons learned will be applied to this ITN for each Medicaid population served (TANF, ABD, dual eligibles). This shall include, but not be limited to, lessons learned regarding enrollee services, provider network, and helping enrollees live successfully and safely in the community.

Vendor Response:

SRC #3 Evaluation Criteria:

1. *The degree to which the lessons learned for enrollee services and managing the provider network are relevant and significant to this ITN for each population served.*

2. *The extent to which the respondent implemented innovative or best practices in response to the lessons learned for each population served.*

Score: This section is worth a maximum of 10 raw points with each of the above components being worth a maximum of 5 points each.

SRC #4 [CORE]: The respondent (including respondents' parent, affiliate(s) or subsidiary(ies)) shall describe its experience with helping providers unfamiliar with managed care transition to successfully provide services in a managed care setting, including lessons learned, and shall propose how it will help providers unfamiliar with managed care transition to successfully provide services in a managed care environment in relation to this ITN.

Vendor Response:

SRC #4 Evaluation Criteria:

1. *The extent to which the respondent demonstrates success in transitioning providers to managed care.*

2. *The extent to which the lessons learned are applicable to and likely to be effective with providers associated with this ITN.*

3. *The extent to which the respondent's proposed approach is applicable and likely to be effective with providers associated with this ITN.*

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

SRC #5 [CORE]: The respondent shall describe any sanctions levied against it or its affiliates and subsidiaries or its parent company, or its affiliates subsidiaries and subcontractors (whose sub-contracts are paid at $250,000 or more annually), within the last seven (7) years, that have been imposed by the Agency, a Medicaid program in another state, Medicare or any federal government or state regulatory body in any state. Include a description of the Contracts for which the sanction was levied (if the sanction was contractual), a description of the sanction, the specific reason for the sanction and the timeline to resolve or correct the deficiency for which the sanction was levied. Indicate any sanctions that are currently in dispute. Sanctions are defined as any monetary (e.g., penalties and withholds) and non-monetary (e.g., letters of non-compliance and involuntary enrollment freezes) punitive actions taken by regulatory bodies. If there have been no sanctions that meet the criteria described, the respondent

must so state. Failure to provide any item of information requested under this paragraph shall result in a score of zero for this section.

Vendor Response:

SRC #5 Evaluation Criteria:

1. *The extent to which sanctions were due to issues with patient care, including quality and access, versus administrative issues.*

2. *The extent to which sanctions were significant (e.g., high dollar amounts (above $10,000), lengthy, involuntary enrollment freezes) or numerous (e.g., multiple Contracts with similar sanctions).*

3. *The extent to which sanctions were imposed multiple times for the same issue prior to resolution.*

Score: *This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.*

For Item 1:
(a) 5 points if no sanctions or other adverse actions;
(b) 4 points if sanctions related only to administrative issues;
(c) 3 points if non-administrative sanctions were all minor (less than $10,000) and there were fewer than four (4) incidents;
(d) 2 points if non-administrative sanctions were all minor but four (4) or more incidents;
(e) 1 point if any major ($10,000 or above) administrative sanction;
(f) 0 points if any major non-administrative sanction.

For Item 2:
(a) 5 points if no sanctions;
(b) 4 points if sanctions were minor and there were fewer than four (4) incidents;
(c) 3 points if sanctions were all minor (less than $10,000) but four (4) or more incidents;
(d) 2 points if up to two (2) high-dollar amounts or lengthy (longer than 90 days) freezes or more than two (2) Contracts with multiple sanctions;
(e) 1 point if more than two (2) but fewer than five (5) high-dollar amounts or lengthy (longer than 90 days) freezes and/or more than two (2) but fewer than five (5) Contracts with multiple sanctions;
(f) 0 points if performance falls below above limits.

For Item 3:
(a) 5 points if no sanctions;
(b) 4 points if sanction imposed twice for same issue;
(c) 3 points if sanction imposed twice for the same issue and involved such actions for multiple incidences of same action;
(d) 2 points if sanction imposed twice for multiple incidences of same action across multiple Contracts;

(e) 1 point if sanctions imposed more than twice but fewer than five (5) times for the same issue(s);
(f) 0 points if performance falls below above limits.

SRC #6 [CORE]: The respondent shall state whether, in the past seven (7) years, it has voluntarily terminated all or part of a Contract (other than a provider Contract) to provide health care services; has had such a Contract partially or fully terminated before the Contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the Contract; the month and year of the Contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the address and telephone number of the client/other party. If the Contract was terminated based on the respondent's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries.

Vendor Response:

SRC #6 Evaluation Criteria:

1. *The extent to which the respondent or parent or subsidiary or affiliates has voluntarily terminated all or part of a Contract.*

2. *The extent to which the respondent or parent or subsidiary or affiliates has had Contracts terminated due to performance.*

3. *The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).*

Score: *This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.*

For Item 1:
(a) 5 points for no voluntary termination of all or part of a Contract and no service area withdrawals;
(b) 0 points for any voluntary terminations/withdrawals.

For Item 2:
(a) 5 points for no involuntary terminations;
(b) 0 points for any involuntary termination based on performance.

For Item 3:
(a) 5 points for no Contract terminations;
(b) 0 points if termination related to patient care or claims payment.

EXHIBIT E-1
STANDARD SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

SRC #7 [CORE]: The respondent shall state whether there is any pending or recent (within the past seven (7) years) civil, criminal or administrative litigation against the respondent, (to include respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries) including by a state or federal agency. If there is pending or recent litigation against the respondent, describe the Contract that is being litigated (if applicable); the damages being sought or awarded; and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include any outcomes; deferred prosecution agreements (or agreements whose effect is the same); and settlement agreements. Also include any Securities and Exchange Commission (SEC) filings, discussing any pending or recent litigation. Respondent does not need to divulge workers' compensation litigation, real estate litigation, or employment litigation if no Equal Employment Opportunity Commission (EEOC) cause finding (or state/local agency equivalent of cause finding). If there has been no litigation that meets the criteria described, the respondent must so state. Failure to provide any item of information requested under this paragraph shall result in a score of zero for this section.

Vendor Response:

SRC #7 Evaluation Criteria:

1. *The number of Contracts in which litigation occurred, that resulted in adverse outcome (e.g. money damages, findings of liability, settlement payment, deferred prosecution agreements, etc.).*

2. *The number of lawsuits pending against the respondent.*

3. *The extent to which actual and anticipated judgments are not covered by insurance or reserves.*

4. *The extent to which actual and anticipated litigation involves allegations of criminal misconduct (defined as a dereliction of duty); or unlawful or improper behavior) as described in the complaint or other documents filed in the case.*

Score: *This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.*

For Item 1:
(a) 5 points if no litigation, or if litigation did not result in any adverse outcomes;
(b) 4 points if one (1) case (to include equitable, legal or administrative) with an adverse outcome;
(c) 3 points if two (2) cases with an adverse outcome each;
(d) 2 points if five (5) or fewer cases with an adverse outcome;
(e) 1 point if more than five (5) but fewer than eight (8) cases with an adverse outcome(to include equitable, legal or administrative) with more than two (2) Contracts;
(f) 0 points if multiple litigation with multiple Contracts.

For Item 2:
(a) 5 points if no pending cases;
(b) 3 points if fewer than five (5) pending cases;
(c) 0 points if more than five (5) pending cases.

For Item 3:
(a) 5 points if no litigation;
(b) 4 points if sought or awarded damages covered by insurance or reserves;
(c) 0 if not covered.

For Item 4:
(a) 5 points if no criminal litigation that resulted in adverse outcome;
(b) 0 if completed litigation involved criminal or intentional misconduct that resulted in an adverse outcome.

SRC #8 [CORE]: The respondent shall describe its organizational commitment to quality improvement, including active involvement by respondent's medical and administrative leadership, and document its achievements with two (2) examples of quality improvement projects and their results. At least one of the examples shall address well child visits/child health checkup improvement projects.

Vendor Response:

SRC #8 Evaluation Criteria:

1. *The extent to which the respondent describes how it ensures that quality improvement is incorporated into operations throughout the health plan.*

2. *The extent to which the respondent provides examples of quality improvement projects that include data-based root cause analysis, measurement of the intervention and re-evaluation.*

3. *The extent to which the respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer (CEO) is actively involved in quality management.*

4. *The extent to which the quality improvement project methodology and study SRCs have been reviewed by the respondent's medical director and quality management staff.*

Score: *This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.*

SRC #9 [REGIONAL]: The respondent shall provide documentation that it has experience operating as a Florida Medicaid health plan in the Region in which it plans to provide MMA services or in any other Region in the State of Florida. If applicable, the respondent shall provide the Agency Contract number and the county(ies) of operation to show it has experience providing managed care services in Florida. This includes Medicare Advantage Special Needs Plans that have a Standard Contract with the Agency.

Vendor Response:

SRC #9 Evaluation Criteria:

For the Managed Care Plan that is proposing to provide services under this ITN, whether the respondent has an:

- *Existing Florida Medicaid health plan Contract in that Region;*
- *Existing Florida Medicaid health plan Contract in another Region in the State of Florida; or*
- *Medicare Advantage Special Needs Plan Standard Contract with the Agency.*

Score: This section is worth a maximum of 20 raw points as outlined below.

(a) 20 points if the respondent already has a Florida Medicaid health plan Contract in any county in the Region that it plans to provide medical assistance services or if the plan has a Medicare Advantage Special Needs Plan Standard Contract in any county in the Region that it plans to provide medical assistance services;

(b) 10 points if the respondent does not have a Florida Medicaid health plan Contract in the Region, but does have a Contract and is operating as a Florida Medicaid health plan in another Region of the state or if the plan does not have a Medicare Advantage Special Needs Plan Standard Contract in the Region, but does have a Contract and is operating as a Medicare Advantage Special Needs Plan Standard Contract in another Region of the state;

(c) 0 points if the plan does not have a Florida Medicaid health plan Contract or a Medicare Advantage Special Needs Plan Standard Contract with the Agency.

SRC #10 [CORE]: The respondent (including respondents' parent, affiliate(s) or subsidiary(ies)) shall describe its experience in achieving quality standards with populations similar to the target population for this ITN. Include in table format, the target population (TANF, ABD, dual eligibles), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2010 and CY 2011) as compared to the Medicaid national average for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have Medicaid HEDIS results for at least (3) three states, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts compared to the commercial national average. Describe any instances of failure to meet HEDIS or Contract-required quality standards and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract required

standards were met, but improvement was desirable. Respondents shall provide the data requested in Attachment E-2, Standard Quality Measurement Tool to provide results for the following HEDIS measures:

- **Annual Dental Visits;**
- **Antidepressant Medication Management;**
- **Adolescent Well-Care Visit;**
- **Breast Cancer Screening;**
- **Controlling High Blood Pressure;**
- **Timeliness of Pre-natal care;**
- **Post-Partum Care;**
- **Well-Child Visit in the 1st 15 months of life; and**
- **Childhood Immunizations.**

Vendor Response:

SRC #10 Evaluation Criteria:

1. *The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, including HEDIS or Contract-required measures.*

2. *The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures.*

3. *The extent to which the respondent exceeded State standards or goal rates and the national mean for each quality measure reported.*

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

For Item 3, a total of 5 points are available.

Exhibit E-2, Standard Quality Measurement Tool, provides for fifty four (54) opportunities for a respondent to report prior experience in meeting a state quality standard (nine (9) measures, three (3) states each, two (2) years each). For each of the nine (9) measures a total of 6 points is available. The respondent will be awarded 1 point if their reported plan rate exceeded both the State standard or goal rate and the national mean, for each available year, for each available state. An aggregate score will be calculated and respondents will receive a final score of 0 through 5 corresponding to the number of points received out of the total available points, as described below:

a. *5 points if total aggregate score is between 40 and 54 points;*
b. *4 points if total aggregate score is between 30 and 39;*
c. *3 points if total aggregate score is between 10 and 29;*
d. *2 points if total aggregate score is between 5 and 9;*
e. *1 points if total aggregate score is between 1 and 4; and*
f. *0 points if total aggregate score is 0.*

Attachment II

STC 17b: Managed Care Policies

Special Term and Condition #17b: Requirements contained herein are intended to be consistent with and not additional to the requirements of 42 CFR 438. Policies to ensure network adequacy and access requirements which address travel time and distance, as well as the availability of routine, urgent and emergent appointments, and which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The state must implement a thorough and consistent oversight review for determining plan compliance with these requirements and report these findings to Centers for Medicaid and Medicaid Service (Federal CMS) on a quarterly basis. The state must provide these policies to Federal CMS within 90 days of the award of the Managed Medical Assistance (MMA) program demonstration amendment.

The following is provided in response to this requirement.

Florida Medicaid's Managed Care Policy – Network Adequacy and Access Requirements:

The Agency for Health Care Administration (Agency) utilized a competitive bid process to select the MMA plans and released an Invitation to Negotiate (ITN) on December 28, 2012. The Agency anticipates posting of Intent to Award on September 16, 2013. The following are key provisions established in the ITN and the draft contract to address network adequacy and access requirements including travel time and distance, as well as the availability of routine, urgent and emergent appointments, and which are appropriate for the enrolled population The policies demonstrate a thorough and consistent oversight review process for determining plan compliance with the relevant requirements of 42 CFR 438. Please note the competitive procurement process is on-going and plans may negotiate by offering networks that exceed adequacy standards listed in the table on the pages X -X.

