Section I. Definitions and Acronyms

The definitions and acronyms in **Attachment II,** Section I., Definitions and Acronyms, apply to all Managed Care Plans covering MMA services. There are no additional definitions and acronyms unique to the MMA managed care program.

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Section II. General Overview

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

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Section III. Eligibility and Enrollment

A. General Provisions

There are no additional general provisions for eligibility and enrollment unique to the MMA managed care program.

B. Eligibility

Medicaid recipients as defined in s. 409.972, F.S., shall receive Medicaid covered services through the SMMC program.

C. Enrollment

1. Notification of Enrollee Pregnancy

a. The Managed Care Plan shall be responsible for newborns of pregnant enrollees from the date of their birth. The Managed Care Plan shall comply with all requirements and procedures set forth by the Agency or its agent related to unborn activation and newborn enrollment.

b. Newborns are enrolled in the Managed Care Plan of the mother unless the mother chooses another plan or the newborn does not meet the enrollment criteria of the mother's plan. When a newborn does not meet the criteria of the mother's plan, the newborn will be enrolled in a plan in accordance with **Attachment II,** Section III.B., Eligibility of this Contract.

2. If the enrollee has not chosen a PCP, the Agency's enrollment confirmation notice will advise the enrollee that a PCP will be assigned by the Managed Care Plan.

D. Disenrollment

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

E. Medicaid Redetermination Assistance

The Managed Care Plan shall develop a process for tracking redeterminations for the Medicaid ICP when an enrollee under the age of eighteen (18) years resides in a nursing facility, and for documenting the assistance provided by the Managed Care Plan, to ensure the enrollee continues to meet medical/functional eligibility for the Medicaid ICP.

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Section IV. Marketing

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

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Section V. Enrollee Services

A. General Provisions

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

B. Enrollee Material

1. Provider Directory

In addition to the requirements in **Attachment II,** Section V.B., the Managed Care Plan is not required to include outpatient-based specialty providers in ambulatory surgical centers in the online provider database or printed provider directory. However, the Managed Care Plan shall include these providers in the provider network file it submits to the Agency.

2. Online Enrollee Materials

The Managed Care Plan shall provide a link to the Agency's Medicaid PDL on the Managed Care Plan's website without requiring enrollee login. Such Managed Care Plans shall also post the list of covered drugs that are not on the Agency's Medicaid PDL, and that are subject to prior authorization.

C. Enrollee Services

1. Reinstatement Notice

a. In addition to requirements in **Attachment II,** Section V.B.6., Reinstatement Notice, the Managed Care Plan shall include in its reinstatement notice:

(1) The enrollee's PCP, unless the enrollee is a dual eligible.

2. Enrollee ID Card Requirements

a. The Managed Care Plan shall include on its enrollee ID card:

(1) The enrollee's PCP, unless the enrollee is a dual eligible.

3. Toll-Free Enrollee Help Line

The Managed Care Plan shall operate, as part of its emergency services, a crisis emergency hotline available to all enrollees twenty-four hours a day, seven days a week (24/7).

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Section VI. Coverage and Authorization of Services

A. Required MMA Benefits

1. Specific MMA Services to be Provided

a. The Managed Care Plan shall provide covered services specified in s. 409.973, F.S., in accordance with **Attachment II,** Section VI., Coverage and Authorization of Services, the approved federal waiver for the MMA managed care program, and the following Medicaid rules and services listed on the associated fee schedules in the Florida Medicaid Policies and Rule References for MMA Services Table, Table 1, below:

TABLE 1
FLORIDA MEDICAID POLICIES AND RULE REFERENCES FOR MMA SERVICES

Rule No.	Policy Name
59G-4.013	Allergy Services Coverage Policy
59G-4.015	Ambulance Transportation Services Coverage Policy
59G-4.020	Ambulatory Surgical Center Services Coverage Policy
59G-4.022	Anesthesia Services Coverage Policy
59G-4.025	Assistive Care Services Coverage and Limitations Handbook
59G-4.028	Behavioral Health Assessment Services Coverage Policy
59G-4.031	Behavioral Health Community Support Services Coverage Policy
59G-4.370	Behavioral Health Intervention Services Coverage Policy
59G-4.029	Behavioral Health Medicaid Management Services Coverage Policy
59G-4.027	Behavioral Health Overlay Services Coverage and Limitations Handbook
59G-4.052	Behavioral Health Therapy Services Coverage Policy
59G-4.033	Cardiovascular Services Coverage Policy
59G-8.700	Child Health Services Targeted Case Management
59G-4.040	Chiropractic Services Coverage Policy
59G-4.055	County Health Department Services
59G-4.105	Dialysis Services Coverage Policy
59G-4.070	Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook
59G-4.085	Early Intervention Services Coverage Policy
59G-4.015	Emergency Transportation Services Coverage Policy
59G-4.087	Evaluation and Management Services Coverage Policy
59G-4.100	Federally Qualified Health Center Services
59G-4.026	Gastrointestinal Services Coverage Policy
59G-4.108	Genitourinary Services Coverage Policy
59G-4.110	Hearing Services Coverage Policy
59G-4.130	Home Health Services Coverage Policy
59G-4.140	Hospice Services Coverage Policy
59G-4.150	Inpatient Hospital Services Coverage Policy

59G-4.032	Integumentary Services Coverage Policy
59G-4.190	Laboratory Services Coverage Policy
59G-1.045	Medicaid Forms
59G-4.197	Medical Foster Care Services
59G-4.199	Mental Health Targeted Case Management Handbook
59G-4.201	Neurology Services Coverage Policy
59G-4.330	Non-Emergency Transportation Services Coverage Policy
59G-4.200	Nursing Facility Services Coverage Policy
59G-4.318	Occupational Therapy Services Coverage Policy
59G-4.207	Oral and Maxillofacial Surgery Services Coverage Policy
59G-4.211	Orthopedic Services Coverage Policy
59G-4.160	Outpatient Hospital Services Coverage Policy
59G-4.222	Pain Management Services Coverage Policy
59G-4.215	Personal Care Services Coverage Policy
59G-4.320	Physical Therapy Services Coverage Policy
59G-4.220	Podiatry Services Coverage Policy
59G-4.250	Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook
59G-4.261	Private Duty Nursing Services Coverage Policy
59G-4.002	Provider Reimbursement Schedules and Billing Codes
59G-4.240	Radiology and Nuclear Medicine Services Coverage Policy
59G-4.264	Regional Perinatal Intensive Care Center Services
59G-4.030	Reproductive Services Coverage Policy
59G-4.235	Respiratory System Services Coverage Policy
59G-4.322	Respiratory Therapy Services Coverage Policy
59G-4.280	Rural Health Clinic Services
59G-4.295	Specialized Therapeutic Services Coverage and Limitations Handbook
59G-4.324	Speech-Language Pathology Services Coverage Policy
59G-4.120	Statewide Inpatient Psychiatric Program Coverage Policy
59G-4.295	Therapeutic Group Care Services Coverage Policy
59G-4.360	Transplant Services Coverage Policy
59G-4.340	Visual Aid Services Coverage Policy
59G-4.210	Visual Care Services Coverage Policy

(1) Ambulatory Surgical Center Services

The Managed Care Plan shall be responsible for Ambulatory Surgical Center (ASC) services and ancillary medical services provided secondary to dental care authorized by the Prepaid Dental Health Plan (PDHP) and provided in an ASC under the direction of a dentist when medically necessary.

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(2) Child Health Services Targeted Case Management Services

(a) The Managed Care Plan shall provide Child Health Services Targeted Case Management services for all enrollees who are eligible for and enrolled in the Early Steps program.

(b) The Managed Care Plan shall only utilize case managers who are trained and certified by the Department of Health (DOH) Early Steps program to provide Child Health Services Targeted Case Management services for enrollees who are eligible for and enrolled in the Early Steps program.

(c) The Managed Care Plan shall not require prior authorization for Child Health Services Targeted Case Management Services that are provided to assist an enrollee with obtaining the initial screening and/or evaluation to determine eligibility for the Early Steps program and that are provided to assist with the development of the initial Individualized Family Service Plan. Once the initial IFSP has been completed, the Managed Care Plan shall not implement prior authorization requirements for ongoing receipt of Child Health Services Targeted Case Management Services, unless, as provided in **Attachment II, Exhibit II-A**, Section X.F., the Managed Care Plan has identified suspected fraud, waste, or abuse in the utilization of such services.

(3) Clinic Services

(a) The Managed Care Plan shall provide RHC services. Rural Health Clinics provide ambulatory primary care to a medically underserved population in a rural geographical area. An RHC provides primary health care and related diagnostic services.

(i) RHC services reimbursed through the clinic encounter rate include:

- Adult health screening services
- Well-child visits
- Chiropractic services
- Family planning services
- HIV counseling services
- Medical primary care services
- Mental health services
- Optometric services

- Podiatric services.

(ii) RHC services reimbursed outside the clinic encounter rate include:

- Emergency services
- Immunization services
- Any health care services rendered away from the RHC, at a hospital, or a nursing facility, including off-site radiology services and off-site clinical laboratory services
- Radiology and other diagnostic imaging services
- Home health services
- Prescribed drug services
- WIC certifications or recertifications
- Clinic visits for the sole purpose of obtaining lab specimens or to obtain results from a diagnostic test
- Clinic visits for the sole purpose of obtaining immunizations
- Mental health services for chronic conditions without acute exacerbation

(b) The Managed Care Plan shall provide FQHC Services. An FQHC provides primary health care and related diagnostic services.

(i) FQHC services reimbursed through the clinic encounter rate include:

- Adult health screening services
- Well-child visits
- Chiropractic services
- Family planning services
- Medical primary care
- Mental health services
- Optometric services
- Podiatric services

- Diagnostic and treatment radiology services

(ii) FQHC services reimbursed outside of the clinic encounter rate include:

- Emergency services
- Services rendered away from the FQHC clinic or satellite clinic
- Immunization services
- Home health services
- Prescription drug services
- WIC certifications and recertifications
- Mental health services for chronic conditions without acute exacerbation

(c) The Managed Care Plan shall provide CHD Services. County Health Departments provide public health services in accordance with Chapter 154, F.S. A CHD provides primary and preventive health care, and related diagnostic services, including but not limited to:

(i) Adult health screening services

(ii) Well-child visits

(iii) Family planning services

(iv) Immunization services

(v) Medical primary care services

(vi) Registered nurse services.

(4) Community Behavioral Health Services

The Managed Care Plan shall provide behavioral health services in compliance with 42 CFR 438.3(n) with respect to quantitative and non-quantitative limits.

(5) Early Intervention Services

(a) The Managed Care Plan shall promote increased use of prevention and early intervention services (EIS) for at-risk enrollees, birth through thirty-six (36) months of age. The Managed Care Plan shall provide covered EIS services specified in accordance with the following Medicaid rules and

contractual requirements, utilizing only the procedure codes and modifiers listed in the associated fee schedules in the Early Intervention Services Table, Table 2, below:

TABLE 2
EARLY INTERVENTION SERVICES TABLE

Service	Coverage Policy	Procedure Code and Modifier
Evaluation and screenings	59G-4.085 Early Intervention Services Coverage Policy	Per Early Intervention Services Fee Schedule
Assistive technology services and devices	59G-4.070 Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook	Per the Durable Medical Equipment and Medical Supply Services Provider Fee Schedule for All Medicaid Recipients. Procedure codes must include the TL modifier.
Audiology services	59G-4.110 Hearing Services	Per the Hearing Services Fee Schedule. Procedure codes must include the TL modifier.
Nursing services	59G-4.130 Home Health Services Coverage Policy	Per the Home Health Visit Services Fee Schedule. Procedure codes must include the TL modifier.
Medical services (e.g., physician services)	59G-4.087 Evaluation and Management Services Coverage Policy	Per the Practitioner Fee Schedule. Procedure codes must include the TL modifier.
Nutrition services	59G-4.085 Early Intervention Services Coverage Policy	Must use Sessions as provided in the Early Intervention Services Fee Schedule
Occupational therapy services	59G-4.318 Occupational Therapy Services Coverage Policy	Per the Occupational Therapy Services Fee Schedule. Procedure codes must include the TL modifier.

Physical therapy services	59G-4.320 Physical Therapy Services Coverage Policy	Per the Physical Therapy Services Fee Schedule. Procedure codes must include the TL modifier.
Psychological services	59G-4.050 Community Behavioral Health Services Coverage and Limitations Handbook	Per the Community Behavioral Health Services Fee Schedule. Procedure codes must include the TL modifier.
Sessions	59G-4.085 Early Intervention Services Coverage Policy	Per Early Intervention Services Fee Schedule
Speech-language pathology	59G-4.324 Speech-Language Pathology Services Coverage Policy	Per the Speech-Language Pathology Services Fee Schedule. Procedure codes must include the TL modifier.
Vision services	59G-4.210 Visual Care Services Coverage Policy	Per the Visual Services Fee Schedule. Procedure codes must include the TL modifier.

(b) The Managed Care Plan shall cover early intervention screening and evaluation services without authorization. The Managed Care Plan shall not impose any administrative or clinical barriers that impede the early intervention screening and evaluation from being completed within forty-five (45) days of the enrollee's referral to the Early Steps program.

(c) The Managed Care Plan shall reimburse each qualified provider, as identified in Section VIII.A.4.g. of this Exhibit, conducting the early intervention services evaluation.

(d) The Managed Care Plan shall participate in the MDT meetings scheduled to develop and review the Individualized Family Service Plan (IFSP), which documents the need for early intervention services, when:

(i) Invited by the local Early Steps office; or

(ii) The Managed Care Plan has identified specific concerns about the enrollee's care needs.

(e) The Managed Care Plan shall ensure that all early intervention services as described in sub-item (5)(a) above and included on the IFSP are provided to enrollees in their natural environment (i.e., home, school, daycare, etc.), when appropriate.