A. Network Capacity and Access Standards

1. Network Capacity and Geographic Access Standards

- The ITN and draft contract stipulates that pursuant to section (s.) 409.967(2)(c)(1), Florida Statutes (F.S.), Managed Care Plans must maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. At a minimum, Managed Care Plans shall contract with the providers specified in the MMA Provider Network Standards in the below Table. Managed Care Plans shall ensure regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties are met and maintained throughout the life of this contract, as specified in the MMA Provider Network Standards Table.

Please note the provider network standards are more thorough than anything Florida Medicaid has required previously. The Agency drew these standards from Medicare with input from providers statewide including pediatric providers particularly Miami Children's Hospital and All Children's Hospital.

The Agency intends to validate and verify these networks through a provider network verification process that the plans will be required to update weekly so that potential enrollees have the most up-to-date network information available when they select a plan. Florida regards it as imperative that providers listed as network providers actually participate in the plans network.

Managed Medical Assistance Provider Network Standards Table					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Primary Care Providers	30	20	30	20	1:1,500 enrollees
Specialists					
Adolescent Medicine	100	75	110	90	1:31,200 enrollees
Allergy	80	60	90	75	1:20,000 enrollees
Anesthesiology	n/a	n/a	n/a	n/a	1:1,500 enrollees
Cardiology	50	35	75	60	1:3,700 enrollees
Cardiology (PEDS)	100	75	110	90	1:16,667 enrollees
Cardiovascular Surgery	100	75	110	90	1:10,000 enrollees
Chiropractic	80	60	90	75	1:10,000 enrollees
Dermatology	60	45	75	60	1:7,900 enrollees
Endocrinology	100	75	110	90	1:25,000 enrollees
Endocrinology (PEDS)	100	75	110	90	1:20,000 enrollees
Gastroenterology	60	45	75	60	1:8,333 enrollees
General Dentist	50	35	75	60	1:1,500 enrollees
General Surgery	50	35	75	60	1:3,500 enrollees
Infectious Diseases	100	75	110	90	1:6,250 enrollees
Midwife	100	75	110	90	1:33,400 enrollees
Nephrology	80	60	90	75	1:11,100 enrollees
Nephrology (PEDS)	100	75	110	90	1:39,600 enrollees
Neurology	60	45	75	60	1:8,300 enrollees
Neurology (PEDS)	100	75	110	90	1:22,800 enrollees
Neurosurgery	100	75	110	90	1:10,000 enrollees
Obstetrics/Gynecology	50	35	75	60	1:1,500 enrollees
Oncology	80	60	90	75	1:5,200 enrollees
Ophthalmology	50	35	75	60	1:4,100 enrollees
Optometry	50	35	75	60	1:1,700 enrollees
Oral Surgery	100	75	110	90	1:20,600 enrollees
Orthodontist	100	75	110	90	1:38,500 enrollees
Orthopedic Surgery	50	35	75	60	1:5,000 enrollees
Otolaryngology	80	60	90	75	1:3,500 enrollees
Pathology	n/a	n/a	n/a	n/a	1:3,700 enrollees
Pediatrics	50	35	75	60	1:1,500 enrollees

Managed Medical Assistance Provider Network Standards Table					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Pharmacy	30	20	60	45	1:2,500 enrollees
24-hour Pharmacy	60	45	60	45	n/a
Pulmonology	60	45	75	60	1:7,600 enrollees
Rheumatology	100	75	110	90	1:14,400 enrollees
Therapist (Occupational)	50	35	75	60	1:1,500 enrollees
Therapist (Speech)	50	35	75	60	1:1,500 enrollees
Therapist (Physical)	50	35	75	60	1:1,500 enrollees
Therapist (Respiratory)	100	75	110	90	1:8,600 enrollees
Urology	60	45	75	60	1:10,000 enrollees
Facility/ Group/ Organization					
Hospitals (acute care)	30	20	30	20	1 bed: 275 enrollees
Hospital or Facility with Birth/Delivery Services	30	20	30	20	2: County
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	n/a	n/a	n/a	n/a	2: County
Adult Family Care Home	n/a	n/a	n/a	n/a	2: County
ALF	n/a	n/a	n/a	n/a	2: County
Birthing Center	n/a	n/a	n/a	n/a	1: County
Hospice	n/a	n/a	n/a	n/a	2: County
DME/HME	n/a	n/a	n/a	n/a	As required in s. 409.975(1)(d), F.S.
Behavioral Health					
Board Certified or Board Eligible Adult Psychiatrists	30	20	60	45	1:1,500 enrollees
Board Certified or Board Eligible Child Psychiatrists	30	20	60	45	1:7,100 enrollees
Licensed Practitioners of the Healing Arts	30	20	60	45	1:1,500 enrollees
Licensed Community Substance Abuse Treatment Centers	30	20	60	45	2: county
Inpatient Substance Abuse Detoxification Units	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital for capitated plans only	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees

Managed Medical Assistance Provider Network Standards Table					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital for capitated plans only	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees

2. Primary Care Providers

- The ITN and draft contract stipulates that the Managed Care Plan shall enter into provider contracts with at least one (1) Full Time Employee (FTE) Primary Care Physician (PCP) per one-thousand five-hundred (1,500) enrollees. The Managed Care Plan may increase the ratio by seven-hundred fifty (750) enrollees for each FTE advanced registered nurse practitioner (ARNP) or physician's assistant (PA) affiliated with a PCP. The Managed Care plan shall have at least one (1) FTE PCP in each of the following four (4) specialty areas within the geographic access standards indicated above:

  (1) Family Practice;
  (2) General Practice;
  (3) Pediatrics; and
  (4) Internal Medicine.

- The ITN and draft contract stipulates that the Managed Care Plan shall ensure the following:

  (1) The PCP provides, or arranges for coverage of services, consultation or approval for referrals twenty-four hours per day, seven days per week (24/7) by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage shall consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number; and

  (2) The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

  (3) Pregnant enrollees are allowed to choose Managed Care Plan obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

3. Specialists and Other Providers

- The ITN and draft contract stipulates that the Managed Care Plan shall enter into provider contracts with a sufficient number of specialists to ensure adequate accessibility for enrollees of all ages. The Managed Care Plan shall ensure the following:

  (1) At least one (1) of the network infectious disease specialists have expertise in HIV/AIDS and its treatment and care;

  (2) Female enrollees have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist;

  (3) In accordance with s. 641.31, F.S., low-risk enrollees have access to certified nurse midwife services or licensed midwife services, licensed in accordance with Chapter 467, F.S.

- The Draft contract stipulates that for pediatric specialists not listed the Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at a location or via a PCP within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code. Alternatively, for pediatric specialists not listed in the Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.

4. Public Health Providers

- The Draft contract stipulates that the Managed Care Plan shall make a good faith effort to execute memoranda of agreement with the local County Health Departments (CHDs) to provide services which may include, but are not limited to, family planning services, services for the treatment of sexually transmitted diseases, other public health related diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and services related to Healthy Start prenatal and post-natal screenings. The Managed Care Plan shall provide documentation of its good faith effort upon the Agency's request.

- The ITN and draft contract stipulates that Capitated Managed Care Plans shall pay, without prior authorization, at the contracted rate or the Medicaid fee-for-service rate, all valid claims initiated by any CHD for office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis. Capitated Managed Care Plans shall reimburse the CHD when the CHD notifies the Managed Care Plan and provides the Managed Care Plan with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.

- The ITN and draft contract stipulates that the Managed Care Plan shall authorize all claims from a CHD, a migrant health center funded under Section 329 of the Public Health Services Act or a community health center funded under Section 330 of the Public Health Services Act, without prior authorization for the services listed below. Such providers shall attempt to contact the Managed Care Plan before providing health care services to enrollees and shall

provide the Managed Care Plan with the results of the office visit, including test results. The Managed Care Plan shall not deny claims for services delivered by these providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred sixty-five (365) calendar days, and shall be reimbursed by the Managed Care Plan at the rate negotiated between the Managed Care Plan and the public provider or the applicable Medicaid fee-for-service rate. The Medicaid Fee-for-Service (FFS) rate is the standard Medicaid fee schedule rate or the CHD cost-based rate as specified by the County Health Department Clinic Services Coverage and Limitations Handbook for applicable rates.

(1) The diagnosis and treatment of sexually transmitted diseases and other reportable infectious diseases, such as tuberculosis and HIV;
(2) The provision of immunizations;
(3) Family planning services and related pharmaceuticals;
(4) School health services listed in a, b and c above, and for services rendered on an urgent basis by such providers; and
(5) In the event that a vaccine-preventable disease emergency is declared, the Managed Care Plan shall authorize claims from the CHD for the cost of the administration of vaccines.

- The ITN and draft contract stipulates that other clinic-based services provided by a CHD, migrant health center or community health center, including well-child care, dental care, and sick care services not associated with reportable infectious diseases, require prior authorization from the Managed Care Plan in order to receive reimbursement. If prior authorization is provided, the Managed Care Plan shall reimburse at the entity's cost-based reimbursement rate. If prior authorization for prescription drugs is given and the drugs are provided, the Managed Care Plan shall reimburse the entity at Medicaid's standard pharmacy rate.

- The ITN and draft contract stipulates that the Managed Care Plan shall make a good faith effort to execute a contract with a Rural Health Clinic (RHC).

- The ITN and draft contract stipulates that Capitated Managed Care Plans shall reimburse Federally Qualified Health Centers (FQHCs) and RHCs at rates comparable to those rates paid for similar services in the FQHC's or RHC's community.

- The ITN and draft contract stipulates that Capitated Managed Care Plans shall report quarterly to the Agency as part of its quarterly financial reports, the payment rates and the payment amounts made to FQHCs and RHCs for contractual services provided by these entities.

- The ITN and draft contract stipulates that the Managed Care Plan shall make a good faith effort to execute memoranda of agreement with school districts participating in the certified match program regarding the coordinated provision of school-based services pursuant to ss. 1011.70, 409.9071, F.S. and 409.908(21), F.S.

5. Facilities and Ancillary Providers

- The ITN and draft contract stipulates that the Managed Care Plan shall enter into provider contracts with a sufficient number of facilities and ancillary providers to ensure adequate

accessibility for enrollees of all ages. The ITN and draft contract stipulates that the Managed Care Plan shall ensure the following:

- Network emergency service facilities have one (1) or more physicians and one (1) or more nurses on duty in the facility at all times;

- Network facilities are licensed, as required by law and rule, accessible to the handicapped, in compliance with federal Americans with Disabilities Act guidelines, and have adequate space, supplies, good sanitation, and fire, safety, and disaster preparedness and recovery procedures in operation;

- Care for medically high-risk perinatal enrollees is provided in a facility with a NICU sufficient to meet the appropriate level of need for the enrollee;

- Pursuant to s. 409.967(2)(c)1, F.S., the Managed Care Plan may use mail-order pharmacies; however mail-order pharmacies shall not count towards the Managed Care Plan's pharmacy network access standards; and

- In accordance with s. 409. 975(1)(d), F.S., a provider contract is offered to each licensed home medical equipment and supplies provider and to each Medicaid enrolled durable medical equipment (DME) provider in the region, as specified by the Agency, that meets quality and fraud prevention and detection standards established by the Managed Care Plan and that agrees to accept the lowest price previously negotiated between the Managed Care Plan and another such provider.

6. Essential Providers

- The ITN and draft contract stipulates that pursuant to s. 409.975(1)(b), F.S., certain providers are statewide resources and essential providers for all managed care plans in all regions. The Managed Care Plan shall include these essential providers in its network, even if the provider is located outside of the region served by the Managed Care Plan.

- The ITN and draft contract stipulates that statewide essential providers include:

  (1) Faculty plans of Florida medical schools, which include University of Florida College of Medicine, University of Miami School of Medicine, University of South Florida College of Medicine, University of Central Florida College of Medicine, Nova Southeastern University College of Osteopathic Medicine, Florida State University College of Medicine, and Florida International University College of Medicine;

  (2) Regional perinatal intensive care centers (RPICCs) as defined in s. 383.16(2), F.S., including All Children's Hospital, Arnold Palmer Hospital, Bayfront Medical Center, Broward General Medical Center, Jackson Memorial Hospital, Lee Memorial Hospital at HealthPark, Memorial Regional Hospital, Sacred Heart Hospital, Shands – Jacksonville, Shands Teaching Hospital, St. Mary's Hospital and Tampa General Hospital;

  (3) Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28), F.S., including All Children's Hospital, Miami Children's Hospital, Nemours; and Shriners Hospitals for Children; and

(4) Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

- The ITN and draft contract stipulates that if the Managed Care Plan has not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment, the Managed Care Plan must continue to negotiate in good faith.

  (1) The Managed Care Plan shall make payments to physicians on the faculty of non-participating Florida medical schools at the applicable Medicaid rate.
  (2) The Managed Care Plan shall make payments for services rendered by a regional perinatal intensive care center at the applicable Medicaid rate as of the first day of this Contract.
  (3) The Managed Care Plan shall make payments to a non-participating specialty children's hospital equal to the highest rate established by contract between that provider and any other Medicaid managed care plan.

- The ITN and draft contract stipulates that pursuant to s. 409.975(1)(c), F.S., after twelve (12) months of active participation in the Managed Care Plan's network, the Managed Care Plan may exclude any essential provider from the network for failure to meet quality or performance criteria.

- The ITN and draft contract stipulates that pursuant to s. 409.975(1)(a), F.S., the Managed Care Plan must include all providers in the region that are classified by the Agency as essential Medicaid providers, unless the Agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers.