(f) The Managed Care Plan shall make a good faith effort to enter into and maintain agreements with the Local Early Steps Program Office to establish methods of communication and procedures for the timely approval of services covered by Medicaid in accordance with s. 391.308, F.S., and Section VI., Coverage and Authorization of Services.

(6) Emergency Services

(a) The Managed Care Plan shall provide pre-hospital and hospital-based trauma services and emergency services and care to enrollees See ss. 395.1041, 395.4045 and 401.45, F.S.

(b) The Managed Care Plan shall authorize a minimum of three (3) days' coverage of emergency behavioral health inpatient services and care when provided according to this provision, and resulting from a Baker Act admission.

(c) When an enrollee presents at a hospital seeking emergency services and care, a physician of the hospital or, to the extent permitted by applicable law, other appropriate personnel under the supervision of a hospital physician, shall make a determination that an emergency medical condition exists for the purposes of treatment. See ss. 409.9128, 409.901, and 641.513, F.S.

(d) The Managed Care Plan shall not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, the Managed Care Plan shall not deny payment for treatment obtained when a representative of the Managed Care Plan instructs the enrollee to seek emergency services and care in accordance with s. 743.064, F.S.

(e) The Managed Care Plan shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as the Managed Care Plan can safely transport the enrollee to a participating facility. The Managed Care Plan may transfer the enrollee, in accordance with State and federal law, to a participating hospital that has the service capability to treat the enrollee's emergency medical condition. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

(f) In accordance with 42 CFR 438.114 and s. 1932(b)(2)(A)(ii) of the Social Security Act, the Managed Care Plan shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service through a participating or non-participating provider. Those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Managed Care Plan can choose not to cover non-emergency services if they are provided by a non-participating provider, except in those circumstances detailed below.

(i) Post-stabilization care services that were pre-approved by the Managed Care Plan;

(ii) Post-stabilization care services that were not pre-approved by the Managed Care Plan because the Managed Care Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request; or

(iii) The treating provider could not contact the Managed Care Plan for pre-approval.

(g) The Managed Care Plan shall provide emergency services and care without any specified dollar limitations.

(h) The Managed Care Plan shall authorize payment for non-participating physicians for emergency ancillary services provided in a hospital setting.

(i) The Managed Care Plans shall provide emergency behavioral health services pursuant, but not limited, to s. 394.463, F.S.; s. 641.513, F.S.; and Title 42 CFR Chapter IV. Emergency service providers shall make a reasonable attempt to notify the Managed Care Plan within twenty-four (24) hours of the enrollee’s presenting for emergency behavioral health services. In cases in which the enrollee has no identification, or is unable to identify himself/herself orally when presenting for behavioral health services, the provider shall notify the Managed Care Plan within twenty-four (24) hours of learning the enrollee’s identity.

(j) In addition to the requirements outlined in s. 641.513, F.S., the Managed Care Plan will ensure:

(i) The enrollee has a follow-up appointment scheduled within seven (7) days after discharge; and

(ii) All required prescriptions are authorized at the time of discharge.

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(7) Family Planning Services and Supplies

(a) The Managed Care Plan shall furnish family planning services on a voluntary and confidential basis.

(b) The Managed Care Plan shall allow enrollees freedom of choice of family planning methods covered under the Medicaid program, including Medicaid-covered implants, where there are no medical contra-indications.

(c) The Managed Care Plan shall allow each enrollee to obtain family planning services and supplies from any provider and shall not require a referral for such services.

(d) The Managed Care Plan shall make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, including discussion of all appropriate methods of contraception, counseling, and services for family planning to all women and their partners. The Managed Care Plan shall direct providers to maintain documentation in the enrollee records to reflect this provision. (Section 409.967(2), F.S.)

(e) The Managed Care Plan shall implement an outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant.

(8) Hearing Services

Newborn and infant hearing screenings are covered through the Medicaid FFS delivery system.

(9) Hospital Services

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

(b) The Managed Care Plan shall adhere to the provisions of the NMHPA of 1996 regarding postpartum coverage for mothers and their newborns. Therefore, the Managed Care Plan shall provide for no less than a forty-eight (48) hour hospital length of stay following a normal vaginal delivery, and at least a ninety-six (96) hour hospital length of stay following a Cesarean section. In connection with coverage for maternity care, the hospital length of stay shall be decided by the attending physician in consultation with the mother.

(c) The Managed Care Plan shall prohibit the following practices related to the NMHPA:

(i) Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum protections available under NMHPA;

(ii) Penalizing or otherwise reducing or limiting the reimbursement of an attending physician because the physician provided care in a manner consistent with NMHPA; and

(iii) Providing incentives (monetary or otherwise) to an attending physician to induce the physician to provide care in a manner inconsistent with NMHPA.

(d) For all child/adolescent enrollees (under the age of twenty-one (21) years) and pregnant adults, the Managed Care Plan shall be responsible for providing up to three hundred sixty-five (365) days of health-related inpatient care, including behavioral health, for each State fiscal year. For all non-pregnant adults, the Managed Care Plan shall be responsible for up to forty-five (45) days of inpatient coverage and up to three hundred sixty-five (365) days of emergency inpatient care, including behavioral health, in accordance with the Inpatient Hospital Coverage Policy, for each State fiscal year.

(e) The Managed Care Plan shall count inpatient days based on the lesser of the actual number of covered days in the inpatient hospital stay and the average length of stay for the relevant All Patient Refined Diagnosis Related Group (APR-DRG or DRG). This requirement applies whether or not the Managed Care Plan uses DRGs to pay the provider. DRGs can be found at the following website: http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.

(f) If a non-pregnant adult enrollee has not yet met his/her forty-five day (45-day) hospital inpatient limit per State fiscal year at the start of a new hospital admission, the enrollee's Managed Care Plan at the time of admission must cover the entire new stay. This requirement applies even if the actual or average length of stay for the DRG puts the person over the inpatient limit. There is no proration of inpatient days.

(g) Unless otherwise specified in this Contract, where an enrollee uses non-emergency services available under the Managed Care Plan from a non-participating provider, the Managed Care Plan shall not be liable for the cost of such services unless the Managed Care Plan referred the enrollee to the non-participating provider or authorized the out-of-network service.

(h) The Managed Care Plan shall be responsible for the reimbursement of care for enrollees who have been diagnosed with Tuberculosis disease, or show

symptoms of having Tuberculosis and have been designated a threat to the public health by the Florida DOH Tuberculosis Program and shall observe the following:

(i) Treatment plans and discharge determinations shall be made solely by DOH and the treating hospital;

(ii) For enrollees determined to be a threat to public health and receiving Tuberculosis treatment at a DOH contracted hospital, the Managed Care Plan shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and DOH, and shall also pay any wrap-around costs not included in the per-diem rate; and

(iii) The Managed Care Plan shall not deny reimbursement for failure to prior authorize admission or for services rendered pursuant to s. 392.62 F.S.

(i) The Managed Care Plan shall require prior authorization for all non-emergency inpatient hospital admissions.

(j) The Managed Care Plan shall not:

(i) Limit inpatient days for services that are unrelated to the PPC diagnosis present on admission.

(ii) Reduce authorization to a provider when the PPC existed prior to admission.

(k) The Managed Care Plan shall enroll and participate in the Florida Health Information Exchange Event Notification Service as directed by the Agency.

(l) The Managed Care Plan shall provide outpatient hospital services and ancillary medical services secondary to dental care authorized by the PDHP and provided in the outpatient hospital under the direction of a dentist when medically necessary.

(10) Immunizations

(a) The Managed Care Plan shall provide immunizations in accordance with the Recommended Childhood and Adolescent Immunization Schedule for the United States, or when medically necessary for the enrollee's health.

(b) The Managed Care Plan shall participate, or direct its providers to participate, in the VFC. See s. 1905(r)(1)(B)(iii) of the Social Security Act.

(c) The Managed Care Plan shall provide coverage and reimbursement to the participating provider for immunizations covered by Medicaid, but not provided through VFC.

(d) The Managed Care Plan shall ensure that providers have a sufficient supply of vaccines if the provider is enrolled in the VFC program. The Managed Care Plan shall direct those providers that are directly enrolled in the VFC program to maintain adequate vaccine supplies.

(e) The Managed Care Plan shall enroll as a data partner with Florida SHOTS (State Health Online Tracking System) and submit immunization data using the process and format specified by the Agency.

(11) Medical Foster Care Services

(a) The Managed Care Plan shall provide medical foster care services for enrollees under the age of twenty-one (21) years who meet all other eligibility requirements to receive this service.

(b) The Managed Care Plan shall work cooperatively with the DOH, Medical Foster Care program staff and the Community-Based Care Lead Agencies in the provision of medical foster care services.

(c) The Managed Care Plan shall participate in initial and ongoing medical foster care CMAT staffing meetings for its enrollees.

(d) The Managed Care Plan shall ensure that assigned case managers have the authority to authorize medical foster care services during the CMAT staffing if the team reaches consensus on the level of care recommendation.

(e) If there is lack of consensus among the CMAT members in determining the eligibility and recommended level of care for medical foster care services for the enrollee, the Managed Care Plan shall have the authority to make the final determination for its enrollees.

(12) Medical Supplies, Durable Medical Equipment, Prostheses and Orthoses

Notwithstanding the limitations prescribed by the Durable Medical Equipment Services Coverage and Limitations Handbook, the Managed Care Plan shall provide specialized medical equipment and supplies (e.g., incontinence supplies) to enrollees with a diagnosis of AIDS, and who have had a history of an AIDS-related opportunistic infection. The Managed Care Plan may place appropriate limits on such services on the basis of medical necessity.

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(13) Nursing Facility Services

(a) The Managed Care Plan shall provide nursing facility services for enrollees under the age of eighteen (18) years.

(b) The Managed Care Plan shall provide nursing facility services for enrollees ages eighteen (18) years of age and older in the following circumstances:

(1) For up to one-hundred twenty (120) days from the date of the most recent nursing facility admission, regardless of payer, when:

i. The enrollee is in need of long-term nursing facility services and is not receiving nursing facility services in lieu of inpatient hospital services nor admitted for rehabilitation services;

ii. The enrollee has completed all PASRR requirements;

iii. The DCF has determined the enrollee is eligible for Institutional Care Program (ICP) Medicaid; and

iv. The enrollee is not yet enrolled in the Long-Term Care program.

(2) The Managed Care Plan shall reimburse in accordance with Rule 59G-1.052, F.A.C. for nursing facility services provided during the Medicare coinsurance days (day twenty-one (21) up to day one hundred (100)) for Medicare co-payments and co-insurance if the requirements of PASRR are met and the enrollee: has QMB benefits and is also eligible for full Florida Medicaid benefits; is receiving SSI; or has Medicare benefits other than QMB and is also eligible for the Institutional Care Program.

(c) The Managed Care Plan shall provide a monthly report to the Agency of enrollees who are eighteen (18) years of age and older who are receiving nursing facility services for thirty (30) or more consecutive days from the date of admission and have not yet been determined eligible for ICP Medicaid. The Managed Care Plan shall submit the monthly report to the Agency in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

(14) Physician Services

The Managed Care Plan shall be responsible for coverage of preventive dental services when rendered by a non-dental provider.

(15) Laboratory and Imaging Services

Newborn screening services in accordance with s. 383.14, F.S., which outlines the required laboratory screening process to test for metabolic, hereditary, and

congenital disorders known to result in significant impairment of health or intellect. These required laboratory tests shall be processed through the State Public Health Laboratory. The Managed Care Plan shall reimburse for these screenings at the established Medicaid rate and must enter into a provider agreement or a contract with the State Public Health Laboratory.

(16) Prescribed Drug Services

(a) The Agency shall be responsible for administration of the Medicaid prescribed drug program. The Agency shall maintain the Medicaid P&T Committee review of drug options to maintain an array of choices for prescribers within each therapeutic class on the Agency's Medicaid PDL.

(b) The Managed Care Plan shall provide coverage of outpatient drugs as defined in section 1927(k)(2) of the SSA.

(c) The Managed Care Plan shall provide those products and services associated with the dispensing of medicinal drugs pursuant to a valid prescription, as defined in Chapter 465, F.S., Prescribed drug services shall include all prescription drugs listed in the Agency's Medicaid PDL.

(d) The Managed Care Plan shall make available those drugs and dosage forms listed on the Agency's Medicaid PDL, and shall comply with the requirements of s. 409.912(5)(a)5., F.S., regarding the use of counterfeit-proof prescription pads.

(e) The Managed Care Plan may make available generic drugs in a therapeutic category that are not on the Agency's Medicaid PDL, unless a brand-name drug containing the same active ingredient is on the Agency's Medicaid PDL.

(f) The Managed Care Plan shall make available those brand name drugs that are not on the Agency's Medicaid PDL, when medically necessary, if the prescriber:

(i) Writes in his/her own handwriting on the valid prescription that the "Brand Name is Medically Necessary" (pursuant to s. 465.025, F.S.); and

(ii) Submits a completed "Multisource Drug and Miscellaneous Prior Authorization" form to the Managed Care Plan indicating that the enrollee has had an adverse reaction to a generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug.

(g) The Managed Care Plan may have a pharmacy lock-in program that complies with the Agency-established Pharmacy Lock-in Policy and Guidelines. The lock-in period shall not exceed twelve (12) consecutive

months. The Managed Care Plan shall submit its lock-in program procedures in writing for approval by the Agency in advance of implementation.

(h) The Managed Care Plan shall notify providers who may prescribe or are currently prescribing a drug that is being deleted from the Agency's Medicaid PDL within thirty (30) days of the Managed Care Plan being notified of the change by the Agency. Implementation of PDL changes must be completed within forty-five (45) days of being notified of the change by the Agency.

(i) During operation of the Comprehensive Hemophilia Disease Management Program, the Managed Care Plan shall coordinate the care of its enrollees with Agency-approved organizations.

(j) The Managed Care Plan shall implement formulary management tool (FMT) changes from the weekly comprehensive drug list update within fourteen (14) days of a file being provided to the Managed Care Plan by the Agency. Pharmacy prior authorization automation system changes must be implemented within ninety (90) days of being notified by the Agency.