- The ITN and draft contract stipulates that the Agency may determine that the following providers are essential Medicaid providers:

  (1) Federally qualified health centers.
  (2) Statutory teaching hospitals as defined in s. 408.07(45), F.S.
  (3) Hospitals that are trauma centers as defined in s. 395.4001(14), F.S.
  (4) Hospitals located at least twenty-five (25) miles from any other hospital with similar services.

7. Timely Access Standards

- The Draft contract stipulates that the Managed Care Plan must assure that PCP services and referrals to specialists for medical and behavioral health services are available on a timely basis, as follows:

  (1) Urgent Care — within one (1) day of the request;
  (2) Sick Care — within one (1) week of the request; and
  (3) Well Care Visit — within one (1) month of the request.

- The ITN and draft contract stipulates that annually by February 1 of each Contract year, the Managed Care Plan shall review a statistically valid sample of PCP and specialist offices' average appointment wait times to ensure services are in compliance with this subsection, and report the results to the Agency in the format specified, in accordance with Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. (See 42 CFR 438.206(c)(1)(iv),(v) and (vi).)

B. Network Development and Management Plan

1. General Provisions

- The ITN and draft contract stipulates that the Managed Care Plan shall develop and maintain an annual network development and management plan (annual network plan). The Managed Care Plan shall submit this plan annually to the Agency.

- The ITN and draft contract stipulates that the Managed Care Plan shall develop and maintain policies and procedures to evaluate the Managed Care Plan's provider network to ensure that covered services are:

  (1) Available and accessible, at a minimum, in accordance with the access standards in the contract;
  (2) Provided promptly and are reasonably accessible in terms of location and hours of operation; and
  (3) For Long Term Care (LTC) Managed Care Plans and Comprehensive LTC Managed Care Plans, home and community-based services (HCBS) are available to enrollees with LTC benefits on a seven (7) day a week basis, and for extended hours, as dictated by enrollee needs.

- The ITN and draft contract stipulates that the methodology(ies) the Managed Care Plan uses to collect and analyze enrollee, provider and staff feedback about the network designs and performance, and, when specific issues are identified, the protocols for handling them.

2. Annual Network Plan Content

- The ITN and draft contract stipulates that the Managed Care Plan's annual network plan shall include the Managed Care Plan's processes to develop, maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this contract.

- The ITN and draft contract stipulates that the Managed Care Plan's annual network plan must include a description of network design by region and county for the general population, including details regarding special populations as identified by the Managed Care Plan (e.g., medically complex). The description shall also cover:

  (1) How enrollees access the system;
  (2) Analysis of timely access to services; and
  (3) Relationships among various levels of the system.

- The ITN and draft contract stipulates that the Managed Care Plan's annual network plan must include a description of the evaluation of the prior year's plan including an explanation

of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation.

- The ITN and draft contract stipulates that Managed Care Plan's annual network plan must include a description or explanation of the current status of the network by each covered service at all levels including:

  (1) How enrollees access services;
  (2) Analysis of timely access to services;
  (3) Relationships between the various levels, focusing on provider-to-provider contact and facilitation of such by the Managed Care Plan (e.g., PCP, specialists, hospitals, behavioral health, ALFs, home health agencies); and
  (4) For MMA and Comprehensive LTC Managed Care Plans, the assistance and communication tools provided to PCPs when they refer enrollees to specialists and the methods used to communicate the availability of this assistance to the providers.

- The ITN and draft contract stipulates that the Managed Care Plan's annual network plan must any current barriers and/or network gaps and include the following:

  (1) The methodology used to identify barriers and network gaps;
  (2) Immediate short-term interventions to address network gaps;
  (3) Longer-term interventions to fill network gaps and resolve barriers;
  (4) Outcome measures/evaluation of interventions to fill network gaps and resolve barriers;
  (5) Projection of changes in future capacity needs, by covered service; and
  (6) Ongoing activities for network development based on identified gaps and future needs projection.

- The ITN and draft contract stipulates that the Managed Care Plan's annual network plan must include a description of coordination between internal departments, including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (e.g., quality management, medical management/utilization management, grievances, finance, claims) that they represent on the committee.

- The Draft contract stipulates that the Managed Care Plan's annual network plan must include a description of coordination with outside organizations.

3. Waiver of Network Requirements for Rural Areas or Other Special Circumstances

- The ITN and draft contract stipulates that if the Managed Care Plan is able to demonstrate to the Agency's satisfaction that a region as a whole is unable to meet network requirements, the Agency may waive the requirement at its discretion in writing. As soon as additional service providers become available, however, the Managed Care Plan shall augment its network to include such providers in order to meet the network adequacy requirements. Such a written waiver shall require attestation by the Managed Care Plan that it agrees to modify its network to include such providers as they become available.

- The ITN and draft contract stipulates that if the Managed Care Plan is unable to provide medically necessary services to an enrollee through its network, the Managed Care Plan shall cover these services in an adequate and timely manner by using providers and

services that are not in the Managed Care Plan's network for as long as the Managed Care Plan is unable to provide the medically necessary services within its network.

4. Regional Network Changes

- The ITN and draft contract stipulates that the Managed Care Plan shall have procedures to address changes in the Managed Care Plan network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network.

- The ITN and draft contract stipulates that the Managed Care Plan shall provide the Agency with documentation of compliance with access requirements at any time there has been a significant change in the Managed Care Plan's regional operations that would affect adequate capacity and services, including, but not limited to, the following:

  (1) Changes in Managed Care Plan services; and
  (2) Enrollment of a new population in the Managed Care Plan.
- The Managed Care Plan shall notify the Agency within seven (7) business days of any adverse changes to its regional provider network. An adverse change is defined as follows:

  (1) For MMA Managed Care Plans, adverse changes to the composition of the network that impair access standards as specified in the MMA ITN.

- The ITN and draft contract stipulates that significant changes in regional network composition that the Agency determines negatively impact enrollee access to services may be grounds for contract termination or sanctions as determined by the Agency and in accordance with Section XI, Sanctions.

Access to care for enrollees with special health care needs:

Care Coordination / Case Management Requirements

- The ITN and draft contract stipulates that the Managed Care Plan shall be responsible for the management and continuity of medical and behavioral health care for all enrollees.

  (1) A mechanism for direct access to specialists for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs.

- The ITN and draft contract stipulates that pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate behavioral health professionals (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, the Managed Care Plan shall have a mechanism in place to allow enrollees to directly access a behavioral health care specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

Cultural considerations:

- The ITN and draft contract stipulates that the Managed Care Plan shall assign a PCP to those enrollees who did not choose a PCP at the time of managed care plan selection. The Managed Care Plan shall take into consideration the enrollee's last PCP (if the PCP is known and available in the Managed Care Plan's network), closest PCP to the enrollee's ZIP

code location, keeping children/adolescents within the same family together, enrollee's age (adults versus children/adolescents), and PCP performance measures. If the language and/or cultural needs of the enrollee are known to the Managed Care Plan, the Managed Care Plan shall assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee.

Access to care outside of the network:

- The ITN and draft contract stipulates that the Managed Care Plan shall provide timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. The Managed Care Plan may not require paper authorization as a condition of receiving treatment Managed Care Plan. Written follow-up documentation of the approval must be provided to the non-participating provider within one (1) business day after the approval. For capitated Managed Care Plan enrollees, the enrollee shall be liable for the cost of such unauthorized use of covered services from non-participating providers.

Appendix D

ATTACHMENT D
SCOPE OF SERVICES – CORE PROVISIONS

Section V. Covered Services

A. Required Benefits

1. General Provisions

a. The Managed Care 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.

b. The Managed Care 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 Managed Care Plan may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.

c. The Managed Care Plan shall comply with all current Florida Medicaid Handbooks (Handbooks) as noticed in the Florida Administrative Register (FAR), or incorporated by reference in rules relating to the provision of services, except where the provisions of the Contract alter the requirements set forth in the Handbooks and Medicaid fee schedules.

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

e. The Managed Care Plan shall require non-participating 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.

f. LTC Managed Care Plans and Comprehensive LTC Managed Care Plans shall be responsible for tracking enrollees with LTC benefits that transition from the nursing facility into an ALF or other residence in the community, as well as those individuals that transition from the ALF or other residence in the community into a nursing facility. The LTC Managed Care Plan or Comprehensive LTC Managed Care Plan shall notify DCF of the date of nursing facility/ALF admission/discharge prior to the respective admission/discharge date. LTC Managed Care Plans and Comprehensive LTC Managed Care Plans shall submit reports to the Agency as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

2. Specific Services to be Provided

a. MMA Managed Care Plans and Comprehensive LTC Managed Care Plans shall ensure the provision of the covered services specified in the MMA Exhibit, including those covered under s. 409.973(1)(a) through (cc), F.S.

b. LTC Managed Care Plans and Comprehensive LTC Managed Care Plans shall ensure the provision of the covered services specified in the LTC Exhibit, including those covered under s. 409.98(1) through (19), F.S.

c. LTC Managed Care Plans and Comprehensive LTC Managed Care Plans are responsible for implementing and managing the Participant Direction Option (PDO) for enrollees with LTC benefits, as defined in Section I, Definitions and Acronyms, and as specified in LTC Exhibit.

d. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those specified in the Handbooks and Medicaid fee schedules except that, pursuant to s. 409.973(2), F.S., Capitated MMA Managed Care Plans and Comprehensive LTC Managed Care Plans may customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional MMA services as specified in MMA Exhibit.

B. Expanded Benefits

1. General Provisions

a. The Managed Care Plan may offer expanded benefits as approved by the Agency.

b. The Managed Care Plan shall provide approved expanded benefits under this Contract as specified in the resulting Contract.

2. Types of Expanded Benefits

a. The Managed Care Plan may offer services in excess of the amount, duration and scope of those listed in the MMA Exhibit for MMA Managed Care Plans and Comprehensive LTC Plans, and the LTC Exhibit for Comprehensive LTC Managed Care Plans and LTC Managed Care Plans.

b. The following services are defined as expanded benefits that may be offered by the Managed Care Plan. The Managed Care Plan shall define expanded benefits specifically in writing and submit them to the Agency for approval before implementation.

c. The Managed Care Plan may offer an over-the-counter expanded drug benefit. Such benefits shall be limited to nonprescription drugs containing a national drug code (NDC) number, first aid supplies, vitamins and birth control supplies. Such benefits must be offered directly through the Managed Care Plan's fulfillment house or through a subcontractor, in which a debit card system may be used. The Managed

Care Plan shall make payments for the over-the-counter drug benefit directly to the subcontractor, if applicable. Over-the-counter expanded drug benefits shall not exceed the following limits:

(1) For MMA Managed Care Plans, such benefits shall not to exceed twenty-five dollars ($25.00) per household per month for enrollees with MMA benefits.

(2) In addition to MMA Managed Care Plan benefits, LTC Managed Care Plan benefits shall not to exceed fifteen dollars ($15.00) per individual per month for enrollees with LTC benefits.

d. The Managed Care Plan may offer adult dental services not otherwise covered or that exceed limits outlined in the in the Medicaid State Plan and the Florida Medicaid Dental Coverage and Limitations Handbook and the Florida Medicaid Dental Fee Schedules.

e. The Managed Care Plan may offer adult vision services not otherwise covered or that exceed limits outlined in the Medicaid State Plan and the Florida Medicaid Visual Services and Optometric Coverage and Limitation Handbooks and the Florida Medicaid Visual and Optometric Fee Schedules.

f. The Managed Care Plan may offer Adult Hearing Services not otherwise covered or that exceed limits outlined in the Medicaid State Plan and the Florida Medicaid Hearing Services Coverage and Limitations Handbook and the Florida Medicaid Hearing Fee Schedule.

g. The Managed Care Plan may offer other services and benefits not listed above upon approval of the Agency.

3. Changes to Expanded Benefits Offered

a. The Managed Care Plan shall submit to the Agency for approval, by the date specified by the Agency, of each Contract year, a Plan Evaluation Tool (PET) for a CBP.

b. Such changes in the Managed Care Plan's expanded benefits shall only be for additional expanded benefits or if the Managed Care Plan is proposing to exchange an expanded benefit for another, the proposed expanded benefit must be determined to be actuarially equivalent, by the Agency, to the expanded benefit being proposed to be removed. In no instance may the Managed Care Plan reduce or remove an expanded benefit if supplemental expanded benefit(s) are not proposed by the Managed Care Plan and approved by the Agency.

c. The Managed Care Plan's expanded benefits may be changed on a Contract year basis and only as approved in writing by the Agency.

C. Excluded Services

1. General Provisions

The Managed Care Plan is not obligated to provide any services not specified in this Contract. Enrollees who require services available through Medicaid but not covered by this Contract shall receive the services through other appropriate Medicaid programs, including the Medicaid fee-for-service system. In such cases, the Managed Care Plan's responsibility shall include care coordination/case management and referral. Therefore, the Managed Care Plan shall determine the potential need for the services and refer the enrollee to the appropriate Medicaid program and/or service provider. The Managed Care Plan may request assistance from the local Medicaid Area Office or ADRC for referral to the appropriate Medicaid program and/or service setting.

2. Moral or Religious Objections

The Managed Care Plan shall provide or arrange for the provision of all covered services. If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Managed Care Plan elects not to provide, reimburse for, or provide counseling or referral to a covered service because of an objection on moral or religious grounds, the Managed Care Plan shall notify:

a. The Agency within one-hundred twenty (120) days before implementing the policy with respect to any covered service; and

b. Enrollees within thirty (30) days before implementing the policy with respect to any covered service.