(17) Therapeutic Group Care Services

The Managed Care Plan shall provide qualified residential treatment program (QRTP) services for children who are removed from their families and entered into foster care in accordance with the coverage requirements in Rule 59G-4.295, F.A.C. Therapeutic Group Care Services.

(18) Therapy Services

The Managed Care Plan shall provide medical massage therapy services to enrollees diagnosed with AIDS, and who have had a history of an AIDS-related opportunistic infection, as confirmed by the Agency, for the treatment of peripheral neuropathy or severe neuromuscular pain and lymphedema. The Managed Care Plan may place appropriate limits on such services on the basis of medical necessity.

(19) Transplant Services

The Managed Care Plan shall provide medically necessary transplants and related services as outlined in the Transplant Summary of Responsibility Table, Table 3, below. Transplant services specified with one (1) asterisk are covered through Medicaid on a FFS basis and not by the Managed Care Plan.

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TABLE 3 **TRANSPLANT SUMMARY OF RESPONSIBILITY**		
Transplant Service	**Adult** (Twenty-one (21) and Over)	**Pediatric** (Twenty (20) and Under)
Evaluation	Managed Care Plan	Managed Care Plan
Bone Marrow	Managed Care Plan	Managed Care Plan
Cornea	Managed Care Plan	Managed Care Plan
Heart	Managed Care Plan	Managed Care Plan
Intestinal/ Multivisceral	Medicaid*	Medicaid*
Kidney	Managed Care Plan	Managed Care Plan
Liver	Managed Care Plan	Managed Care Plan
Lung	Managed Care Plan	Managed Care Plan
Pancreas	Managed Care Plan	Managed Care Plan
Pre- and Post-Transplant Care, **including** Transplants Not Covered by Medicaid	Managed Care Plan	Managed Care Plan
Other Transplants Not Covered by Medicaid	Not Covered	Not Covered

(20) Transportation Services

(a) The Managed Care Plan shall provide NET and emergency transportation services to eligible enrollees twenty-four (24) hours per day, seven (7) days per week for its enrollees who have no other means of transportation available to any covered service and transportation to services not covered by the Managed Care Plan specified in Section VI.C., Excluded Services, including prepaid dental services, prescribed drugs, and expanded benefits.

(b) The Managed Care Plan shall develop and implement written procedures for transportation services for the following:

(i) Determining service eligibility for each enrollee and what type of transportation to provide that enrollee;

(ii) Establishing a minimum twenty-four (24) hour advance notification policy to obtain transportation services, and communicate that policy to its enrollees and transportation providers. However, advance notification policies shall comport with the timely access to medical care requirements as specified in Section VIII.A. of this Exhibit; and

(iii) Complying with Agency-prescribed pick-up windows to enrollees and transportation providers.

2. The Managed Care Plan may provide any of the following in lieu of services to enrollees when determined medically appropriate, in accordance with the requirements specified in **Attachment II,** Section VI., Coverage and Authorization of Services.

a. The Managed Care Plan may provide the following in lieu of services without any Agency approval:

(1) Nursing facility services in lieu of inpatient hospital services when the enrollee does not require long-term nursing facility care and meets the requirements of PASRR.

Such services shall not be counted as inpatient hospital days.

(2) Crisis stabilization units (CSU) and Class III and Class IV freestanding psychiatric specialty hospitals in lieu of inpatient psychiatric hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If CSU beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Managed Care Plan shall demonstrate adequate capacity for psychiatric inpatient hospital care in anticipation of such transfers. Such services shall be subject to the requirements of 42 CFR 438.6(e).

(3) Detoxification or addictions receiving facilities licensed under s. 397, F.S., in lieu of inpatient detoxification hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If detoxification or addictions receiving facility beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Managed Care Plan shall demonstrate adequate capacity for inpatient

detoxification hospital care in anticipation of such transfers. Such services shall be subject to the requirements of 42 CFR 438.6(e).

b. The Managed Care Plan may provide the following in lieu of services subject to Agency review and approval:

(1) Partial hospitalization services in a hospital in lieu of inpatient psychiatric hospital care for up to ninety (90) days annually for adults ages twenty-one (21) and older; there is no annual limit for children under the age of twenty-one (21).

(2) Mobile crisis assessment and intervention for enrollees in the community may be provided in lieu of emergency behavioral health care.

(3) Ambulatory detoxification services may be provided in lieu of inpatient detoxification hospital care when determined medically appropriate.

(4) Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services.

(5) Drop-In Center in lieu of Clubhouse services.

(6) Infant Mental Health Pre and Post Testing Services in lieu of Psychological Testing services.

(7) Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services.

(8) Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.

(9) Behavioral Health Services – Child Welfare in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.

(10) Substance Abuse Intensive Outpatient Program (IOP) in lieu of inpatient detoxification hospital care.

(11) Substance Abuse Short-term Residential Treatment (SRT) in lieu of inpatient detoxification hospital care.

(12) Mental Health Partial Hospitalization Program (PHP) in lieu of inpatient psychiatric hospital care.

(13) Multi Systemic Therapy in lieu of inpatient and residential stay or SIPP.

3. Behavioral Health and Supportive Housing Assistance Pilot

a. The Agency shall implement a voluntary pilot program to provide additional behavioral health services and supportive housing assistance services appropriate for Medicaid enrollees ages twenty-one (21) years and older with serious mental illness (SMI),

substance use disorder (SUD), or SMI with co-occurring SUD, who are homeless or at risk of homelessness.

b. The Agency shall be responsible for selecting eligible Managed Care Plans to provide behavioral health and supportive housing assistance services in Regions 5 and 7.

c. The Agency shall be responsible for providing programmatic expectations and overall direction to the selected Managed Care Plans regarding the implementation of behavioral health and supportive housing assistance services.

d. The selected Managed Care Plans shall ensure the provision of behavioral health and supportive housing assistance services in compliance with the approved 1115 MMA Waiver and as directed by the Agency.

e. The Managed Care Plan shall ensure behavioral health and supportive housing assistance services meet the home and community-based setting requirements specified in 42 CFR 441.710(a)(1) and (2).

4. Customized Benefits

a. The Managed Care Plan may customize expanded benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services.

b. Submitted proposals for customized benefit packages must comply with instructions available from the Agency. The Agency shall evaluate the Managed Care Plan's CBP for actuarial equivalency and sufficiency of benefits before approving the CBP. Actuarial equivalency is tested by using a proposal that:

(1) Compares the value of the level of benefits in the proposed package to the value of the contracted benefit package for the average member of the covered population;

(2) Ensures that the overall level of benefits is appropriate; and

(3) Compares the proposed CBP to State-established standards. The standards are based on the covered population's historical use of Medicaid services. These standards are used to ensure that the proposed CBP is adequate to cover the needs of the vast majority of the enrollees.

c. If, in its CBP, the Managed Care Plan limits a service to a maximum annual dollar value, the Managed Care Plan must calculate the dollar value of the service using the Medicaid fee schedule.

d. The CBPs may change on a Contract year basis and only if approved by the Agency in writing. The Managed Care Plan shall submit to the Agency a proposal for its proposed CBP for evaluation of actuarial equivalency and sufficiency standards no later than the date established by the Agency each year.

e. The Managed Care Plan shall send letters of notification to enrollees regarding exhaustion of benefits for services restricted by unit amount if the amount is more restrictive than Medicaid. The Managed Care Plan shall send an exhaustion of benefits letter, including notification of the enrollee's right to a Medicaid Fair Hearing, for any service restricted by a dollar amount. The Managed Care Plan shall implement said letters upon the written approval of the Agency. The letters of notification include the following:

(1) A letter notifying an enrollee when he/she has reached fifty percent (50%) of any maximum annual dollar limit established by the Managed Care Plan for a benefit;

(2) A follow-up letter notifying the enrollee when he/she has reached seventy-five percent (75%) of any maximum annual dollar limit established by the Managed Care Plan for a benefit; and

(3) A final letter notifying the enrollee that he/she has reached the maximum dollar limit established by the Managed Care Plan for a benefit.

f. The Managed Care Plan shall submit the Customized Benefit Notifications Report to the Agency in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

B. Expanded Benefits

There are no additional expanded benefits provisions unique to the MMA managed care program.

C. Excluded Services

The following services are not provided by the Managed Care Plan, but are available to eligible Medicaid recipients through the Medicaid FFS delivery system:

1. CHD Certified Match Program services
2. Developmental Disabilities Individual Budgeting (iBudget) HCBS Waiver services
3. Familial Dysautonomia HCBS Waiver services
4. Hemophilia Factor-related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program services
5. ICF/IID services
6. School-based services provided through the Medicaid Certified School Match Program
7. Model HCBS Waiver services
8. Newborn Hearing services

9. Prescribed Pediatric Extended Care services

10. Program for All-Inclusive Care for Children services

11. Behavior Analysis services

12. Substance Abuse County Match Program services

13. PACE services

14. FACT services

D. Coverage Provisions

1. Primary Care Provider Initiatives

a. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall establish a program to encourage enrollees to establish a relationship with their PCP.

b. This program shall provide information to each enrollee on the importance of selecting a PCP and the procedure for selecting a PCP (s. 409.973(4), F.S.).

c. The Managed Care Plan shall offer each enrollee a choice of PCPs. After making a choice, each enrollee shall have a single or group PCP.

d. The Managed Care Plan shall allow pregnant enrollees to choose Managed Care Plan obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP, as specified in Section VIII., Provider Services.

e. No later than the beginning of the last trimester of gestation, the Managed Care Plan shall assign a pediatrician or other appropriate PCP to all pregnant enrollees for the care of their newborn babies if the enrollee has not selected a provider for a newborn.

f. 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.

(1) 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.

(2) If the enrollee is a full-benefit dual eligible:

(a) The Managed Care Plan shall not assign or require the enrollee to choose a new PCP through the Managed Care Plan.

(b) The Managed Care Plan shall not prevent the enrollee from receiving primary care services from the enrollee's existing Medicare PCP.

(c) The Managed Care Plan may assist the enrollee in choosing a PCP, if the enrollee does not have a Medicare assigned PCP.

g. The Managed Care Plan shall permit enrollees to request to change PCPs at any time. If the enrollee request is not received by the Managed Care Plan's established monthly cut-off date for system processing, the PCP change will be effective the first day of the next month.

h. The Managed Care Plan shall assign all enrollees that are reinstated after a temporary loss of eligibility to the PCP who was treating them prior to loss of eligibility, unless the enrollee specifically requests another PCP or the PCP no longer participates in the Managed Care Plan or is at capacity.

i. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall report on the number of enrollees assigned to each participating PCP and the number of enrollees who have not had an appointment with their PCP within their first year of enrollment as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

j. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall report on the number of emergency room visits by enrollees who have not had at least one appointment with their PCP as specified in the Managed Care Plan Report Guide and as referenced in Section XVI., Reporting Requirements.

2. New Enrollee Procedures

a. The Managed Care Plan shall contact each new enrollee at least twice, if necessary, within sixty (60) days of the enrollee's enrollment to offer to schedule the enrollee's initial appointment with the PCP and to complete an initial health risk assessment. For this subsection "contact" is defined as mailing a notice to or telephoning an enrollee at the most recent address or telephone number available. Contact may also include emailing as permitted by **Attachment II**, Section V.B.3, Requirements for Mailing Materials to Enrollees.

b. Within thirty (30) days of enrollment, the Managed Care Plan shall ask the enrollee to authorize release of the provider's enrollee records to the new PCP or other appropriate provider and shall assist by requesting those records from the enrollee's previous provider(s).

c. The Managed Care Plan shall comply with the following standards, measured on a quarterly basis, for completion of health risk assessments within sixty (60) days of enrollment for enrollees who are identified by the Agency enrollment files as being pregnant or diagnosed with a serious mental illness.

(1) The Managed Care Plan shall ensure that health risk assessments are completed on at least seventy percent (70%) of pregnant enrollees.

(2) The Managed Care Plan shall ensure that health risk assessments are completed on at least fifty percent (50%) of enrollees diagnosed with a serious mental illness.

d. The Managed Care Plan shall comply with the following standards, measured on a quarterly basis, for completion of health risk assessments within sixty (60) days of receipt of a claim or encounter indicating that a new enrollee is diagnosed with diabetes or asthma.

(1) The Managed Care Plan shall ensure that health risk assessments are completed on at least fifty percent (50%) of enrollees diagnosed with diabetes.

(2) The Managed Care Plan shall ensure that health risk assessments are completed on at least fifty percent (50%) of enrollees diagnosed with asthma.

e. The Managed Care Plan agrees to submit a quarterly report of the completion rates for health risk assessments on the target populations identified in c. and d. above, to the Agency.

f. If the Managed Care Plan fails to comply with the requirements of items c., d., and e. above, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.

3. Enrollee Screening and Education

a. Within thirty (30) days of enrollment, the Managed Care Plan shall notify enrollees of, and ensure the availability of, a screening for all enrollees known to be pregnant or who advise the Managed Care Plan that they may be pregnant. The Managed Care Plan shall refer enrollees who are, or may be, pregnant to a provider to obtain appropriate care.

b. The Managed Care Plan shall use the enrollee's health risk assessment and/or released enrollee record to identify enrollees who have not received child health screenings in accordance with the Agency-approved periodicity schedule.

c. The Managed Care Plan shall develop and implement an education and outreach program to increase the number of eligible enrollees receiving well-child visits. This program shall include, at a minimum, the following:

(1) A tracking system to identify enrollees for whom a screening is due or overdue;

(2) Systematic reminder notices sent to enrollees before a screening is due. The notice shall include an offer to assist with scheduling and transportation;

(3) If the Managed Care Plan's well-child visit rate is below eighty percent (80%), contacts (which may include automated calls) to all new enrollees under the age of twenty-one (21) years to inform them of well-child visit services and offer to assist with scheduling and transportation;

(4) A process for following up with enrollees who do not get timely screenings. This shall include contacting, twice if necessary, any enrollee more than two (2) months behind in the Agency-approved periodicity screening schedule to urge those enrollees, or their legal representatives, to make an appointment with the enrollee's PCP for a screening visit and offering to assist with scheduling and transportation. The Managed Care Plan shall document all outreach education attempts. For this subsection "contact" is defined as mailing a notice to or calling an enrollee at the most recent address or telephone number available; and

(5) Provision of enrollee education and outreach in community settings.

d. The Managed Care Plan shall develop and implement an education outreach program to encourage wellness visits to prevent illness or exacerbations of chronic illness.

e. The Managed Care Plan shall take immediate action to address any identified urgent medical needs.

f. Pursuant to s. 409.966(3)(c)2, F.S., the Managed Care Plan shall have a program for recognizing PCMHs and providing increased compensation for recognized PCMHs, as defined by the Managed Care Plan. The Managed Care Plan shall submit its procedures for such program to the Agency, which shall include recognition standards and increased compensation protocols developed by the Managed Care Plan for the program.

4. Protective Custody Coverage Provisions

a. The Managed Care Plan shall provide a physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter, or the foster care program by the DCF. (Rule 65C-29.008, F.A.C.)

b. The Managed Care Plan shall provide these required examinations without requiring prior authorization, or, if DCF uses a non-participating provider, approve and process the claim.

E. Care Coordination/Case Management

1. General Provisions

a. The Managed Care Plan shall implement case management processes for enrollees under the age of twenty-one (21) years who are receiving services in a skilled nursing

facility, receiving private duty nursing services in their family home or other community based setting, and receiving medical foster care services.

b. If an enrollee under the age of twenty-one (21) years receiving private duty nursing, medical foster care services, or nursing facility services, or their authorized representative, declines to receive case management services, the Managed Care Plan shall nevertheless comply with all requirements specified in this Section of the Contract, with the exception of maintaining monthly contact with the enrollee or the authorized representative, and shall offer case management services to the enrollee or the enrollee's authorized representative no less than annually. The Managed Care Plan shall document all such activities in the enrollee record.

c. The Managed Care Plan shall assign case managers to participate in all CMAT meetings for enrollees under the age of twenty-one (21) years receiving private duty nursing, nursing facility services, or medical foster care services.

d. The Managed Care Plan shall ensure each enrollee receiving services in the Early Steps program is assigned a Child Health Services Targeted Case Manager, as identified by the Agency on the Panel Roster Report.

e. The Managed Care Plan shall maintain a secure email account for receipt of scheduling information (date, time, location) for all CMAT and other interagency or MDT staffing meetings for which the plan is required to participate.

2. Case Management Program Description

In addition to the provisions of **Attachment II**, Section VI.E.2., Case Management Program Description, the Managed Care Plan shall maintain written procedures for the case management of enrollees under the age of twenty-one (21) years receiving private duty nursing services, medical foster care services, or nursing facility services, which shall include:

a. A description of the Managed Care Plan procedures for assigning a case manager to enrollees.

b. A description of the Managed Care Plan's procedures for documenting an enrollee's or the enrollee's authorized representative's rejection of case management services.

c. The responsibilities of the case manager in participating in all scheduled and any ad hoc CMAT meeting(s) for assigned enrollees.

3. Initial Plan of Care/ Reviews

a. The Managed Care Plan shall convene an MDT every six (6) months for enrollees under the age of twenty-one (21) years receiving private duty nursing or nursing facility services to provide a comprehensive review of the services and supports that the enrollee needs, and to authorize any Medicaid reimbursable services that are prescribed for the enrollee. The Managed Care Plan shall develop a person centered

individualized service plan documenting all service needs for enrollees under the age of twenty-one (21) years receiving private duty nursing or nursing facility services. The Managed Care Plan shall convene an MDT meeting more frequently, if needed, based on any changes in the enrollee's medical condition or a significant life change.

b. The Managed Care Plan shall develop and maintain a plan of care for enrollees receiving medical foster care services that describes all interventions that the medical foster care provider must implement in accordance with the physician's order. The Managed Care Plan shall update the plan of care for medical foster care services at least every one hundred eighty (180) days, or more frequently to reflect changes in the physician's orders. The Managed Care Plan shall ensure that the medical foster care plan of care is signed by a physician who is experienced in providing services to children with complex medical needs.

c. The Managed Care Plan shall provide a copy of the plan of care to the DOH, Medical Foster Care program staff, the Community-Based Care Lead Agency, and the medical foster care provider.

d. The Managed Care Plan shall participate in interagency staffings (e.g., DCF, DJJ, and community based care organizations) or school staffings for all enrollees under the age of twenty-one (21) years that may result in the provision of behavioral health or medical services. The Managed Care Plan or designee shall participate in such staffings as required by the Agency.

e. The Managed Care Plan shall report the total number of behavioral health-related and medical neglect staffing meetings that are attended as specified in Section XVI. Reporting Requirements, and the Managed Care Plan Report Guide.

4. Monthly Contact

a. The Managed Care Plan shall maintain monthly contact with the parent or legal guardian of enrollees under the age of twenty-one (21) years receiving private duty nursing services, medical foster care services, or nursing facility services. The Managed Care Plan shall document the monthly contact in the enrollee record.

b. The Managed Care Plan shall ensure an enrollee under the age of twenty-one (21) years receiving private duty nursing services, or the enrollee's authorized representative, signs and dates a completed Agency-approved form to document voluntary suspension of private duty nursing services, if applicable.

5. Freedom of Choice

For an enrollee under the age of twenty-one (21) years receiving nursing facility services, the Managed Care Plan shall ensure the enrollee or enrollee's authorized representative reviews, signs, and dates a completed Agency-approved Freedom of Choice Certification Form on the following schedule:

a. Within seven (7) business days of instituting nursing facility services and prior to authorization of such services; and

b. At the bi-annual MDT meeting every six (6) months thereafter, for the duration that the enrollee resides in a nursing facility.

6. Pre-Admission Screening and Resident Review

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

7. Disease Management Program

a. Disease management programs provided by the Managed Care Plan shall address enrollees with cancer, diabetes, asthma, hypertension, behavioral health, and other special health care needs.

b. Within ninety (90) calendar days of enrollment, beginning the first of the month after the month of enrollment, the Managed Care Plan shall identify every new individual with special health care needs.

c. The Managed Care Plan shall implement mechanisms to comprehensively assess each Medicaid enrollee identified as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

d. Disease Management programs provided by the Managed Care Plan shall include, but are not limited to, the following components:

(1) 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;

(3) Emotional issues of the caregiver;

(4) Behavioral management issues of the enrollee;

(5) Communicating effectively with providers; and

(6) Medication management, including the review of medications that an enrollee is currently taking to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications.

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8. Transition of Care

a. In addition to the provisions of **Attachment II,** Section VI.E.2., Case Management Program Description, the Managed Care Plan's transition of care procedures shall include the following minimum functions:

(1) Coordination of hospital/institutional discharge planning and post discharge care:

(2) Assisting with schedule any follow-up appointments;

(3) Collaborating with the hospital/institution discharge planner/coordinator to implement the discharge plan in the enrollee's home;

(4) Facilitating communication with community service providers; and

(5) Coordination of care after emergency department visits. (42 CFR 438.208(b)(2)(i))

b. Long-Term Care Program Referrals

(1) The Managed Care Plan shall ensure referrals with the required medical documentation needed to complete the clinical eligibility process for the LTC program are submitted to CARES for the following enrollees:

(a) Six (6) months prior to an enrollee turning the age of eighteen (18) years for enrollees residing in a nursing facility;

(b) Six (6) months prior to an enrollee turning the age of twenty-one (21) years for enrollees receiving private duty nursing services, if the enrollee or their authorized representative has expressed a desire to enroll in the LTC program; and

(c) Upon the request of the enrollee or their representative for an individual who is eighteen (18), nineteen (19), or twenty (20) years of age and who has a chronic debilitating disease or condition of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention (s.409.979(3)(f)1., F.S.

(2) The following information must be included with the referral to CARES:

(a) For all referrals, a completed and signed Informed Consent Form and a completed and signed Medical Certification for Medicaid Long-term Care Services and Patient Transfer Form, AHCA Form 5000-3008, and

(b) For referrals made pursuant to s.409.979(3)(f)(1), F.S., in addition to the above, the information in the CARES Long-Term Care Transition Referral Form and Instructions.

All referenced forms may be found at https://ahca.myflorida.com/Medicaid/statewide_MC/app_contract_materials.shtml.

c. The Managed Care Plan shall maintain written protocols that address the transition/discharge planning process for enrollees who are receiving services in a skilled nursing facility. The Managed Care Plan shall ensure that transition planning begins upon admission to a skilled nursing facility. In those cases where the enrollee has been residing in a skilled nursing facility prior to enrollment in the Managed Care Plan, the Managed Care Plan shall begin the transition planning process upon enrollment in the Managed Care Plan.

9. Additional Care Coordination/Case Management Requirements

a. The Managed Care Plan shall maintain written care coordination and continuity of care procedures that include the following minimum functions:

(1) Appropriate referral and scheduling assistance for enrollees needing specialty health care or transportation services, including those identified through well-child visits;

(2) Care coordination follow-up services for children/adolescents whom the Managed Care Plan identifies through blood screenings as having abnormal levels of lead; and

(3) A mechanism for access to specialists, without the need for a referral, for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs.

b. The Managed Care Plan shall ensure that assigned case managers receive training through the DOH on the level of care requirements for medical foster care services.

c. The Managed Care Plan shall attend any dependency court hearings, when requested by the Department of Children and Families (or its designee) to provide status updates related to enrollees in receipt of medical foster care services.

d. Pursuant to s. 409.975(4)(b), F.S., the Managed Care Plan shall establish specific procedures to improve pregnancy outcomes and infant health, inter-conception care, and reproductive life planning, in coordination with the Healthy Start program.

e. Prenatal Care

The Managed Care Plan shall:

(1) Require care coordination through the gestational period according to the needs of the enrollee.

(2) Contact those enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care.

(3) Assist enrollees in making delivery arrangements, if necessary.

f. The Managed Care Plan shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:

(1) Identifying eligible enrollees and stratifying enrollees by severity and risk level including developing an algorithm to identify and stratify eligible enrollees, including:

(a) Identifying enrollees with co-morbid mental health and substance abuse disorders, including a depression screening, and addressing those disorders;

(b) Identifying enrollees with co-morbid medical conditions and addressing the co-morbid medical conditions; and

(c) Identifying enrollees in out-of-home behavioral health placements.

(2) Developing different types of interventions and specifying minimum touch frequency for each severity and/or risk level;

(3) Determining maximum caseloads for each case manager and support staff and managing and monitoring caseloads;

(4) Specifying experience and educational requirements for case managers and case management support staff;

(5) Providing training and continuing education for case management staff;

(6) Using evidence-based guidelines to enhance enrollee engagement;

(7) Developing treatment plans that address all of the following:

(a) Incorporate the health risk issues identified during the assessment;

(b) Incorporate the treatment preferences of the enrollee;

(c) Contain goals that are outcomes based and measurable;

(d) Include the interventions and services to be provided to obtain goals;

(e) Include community service linkage, improving support services, and lifestyle management as appropriate based on the enrollee's identified issues.

(f) Assessing enrollees for literacy levels and other hearing, vision or cognitive functions that may impact an enrollee's ability to participate in his/her care and implementing interventions to address the limitations;

(g) Assessing enrollees for community, environmental or other supportive services needs and referring enrollees to get needed assistance;

The Managed Care Plan shall ensure treatment plans are updated at least every six (6) months when there are significant changes in enrollee's condition;

(8) Interfacing with the enrollee's PCP and/or specialists; and

(9) Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services for enrollees who have justice system involvement.

g. The Managed Care Plan shall work in coordination with DCF's behavioral health managing entity to establish specific organizational supports and protocols that enhance the integration and coordination of primary care and behavioral health services for enrollees, in accordance with s. 409.973(6), F.S.

h. The Managed Care Plan shall maintain written procedures for discharge planning through the evaluation of an enrollee's medical care needs, mental health service needs, and substance use service needs and coordination of appropriate care after discharge from one level of care to another. The Managed Care Plan shall:

(1) Monitor all enrollee discharge plans from behavioral health inpatient admissions to ensure that they incorporate the enrollee's needs for continuity in existing behavioral health therapeutic relationships;

(2) Ensure enrollees' family members, guardians, outpatient individual practitioners and other identified supports are given the opportunity to participate in enrollee treatment to the maximum extent practicable and appropriate, including behavioral health treatment team meetings and discharge plan development. For adult enrollees, family members and other identified supports may be involved in the development of the discharge plan only if the enrollee consents to their involvement;

(3) Designate care coordination/case management staff who are responsible for identifying and providing care coordination/case management to enrollees who remain in the hospital for non-clinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk enrollees and enrollees with multiple agency involvement);

(4) Develop and implement a plan that monitors and ensures that clinically indicated behavioral health services are offered and available to enrollees within seven (7) days of discharge from an inpatient setting;

(5) Ensure that a behavioral health program clinician provides medication management to enrollees requiring medication monitoring within seven (7) days of discharge from a behavioral health program inpatient setting. The Managed Care Plan shall ensure that the behavioral health program clinician is duly qualified and licensed to provide medication management; and

(6) Upon the admission of an enrollee, the Managed Care Plan shall make its best efforts to ensure the enrollee's smooth transition to the next service or to the community and shall require that behavioral health care providers:

(a) Assign a mental health targeted case manager to oversee the care given to the enrollee;

(b) Develop an individualized discharge plan, in collaboration with the enrollee where appropriate, for the next service or program or the enrollee's discharge, anticipating the enrollee's movement along a continuum of services; and

(c) Document all significant efforts related to these activities, including the enrollee's active participation in discharge planning.

i. The Managed Care Plan shall report monthly on the enrollees under the age of twenty-one (21) years receiving out-of-home behavioral health treatment, in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

j. The Managed Care Plan shall maintain written care coordination and continuity of care procedures that include coordination with the enrollee's PDHP for oral health issues that fall within the coverage of this Contract (e.g., oral cancer; services required in a facility, emergency room, or urgent care place of service).

k. The Managed Care Plan shall assign a care coordinator to an enrollee under the age of twenty-one (21) years who has special health care needs and is in need of out-of-home/residential treatment services (e.g., group home placement) to ensure timely placement and access to care. The Managed Care Plan's care coordinator shall assume a lead role in identifying a service provider that can meet the enrollee's need even when there are multiple state agencies (i.e., DCF and APD) involved in the child's care. The Managed Care Plan shall coordinate and maintain routine contact with other state agencies involved in the enrollee's care until placement is made. The Managed Care Plan shall document all efforts to find an appropriate placement in the enrollee record.