D. Coverage Provisions

1. Service-Specific Requirements

The Managed Care Plan shall provide the services listed in the resulting Contract in accordance with the provisions herein, and shall comply with all state and federal laws pertaining to the provision of such services. The Managed Care Plan shall provide coverage in accordance with the Florida Medicaid Coverage and Limitations Handbooks, Medicaid fee schedules and the Florida Medicaid State Plan, as well as specific coverage requirements with respect to the applicable SMMC program, as follows:

a. MMA Managed Care Plans must comply with additional provisions for covered services specified in the MMA Exhibit.

b. LTC Managed Care Plans must comply with additional provisions for covered services specified in the LTC Exhibit.

c. Comprehensive LTC Managed Care Plans must comply with additional provisions for covered services specified in both the MMA Exhibit and the LTC Exhibit.

2. Behavioral Health

a. For SMMC enrollees, behavioral health services will be provided to enrollees by other sources, including Medicare, and state-funded programs and services. The Managed Care Plan shall coordinate with other entities, including MMA Managed Care Plans, Medicare plans, Medicare providers, and state-funded programs and services.

b. LTC Managed Care Plans shall be responsible for coordinating with other entities' MMA Managed Care Plans available to provide behavioral health services for these enrollees as specified in the LTC Exhibit.

c. MMA Managed Care Plans and Comprehensive LTC Managed Care Plans shall provide a full range of medically necessary behavioral health services for enrollees as authorized under the Medicaid State Plan and specified in the MMA Exhibit.

3. Managing Mixed Services

a. The Managed Care Plan shall provide case management and care coordination with other Managed Care Plans for enrollees with both MMA benefits and LTC benefits to ensure mixed services are not duplicative but rather support the enrollee in an efficient and effective manner. Mixed Services include:

(1) Assistive Care Services;

(2) Home health and nursing care (intermittent and skilled nursing);

(3) Hospice services;

(4) Medical equipment and supplies (including durable medical equipment); and

(5) Therapy services (physical, occupational, respiratory and speech).

b. MMA Managed Care Plans shall provide mixed services to enrollees with only MMA benefits.

c. The Managed Care Plan, if a Comprehensive LTC Plan, shall provide mixed services to enrollees receiving LTC benefits from the Managed Care Plan.

d. LTC Managed Care Plans shall provide mixed services to enrollees with LTC benefits, regardless of an enrollee's enrollment in an MMA Managed Care Plan.

e. Comprehensive LTC Plans shall provide mixed services to enrollees with both MMA benefits and LTC benefits enrolled in the Comprehensive LTC Plan for both MMA benefits and LTC benefits.

f. Managed Care Plans shall provide non-emergency transportation (NET) services to enrollees with both MMA benefits and LTC benefits as follows:

(1) MMA Managed Care Plans shall provide NET to all MMA benefits.

(2) LTC Managed Care Plans shall provide NET to all LTC benefits.

(3) Comprehensive LTC Managed Care Plans shall provide NET to enrollees with both MMA and LTC benefits, and provide NET to all MMA benefits for enrollees with only MMA benefits.

g. The Managed Care Plan shall also provide case management and care coordination with other service delivery systems serving enrollees in the Managed Care Plan to ensure services are not duplicative but rather support the enrollee in an efficient and effective manner.

E. Care Coordination/Case Management

The Managed Care Plan shall be responsible for care coordination and case management for all enrollees with respect to the applicable SMMC program as follows:

1. MMA Managed Care Plans shall comply with care coordination and case management requirements specified in the MMA Exhibit.

2. LTC Managed Care Plans shall comply with care coordination and case management requirements specified in the LTC Exhibit.

3. Comprehensive LTC Managed Care Plans shall comply with care coordination and case management requirements specified in the MMA Exhibit and the LTC Exhibit.

2. Transition of Care

a. The Managed Care Plan shall develop and maintain transition of care policies and procedures that address all transitional care coordination/care management requirements and submit these policies and procedures for review and approval to the Agency. Transition of care policies and procedures shall include the following minimum functions:

(1) Appropriate support to case managers, and to enrollees and caregivers as needed, for referral and scheduling assistance for enrollees needing specialty health care, transportation or other service supports;

(2) Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting with assistance, as needed, by the Agency. Transfer of medical/case records in compliance with HIPAA privacy and security rules;

(3) Documentation of referral services in enrollee medical/case records, including follow up resulting from the referral;

(4) Monitoring of enrollees with co-morbidities and complex medical conditions and coordination of services for high utilizers to identify gaps in services and evaluate progress of case management;

(5) Identification of enrollees with hospitalizations, including emergency care encounters and documentation in enrollee medical/case records of appropriate follow-up to assess contributing reasons for emergency visits and develop actions to reduce avoidable emergency room visits and potentially avoidable hospital admissions;

(6) Transitional care coordination/care management that includes coordination of hospital/institutional discharge planning and post-discharge care, including conducting a comprehensive assessment of enrollee and family caregiver needs, coordinating the patient's discharge plan with the family and hospital provider team, collaborating with the hospital or institution's care coordinator/case manager to implement the plan in the patient's home and facilitating communication and the transition to community providers and services. The policy and procedures shall define reporting requirements for nursing facility transition, including reporting schedules for case management and submission to the Agency on a quarterly basis; and

(7) Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describing the requirements regarding the privacy of individually identifiable health information.

b. The Managed Care Plan shall be responsible for coordination of care for new enrollees transitioning into the Managed Care Plan.

c. The Managed Care Plan shall be responsible for coordination of care for enrollees transitioning to another Managed Care Plan or delivery system and shall assist the new Managed Care Plan with obtaining the enrollee's medical/case records.

d. The Managed Care Plan shall implement a process determined by the Agency to ensure records and information are shared and passed to the new Managed Care Plan within thirty (30) days.

4. Health Management

a. The Managed Care Plan shall develop and maintain written policies and procedures that address components of effective health management including, but not limited to, anticipation, identification, monitoring, measurement, evaluation of enrollee's health care needs and effective action to promote quality of care.

b. The Managed Care Plan shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization and focus on improved outcome management achieving the highest level of success.

c. The Managed Care Plan, through its QI plan, shall demonstrate specific interventions in its health management to better manage the care and promote healthier enrollee outcomes.

5. Disease Management Program

a. The Managed Care Plan may develop and implement disease management programs for enrollees living with chronic conditions. If implemented, the disease management programs shall address co-morbid conditions and consider the whole health of the enrollee.

b. Disease Management program components may include, but are not limited to, the following:

(1) Disease management including education based on the enrollee assessment of health risks and chronic conditions;

(2) Symptom management including addressing needs such as working with the enrollee on health goals such as smoking cessation, constipation prevention, pain management and other problems;

(3) Medication support and safety in the home;

(4) Emotional issues of the caregiver;

(5) Behavioral management issues of the enrollee;

(6) Safety concerns in the home and fall prevention;

(7) Communicating effectively with providers; and

(8) End of life issues, including information on advance directives.

d. Each Managed Care Plan that chooses to implement disease management programs shall have policies and procedures that include the following:

(1) How enrollees are identified for eligibility and stratified by severity and risk level, including details regarding the algorithm and data sources used to identify eligible enrollees;

(2) How eligible enrollees are contacted for outreach and attempts are made to engage enrollees in disease management services. The Managed Care Plan shall maintain documentation that demonstrates that reasonable attempts were made by the Managed Care Plan to contact and engage eligible enrollees into disease management services;

(3) How the disease management program interfaces with the enrollee's PCP and/or specialist providers and ensures coordination of care; and

(4) How the Managed Care Plan identifies available community support services and facilitates enrollee referrals to those entities for enrollees with identified community support needs.

e. If the Managed Care Plan implements disease management programs, the Managed Care Plan shall submit a copy of its policies and procedures and program description for each of its disease management programs to the Agency by April 1 of each Contract year. If no changes, the Managed Care Plan shall attest to such.

f. If the Managed Care Plan implements disease management programs, the Managed Care Plan shall develop and use a plan of treatment for chronic disease follow-up care that is tailored to the individual enrollee. The purpose of the plan of treatment is to assure appropriate ongoing treatment reflecting the highest standards of medical care designed to minimize further deterioration and complications. The plan of treatment shall be on file for each enrollee with a chronic disease and shall include measurable goals/outcomes and sufficient information to determine if goals/outcomes are met. Medication management, the review of medications that an enrollee is currently taking, should be an ongoing part of the plan of treatment to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications. The enrollee's ability to adhere to a treatment regimen should be monitored in the plan of treatment and include interventions designed to improve the enrollee's ability to adhere to the plan of treatment. The plan of treatment shall be updated at least annually and as required by changes in an enrollee's condition.

F. Quality Enhancements

a. In addition to the covered services specified in this section, the Managed Care Plan shall offer and coordinate access to quality enhancements (QEs). Managed Care Plans are not reimbursed by the Agency for these services, nor may the Managed Care Plan offer these services as expanded benefits. The Managed Care Plan must offer QEs to as follows:

(1) MMA Managed Care Plans shall offer additional quality enhancements as specified in the MMA Exhibit.

(2) LTC Managed Care Plans shall offer additional quality enhancements as specified in the LTC Exhibit.

(3) Comprehensive LTC Managed Care Plans shall offer additional quality enhancements as specified in the MMA Exhibit for enrollees with MMA benefits only and the LTC Exhibit for enrollees with LTC benefits.

b. The Managed Care Plan shall develop and maintain written policies and procedures to implement QEs.

c. The Managed Care Plan shall provide information in the enrollee and provider handbooks on the QEs and how to access related services.

d. The Managed Care Plan shall offer QEs in community settings accessible to enrollees.

e. The Managed Care Plan is encouraged to actively collaborate with community agencies and organizations.

f. If the Managed Care Plan involves the enrollee in an existing community program for purposes of meeting the QE requirements, the Managed Care Plan shall ensure documentation in the enrollee's medical/case record of referrals to the community program and follow up on the enrollee's receipt of services from the community program.

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Appendix E

Section VI. Provider Network

A. Network Adequacy Standards

1. Network Capacity and Geographic Access Standards

Pursuant to s. 409.967(2)(c)(1), Managed Care Plans must maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. At a minimum, Managed Care Plans shall contract with the providers specified in the MMA Provider Network Standards Table (table) below. Managed Care Plans shall ensure regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the table.

Managed Medical Assistance
Provider Network Standards Table

	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Primary Care Provider	30	20	30	20	1:1,500
Specialists					
Adolescent Medicine	100	75	110	90	1:31,200
Allergy	80	60	90	75	1:20,000
Anesthesiology	50	35	75	60	1:1,500
Cardiology	50	35	75	60	1:3,700
Cardiology (PEDS)	100	75	110	90	1:16,667
Cardiovascular Surgery	100	75	110	90	1:10,000
Cardiovascular Surgery (PEDS)	100	75	110	90	1:60,000
Chiropractic	80	60	90	75	1:10,000
Dermatology	60	45	75	60	1:7,900
Endocrinology	100	75	110	90	1:25,000

Endocrinology (PEDS)	100	75	110	90	1:20,000
Gastroenterology	60	45	75	60	1:8,333
General Dentist	50	35	75	60	1:1,500
General Surgery	50	35	75	60	1:3,500
Infectious Diseases	100	75	110	90	1:6,250
Midwife	100	75	110	90	1:33,400
Nephrology	80	60	90	75	1:11,100
Nephrology (PEDS)	100	75	110	90	1:39,600
Neurology	60	45	75	60	1:8,300
Neurology (PEDS)	100	75	110	90	1:22,800
Neurosurgery	100	75	110	90	1:10,000
Obstetrics/Gynecology	50	35	75	60	1:1,500
Oncology	80	60	90	75	1:5,200
Ophthalmology	50	35	75	60	1:4,100
Optometry	50	35	75	60	1:1,700
Oral Surgery	100	75	110	90	1:20,600
Orthodontist	100	75	110	90	1:38,500
Orthopedics	100	75	110	90	1:15,000
Orthopedics (PEDS)	100	75	110	90	1:40,000
Orthopedic Surgery	50	35	75	60	1:5,000
Orthopedic Surgery (PEDS)	100	75	110	90	1:40,000
Otolaryngology	80	60	90	75	1:3,500
Pathology	80	60	90	75	1:3,700
Pediatrics	50	35	75	60	1:1,500
Podiatry	60	45	75	60	1:5,200
Pedodontist	100	75	110	90	1:13,900
Pulmonology	60	45	75	60	1:7,600
Rheumatology	100	75	110	90	1:14,400
Therapist (Occupational)	50	35	75	60	1:1,500
Therapist (Speech)	50	35	75	60	1:1,500
Therapist (Physical)	50	35	75	60	1:1,500
Therapist (Respiratory)	100	75	110	90	1:8,600
Urology	60	45	75	60	1:10,000
Facility/ Group/ Organization					
Hospitals (acute care)	30	20	30	20	1 bed: 275 enrollees
Hospital or Facility with Birth/Delivery Services	30	20	30	20	2: County
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	30	20	30	20	2: County
Adult Family Care Home	n/a	n/a	n/a	n/a	2: County