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10. Healthy Behaviors Program

a. At a minimum, the Managed Care Plan must establish a medically-approved tobacco cessation program, a medically-directed weight loss program, and a medically-approved alcohol recovery program or substance abuse recovery program that must include, but may not be limited to, opioid abuse recovery. The Managed Care Plan must identify enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance use in order to establish written agreements to secure the enrollees' commitment to participation in these programs.

(1) A medically-approved smoking cessation program shall be evidence-based and recognized by medical professionals as an effective treatment method in addressing tobacco/nicotine dependence. The program may include interventions such as counseling and/or the use of medications (nicotine replacement products) as a part of the overall therapeutic process.

(2) A medically directed weight loss program shall require ongoing supervision by a physician and may include the use of prescription drugs/supplements depending upon the need and goals of the enrollee, along with other physician approved interventions (e.g., diet, exercise, etc.).

(3) A medically approved alcohol or substance abuse recovery program shall be evidenced-based and recognized by medical professionals as an effective treatment method/approach. The program may include interventions such as medically-assisted detoxification, medication and behavioral therapy, followed by treatment and relapse prevention as a part of the overall therapeutic process.

b. As part of its smoking cessation program, the Managed Care Plan shall provide participating PCPs with the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions. (The Managed Care Plan can obtain copies of the guide by contacting the DHHS, Agency for Health Care Research & Quality (AHR) Publications Clearinghouse at (800) 358-9295 or P.O. Box 8547, Silver Spring, MD 20907.)

c. As part of its medically-approved alcohol or substance abuse recovery program, the Managed Care Plan shall offer annual alcohol or substance abuse screening training to its providers. The Managed Care Plan shall have all PCPs screen enrollees for signs of alcohol or substance abuse as part of prevention evaluation at the following times:

(1) Initial contact with a new enrollee;

(2) Routine physical examinations;

(3) Initial prenatal contact;

(4) When the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services; and

(5) When documentation of emergency room visits suggests the need.

F. Quality Enhancements

The Managed Care Plan shall offer QEs to enrollees as specified below:

1. Children's Programs

The Managed Care Plan shall provide regular general wellness programs targeted specifically toward enrollees from birth to the age of five (5) years, or the Managed Care Plan shall make a good faith effort to involve enrollees in existing community children's programs.

2. Domestic Violence

The Managed Care Plan shall ensure that participating PCPs screen enrollees for signs of domestic violence and shall offer referral services, as applicable, to domestic violence prevention community agencies.

3. Pregnancy Prevention

The Managed Care Plan shall conduct regularly scheduled pregnancy prevention programs, or shall make a good faith effort to involve enrollees in existing community pregnancy prevention programs. The programs shall be targeted towards teen enrollees, but shall be open to all enrollees, regardless of age, gender, pregnancy status, or parental consent.

4. Pregnancy-Related Programs

a. The Managed Care Plan shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Managed Care Plan's prenatal and postpartum programs. The Managed Care Plan shall coordinate its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services.

b. The Managed Care Plan shall ensure that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate.

c. The Managed Care Plan shall ensure that providers give all women of childbearing age HIV counseling and offer them HIV testing. (Chapter 381, F.S.)

5. Healthy Start Services

a. The Managed Care Plan shall develop agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants.

b. The program for pregnant women and infants must be aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes.

c. The Managed Care Plan shall collaborate with the Healthy Start care coordinator within the enrollee's county of residence to assure delivery of risk-appropriate care.

d. The Managed Care Plan shall ensure submission of a completed Practitioner Disease Report Form (DH Form 2136) to the Perinatal Hepatitis B Prevention Coordinator at the local CHD for all prenatal or postpartum enrollees and their infants who test HBsAg-positive.

6. Nutritional Assessment/Counseling

a. The Managed Care Plan shall ensure that its providers supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children.

b. The Managed Care Plan shall determine the need for non-covered services and referral of the enrollee for assessment and refer the enrollee to the appropriate service setting (to include referral to WIC and Healthy Start and other social services) with assistance.

c. The Managed Care Plan shall:

(1) Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes.

(2) Offer a mid-level nutrition assessment.

(3) Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or physician following the nutrition assessment.

(4) Refer all enrollees under the age of five (5), and pregnant, breast-feeding and postpartum enrollees to the local WIC program office using the Florida WIC Program Medical Referral Form (DH 3075).

(5) For subsequent WIC certifications, the Managed Care Plan shall ensure that providers coordinate with the local WIC office to provide the above referral data from the most recent well-child visit.

(6) Each time the provider completes a WIC referral form, the Managed Care Plan shall ensure that the provider gives a copy of the form to the enrollee.

7. Behavioral Health Programs

The Managed Care Plan shall provide outreach to homeless and other populations of enrollees at risk of justice system involvement, as well as those enrollees currently

involved in this system, to assure that services are accessible and provided when necessary. This activity shall be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system.

G. Authorization of Services

1. General Provisions

The Managed Care Plan shall not delegate to its subcontractors any aspect of authorization of services for early intervention services. This requirement does not apply to contracts or agreements with the Local Early Steps offices located in the regions in which the Managed Care Plan is providing services under this Contract.

2. Utilization Management Program Description

The Managed Care Plan shall supplement the Utilization Management Program Description required in **Attachment II,** Section VI.G., Coverage and Authorization of Services, to include distinct procedures related to the authorization of MMA services, including but not limited to:

a. Procedures for monitoring for and demonstrating compliance with 42 CFR 438, subpart K regarding the Mental Health Parity and Addictions Equity Act (MHPAEA) and 42 CFR 438.910(d), including procedures to monitor for and assure parity in the application of quantitative and non-quantitative treatment limits for medical and behavioral health services.

   If the Managed Care Plan fails to comply with the requirements of this section, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.

b. For enrollees with special health care needs identified in accordance with Section V.E.4.c. of this Exhibit, a mechanism to allow enrollees with special health care needs to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

c. If the Managed Care Plan requires authorization of early intervention services, use of the IFSP as the sole document. The Managed Care Plan may require additional supplemental documentation, subject to prior approval of the Agency.

d. A description of a prior authorization program for covered outpatient drugs that complies with the following:

   (1) The requirements of section 1927(d)(5) of the SSA, as if such requirements applied to the Managed Care Plan instead of the state.

(2) A description for complying with the requirements of s. 409.912(5)(a)14., 15., and 16., F.S., regarding prior authorization for covered outpatient drugs.

(3) The requirements of s. 409.912(5)(a)1., F.S., regarding responding to requests for prior authorization and seventy-two (72)-hour drug supplies;

e. A procedure for the authorization, in accordance with this Exhibit, Section VIII.A.8., Timely Access Standards, for facility services and associated ancillary medical services secondary to dental care authorized by the PDHP and provided in a facility under the direction of a dentist when considered medically necessary due to the enrollee's special healthcare needs.

f. Issuing service authorizations to enrollees requesting transportation services.

3. Service Authorization System

There are no additional service authorization system provisions unique to the MMA managed care program.

4. Practice Guidelines/Evidence-based Criteria

a. In accordance with s. 409.967(2)(c)2, F.S., the Managed Care Plan shall assure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.

b. The Managed Care Plan's prior authorization criteria and protocols for prescribed drugs shall not be more restrictive than those posted on the Agency website and used by the Agency, as authorized by federal and State laws, rules, or regulations, and the federal CMS waivers applicable to this Contract.

5. Clinical Decision-Making

There are no additional clinical decision-making provisions unique to the MMA managed care program.

6. Service Authorization Standards for Decisions

There are no additional service authorization standards for decisions provisions unique to the MMA managed care program.

7. Changes to Utilization Management Components

There are no additional changes to UM components provisions unique to the MMA managed care program.

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Section VII. Grievance and Appeal System

A. General Provisions

There are no additional general grievance and appeal system provisions unique to the MMA managed care program.

B. Use of Independent Review Organization

There are no additional independent review organization provisions unique to the MMA managed care program.

C. Process for Complaints

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

D. Process for Grievances

Title XXI MediKids enrollees are not eligible to participate in the Medicaid Fair Hearing process.

E. Notice of Adverse Benefit Determination

1. In addition to the requirements in **Attachment II,** Section VI.G., Authorization of Services, the Managed Care Plan shall ensure a notice of action is provided to enrollees under the age of twenty-one (21) years receiving residential psychiatric treatment (including SIPP and TGC services) in each instance during a course of treatment where the Managed Care Plan authorizes fewer units or days subsequent to the initial authorization for the service.

2. Hernandez Settlement Agreement Requirements

a. The Managed Care Plan shall ensure all participating pharmacy locations provide notice to an enrollee when the payment is denied for a prescription, in compliance with the Settlement Agreement to *Hernandez, et al v. Medows* (case number 02-20964 Civ-Gold/Simonton) (HSA). An HSA situation arises when an enrollee attempts to fill a prescription at a participating pharmacy location and is unable to receive the prescription as a result of:

(1) An unreasonable delay in filling the prescription;

(2) A denial of the prescription;

(3) The reduction of a prescribed good or service; and/or

(4) The expiration of a prescription.

b. The Managed Care Plan shall maintain a log of all correspondence and communications from enrollees relating to the HSA ombudsman process. The Managed Care Plan shall submit the ombudsman log report quarterly to the Agency, as required in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

F. Standard Resolution of Plan Appeals

There are no additional standard resolution of plan appeals provisions unique to the MMA managed care program.

G. Extension of Plan Appeal

There are no additional extension of plan appeal provisions unique to the MMA managed care program.

H. Expedited Resolution of Plan Appeals

There are no additional expedited resolution of plan appeals provisions unique to the MMA managed care program.

I. Notice of Plan Appeal Resolution

There are no additional notice of plan appeal resolution provisions unique to the MMA managed care program.

J. Process for Medicaid Fair Hearings

There are no additional process for Medicaid Fair Hearings provisions unique to the MMA managed care program.

K. Appellate Responsibilities

There are no additional appellate responsibilities provisions unique to the MMA managed care program.

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Section VIII. Provider Services

A. Network Adequacy Standards

1. General Provisions

The Managed Care Plan shall not delegate to its subcontractors any aspect of claims payment, utilization management, credentialing, or network management for early intervention services providers. This requirement does not apply to contracts or agreements with the Local Early Steps offices located in the regions in which the Managed Care Plan is providing services under this Contract.

2. Network Capacity and Geographic Access Standards

a. Pursuant to s. 409.967(2)(c)(1) and 42 CFR 438.68(b)(1)(i)-(viii), 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 plan enrollees. At a minimum, Managed Care Plans shall contract with the providers specified in the MMA Provider Network Standards Table, Table 4, below. Managed Care Plans shall ensure regional provider ratios and provider-specific geographic access standards for enrollees in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the table. The regional provider ratios shall be based upon one hundred twenty percent (120%) of the Managed Care Plan's actual monthly enrollment measured at the first of each month, by region, for all regions.

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TABLE 4
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 Enrollee*
Primary Care Providers	30	20	30	20	1:750 enrollees
Specialists					
Allergy	80	60	90	75	1:20,000 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 Surgery	50	35	75	60	1:3,500 enrollees
Infectious Diseases	100	75	110	90	1:6,250 enrollees
Internal Medicine Specialist	30	20	30	20	1:3,000 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
Orthopaedic Surgery	50	35	75	60	1:5,000 enrollees

TABLE 4
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 Enrollee*
Otolaryngology	80	60	90	75	1:3,500 enrollees
Pediatrics (including Adolescent Medicine)	50	35	75	60	1:1,500 enrollees
Pharmacy	15	10	15	10	1:2,500 enrollees
24-hour Pharmacy	60	45	60	45	n/a
Podiatry	60	45	75	60	1:5,200
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, Pediatric (Occupational)	30	20	60	45	1:1,500 enrollees
Therapist (Speech)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Speech)	30	20	60	45	1:1,500 enrollees
Therapist (Physical)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Physical)	30	20	60	45	1:1,500 enrollees
Therapist (Respiratory)	100	75	110	90	1:8,600 enrollees
Therapist, Pediatric (Respiratory)	60	45	75	60	1:1,500 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 (including Birthing Center)	30	20	30	20	1 bed: 275 enrollees

TABLE 4
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 Enrollee*
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	n/a	n/a	n/a	n/a	2: County
Hospice	n/a	n/a	n/a	n/a	2: County
DME/HME	30	20	30	20	2: County
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	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees

TABLE 4 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 Enrollee*
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees
Medication and Methadone Treatment Programs	30	20	60	45	n/a

3. Primary Care Providers

a. The Managed Care Plan shall enter into provider agreements with at least one (1) FTE PCP per one thousand five hundred (1,500) enrollees. The Managed Care Plan may increase the physician's ratio by seven hundred fifty (750) enrollees for each FTE ARNP or PA affiliated with the participating physician's office. The Managed Care plan shall ensure a sufficient selection of FTE PCPs 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.

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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 a Medicaid-enrolled PCP(s). After-hours coverage must be accessible using the medical office's daytime telephone number. After-hours 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.

(2) The PCP arranges for coverage of primary care services during PCP 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.

4. Specialists and Other Providers

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

(1) A sufficient selection of the network infectious disease specialists has expertise in HIV/AIDS and its treatment and care, based on the actual number of enrollees with HIV/AIDS;

(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; and

(3) In accordance with s. 641.31, F.S., low-risk enrollees have access to midwifery services from providers licensed in accordance with Chapter 467, F.S.

b. For pediatric specialists not listed on the Managed Medical Assistance Provider Network Standards Table, Table 4, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at an agreed upon location or at a PCP's office 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.

c. The Managed Care Plan may increase the Psychiatrist's ratio by seven hundred fifty (750) enrollees for each FTE ARNP with a certificate of psychiatric nursing through the American Nurses Credentialing Center or physician's assistant (PA) with a

Certificate of Added Qualifications in psychiatry through the National Commission on Certification of Physician Assistants, and affiliated with the participating Psychiatrist's office.

d. The Managed Care Plan shall comply with the requirements in s. 409.912(5)(a)4., F.S., regarding limiting pharmacy networks.

e. For each county it serves, the Managed Care Plan shall designate an emergency service facility that operates twenty-four hours a day, seven days a week, (24/7) with Registered Nurse coverage and on-call coverage by a behavioral health specialist. (42 CFR 438.3(q))

f. The Managed Care Plan shall ensure the availability of massage therapists licensed in accordance with Chapter 480, F.S. and physical therapists licensed in accordance with Chapter 486, F.S. for the provision of services under Section V.A.1.a.(27) of this Exhibit.

g. The Managed Care Plan shall enter into agreements with early intervention services providers as identified by the Agency.

   (1) Early intervention services providers must be:

      a. Qualified to render early intervention services in accordance with 34 CFR 303.321;

      b. Trained and certified by the DOH, Early Steps Program;

      c. Enrolled in Florida Medicaid;

      d. Qualified as specified in the service-specific Medicaid policy. Such providers may include Infant Toddler Developmental Specialists, audiologists, family therapists, nurses, occupational therapists, physical therapists, speech-language pathologists, ophthalmologists/optometrists, pediatricians, psychologists, registered dieticians, targeted case managers, and social workers.

   (2) The Managed Care Plan shall make a good faith effort to execute agreements with the Local Early Steps offices located in the regions in which the Managed Care Plan is providing services under this Contract.

h. When an enrollee has been determined eligible for medical foster care services, and the Community-Based Care Lead Agency and the DOH, Medical Foster Care Program have identified an appropriate and qualified medical foster care provider (i.e., home) in which to place the enrollee, the Managed Care Plan shall enter into an agreement with the provider to furnish medical foster care services within seven (7) days of notification of the placement of the enrollee with the medical foster care parent.

i. For enrollees participating in the DOH Early Steps program, the Managed Care Plan shall ensure the availability of EIS authorized on the IFSP to be provided in the enrollee's natural environment (i.e., home, daycare, school, etc.).

j. The Managed Care Plan shall develop and implement written procedures for determining how the Managed Care Plan will provide transportation services outside its region, when medically necessary.

5. Public Health Providers

a. The Managed Care Plan shall make a good faith effort to execute memoranda of agreements, as specified in this Sub-Section, with public health providers, including:

(1) CHDs qualified pursuant to rule 59G-4.055, F.A.C.;

(2) RHCs qualified pursuant to rule 59G-4.280, F.A.C.; and

(3) FQHCs qualified pursuant to rule 59G-4.100, F.A.C.

The Managed Care Plan shall provide documentation of its good faith effort upon the Agency's request.

b. The Managed Care Plan shall pay at the contracted rate or the Medicaid FFS rate, without authorization, all authorized claims for the following services provided by a CHD, migrant health center funded under Section 329 of the Public Health Services Act, or community health center funded under Section 330 of the Public Health Services Act. The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD encounter rate as specified by the County Health Department Clinic Rule and the associated Florida Medicaid fee schedule for applicable rates for the following services:

(1) Office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis.

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

(3) The provision of immunizations;

(4) Family planning services and related pharmaceuticals;

(5) School health services provided by CHDs, and for services rendered on an urgent basis by such providers; and

(6) In the event that a vaccine-preventable disease emergency is declared, claims from the CHD for the cost of the administration of vaccines.

The Managed Care Plan may require prior authorization for all other covered services provided by CHDs.

c. The Managed Care Plan 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.

d. The Managed Care Plan 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. The Managed Care Plan 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.

e. The Managed Care Plan shall not deny claims for services delivered by CHD 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) days.

f. The Managed Care Plan shall not deny reimbursement for failure to prior authorize services rendered pursuant to s. 392.62 F.S.

g. The Managed Care Plan shall reimburse FQHCs and RHCs at rates comparable to those rates paid for similar services in the community.

h. When billing for prescribed drug services outside of the cost-based reimbursement rate, the Managed Care Plan shall reimburse CHDs for authorized prescription drugs in accordance with Rule 59G-4.251, F.A.C., Prescribed Drugs Reimbursement Methodology.

i. The Managed Care Plan shall report quarterly to the Agency as part of its quarterly financial reports (as specified in Section XIV., Reporting Requirements, and the Managed Care Plan Report Guide), the payment rates and the payment amounts made to FQHCs and RHCs for contractual services provided by these entities.

j. The Managed Care Plan shall make a good faith effort to execute memoranda of agreement with private schools, charter schools, and 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., 409.908(22), F.S., and 409.9072, F.S.

k. The Managed Care Plan Shall reimburse Indian Health Care Providers (IHCPs) at rates comparable to those rates paid for similar services in the IHCPs' community.

l. The Managed Care Plan shall report quarterly to the Agency in a format specified by the Agency, the payment rates and the payment amounts made to IHCPs for

contractual services provided by these entities. When the amount the IHCP would have received under the fee-for-service reimbursement system, the Agency shall comply with 42 CFR 438.14(c)(3).

6. Facilities and Ancillary Providers

a. The Managed Care Plan shall enter into provider agreements 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:

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

(2) Network facilities are licensed as required by law and rule;

(3) Hospital providers in the Managed Care Plan's provider network participate in the ENS; the Managed Care Plan shall achieve and maintain ENS participation of at least eighty percent (80%) of total hospital beds in each region of the Managed Care Plan's provider network; and

(4) 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.

b. 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.

c. The Managed Care Plan may have procedures to assign enrollees to specialty pharmacies for specialty drugs. The Managed Care Plan shall notify an enrollee in writing at the time of a specialty pharmacy assignment of how to opt-out of a specialty pharmacy assignment and choose among participating providers. The Managed Care Plan shall allow an enrollee to request to opt-out of a specialty pharmacy assignment at any time. The Managed Care Plan shall provide the Agency a copy of its procedures for approval in advance of implementation; and

d. In accordance with s. 409.975(1)(e), F.S., the Managed Care Plan may offer a provider agreement to each licensed home medical equipment and supplies provider and to each Medicaid enrolled 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, by service and provider type, as specified by the Agency.

e. The Managed Care Plan's provider network shall include a sufficient number of qualified providers to cover all services in accordance with the service-specific coverage policy.

7. 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 school faculty physician groups;

(2) Regional perinatal intensive care centers as defined in s. 383.16(2), F.S.;

(3) Hospitals licensed as specialty children's hospitals as defined in s. 395.002(27), F.S.;

(4) Florida cancer hospitals that meet the criteria in 42 U.S.C., s. 1395ww(d)(1)(B)(v); and

(5) Accredited and integrated systems serving medically complex children which comprise 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 monthly payments to faculty plans of Florida medical school faculty physician groups in an amount specified by the Agency. The payment amount shall be the per member, per month amount multiplied by the Managed Care Plan’s monthly enrollment.

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

(3) Except for payments for emergency services, the Managed Care Plan shall make payments to a non-participating specialty children's hospital, and non-participating Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v), 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 Agency may determine that providers are essential Medicaid providers.

Pursuant to s. 409.975(1)(a), F.S., the Managed Care Plan shall 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. Essential providers include SIPP providers.

8. Timely Access Standards

a. The Managed Care Plan shall ensure that appointments for medical services and behavioral health services are available on a timely basis.

(1) Appointments for urgent medical or behavioral health care services shall be provided:

(a) Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.

(b) Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization.

(2) Appointments for non-urgent care services shall be provided:

(a) Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.

(b) Within fourteen (14) days for initial outpatient behavioral health treatment.

(c) Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.

(d) Within thirty (30) days of a request for a primary care appointment.

(e) Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.

b. Quarterly, the Managed Care Plan shall review a statistically valid sample of PCP, specialist, and behavioral health offices' average appointment wait times to ensure services are in compliance with this subsection (a) above, and report the results to the Agency as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. (42 CFR 438.206(c)(1)(iv),(v), and (vi))

c. The Managed Care Plan shall ensure that early intervention services are provided no later than thirty (30) days from the date the IFSP was completed for children enrolled in the Early Steps Program.

9. Network Adequacy Measures

a. The Managed Care Plan shall collect regional data on the measures as specified in the Provider Network Adequacy Standards Table, Table 5, below, in order to evaluate its provider network and to ensure that covered services are reasonably accessible.

b. The Managed Care Plan shall comply with the regional standards for each measure as specified in the Provider Network Adequacy Standards Table below.

c. The Managed Care Plan shall submit the results of the network adequacy standards specified in the table below to the Agency quarterly as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

d. The Agency reserves the right to require Managed Care Plans to collect data and report results on additional network adequacy standards.

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TABLE 5
PROVIDER NETWORK ADEQUACY MEASURES TABLE

Measure		Region										
		1	2	3	4	5	6	7	8	9	10	11
The Managed Care Plan agrees that at least ___ percent of required participating PCPs (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1), by region, are accepting new Medicaid enrollees.	Standard	90	85	90	85	85	90	85	90	85	85	85
The Managed Care Plan agrees that at least ___ percent of required participating specialist providers, (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1), by region, are accepting new Medicaid enrollees.		90	90	85	90	90	90	90	90	90	90	90
The Managed Care Plan agrees that at least ___ percent of required participating PCPs (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1), by region, offer after hours appointment availability to Medicaid enrollees.		40	50	45	50	45	45	50	40	50	50	50
The Managed Care Plan agrees that no more than ___ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in Subsection IX.G., Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.		5	5	8	5	3	5	5	5	5	10	8
The Managed Care Plan agrees that no more than ___ percent of enrollee specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in Subsection IX.G., Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.		8	10	10	10	8	8	8	8	10	10	8

B. Network Management

1. Annual Network Development Plan

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

(1) 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; and

(2) Pharmacy features (The availability of non-sterile compounding, and home delivery pharmacy services).

2. Regional Network Changes

In addition to the requirements of **Attachment II**, Section VIII.B., Network Management, the Managed Care Plan shall notify the Agency within seven (7) business days of a decrease in the total number of PCPs by more than five percent (5%).

C. Provider Credentialing and Contracting

1. General Provisions

There are no additional general provisions applicable to provider credentialing and contracting.

2. Credentialing and Recredentialing

a. The Managed Care Plan's credentialing and recredentialing processes must include verification of the following additional requirements for physicians:

(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 physician with whom the physician has entered into an arrangement for hospital coverage.

(2) Valid Drug Enforcement Administration certificates, where applicable.

(3) Attestation that the total active patient load (all populations, including but not limited to Medicaid FFS, Children's Medical Services, SMMC plans, Medicare, KidCare, and commercial coverage) is no more than three thousand (3,000) patients per primary care physician. An active patient is one that is seen by the provider a minimum of two (2) times per year.

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

(a) Evidence that the Managed Care Plan has evaluated the provider's facilities using the Managed Care Plan's organizational standards;

(b) 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; and

(c) Evidence that the Managed Care Plan has evaluated the provider's enrollee record keeping practices at each site to ensure conformity with the Managed Care Plan's organizational standards.

(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:

(a) Any physical or behavioral health problems that may affect the provider's ability to provide health care; and

(b) Any history of chemical dependency/substance abuse.

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

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

(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.

3. Hernandez Settlement Agreement Surveys

The Managed Care Plan shall comply with the following requirements of the HSA.

a. The Managed Care Plan shall conduct annual HSA onsite surveys of no less than five percent (5%) of all participating pharmacy locations to ensure compliance with the HSA.

b. The Managed Care Plan may survey less than five percent (5%), with written approval from the Agency, if the Managed Care Plan can show that the number of participating pharmacies it surveys is a statistically significant sample that adequately represents the pharmacies that have contracted with the Managed Care Plan to provide pharmacy services.

c. The Managed Care Plan shall not include in the HSA survey any participating pharmacy location that the Managed Care Plan found to be in complete compliance with the HSA requirements within the past twelve (12) months.

d. The Managed Care Plan shall require all participating pharmacy locations that fail any aspect of the HSA survey to undergo mandatory training within six (6) months and then be re-evaluated within one (1) month of the training to ensure that the pharmacy location is in compliance with the HSA.

   The Managed Care Plan shall ensure that it complies with all aspects and surveying requirements set forth in the Managed Care Plan Report Guide.

e. The Managed Care Plan shall submit an annual report to the Agency by August 1 of each Contract year providing survey results in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

4. Provider Agreement Requirements

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

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

   (3) Contain no provision that prohibits the PCP 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;

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

(5) 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;

(6) For hospital contracts, include PPC reporting requirements as specified in Section X., Administration and Management;

(7) For pharmacy contracts, ensure its pharmacy benefits manager provides the following electronic message alerting the pharmacist to provide Medicaid recipients with the HSA notice/pamphlet when coverage is rejected due to the drug not being on the PDL:

Non-preferred drug; Contact provider for change to preferred drug or to obtain prior authorization. Give Medicaid pamphlet if not corrected; and

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

(a) Authentication and authorization of users;

(b) Authentication of the origin of the information;

(c) The prevention of unauthorized access to the system or information;

(d) System security, including the integrity of information that is collected, program integrity and system integrity; and

(e) Maintenance of documentation about system and information usage; and

(9) For contracts with public health providers, require such providers to contact the Managed Care Plan before providing health care services to enrollees and provide the Managed Care Plan with the results of the office visit, including test results.