ALF	n/a	n/a	n/a	n/a	2: County
Birthing Center	n/a	n/a	n/a	n/a	1: County
Hospice	n/a	n/a	n/a	n/a	2: County
DME/HME	n/a	n/a	n/a	n/a	As required in s. 409.975(1)(d), F.S.
Pharmacy	30	20	60	45	1:2500
24-hour Pharmacy	60	45	60	45	1:Region
Behavioral Health					
Board Certified or Board Eligible Adult Psychiatrists	30	20	60	45	1:1,500
Board Certified or Board Eligible Child Psychiatrists	30	20	60	45	1:7,100
Licensed Practitioners of the Healing Arts	30	20	60	45	1:1,500
Licensed Community Substance Abuse Treatment Centers	30	20	60	45	2: county
Inpatient Substance Abuse Detoxification Units	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units (capitated plans only)	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units (capitated plans only)	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees

2. Primary Care Providers

a. The Managed Care Plan shall enter into provider contracts with at least one (1) FTE PCP per one-thousand five-hundred (1,500) enrollees. The Managed Care Plan may increase the ratio by seven-hundred fifty (750) enrollees for each FTE advanced registered nurse practitioner (ARNP) or physician's assistant (PA) affiliated with a PCP. The Managed Care plan shall have at least one (1) FTE PCP in each of the following four (4) specialty areas within the geographic access standards indicated above:

(1) Family Practice;

(2) General Practice;

(3) Pediatrics; and

(4) Internal Medicine.

b. The Managed Care Plan shall ensure the following:

(1) The PCP provides, or arranges for coverage of services, consultation or approval for referrals twenty-four hours per day, seven days per week (24/7) by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage shall consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number; and

(2) The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

(3) Pregnant enrollees are allowed to choose Managed Care Plan obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

3. Specialists and Other Providers

a. The Managed Care Plan shall enter into provider contracts with a sufficient number of specialists to ensure adequate accessibility for enrollees of all ages. The Managed Care Plan shall ensure the following:

(1) At least one (1) of the network infectious disease specialists have expertise in HIV/AIDS and its treatment and care;

(2) Female enrollees have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist;

(3) In accordance with s. 641.31, F.S., low-risk enrollees have access to certified nurse midwife services or licensed midwife services, licensed in accordance with Chapter 467, F.S.

c. For pediatric specialists not listed the Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at a location or via a PCP within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code. Alternatively, for pediatric specialists not listed in the Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.

4. Public Health Providers

a. The Managed Care Plan shall make a good faith effort to execute memoranda of agreement with the local County Health Departments (CHDs) to provide services which may include, but are not limited to, family planning services, services for the treatment of sexually transmitted diseases, other public health related diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and services related to Healthy Start prenatal and post-natal screenings. The Managed Care Plan shall provide documentation of its good faith effort upon the Agency's request.

b. Capitated Managed Care Plans shall pay, without prior authorization, at the contracted rate or the Medicaid fee-for-service rate, all valid claims initiated by any CHD for office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis. Capitated Managed Care Plans shall reimburse the CHD when the CHD notifies the Managed Care Plan and provides the Managed Care Plan with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.

c. The Managed Care Plan shall authorize all claims from a CHD, a migrant health center funded under Section 329 of the Public Health Services Act or a community health center funded under Section 330 of the Public Health Services Act, without prior authorization for the services listed below. Such providers shall attempt to contact the Managed Care Plan before providing health care services to enrollees and shall provide the Managed Care Plan with the results of the office visit, including test results. The Managed Care Plan shall not deny claims for services delivered by these providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred sixty-five (365) calendar days, and shall be reimbursed by the Managed Care Plan at the rate negotiated between the Managed Care Plan and the public provider or the applicable Medicaid fee-for-service rate. The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD cost-based rate as specified by the County Health Department Clinic Services Coverage and Limitations Handbook for applicable rates.

(1) The diagnosis and treatment of sexually transmitted diseases and other reportable infectious diseases, such as tuberculosis and HIV;

(2) The provision of immunizations;

(3) Family planning services and related pharmaceuticals;

(4) School health services listed in a, b and c above, and for services rendered on an urgent basis by such providers; and

(5) In the event that a vaccine-preventable disease emergency is declared, the Managed Care Plan shall authorize claims from the CHD for the cost of the administration of vaccines.

d. Other clinic-based services provided by a CHD, migrant health center or community health center, including well-child care, dental care, and sick care services not associated with reportable infectious diseases, require prior authorization from the Managed Care Plan in order to receive reimbursement. If prior authorization is provided, the Managed Care Plan shall reimburse at the entity's cost-based reimbursement rate. If prior authorization for prescription drugs is given and the drugs are provided, the Managed Care Plan shall reimburse the entity at Medicaid's standard pharmacy rate.

e. The Managed Care Plan shall make a good faith effort to execute a contract with a Rural Health Clinic (RHC).

f. Capitated Managed Care Plans shall reimburse FQHCs and RHCs at rates comparable to those rates paid for similar services in the FQHC's or RHC's community.

g. Capitated Managed Care Plans shall report quarterly to the Agency as part of its quarterly financial reports, the payment rates and the payment amounts made to FQHCs and RHCs for contractual services provided by these entities.

h. The Managed Care Plan shall make a good faith effort to execute memoranda of agreement with school districts participating in the certified match program regarding the coordinated provision of school-based services pursuant to ss. 1011.70, 409.9071, F.S. and 409.908(21), F.S.

5. Facilities and Ancillary Providers

The Managed Care Plan shall enter into provider contracts with a sufficient number of facilities and ancillary providers to ensure adequate accessibility for enrollees of all ages. The Managed Care Plan shall ensure the following:

a. Network emergency service facilities have one (1) or more physicians and one (1) or more nurses on duty in the facility at all times;

b. Network facilities are licensed, as required by law and rule, accessible to the handicapped, in compliance with federal Americans with Disabilities Act guidelines, and have adequate space, supplies, good sanitation, and fire, safety, and disaster preparedness and recovery procedures in operation;

c. Care for medically high-risk perinatal enrollees is provided in a facility with a NICU sufficient to meet the appropriate level of need for the enrollee;

d. Pursuant to s. 409.967(2)(c)1, F.S., the Managed Care Plan may use mail-order pharmacies; however mail-order pharmacies shall not count towards the Managed Care Plan's pharmacy network access standards; and

e. In accordance with s. 409. 975(1)(d), F.S., a provider contract is offered to each licensed home medical equipment and supplies provider and to each Medicaid enrolled durable medical equipment (DME) provider in the region, as specified by the Agency, that meets quality and fraud prevention and detection standards established

by the Managed Care Plan and that agrees to accept the lowest price previously negotiated between the Managed Care Plan and another such provider.

6. Essential Providers

a. Pursuant to s. 409.975(1)(b), F.S., certain providers are statewide resources and essential providers for all managed care plans in all regions. The Managed Care Plan shall include these essential providers in its network, even if the provider is located outside of the region served by the Managed Care Plan.

b. Statewide essential providers include:

(1) Faculty plans of Florida medical schools, which include University of Florida College of Medicine, University of Miami School of Medicine, University of South Florida College of Medicine, University of Central Florida College of Medicine, Nova Southeastern University College of Osteopathic Medicine, Florida State University College of Medicine, and Florida International University College of Medicine;

(2) Regional perinatal intensive care centers (RPICCs) as defined in s. 383.16(2), F.S., including All Children's Hospital, Arnold Palmer Hospital, Bayfront Medical Center, Broward General Medical Center, Jackson Memorial Hospital, Lee Memorial Hospital at HealthPark, Memorial Regional Hospital, Sacred Heart Hospital, Shands – Jacksonville, Shands Teaching Hospital, St. Mary's Hospital and Tampa General Hospital;

(3) Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28), F.S., including All Children’s Hospital, Miami Children’s Hospital, Nemours; and Shriners Hospitals for Children; and

(4) Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

c. If the Managed Care Plan has not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment, the Managed Care Plan must continue to negotiate in good faith.

(1) The Managed Care Plan shall make payments to physicians on the faculty of non-participating Florida medical schools at the applicable Medicaid rate.

(2) The Managed Care Plan shall make payments for services rendered by a regional perinatal intensive care center at the applicable Medicaid rate as of the first day of this Contract.

(3) The Managed Care Plan shall make payments to a non-participating specialty children's hospital equal to the highest rate established by contract between that provider and any other Medicaid managed care plan.

d. Pursuant to s. 409.975(1)(c), F.S., after twelve (12) months of active participation in the Managed Care Plan's network, the Managed Care Plan may exclude any essential provider from the network for failure to meet quality or performance criteria.

e. Pursuant to s. 409.975(1)(a), F.S., the Managed Care Plan must include all providers in the region that are classified by the Agency as essential Medicaid providers, unless the Agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers.

f. The Agency may determine that the following providers are essential Medicaid providers:

(1) Federally qualified health centers.
(2) Statutory teaching hospitals as defined in s. 408.07(45), F.S.
(3) Hospitals that are trauma centers as defined in s. 395.4001(14), F.S.
(4) Hospitals located at least twenty-five (25) miles from any other hospital with similar services.

7. Timely Access Standards

a. The Managed Care Plan must assure that PCP services and referrals to specialists for medical and behavioral health services are available on a timely basis, as follows:

(1) Urgent Care — within one (1) day of the request;

(2) Sick Care — within one (1) week of the request; and

(3) Well Care Visit — within one (1) month of the request.

b. Annually by February 1 of each Contract year, the Managed Care Plan shall review a statistically valid sample of PCP and specialist offices' average appointment wait times to ensure services are in compliance with this subsection, and report the results to the Agency in the format specified, in accordance with Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. (See 42 CFR 438.206(c)(1)(iv),(v) and (vi).)

B. Network Development and Management Plan

1. Regional Network Changes

a. The Managed Care Plan shall notify the Agency within seven (7) business days of any significant changes to its regional provider network. A significant change is defined as follows:

(1) Any change that would cause more than five percent (5%) of enrollees in the region to change the location where services are received or rendered; or

(2) For MMA Managed Care Plans, a decrease in the total number of PCPs by more than five percent (5%).

C. Provider Credentialing and Contracting

1. Credentialing and Recredentialing

a. Managed Care Plan credentialing and recredentialing processes must include verification of the following additional requirements for physicians and must ensure compliance with 42 CFR 438.214:

(1) Good standing of privileges at the hospital designated as the primary admitting facility by the physician or if the physician does not have admitting privileges, good standing of privileges at the hospital by another provider with whom the physician has entered into an arrangement for hospital coverage;

(2) Valid Drug Enforcement Administration (DEA) certificates, where applicable;

(3) Attestation that the total active patient load (all populations, including but not limited to, Medicaid FFS; Children's Medical Services Network; SMMC plans; Medicare; KidCare and commercial coverage) is no more than three-thousand (3,000) patients per PCP. An active patient is one that is seen by the provider a minimum of three (3) times per year;

(4) A good standing report on a site visit survey. For each PCP, documentation in the Managed Care Plan's credentialing files regarding the site survey shall include the following:

i. Evidence that the Managed Care Plan has evaluated the provider's facilities using the Managed Care Plan's organizational standards;

ii. Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place;

iii. Evidence that the Managed Care Plan has evaluated the provider's medical/case record keeping practices at each site to ensure conformity with the Managed Care Plan's organizational standards;

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

(5) Attestation to the correctness/completeness of the provider's application;

(6) Statement regarding any history of loss or limitation of privileges or disciplinary activity as described in s. 456.039, F.S.;

(7) A statement from each provider applicant regarding the following:

i. Any physical or mental health problems that may affect the provider's ability to provide health care;

ii. Any history of chemical dependency/substance abuse;

iii. Any history of loss of license and/or felony convictions; and

iv. The provider is eligible to become a Medicaid provider.

(8) Current curriculum vitae, which includes at least five (5) years of work history.

(9) Proof of the provider's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, if applicable, and;

(10) Evidence of specialty board certification, if applicable.

b. The Managed Care Plan shall recredential its providers at least every three (3) years using information from ongoing provider monitoring.

c. Hospital ancillary providers are not required to be independently credentialed if those providers serve Managed Care Plan enrollees only through the hospital.

2. Provider Contract Requirements

a. The Managed Care Plan shall include the following additional provisions in its MMA provider contracts:

(1) If there is a Managed Care Plan physician incentive plan, include a statement that the Managed Care Plan shall make no specific payment directly or indirectly under a physician incentive plan to a provider as an inducement to reduce or limit, medically necessary services to an enrollee, and that incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care;

(2) Require providers to meet timely access standards pursuant to this Contract;

(3) Require that all providers agreeing to participate in the network as PCPs fully accept and agree to responsibilities and duties associated with the PCP designation;

(4) Contain no provision that prohibits the provider from providing inpatient services in a participating hospital to an enrollee if such services are determined to be medically necessary and covered services under this Contract;

(5) For hospital contracts, include rates that are in accordance with s. 409.975(6), F.S.;

(6) For hospital contracts, include a clause that states whether the Managed Care Plan or the hospital will complete the DCF Excel spreadsheet for unborn activation;

(7) If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount or for FFS Managed Care Plans, the Medicaid fee schedule amount, less any applicable copayments; and

(8) If the provider has been approved by the Managed Care Plan to provide services through telemedicine, specify that the provider is required to have protocols to prevent fraud and abuse. The provider must implement telemedicine fraud and abuse protocols that address:

i. Authentication and authorization of users;

ii. Authentication of the origin of the information;

iii. The prevention of unauthorized access to the system or information;

iv. System security, including the integrity of information that is collected, program integrity and system integrity; and

v. Maintenance of documentation about system and information usage.

D. Provider Services

1. Additional Provider Handbook Requirements

The Managed Care Plan shall include the following information in provider handbooks:

(1) Child Health Check-Up program services and standards;

(2) PCP responsibilities;

(3) Information on the Managed Care Plan's Healthy Behaviors programs;

(4) If Managed Care Plan allows the use of telemedicine, telemedicine requirements for providers; and

(5) If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount or for FFS Managed Care Plans, the Medicaid fee schedule amount, less any applicable copayments.

E. Medical/Case Record Standards

1. Standards for Medical/Case Records

a. All records shall contain documentation to include the following items for services provided through telemedicine:

(1) A brief explanation of the use of telemedicine in each progress note;

(2) Documentation of telemedicine equipment used for the particular covered services provided;

(3) A signed statement from the enrollee or the enrollee's representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided; and

(4) For telepsychiatry, the results of the assessment, findings and practitioner(s) plan for next steps.

Section VII. Quality and Utilization Management

A. Quality Improvement

There are no additional quality improvements provisions unique to the MMA managed care program.

B. Performance Measures (PMs)

The Managed Care Plan shall collect and report the following performance measures, certified via qualified auditor.

HEDIS	
1	Adolescent Well Care Visits - (AWC)
2	Adults' Access to Preventive/Ambulatory Health Services - (AAP)
3	Annual Dental Visits - (ADV)
4	Antidepressant Medication Management - (AMM)
5	BMI Assessment – (ABA)
6	Breast Cancer Screening – (BCS)
7	Cervical Cancer Screening – (CCS)
8	Childhood Immunization Status – (CIS) – Combo 2 and 3

Appendix F

Section VI. Provider Network

A. Network Adequacy Standards

1. General Provisions

a. The Managed Care Plan shall enter into provider contracts with a sufficient number of providers to provide all covered services to enrollees and ensure that each covered service is provided promptly and is reasonably accessible.

b. The Managed Care Plan shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements of this Contract.

c. When establishing and maintaining the provider network or requesting enrollment level increases, the Managed Care Plan shall take the following into consideration as required by 42 CFR 438.206:

(1) The anticipated number of enrollees;

(2) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented;

(3) The numbers and types (in terms of training, experience and specialization) of providers required to furnish the covered services;

(4) The numbers of participating providers who are not accepting new enrollees; and

(5) The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees and whether the location provides physical access for Medicaid enrollees with disabilities.

d. Except as otherwise provided in the Contract, the Managed Care Plan may limit the providers in its network based on credentials, quality indicators, and price.

e. The Managed Care Plan shall allow each enrollee to choose among participating providers in accordance with 42 CFR 431.51.

2. Network Capacity and Geographic Access Standards

a. The Managed Care Plan shall have sufficient facilities, service locations and practitioners to provide the covered services as required by this Contract.

b. The Managed Care Plan shall have the capacity to provide covered services to all enrollees up to the maximum enrollment level, by region, as indicated in the resulting Contract.

c. Pursuant to s. 409.967(2)(c)(1), F.S., the Managed Care Plan shall maintain a region-wide network of providers in sufficient numbers to meet the network capacity and geographic access standards for services with respect to the applicable SMMC program, as follows:

(1) MMA Managed Care Plans shall meet the network capacity and geographic access standards specified in MMA Exhibit.

(2) LTC Managed Care Plans shall meet the network capacity and geographic access standards specified in LTC Exhibit.

(3) Comprehensive LTC Managed Care Plans shall meet the network capacity and geographic access standards specified in the both the MMA Exhibit and the LTC Exhibit.

3. Demonstration of Network Adequacy

The Managed Care Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

4. Timely Access Standards

a. The Managed Care Plan shall contract with and maintain a provider network sufficient to comply with timely and geographic access standards as specified in this Contract with respect to the applicable SMMC program as follows:

(1) MMA Managed Care Plans and Comprehensive LTC Managed Care Plans shall comply with timely access standards specified in the MMA Exhibit.

b. In accordance with 42 CFR 438.206 (c), the Managed Care Plan shall establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.

B. Network Development and Management Plan

1. General Provisions

a. The Managed Care Plan shall develop and maintain an annual network development and management plan (annual network plan). The Managed Care Plan shall submit this plan annually to the Agency.

b. The Managed Care Plan shall develop and maintain policies and procedures to evaluate the Managed Care Plan's provider network to ensure that covered services are:

(1) Available and accessible, at a minimum, in accordance with the access standards in the Contract;

(2) Provided promptly and are reasonably accessible in terms of location and hours of operation; and

(3) For LTC Managed Care Plans and Comprehensive LTC Managed Care Plans, home and community-based services (HCBS) are available to enrollees with LTC benefits on a seven (7) day a week basis, and for extended hours, as dictated by enrollee needs.

c. The methodology(ies) the Managed Care Plan uses to collect and analyze enrollee, provider and staff feedback about the network designs and performance, and, when specific issues are identified, the protocols for handling them.

2. Annual Network Plan Content

a. The Managed Care Plan's annual network plan shall include the Managed Care Plan's processes to develop, maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.

b. The Managed Care Plan's annual network plan must include a description of network design by region and county for the general population, including details regarding special populations as identified by the Managed Care Plan (e.g., medically complex). The description shall also cover:

(1) How enrollees access the system;

(2) Analysis of timely access to services; and

(3) Relationships among various levels of the system.

c. The Managed Care Plan's annual network plan must include a description of the evaluation of the prior year's plan including an explanation of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation.

d. Managed Care Plan's annual network plan must include a description or explanation of the current status of the network by each covered service at all levels including:

(1) How enrollees access services;

(2) Analysis of timely access to services;

(3) Relationships between the various levels, focusing on provider-to-provider contact and facilitation of such by the Managed Care Plan (e.g., PCP, specialists, hospitals, behavioral health, ALFs, home health agencies); and

(4) For MMA and Comprehensive LTC Managed Care Plans, the assistance and communication tools provided to PCPs when they refer enrollees to specialists and the methods used to communicate the availability of this assistance to the providers.

e. The Managed Care Plan's annual network plan must any current barriers and/or network gaps and include the following:

(1) The methodology used to identify barriers and network gaps;

(2) Immediate short-term interventions to address network gaps;

(3) Longer-term interventions to fill network gaps and resolve barriers;

(4) Outcome measures/evaluation of interventions to fill network gaps and resolve barriers;

(5) Projection of changes in future capacity needs, by covered service; and

(6) Ongoing activities for network development based on identified gaps and future needs projection.

f. The Managed Care Plan's annual network plan must include a description of coordination between internal departments, including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (e.g., quality management, medical management/utilization management, grievances, finance, claims) that they represent on the committee.

g. The Managed Care Plan's annual network plan must include a description of coordination with outside organizations.

3. Waiver

a. If the Managed Care Plan is able to demonstrate to the Agency's satisfaction that a region as a whole is unable to meet network requirements, the Agency may waive the requirement at its discretion in writing. As soon as additional service providers become available, however, the Managed Care Plan shall augment its network to include such providers in order to meet the network adequacy requirements. Such a written waiver shall require attestation by the Managed Care Plan that it agrees to modify its network to include such providers as they become available.

b. If the Managed Care Plan is unable to provide medically necessary services to an enrollee through its network, the Managed Care Plan shall cover these services in an adequate and timely manner by using providers and services that are not in the Managed Care Plan's network for as long as the Managed Care Plan is unable to provide the medically necessary services within its network.

4. Regional Network Changes

a. The Managed Care Plan shall have procedures to address changes in the Managed Care Plan network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network.

b. The Managed Care Plan shall provide the Agency with documentation of compliance with access requirements at any time there has been a significant change in the Managed Care Plan's regional operations that would affect adequate capacity and services, including, but not limited to, the following:

(1) Changes in Managed Care Plan services; and

(2) Enrollment of a new population in the Managed Care Plan.

c. The Managed Care Plan shall notify the Agency within seven (7) business days of any adverse changes to its regional provider network. An adverse change is defined as follows:

(1) For MMA Managed Care Plans, adverse changes to the composition of the network that impair access standards as specified in the MMA Exhibit;

(2) For LTC Managed Care Plans, adverse changes to the composition of the network that impair access standards as specified in the LTC Exhibit; or

(3) For Comprehensive LTC Managed Care Plans, adverse changes to the composition of the network that impair access standards as specified in both the MMA Exhibit and the LTC Exhibit.

e. Significant changes in regional network composition that the Agency determines negatively impact enrollee access to services may be grounds for Contract termination or sanctions as determined by the Agency and in accordance with Section XI, Sanctions.

C. Provider Credentialing and Contracting

1. General Provision

The Managed Care Plan shall be responsible for the credentialing and recredentialing of its provider network.

2. Credentialing and Recredentialing

a. The Managed Care Plan's credentialing and recredentialing policies and procedures shall be in writing and include the following:

(1) Formal delegations and approvals of the credentialing process;

(2) A designated credentialing committee;

(3) Identification of providers who fall under its scope of authority;

(4) A process that provides for the verification of the credentialing and recredentialing criteria required under this Contract;

(5) Approval of new providers and imposition of sanctions, termination, suspension and restrictions on existing providers;

(6) Identification of quality deficiencies that result in the Managed Care Plan's restriction, suspension, termination or sanctioning of a provider.

b. The Managed Care Plan shall establish and verify credentialing and recredentialing criteria for all providers that, at a minimum, meet the Agency's Medicaid participation standards. The Agency's criteria include:

(1) A copy of each provider's current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualifications;

(2) No revocation, moratorium or suspension of the provider's state license by the Agency or the Department of Health, if applicable;

(3) Evidence of the provider's professional liability claims history;

(4) Any sanctions imposed on the provider by Medicare or Medicaid;

(5) Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106); and

(6) A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program, in accordance with the following:

(a) The Managed Care Plan shall ensure providers not currently enrolled in Medicaid's fee-for-service program submit fingerprints electronically following the process described on the Agency's Background Screening website. The Managed Care Plan shall verify Medicaid eligibility through the background screening system;

(b) The Managed Care Plan shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;

(c) Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department

using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening; and

(d) Individuals listed in s. 409.907(8)(a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.

d. The Managed Care Plan's credentialing and recredentialing files must document the education, experience, prior training and ongoing service training for each staff member or provider rendering services.

e. The Managed Care Plan shall collect and verify each provider's National Provider Identifier (NPI) and taxonomy as part of the credentialing and recredentialing process, as applicable.

f. The Managed Care Plan shall establish and verify additional provider credentialing and recredentialing criteria with respect to the applicable SMMC program as follows:

(1) MMA Managed Care Plans shall verify the additional criteria specified in the MMA Exhibit.

(2) LTC Managed Care Plans shall verify the additional criteria specified in the LTC Exhibit.

(3) Comprehensive LTC Managed Care Plans shall verify the additional criteria specified in the MMA Exhibit for MMA providers and the LTC Exhibit for LTC providers. Comprehensive LTC Managed Care Plans shall verify the additional criteria for all mixed service providers specified in the MMA Exhibit.

g. The Managed Care Plan must submit disclosures and notifications to the federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) and to MPI in accordance with s. 1128, s. 1156, and s. 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in Section VIII.F.

h. The Managed Care Plan shall not pay, employ or contract with individuals on the state or federal exclusions lists.

i. If the Managed Care Plan declines to include individual providers or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

3. Provider Registration

a. If the Managed Care Plan is capitated, it shall ensure that all providers are eligible for participation in the Medicaid program. If a provider is currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or

sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. If the Managed Care Plan is not capitated, its providers shall be enrolled as Florida Medicaid providers. Suspension and termination are described further in Rule 59G-9.070, F.A.C.

b. The Managed Care Plan shall require each provider to have a unique Florida Medicaid provider number, Medicaid provider registration number or documentation of submission of the Medicaid provider registration form.

c. The Managed Care Plan shall require each provider to have a National Provider Identifier (NPI) in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The provider contract shall require providers to submit all NPIs to the Managed Care Plan. The Managed Care Plan shall file the providers' NPIs as part of its provider network file to the Agency or its agent, as set forth in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. The Managed Care Plan need not obtain an NPI from an entity that does not meet the definition of "health care provider" found at 45 CFR 160.103:

(1) Individuals or organizations that furnish atypical or nontraditional services that are only indirectly related to the provision of health care (examples include taxis, home modifications, home delivered meals and homemaker services); and

(2) Individuals or businesses that only bill or receive payment for, but do not furnish, health care services or supplies (examples include billing services and repricers).

4. Minority Recruitment and Retention Plan

The Managed Care Plan shall implement and maintain a minority recruitment and retention plan in accordance with s. 641.217, F.S. The Managed Care Plan shall have policies and procedures for the implementation and maintenance of such a plan. The minority recruitment and retention plan may be company-wide for all product lines.

5. Prohibition Against Discriminatory Practices

a. The Managed Care Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification, in accordance with s. 1932(b) (7) of the Social Security Act (as enacted by s. 4704[a] of the Balanced Budget Act of 1997).

b. The Managed Care Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments.