5. Provider Termination and Continuity of Care

a. The Managed Care Plan shall notify enrollees in accordance with the provisions of this Contract and State and federal law regarding provider termination. (42 CFR 438.10(f)(1))

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

c. The Managed Care Plan shall allow pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the completion of postpartum care.

D. Provider Services

1. Provider Handbook and Bulletin Requirements

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

a. Well-child visit program services and standards;

b. Procedures to obtain authorization of any medically necessary service to enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

c. PCP responsibilities; and

d. Telemedicine requirements for providers.

2. Provider Education and Training

The Managed Care Plan shall offer training to all new and existing participating pharmacy locations about the HSA requirements.

E. Claims and Provider Payment

1. MMA Physician Incentive Program

a. Pursuant to s. 409.967(2)(a), F.S., and as specified by the Agency, the Managed Care shall implement an incentive program wherein payment rates for the following eligible physicians, who meet certain qualifying criteria, as approved by the Agency, shall equal or exceed Medicare rates for services provided. This incentive program shall be referred to as the MMA Physician Incentive Program (MPIP):

(1) Primary care providers (including pediatricians, family practitioners, and general practitioners) for all services provided to enrollees under the age of twenty-one (21) years.

(2) Specialist Physicians for all services provided to enrollees under the age of twenty-one (21) years.

(3) Obstetricians/Gynecologists for all services rendered to pregnant enrollees of any age.

(4) Hospital-based specialty physicians for services rendered to enrollees under the age of twenty-one (21) years, regardless of whether the physician is part of the Managed Care Plan's network.

Hospital-based specialty physicians include medical doctors of osteopathic medicine who render the majority of all the specialty services they provide in an inpatient hospital setting (place of service code 21) or emergency room-hospital (place of service code 23) and who practice in one of the following specialties:

(a) Anesthesiology;

(b) Critical Care Medicine;

(c) Emergency Medicine;

(d) Hospitalist;

(e) Neonatology;

(f) Pathology; or

(g) Radiology.

b. The Managed Care Plan may propose to include additional provider types or services in its MPIP, except as follows:

(1) Providers that do not have a contractual arrangement with the Managed Care Plan (except for emergency room pediatric physicians).

(2) Services provided in an FQHC.

(3) Services provided in a RHC.

(4) Services provided in a CHD.

(5) Services provided in a Medical School Faculty Plan.

c. The Managed Care Plan shall submit a proposal to the Agency for review and approval by April 1 of each year (in a format prescribed by the Agency) identifying the qualifying criteria (performance and quality measures) that each physician type must meet in order to earn the enhanced payment, beginning October 1 of the upcoming Contract year. The Managed Care Plan shall not propose more restrictive qualifying criteria in its submission than was previously approved by the Agency in the preceding annual submission. If the Agency determines that the Managed Care Plan's proposal is deficient or cannot be approved, the Managed Care Plan shall be required to implement the Agency's default MPIP qualifying criteria.

d. The Managed Care shall notify eligible providers of the Agency approved qualifying criteria at least 60 days prior to October 1 of each year. The Managed Care Plan shall ensure that the provider contracts for physicians who meet the qualifying criteria are amended and executed with any updated qualification and payment information prior to October 1 of each Contract year.

e. The Managed Care Plan's approved qualifying criteria shall remain in place, at a minimum, for one full contract year beginning October 1 through September 30.

f. The Managed Care Plan shall maintain and continuously update the Provider Network Verification files with the appropriate indicators, as defined by the Agency, to identify those providers that qualify for the MPIP.

g. Non-compliance with this section, including failure to make appropriate payment to an eligible physician that meets the qualifying criteria, may be subject to liquidated damages and sanctions, as determined by the Agency.

h. The Managed Care Plan shall submit a report bi-annually to provide MPIP payment data to the Agency in accordance with Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.

i. The Managed Care Plan agrees to evaluate whether the physician was paid equal to or greater than the Medicare fee schedule amount using the following guiding principles in its rate calculation methodology:

Step 1: The Managed Care Plan shall calculate the physician's total compensation for included services provided to eligible enrollees for the time period (e.g., October 1, 2018 – September 30, 2019), including all of the following: fee-for-service payments, capitation payments, case management fees, incentive payments, shared savings payments (upside), and shared risk payments (upside or downside).

Step 2: The Managed Care Plan shall calculate the physician's compensation if they were paid at the Medicare fee schedule rate for included services that were provided to eligible enrollee, including:

- For services that the physician was paid under a fee-for-service arrangement, reprice all FFS claims at the Medicare fee schedule amount.

- For services that the physician was paid under a sub-capitated arrangement, reprice all encounter claims at the Medicare fee schedule amount.

Step 3: The Managed Care Plan shall compare the results of Step 1 and 2. The physician is deemed to be paid equal to or greater than the Medicare rate if the sum of all payments under Step 1 is equal to or greater than the sum of all payments under Step 2.

2. The Managed Care Plan shall not deny claims submitted by a non-participating provider rendering services pursuant to Section VI.D.1., Primary Care Provider Initiatives, of this Exhibit, 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) days.

3. The Managed Care Plan shall not deny claims for the provision of emergency services and care submitted by a non-participating provider 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) days.

4. Pursuant to s. 409.975(6), F.S., a Managed Care Plan and hospital(s) shall negotiate mutually acceptable rates, methods, and terms of payment. Such payments to hospitals may not exceed one hundred twenty percent (120%) of the rate the Agency would have paid on the first day of the Contract between the provider and the Managed Care Plan, unless specifically approved by the Agency. Payment rates may be updated periodically.

5. Regardless of how an inpatient facility is reimbursed (Diagnosis Related Group or per diem), the enrollee's MMA Managed Care Plan at the time of admission shall be responsible for payment of the entire inpatient stay for that admission, even if the enrollee changes Managed Care Plans during the hospital stay.

6. If the recipient is receiving services through the Medicaid fee-for-service (FFS) delivery system at the time of admission and becomes enrolled in the MMA Managed Care Plan during the hospital stay, the Medicaid FFS delivery system shall be responsible for payment of the enrollee's entire stay.

7. The enrollee's MMA Managed Care Plan at the time of admission shall be responsible for payment of the entire outpatient observation stay, even if the enrollee changes Managed Care Plans during the hospital stay.

8. Pursuant to s. 409.975(1)(a) and (b), F.S., except for payment for emergency services, an MMA Managed Care Plan shall make payments to essential providers as specified in this Exhibit. In accordance with s. 409.976(2), F.S., a MMA Managed Care Plan shall pay statewide inpatient psychiatric program (SIPP) providers, at a minimum, the payment rates established by the Agency.

9. The Managed Care Plan shall make payments for institutional hospice services in accordance with Section 1902(a)(13) of the Social Security Act.

10. When the Managed Care Plan or its authorized physician authorizes medically necessary ancillary medical services in a hospital setting (either inpatient or outpatient), the Managed Care Plan shall reimburse the provider of the service at the Medicaid line item rate, unless the Managed Care Plan and the hospital have negotiated another reimbursement rate.

11. Pursuant to s. 409.967(2)(b), F.S., the Managed Care Plan shall pay for services required by ss. 395.1041 and 401.45, F.S., provided to an enrollee for the provision of emergency

services and care by a non-participating provider. The Managed Care Plan must comply with s. 641.3155, F.S., Reimbursement for services under this paragraph is the lesser of:

a. The non-participating provider's charges;

b. The usual and customary provider charges for similar hospital-based services in the community where the services were provided;

c. The charge mutually agreed to by the Managed Care Plan and the non-participating provider within sixty (60) days after the non-participating provider submits a claim.

d. The Medicaid rate which, for the purposes of this paragraph, means the amount the provider would collect from the Agency on a FFS basis, less any amounts for the indirect costs of graduate medical education that are otherwise included in the Agency's FFS payment, as required under 42 U.S.C. s.1396u-2(b)(2)(D). For the purpose of establishing amounts specified in this paragraph, the applicable FFS fee schedules and their effective dates shall be published on the Agency's website annually, or more frequently as needed, less any amounts for indirect costs of graduate medical education that are otherwise included in the Agency's FFS payments.

The Managed Care Plan shall reimburse nonparticipating freestanding psychiatric specialty hospitals in accordance with a., b., or c. above, s. 409.975(6), F.S., and 42 CFR 438.3(e)(2)(i).

12. Notwithstanding the requirements set forth for coverage of emergency services and care, the Managed Care Plan shall approve all claims for emergency services and care by participating and non-participating providers pursuant to the requirements set forth in s. 641.3155, F.S., and 42 CFR 438.114.

13. In accordance with s. 409.967(2), F.S., the Managed Care Plan shall reimburse any hospital or physician that is outside the Managed Care Plan's authorized service area for Managed Care Plan-authorized services at a rate negotiated with the hospital or physician or according to the lesser of the following:

    a. The usual and customary charge made to the general public by the hospital provider; or

    b. The Florida Medicaid reimbursement rate established for the hospital or provider.

14. The Managed Care Plan may directly reimburse for cochlear implant devices to the manufacturer of the cochlear implant device or the facility performing the implantation of the cochlear implant device.

15. If the enrollee is a full-benefit dual eligible and has an existing Medicare provider authorized through Medicare:

a. The Managed Care Plan shall not require an enrollee's assigned Medicare provider to enter into a contract or agreement to receive payment for copayments, co-insurance, or deductibles.

b. The Medicare provider must be either limited enrolled or fully enrolled with the Florida Medicaid program in order to be reimbursed for any copayments, co-insurance, or deductibles by the Managed Care Plan.

16. The Managed Care Plan shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services.

17. Provider Preventable Conditions

    a. Pursuant to Section 2702 of the ACA, the Florida Medicaid State Plan and 42 CFR 434.6(12) and 447.26, the Managed Care Plan shall comply with the following requirements:

        (1) Deny reimbursement for PPCs occurring after admission in any inpatient hospital or inpatient psychiatric hospital setting, including CSUs, as listed under Forms at: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/Managed_Care_contracting/MHMO/docs/Forms/ProviderPreventableConditions-PPC-3-1-13.pdf;

        (2) Ensure that non-payment for PPCs does not prevent enrollee access to services;

        (3) Ensure that documentation of PPC identification is kept and accessible for reporting to the Agency;

        (4) Relative to all above requirements, not:

            (a) Deny reimbursement to inpatient hospitals and inpatient psychiatric hospitals, including CSUs, for services occurring prior to the PPC event;

            (b) Deny reimbursement to surgeons, ancillary and other providers that bill separately through the CMS-1500;

            (c) Deny reimbursement for health care settings other than inpatient hospital and inpatient psychiatric hospital, including CSUs; or

            (d) Deny reimbursement for clinic services provided in clinics owned by hospitals.

    b. By federal law, Deep Vein Thrombosis/Pulmonary Embolism, as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, are not reportable PPCs/HCACs. HCACs also include never events.

18. Unless otherwise stated in this Contract, the Managed Care Plan shall pay no more than the Medicaid program vaccine fee for immunizations.

19. The Managed Care Plan shall pay the Medicaid program vaccine administration fee when an enrollee receives immunizations from a non-participating provider so long as:

    a. The non-participating provider contacts the Managed Care Plan at the time of service delivery;

    b. The Managed Care Plan is unable to provide documentation to the non-participating provider that the enrollee has already received the immunization; and

    c. The non-participating provider submits a claim for the administration of immunization services and provides medical records documenting the immunization to the Managed Care Plan.

20. The Managed Care Plan shall reimburse IHCPs, whether participating in the network or not, for covered managed care services provided to Indian enrollees who are eligible to receive services from the IHCP either at a negotiated rate between the Managed Care Plan and the IHCP or, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made to a participating provider which is not an IHCP, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR 438.14(b).

21. The Managed Care Plan may request to be notified, but shall not deny claims payment based solely on lack of notification, for the following:

    a. Inpatient emergency admissions (within ten (10) days);

    b. Obstetrical care (at first visit);

    c. Obstetrical admissions exceeding forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for caesarean section; and

    d. Transplants.

22. The Managed Care Plan shall make the Public Hospital Physician Uniform Payment Increase to qualified physicians as specified in **Attachment I**, Section III.D.

23. The Managed Care Plan shall make monthly payments as specified in **Attachment I**, Section III.E., to qualified Florida cancer hospitals The payment amount shall be the per-member, per-month amount multiplied by the Managed Care Plan's monthly enrollment in the applicable region. Florida cancer hospitals that are qualified for monthly payments that meet the criteria under 42 USC s. 1395www(d)(1)(B)(v), as specified in **Attachment I**, Exhibit I-H.

24. The Managed Care Plan shall make the MMA hospital inpatient and outpatient exemption payments as specified in **Attachment I**, Section III.H. to qualified hospitals. The payment

amount shall be the per-member, per-month amount multiplied by the Managed Care Plan's monthly enrollment in the applicable region. Florida hospitals that qualify for these payments are designated in the Conference Report on Senate Bill 2500, State Fiscal Year 2020-2021 General Appropriations Act.

25. The Managed Care Plan shall make the MMA hospital increase payments to qualified hospitals as specified in **Attachment I**, Section III.J. The payment amount shall be the uniform percentage increase amount multiplied by the Managed Care Plan's payment amount in the applicable region. Florida hospitals that quality for these payments are private hospitals, public hospitals, which include state government and non-state government hospitals; and cancer hospitals who meet the criteria in 42 USC 1395ww(d)(1)B)(v).

26. The Managed Care Plan shall make payments for COVID-19 vaccine administration to qualified providers as specified in **Attachment I**, Section III.K. The payment amounts shall be the Medicaid program vaccine administration fee.