6. Provider Contract Requirements

a. The Managed Care Plan shall comply with all Agency requirements for provider contract review and approval submission.

b. The Managed Care Plan shall ensure all provider contracts comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.

c. All provider contracts and amendments executed by the Managed Care Plan shall be in writing, signed and dated by the Managed Care Plan and the provider, and shall meet the following requirements:

(1) Contain no provision that in any way prohibits or restricts the provider from entering into a commercial contract with any other Managed Care Plan (see s. 641.315, F.S.);

(2) Contain no provision requiring the provider to contract for more than one (1) Managed Care Plan product or otherwise be excluded (see s. 641.315, F.S.);

(3) Not prohibit a provider from acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee for the enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;

(4) Not prohibit a provider from discussing treatment or non-treatment options with enrollees that may not reflect the Managed Care Plan's position or may not be covered by the Managed Care Plan;

(5) Not prohibit a provider from advocating on behalf of the enrollee in any grievance system or UM process, or individual authorization process to obtain necessary services;

(6) Require providers to offer hours of operation that are no less than the hours of operation offered to commercial Managed Care Plan members or comparable Medicaid fee-for-service recipients if the provider serves only Medicaid recipients;

(7) Specify covered services and populations to be served under the provider contract;

(8) Require providers to immediately notify the Managed Care Plan of an enrollee’s pregnancy, whether identified through medical history, examination, testing, claims or otherwise;

(9) For nursing facility and hospice, include a bed hold days provision that comports with Medicaid FFS bed hold days policies and procedures;

(10) Require all direct service providers to complete abuse, neglect and exploitation training;

(11) Include provisions for the immediate transfer to another provider if the enrollee's health or safety is in jeopardy;

(12) Require providers of transitioning enrollees to cooperate in all respects with providers of other Managed Care Plans to assure maximum health outcomes for enrollees;

(13) Provide for continuity of treatment in the event a provider contract terminates during the course of an enrollee's treatment by that provider;

(14) Prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of this Contract;

(15) Require the provider to look solely to the Managed Care Plan for compensation for services rendered, with the exception of nominal cost sharing and patient responsibility, pursuant to the Medicaid State Plan and the Medicaid Provider General and Coverage and Limitations Handbooks and in accordance with this Contract as follows:

(a) If a capitated Managed Care Plan, then to the capitated Managed Care Plan for compensation;

(b) If a FFS Managed Care Plan, then to the Agency or its fiscal agent, unless the service is a transportation service for which the Managed Care Plan receives a capitation payment from the Agency. For such capitated transportation services, the Managed Care Plan shall require providers to look solely to the Managed Care Plan;

(16) Specify that any claims payment be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of the Managed Care Plan;

(17) Require the provider to cooperate with the Managed Care Plan's peer review, grievance, QI and UM activities, provide for monitoring and oversight, including monitoring of services rendered to enrollees, by the Managed Care Plan (or its subcontractor), and identify the measures that will be used by the Managed Care Plan to monitor the quality and performance of the provider. If the Managed Care Plan has delegated the credentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Managed Care Plan’s and the Agency’s credentialing requirements as found in Section VI. C.2.;

(18) Require that providers and subcontractors comply with the Managed Care Plan's cultural competency plan;

(19) Require that any marketing materials related to this Contract that are displayed by the provider be submitted to the Agency for written approval before use;

(20) Specify that the provider shall comply with the marketing requirements specified in Section III.D.;

(21) Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Managed Care Plan;

(22) Require that records be maintained for a period not less than six (6) years from the close of the Contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the provider contract is continuous;

(23) Specify that DHHS, the Agency, DOEA, MPI and MFCU shall have the right to inspect, evaluate, and audit all of the following related to this Contract:

(a) Pertinent books;

(b) Financial records;

(c) Medical/case records; and

(d) Documents, papers and records of any provider involving financial transactions;

(24) Provide for submission of all reports and clinical information required by the Managed Care Plan, including Child Health Check-Up reporting (if applicable);

(25) Require providers to submit timely, complete and accurate encounter data to the Managed Care Plan in accordance with the requirements of Section VIII.E.;

(26) Require providers to cooperate fully in any investigation by the Agency, MPI, MFCU or other state or federal entity and in any subsequent legal action that may result from such an investigation involving this Contract;

(27) Require compliance with the background screening requirements of this Contract;

(28) Require safeguarding of information about enrollees according to 42 CFR 438.224;

(29) Require compliance with HIPAA privacy and security provisions;

(30) Require providers to submit notice of withdrawal from the network at least ninety (90) calendar days before the effective date of such withdrawal;

(31) Specify that in addition to any other right to terminate the provider contract, and notwithstanding any other provision of this Contract, the Agency or the Managed Care Plan may request immediate termination of a provider contract if, as determined by the Agency, a provider fails to abide by the terms and conditions of the provider contract, or in the sole discretion of the Agency, the provider fails to come into compliance with the provider contract within fifteen (15) calendar days after receipt of notice from the Managed Care Plan specifying such failure and requesting such provider abide by the terms and conditions thereof;

(32) Specify that any provider whose participation is terminated pursuant to the provider contract for any reason shall utilize the applicable appeals procedures outlined in the provider contract. No additional or separate right of appeal to the Agency or the Managed Care Plan is created as a result of the Managed Care Plan's act of terminating, or decision to terminate, any provider under this Contract. Notwithstanding the termination of the provider contract with respect to any particular provider, this Contract shall remain in full force and effect with respect to all other providers;

(33) Require an exculpatory clause, which survives provider agreement termination, including breach of provider contract due to insolvency, which assures that neither Medicaid recipients nor the Agency shall be held liable for any debts of the provider;

(34) Require that the provider secure and maintain during the life of the provider contract workers' compensation insurance (complying with the Florida workers' compensation law) for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Managed Care Plan;

(35) Require all providers to notify the Managed Care Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida statutes;

(36) Contain a clause indemnifying, defending and holding the Agency and the Managed Care Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the provider agreement. This clause must survive the termination of the agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Managed Care Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers shall be approved in writing by the Agency;

(37) Make provisions for a waiver of those terms of the provider contract that, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract; and

(38) Specify that any contracts, agreements or subcontracts entered into by the provider for purposes of carrying out any aspect of this Contract shall include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of this Contract.

d. The Managed Care Plan shall include additional provisions in its provider contracts with respect to the applicable SMMC program as follows:

(1) MMA Managed Care Plans shall include the additional provisions specified in the MMA Exhibit.

(2) LTC Managed Care Plans shall include the additional provisions specified in the LTC Exhibit.

(3) Comprehensive LTC Managed Care Plans shall include additional provisions specified in the MMA Exhibit for MMA only providers, the LTC Exhibit for LTC only providers and the MMA Exhibit for mixed service providers.

e. No provider contract that the Managed Care Plan enters into with respect to performance under this Contract shall in any way relieve the Managed Care Plan of any responsibility for the provision of services or duties under this Contract. The Managed Care Plan shall assure that all services and tasks related to the provider contract are performed in accordance with the terms of this Contract. The Managed Care Plan shall identify in its provider contract any aspect of service that may be subcontracted by the provider.

f. The Managed Care Plan shall prohibit discrimination with respect to participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of such license or certification. This provision shall not be construed as an any willing provider law, as it does not prohibit the Managed Care Plan from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision does not interfere with measures established by the Managed Care Plan that are designed to maintain quality and control costs;

7. Network Performance Management

a. The Managed Care Plan shall monitor the quality and performance of each participating provider.

b. The Managed Care Plan shall include using performance measures specified and collected by the Agency, as well as additional measures agreed upon by the provider and the Managed Care Plan.

c. The Managed Care Plan is not prohibited from including providers only to the extent necessary to meet the needs of the Managed Care Plan's enrollees or from

establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Managed Care Plan.

d. The Managed Care Plan shall have policies and procedures for imposing provider sanctions, restrictions, suspensions and/or terminations.

e. The Managed Care Plan shall develop and implement an appeal procedure for providers against whom the Managed Care Plan has imposed sanctions, restrictions, suspensions and/or terminations.

8. Provider Termination and Continuity of Care

a. The Managed Care Plan shall comply with all state and federal laws regarding provider termination.

b. The Managed Care Plan shall notify enrollees in accordance with the provisions of this Contract and state and federal law regarding provider termination. Additionally, the Managed Care Plan shall provide notice to enrollees as follows:

(1) Pursuant to s. 409.982(1), F.S., if a LTC Managed Care Plan or Comprehensive LTC Managed Care Plan excludes an aging network provider for failure to meet quality or performance criteria specified in s. 409.967, F.S., the Managed Care Plan must provide written notice to all enrollees who have chosen that provider for care, and the notice must be provided at least thirty (30) calendar days before the effective date of the exclusion.

(2) For MMA Managed Care Plans and Comprehensive LTC Managed Care Plans, if a PCP ceases participation in the Managed Care Plan's network, the Managed Care Plan shall send written notice to the enrollees who have chosen the provider as their PCP. This notice must be provided at least thirty (30) calendar days before the effective date of the termination notice. The requirement to provide notice prior to the effective dates of termination shall be waived in instances where a provider becomes physically unable to care for enrollees due to illness, death or leaving the Managed Care Plan's region(s) and fails to notify the Managed Care Plan, or when a provider fails credentialing. Under these circumstances, notice shall be issued immediately upon the Managed Care Plan's becoming aware of the circumstances.

(3) Pursuant to s. 409.975(1)(c), F.S., if a MMA or Comprehensive LTC Managed Care Plan excludes any essential provider from its network for failure to meet quality or performance criteria, the Managed Care Plan must provide written notice to all enrollees who have chosen that provider for care. The notice shall be provided at least thirty (30) calendar days before the effective date of the exclusion.

c. The Managed Care Plan shall notify the provider and enrollees in active care at least sixty (60) calendar days before the effective date of the suspension or termination of a provider from the network. If the termination was for "cause," the Managed Care Plan shall provide to the Agency the reasons for termination.

d. If an enrollee is receiving prior authorized care from any provider who becomes unavailable to continue to provide services, the Managed Care Plan shall notify the enrollee in writing within ten (10) calendar days from the date the Managed Care Plan becomes aware of such unavailability. These requirements to provide notice prior to the effective dates of termination shall be waived in instances where a provider becomes physically unable to care for enrollees due to illness, death or leaving the Managed Care Plan's region(s) and fails to notify the Managed Care Plan, or when a provider fails credentialing. Under these circumstances, notice shall be issued immediately upon the Managed Care Plan's becoming aware of the circumstances.

e. In a case in which a patient's health is subject to imminent danger or a provider's ability to practice medicine or otherwise provide services is effectively impaired by an action by the Board of Medicine or other governmental agency, notice to both the provider, the enrollee and the Agency shall be immediate. The Managed Care Plan shall work cooperatively with the Agency to develop and implement a plan for transitioning enrollees to another provider.

f. The Managed Care Plan shall allow enrollees to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such recipients until the enrollee selects another provider as specified below:

(1) For MMA and LTC services, continuation shall be provided for a minimum of sixty (60) calendar days after the termination of the provider's contract for the provision of services;

(2) For MMA services, continuation shall not exceed six (6) months after the termination of the provider's contract for the provision of MMA services; and

(3) For any pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, continuation shall be provided until the completion of postpartum care.

g. Notwithstanding the provisions in this section, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

h. For continued care under this section, the Managed Care Plan and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

i. The requirements set forth in this section, shall not apply to providers who have been terminated from the Managed Care Plan for cause.

ATTACHMENT D
SCOPE OF SERVICES – CORE PROVISIONS

D. Provider Services

1. General Provisions

a. The Managed Care Plan shall establish and maintain a formal provider relations function to respond timely and adequately to inquiries, questions and concerns from participating providers.

b. The Managed Care Plan shall provide sufficient information to all providers in order to operate in full compliance with this Contract and all applicable federal and state laws and regulations.

c. The Managed Care Plan shall monitor provider compliance with Contract requirements and take corrective action when needed to ensure compliance.

2. Provider Handbook and Bulletin Requirements

a. The Managed Care Plan shall issue a provider handbook to all providers at the time the provider credentialing is complete.

b. The Managed Care Plan may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the handbook from the Managed Care Plan's website. This notification shall also detail how the provider can request a hard copy from the Managed Care Plan at no charge.

c. The Managed Care Plan shall keep all provider handbooks and bulletins up to date and in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding Managed Care Plan covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are met.

d. The Managed Care Plan's provider handbook must, at a minimum, include the following information:

(1) Description of the Medicaid program and the SMMC program;

(2) Listing of covered services;

(4) Emergency service responsibilities;

(5) Provider or subcontractor responsibilities;

(6) Requirements regarding background screening;

(7) Agency medical necessity standards and practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

(8) Prior authorization and referral procedures, including required forms;

(9) Information on the Managed Care Plan's quality enhancement programs;

(10) Medical/case records standards;

(11) Claims submission protocols and standards, including instructions and all information required for a clean or complete claim;

(12) Protocols for submitting encounter data;

(13) Information notifying providers that the Managed Care Plan is authorized to take whatever steps are necessary to ensure that the provider is recognized by the Agency and its agent(s) as a participating provider of the Managed Care Plan and that the provider's submission of encounter data is accepted by the Agency;

(14) Requirements regarding community outreach activities and marketing prohibitions;

(16) Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Managed Care Plan to file a provider complaint, including complaints about claims issues, and which individual(s) has authority to review a provider complaint;

(17) A summary of the Managed Care Plan's cultural competency plan and how to get a full copy at no cost to the provider;

(18) Information on identifying and reporting abuse, neglect and exploitation of enrollees;

(19) Enrollee rights and responsibilities (see 42 CFR 438.100); and

(20) Required procedural steps in the enrollee grievance process, including the address, telephone number and office hours of the grievance staff; the enrollee's right to request continuation of benefits while utilizing the grievance system; and information about the Beneficiary Assistance Program. The Managed Care Plan shall specify telephone numbers to call to present a complaint, grievance or appeal. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the Managed Care Plan without undue delays.

e. The Managed Care Plan shall include information in provider handbooks with respect to the applicable SMMC program as follows:

(1) MMA Managed Care Plans shall provide the additional information specified in the MMA Exhibit.

(2) LTC Managed Care Plans shall provide the additional information specified in the LTC Exhibit.

(3) Comprehensive LTC Managed Care Plans shall issue one (1) provider handbook to all network providers and shall provide additional information as specified in the both the MMA Exhibit and the LTC Exhibit.

f. The Managed Care Plan shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

3. Provider Education and Training

a. The Managed Care Plan shall offer training to all providers and their staff regarding the requirements of this Contract and special needs of enrollees.

b. The Managed Care Plan shall conduct initial training within thirty (30) calendar days of placing a newly contracted provider, or provider group, on active status. The Managed Care Plan also shall conduct ongoing training, as deemed necessary by the Managed Care Plan or the Agency, in order to ensure compliance with program standards and this Contract.

c. The Managed Care Plan shall provide training and education to providers regarding the Managed Care Plan's enrollment and credentialing requirements and processes.

d. For a period of at least twelve (12) months following the implementation of this Contract, the Managed Care Plan shall conduct monthly education and training for providers regarding claims submission and payment processes, which shall include, but not be limited to, an explanation of common claims submission errors and how to avoid those errors. Such period may be extended as determined necessary by the Agency.

e. The Managed Care Plan shall ensure all participating and direct service providers required to report abuse, neglect, or exploitation of vulnerable adults under s. 415.1034, F.S., obtain training on these subjects. If the Managed Care Plan provides such training to its participating and direct service providers, training materials must, at minimum, include the Agency's specified standards.

4. Toll-Free Provider Help Line

a. The Managed Care Plan shall operate a toll-free telephone help line to respond to provider questions, comments and inquiries.

b. The Managed Care Plan shall develop provider help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means and compliance with Managed Care Plan standards.

c. The help line must be staffed twenty-four hours a day, seven days a week (24/7) to respond to prior authorization requests.

d. This help line shall have staff to respond to provider questions in all other areas, including but not limited to the provider complaint system and provider responsibilities, between the hours of 8 a.m. and 7 p.m. in the provider's time zone, Monday through Friday, excluding state holidays.

e. The Managed Care Plan shall ensure that after regular business hours the provider services line (not the prior authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for an enrollee with an emergency or urgent medical condition. This requirement shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

f. The Managed Care Plan's call center systems shall have the capability to track call management metrics identified in Section IV, Enrollee Services and Grievance Procedures.

5. Provider Complaint System

a. The Managed Care Plan shall establish and maintain a provider complaint system that permits a provider to dispute the Managed Care Plan's policies, procedures, or any aspect of a Managed Care Plan's administrative functions, including proposed actions, claims, billing disputes, and service authorizations. The Managed Care Plan's process for provider complaints concerning claims issues shall be in accordance with s. 641.3155, F.S. Disputes between the Managed Care Plan and a provider may be resolved as described in s. 408.7057.

b. The Managed Care Plan shall include its provider complaint system policies and procedures in its provider handbook as described above.

c. The Managed Care Plan shall also distribute the provider complaint system policies and procedures, including claims issues, to out-of-network providers upon request. The Managed Care Plan may distribute a summary of these policies and procedures, if the summary includes information about how the provider may access the full policies and procedures on the Managed Care Plan's website. This summary shall also detail how the provider can request a hard copy from the Managed Care Plan at no charge.

d. As a part of the provider complaint system, the Managed Care Plan shall:

(1) Have dedicated staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems;

(2) Identify a staff person specifically designated to receive and process provider complaints;

(3) Allow providers forty-five (45) calendar days to file a written complaint for issues that are not about claims;

(4) Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;

(5) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the Managed Care Plan's written policies and procedures;

(6) Document why a complaint is unresolved after fifteen (15) calendar days of receipt and provide written notice of the status to the provider every fifteen (15) calendar days thereafter;

(7) Resolve all complaints within ninety (90) calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution; and

(8) Ensure that Managed Care Plan executives with the authority to require corrective action are involved in the provider complaint process.

e. The Managed Care Plan shall report provider complaints as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

E. Medical/Case Records Requirements

1. General Provisions

a. The Managed Care Plan shall ensure maintenance of medical/case records for each enrollee in accordance with this section and with 42 CFR 431 and 42 CFR 456. Medical/case records shall include the quality, quantity, appropriateness and timeliness of services performed under this Contract.

b. The Managed Care Plan shall comply with additional documentation requirements with respect to the applicable SMMC program as follows:

(1) MMA Managed Care Plans shall comply with the additional requirements specified in the MMA Exhibit.

(2) LTC Managed Care Plans shall comply with the additional requirements specified in the LTC Exhibit.

(3) Comprehensive LTC Managed Care Plans shall comply with the additional requirement as specified in the both the MMA Exhibit and the LTC Exhibit.

2. Confidentiality of Medical/Case Records

a. The Managed Care Plan shall have a policy to ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

b. The Managed Care Plan shall have a policy to ensure the confidentiality of medical/case records in accordance with 42 CFR, Part 431, Subpart F.

c. The enrollee or authorized representative shall sign and date a release form before any clinical/case records can be released to another party. Clinical/case record release shall occur consistent with state and federal law.

3. Standards for Medical/Case Records

a. The Managed Care Plan shall follow the medical/case record standards set forth below for each enrollee's medical/case records, as appropriate:

(1) Include the enrollee's identifying information, including name, enrollee identification number, date of birth, sex and legal guardianship (if any);

(2) Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications;

(3) Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases;

(4) Document referral services in enrollees' medical/case records;

(5) Each record shall be legible and maintained in detail;

(6) All records shall contain an immunization history;

(7) All records shall contain information relating to the enrollee's use of tobacco, alcohol, and drugs/substances;

(8) All records shall contain summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up;

(9) All records shall reflect the primary language spoken by the enrollee and any translation needs of the enrollee;

(10) All records shall identify enrollees needing communication assistance in the delivery of health care services;

(11) All entries shall be dated and signed by the appropriate party;

(12) All entries shall indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider;

(13) All entries shall indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports;

(14) All entries shall indicate therapies administered and prescribed;

(15) All entries shall include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider;

(16) All entries shall include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services; and

(17) Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13).

b. The Managed Care Plan shall maintain written policies and procedures for enrollee advance directives which address how the Managed Care Plan will access copies of any advance directives executed by the enrollee. All medical/case records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the enrollee has executed an advance directive. Neither the Managed Care Plan, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive.

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Appendix G

Section XIV. Reporting Requirements

A. Managed Care Plan Reporting Requirements

1. General Provisions

a. The Managed Care Plan shall comply with all reporting requirements set forth in this Contract.

b. The Managed Care Plan shall use the Managed Care Plan Report Guide in submitting required reports, including the report formats, templates, instructions, data specifications, submission timetables and locations, and other materials contained in the guide. The Managed Care Plan Report Guide will be posted on the Agency's website. The Agency shall furnish the Managed Care Plan with appropriate technical assistance in using the Managed Care Plan Report Guide.

c. Unless otherwise specified, all reports are to be submitted electronically, as prescribed in the reporting guidelines.

d. Reports are to be transmitted electronically or hard copy as indicated in the Managed Care Plan Report Guide. PHI information must be submitted to the Agency SFTP sites.

2. Submission Deadlines

a. Deadlines for report submission referred to in this Contract specify the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.

b. If a reporting due date falls on a weekend or state holiday, the report shall be due to the Agency on the following business day.

c. All reports filed on a quarterly basis shall be filed on a calendar year quarter.

3. Required Reports

a. Managed Care Plans shall comply with reports required by the Agency as specified in the Summary of Reporting Requirements Table below.

Summary of Reporting Requirement			
Report Name	**Plan Type**	**Frequency**	**Submit To**
Marketing Agent Terminations	All Plans	Monthly, due within fifteen (15) days after end of the reporting monthly	Agency Contract Manager unless otherwise indicated.
Marketing/Educational Events Report	All Plans	Monthly, due within twenty (20) days after end of the reporting monthly	

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Summary of Reporting Requirement			
Report Name	**Plan Type**	**Frequency**	**Submit To**
Medicaid Redetermination Notice Summary Report	All Plans	Quarterly, forty-five (45) calendar days after the end of the reporting quarter	
Enrollee Complaints, Grievance and Appeals Report	All Plans	Monthly, due within fifteen (15) days after end of the reporting month	
Enrollee Facility Residence Report	All Plans	Monthly, due within fifteen (15) days after the end of the reporting month	
Provider Network File	All Plans	Weekly, due each Thursday by 5 p.m. EST	
Provider Complaint Report	All Plans	Monthly, due within fifteen (15) days after the end of reporting month	
Critical Incident Report	All Plans	Immediately upon occurrence and no less than within twenty-four (24) hours of detection or notification	
Critical Incident Summary	All Plans	Monthly and rolled up for quarter and year — Due within fifteen (15) days after the end of reporting month	
Claims Aging Report and Supplemental Filing Report	All Plans	Quarterly, forty-five (45) days after end of reporting quarter; Capitated Plans, optional supplemental filing — one-hundred five (105) calendar days after end of reporting quarter	
Suspected/ Confirmed Fraud & Abuse Reporting	All Plans	Within fifteen (15) calendar days of detection	MPI
Quarterly Fraud & Abuse Activity Report	All Plans	Quarterly, fifteen (15) calendar days after the end of reporting quarter	MPI
Annual Fraud and Abuse Activity Report	All Plans	Annually by September 1	MPI

Summary of Reporting Requirement			
Report Name	**Plan Type**	**Frequency**	**Submit To**
Insolvency Protection Multiple Signatures Agreement Form	All Plans	Annually, by April 1; Thirty (30) calendar days after any change	
Audited Annual and Unaudited Quarterly Financial Reports	All Plans	Audited — Annually by April 1 for calendar year; Unaudited — Quarterly, forty-five (45) calendar days after end of reporting quarter	
Administrative Subcontractor and Affiliates Report	All Plans	Quarterly within fifteen (15) calendar days of end of reporting quarter	

b. MMA Managed Care Plans shall comply with the additional reporting requirements specified in the MMA Exhibit.

c. LTC Managed Care Plans shall comply with the additional reporting requirements as specified in the LTC Exhibit.

d. Comprehensive LTC Managed Care Plans shall comply with the additional reporting requirements as specified in both the MMA Exhibit and the LTC Exhibit.

4. Modifications to Reporting Requirements

a. The Agency reserves the right to modify the reporting requirements, with a ninety (90) calendar day notice to allow the Managed Care Plan to complete implementation, unless otherwise required by law.

b. The Agency shall provide the Managed Care Plan with written notification of any modifications to the reporting requirements.

5. Certification of Timely, Complete and Accurate Submission

a. The Managed Care Plan is responsible for assuring the accuracy, completeness and timely submission of each report.

b. The Managed Care Plan's chief executive officer (CEO), chief financial officer (CFO) or an individual who reports to the CEO or CFO and who has delegated authority to certify the Managed Care Plan's reports, shall attest, based on his/her best knowledge, information and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful and complete (see 42 CFR 438.606(a) and (b)).

c. The Managed Care Plan shall submit its certification at the same time it submits the certified data reports (see 42 CFR 438.606(c)). The certification page shall be scanned and submitted electronically.

d. If the Managed Care Plan fails to submit the required reports accurately or within the timeframes specified, the Agency shall fine or otherwise sanction the Managed Care Plan in accordance with Section XI, Sanctions, and 59A-12.0073, F.A.C.

6. Other Required Submissions

Other Managed Care Plan submissions required by the Agency are as follows:

Summary of Reporting Requirement			
Submission Name	**Plan Type**	**Frequency**	**Submit To**
Cultural Competency Plan (and Annual Evaluation)	All Plans	Annually, June 1	Agency Contract Manager unless otherwise indicated.
Plan Evaluation Tool (for Customized Benefits)	MMA Plans	TBD	
Network Development Plan	All Plans		
Quality Improvement Plan	All Plans	Annually, by April 1	
Performance Measure Data and Certification		Annually, by July 1	
Performance Improvement Plan Proposals	All Plans	Annually, by August 1	
Results of CAHPS Survey and Action Plan	All Plans	Annually, by July 1	
Provider Satisfaction Survey Plan	All Plans	Annually, by March 1	
Results of Provider Satisfaction Survey and Action Plan	All Plans	Annually, by July 1	
Emergency Management Plan	All Plans	Annually, by May 31	
Business Continuity-Disaster Recovery Plan (certification with demonstration of BC-DR Plan testing)	All Plans	Annually, by April 30	
Anti-Fraud Plan	All Plans	Annually, by September 1	MPI

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SCOPE OF SERVICES – CORE PROVISIONS

Summary of Reporting Requirement			
Submission Name	**Plan Type**	**Frequency**	**Submit To**
Multiple Signature Agreement Form	All Plans	Annually, by April 1; Thirty (30) calendar days after any change	
PSN Conversion Application	FFS PSNs	TBD	
Transition plan	All Plans	Upon notice of intent to withdraw from region	
Ownership and Management Disclosure Forms	All Plans	Annually, by September 1	
Fingerprints of Principals	All Plans	Upon Change within thirty (30) days of the hire date.	

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