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Section IX. Quality

A. Quality Improvement

(a) Quality Improvement Plan

The Managed Care Plan and its QI plan shall demonstrate specific interventions in its behavioral health care coordination/case management to better manage behavioral health services and promote positive enrollee outcomes. The Managed Care Plan's written procedures shall address components of effective behavioral health care coordination/case management including but not limited to: anticipation, identification, monitoring, measurement, evaluation of enrollee's behavioral health needs, and effective action to promote quality of care; participation in the DCF planning process outlined in s. 394.75, F.S.; and the provision of enhanced care coordination and management for high-risk populations. Such populations shall include, at a minimum, enrollees that meet any of the following conditions:

a. Have resided in a State mental health facility for at least six (6) of the past thirty-six (36) months;

b. Reside in the community and have had two (2) or more admissions to a State mental health facility in the past thirty-six (36) months;

c. Reside in the community and have had three (3) or more admissions to a crisis stabilization unit, short-term treatment facility, inpatient psychiatric unit, or any combination of these facilities within the past twelve (12) months;

d. Have been diagnosed with a behavioral health disorder in conjunction with a complex medical condition and have been prescribed numerous prescription medications;

e. Have been identified as exceeding the Managed Care Plan's prescription limits as permitted under Section VI., Coverage and Authorization of Services;

f. Are under the age of six (6) years and are prescribed a psychotropic medication; or

g. Have had two (2) or more admissions to residential psychiatric treatment (e.g., SIPP services and comparable treatment settings).

B. Performance Measures (PMs)

1. Required Performance Measures

a. The Managed Care Plan shall collect and report the performance measures in the Required Performance Measures Table, Table 6, below, certified via a qualified auditor.

TABLE 6 **REQUIRED PERFORMANCE MEASURES**	
Healthcare Effectiveness Data and Information Set (HEDIS)	
1.	Adults' Access to Preventive/Ambulatory Health Services - (AAP)
2.	Antidepressant Medication Management - (AMM)
3.	Breast Cancer Screening – (BCS)
4.	Cervical Cancer Screening – (CCS)
5.	Child and Adolescent Well-Care Visits (WCV)
6.	Childhood Immunization Status – (CIS) – Combo 2 and 3
7.	Comprehensive Diabetes Care – (CDC) · Hemoglobin A1c (HbA1c) testing · HbA1c poor control · HbA1c control (<8%) · Eye exam (retinal) performed
8.	Controlling High Blood Pressure – (CBP)
9.	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)
10.	Follow-up Care for Children Prescribed ADHD Medication – (ADD)
11.	Immunizations for Adolescents – (IMA)
12.	Chlamydia Screening in Women – (CHL)
13.	Prenatal and Postpartum Care – (PPC)
14.	Asthma Medication Ratio – Total - (AMR)
15.	Well-Child Visits in the First 30 Months of Life (W30)
16.	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - (IET)
17.	Ambulatory Care - (AMB)
18.	Lead Screening in Children – (LSC)

19.	Annual Monitoring for Patients on Persistent Medications - (MPM)
20.	Adherence to Antipsychotic Medications for Individuals With Schizophrenia – (SAA)
21.	Metabolic Monitoring for Children and Adolescents on Antipsychotics – (APM)
22.	Use of Multiple Concurrent Antipsychotics in Children and Adolescents - (APC)
23.	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – (APP)
24.	Follow-Up After Emergency Department Visit for Mental Illness – (FUM)
25.	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Treatment – (FUA)
26.	Plan All-Cause Readmissions – (PCR)
27.	Use of Opioids at High Dosage – (UOD)
HEDIS & Agency-Defined	
28.	Follow-Up after Hospitalization for Mental Illness – (FHM)
Child Core Set	
29.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents – (WCC)
30.	Contraceptive Care – Postpartum Women Ages 15-20 - (CCP-CH)
31.	Contraceptive Care – All Women Ages 15-20 (CCW-CH)
32.	Elective Delivery – (PC-01)
33.	Cesarean Section – (PC-02)
Adult Core Set	
34.	HIV Viral Load Suppression - (VLS)
35.	Medical Assistance with Smoking and Tobacco Use Cessation – (MSC)
36.	Contraceptive Care – Postpartum Women Ages 21-44 – (CCP-AD)
37.	Contraceptive Care – All Women Ages 21-44 (CCW-AD)
38.	Use of Pharmacotherapy for Opioid Use Disorder (OUD)

b. The Managed Care Plan shall submit the first Performance Measure Report to the Agency no later than July 1, 2019, covering the measurement period of year 2018. Measures should be collected based on the technical specifications for the measure, across the current Contract and the previous Managed Care Plan Contract, as applicable.

c. Due to year 2018 being a transition year across Contracts, the Agency shall collect and may report performance measures publicly. The Agency shall label such performance measures as "transition year" measures. The Agency shall not assess liquidated damages or sanctions related to where performance measure results fall relative to the National Medicaid Means and Percentiles (as published by the National Committee for Quality Assurance), but shall assess liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting.

d. Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2020, covering the measurement period of year 2019 all performance measure-related liquidated damages and sanctions will be in effect.

e. Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2021, covering the measurement period of year 2020, the Managed Care Plan shall report on all contractually required performance measures by region and statewide. The following measures are excluded from regional reporting but must still be reported at the statewide level:

(1) Elective Delivery;

(2) Cesarean Section;

(3) HIV Viral Load Suppression; and

(4) Medical Assistance with Smoking and Tobacco Use Cessation.

f. Managed Care Plans shall submit their HEDIS data to the NCQA by the NCQA deadline as well as to the Agency by July 1 of each year.

2. Well-Child Visit Performance Measures

a. Pursuant to s. 409.975(5), F.S., the Managed Care Plan shall achieve a well-child visit rate of at least eighty percent (80%) for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1 – September 30). This screening compliance rate shall be based on the well-child visit data reported by the Managed Care Plan in its Child Health Check-Up (CMS-416) and FL 80% Screening Report and/or supporting encounter data, and due to the Agency as specified in Section XVI., Reporting Requirements. The data shall be monitored by the Agency for accuracy. Any data reported by the Managed Care Plan that is found to be inaccurate shall be disallowed by the Agency, and such findings shall be considered in violation of the Contract. Failure to meet the eighty percent (80%) screening rate

may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit.

b. The Managed Care Plan shall adopt annual participation goals to achieve at least an eighty percent (80%) well-child visit participation rate, as required by the Centers for Medicare & Medicaid Services. This participation compliance rate shall be based on the well-child visit data reported by the Managed Care Plan in its Child Health Check-Up (CMS-416) and FL 80% Screening Report (see sub-item a. above) and/or supporting encounter data. Upon implementation and notice by the Agency, the Managed Care Plan shall submit additional data, as required by the Agency for its submission of the CMS-416, to the Centers for Medicare & Medicaid Services, within the schedule determined by the Agency. Any data reported by the Managed Care Plan that is found to be inaccurate shall be disallowed by the Agency, and such findings shall be considered in violation of the Contract. Failure to meet the eighty percent (80%) participation rate during a federal fiscal year may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit. (s. 1902(a)(43)(D)(iv) of the Social Security Act)

c. Due to Federal Fiscal Year (FFY) 2018-19 being a transition year across Contracts, the Agency shall not assess liquidated damages or sanctions where the well-child visit participation rate falls below eighty percent (80%) or where the screening rate falls below eighty percent (80%), but will assess liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting on the Child Health Check-Up (CMS-416) and FL 80% Screening Report.

d. Beginning with the Child Health Check-Up (CMS-416) and FL 80% Screening Report that is due to the Agency no later than July 1, 2021, covering the measurement period of FFY 2019-20 all performance measure-related liquidated damages and sanctions will be in effect.

3. Agency-Established Performance Targets

a. In accordance with Section 409.967, F.S., the Agency has established certain Agency goals that are necessary for the successful operation of the SMMC program and as such intends to hold Managed Care Plans accountable for specific performance standards and expected milestones or timelines for improving performance over the term of the Contract. These goals are to reduce potentially preventable inpatient and outpatient hospital events (PPEs) and improve birth outcomes.

b. The Managed Care Plan shall participate in workgroups relating to the agency-established performance targets developed by the Agency in order to: facilitate transparency with stakeholders; provide feedback to the Agency on advancements/progress made; address barriers to achieving performance standards/targets; share lessons learned; and to address any other requests expressed by the Agency necessary to support the Agency goals.

c. The Managed Care Plan shall meet the regional performance targets specified in **Attachment I, Exhibit I-F**, Quality Benchmarks Statewide Target Averages and

Impact. The Agency shall incorporate any potential managed care savings as a result of the achievement of these benchmarks into the capitation rate setting process based upon the successful deployment of interventions by the Managed Care Plan to address the Agency's goals. The Agency shall have sole discretion in determining the methodology for compliance with the negotiated performance standards/targets.

d. In Year 2 of the Contract, the Agency shall update the baseline performance standard for the region related to birth outcomes utilizing data from Fiscal Year 2018 – 2019. Based upon the results, the Agency will determine if the performance targets proposed by the Managed Care Plan need to be adjusted for the remainder of the Contract term (Contract Year 2 through 5).

e. In Year 3 of the Contract, the Agency shall update the baseline performance standard for the region related to PPEs utilizing data from Fiscal year 2018 – 2019. Based upon the results, the Agency will determine if the performance targets proposed by the Managed Care Plan need to be adjusted for the remainder of the Contract term (Contract Year 3 through 5).

f. The Managed Care Plan shall purchase and utilize for the duration of this Contract the 3M™ Health Information Systems Potentially Preventable Readmissions (PPR) and Population-Focused Preventables (PFP) Grouping Software.

g. If the Managed Care Plan fails to meet the performance targets associated with Agency goals as specified in this section and Exhibit I-F, Quality Benchmarks Statewide Targets, the Managed Care Plan may be subject to any of the following, as determined by the Agency:

   (1) Discontinuation of enrollment into the Managed Care Plan.

   (2) Liquidated damages pursuant to Section XIV., Liquidated Damages.

h. The Agency may implement any of the following initiatives to ensure compliance with the negotiated performance targets related to the Agency goals:

   (1) In accordance with section 409.977, F.S., align the mandatory assignment enrollment process to enroll more recipients in a Managed Care Plan that meets or exceeds the negotiated performance standards/targets.

   (2) Establish a performance withhold (Medicaid Program revenue neutral) in the capitation rate setting process in order to pay top performing Managed Care Plans an incentive for meeting or exceeding the negotiated performance standards/targets.

C. Performance Improvement Projects

The Managed Care Plan shall perform four (4) Agency-approved statewide performance improvement projects (PIPs) as specified below:

1. One (1) of the PIPs shall combine a focus on improving primary C-section rates, pre-term delivery rates, and neonatal abstinence syndrome rates;

2. One (1) of the PIPs shall focus on reducing potentially preventable events, including hospital admissions, readmissions, and emergency department visits;

3. One (1) of the PIPs shall be an administrative PIP focusing on the administration of the transportation benefit, specifically focusing on the rate of trips resulting in the enrollee arriving to their scheduled appointment on time; and

4. One (1) PIP shall be a choice of PIP in one of two topic areas: behavioral health or integrating primary care and behavioral health.

5. The first three PIPs listed above shall be collaborative PIPs coordinated by the Agency and the EQRO. The EQRO will put together proposed methodologies for the collaborative PIPs, which will be sent to the Managed Care Plans for review. Once the proposed methodologies for the collaborative PIPs have been sent to the Managed Care Plans, the Managed Care Plan has two (2) weeks to submit feedback to the Agency and the EQRO on the methodologies.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

a. The Managed Care Plan shall conduct an annual CAHPS survey for a time period specified by the Agency, using the following surveys, as applicable:

(1) For adults, the CAHPS Health Plan Survey - Medicaid Survey 5.0

(2) For children, the CAHPS Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items.

b. In addition to the core survey, the Managed Care Plan shall include items MH2 through MH4 (related to Behavioral Health) from the CAHPS Health Plan Survey – Supplemental Items for the Adult Questionnaires in its Adult CAHPS surveys.

c. The Managed Care Plan shall also include the following item in its Adult and Child CAHPS surveys.

(1) How would you rate the number of doctors you had to choose from?

Response options: Excellent, Very Good, Good, Fair, Poor, No Experience

d. The Managed Care Plan shall submit to the Agency, in writing within ninety (90) days of initial Contract execution, a proposal for survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a CAHPS survey vendor; sampling methodology; administration protocol; analysis plan; and reporting description.

2. The Managed Care Plan shall use the results of the annual CAHPS survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities conducted by the Managed Care Plan pertaining to improving member satisfaction resulting from the annual member satisfaction survey must be reported to the Agency on a quarterly basis.

E. Enrollee Record Requirements

1. In addition to the requirements of **Attachment II,** Section IX.E., Enrollee Record Requirements, the Managed Care Plan shall ensure the following documentation is included in the enrollee record:

   a. A copy of the completed screening instrument in the enrollee record and provides a copy to the enrollee.

   b. Documentation of preterm delivery risk assessments in the enrollee record by week twenty-eight (28) of pregnancy.

   c. Documentation of referral services in the enrollee record, including reports resulting from the referral.

   d. Documentation of emergency care encounters in the enrollee record with appropriate medically indicated follow-up.

   e. Documentation of the express written and informed consent of the enrollee's authorized representative prescriptions for psychotropic medication (i.e., antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years. In accordance with s. 409.912(13), F.S., the Managed Care Plan shall ensure the following requirements are met:

      (1) The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription.

      (2) The prescriber must ensure completion of an appropriate attestation form. Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link:

      http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml

         (a) The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years.

         (b) Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.

         (c) Every new prescription will require a new informed consent form.

(d) The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents under the age of eighteen (18) years.

F. Provider-Specific Performance Monitoring

There are no additional provider-specific performance monitoring provisions unique to the MMA managed care program.

G. Additional Quality Management Requirements

1. Incident Reporting Requirements

a. The Managed Care Plan shall develop a reporting and management system for critical and adverse incidents that occur in all service delivery settings applicable to enrollees with MMA benefits only.

b. The Managed Care Plan shall require providers to report adverse incidents to the Managed Care Plan within forty-eight (48) hours of the incident.

c. The Managed Care Plan shall not require provider submission of adverse incident reports from the following providers: health maintenance organizations and health care clinics reporting in accordance with s. 641.55, F.S.; ambulatory surgical centers and hospitals reporting in accordance with s. 395.0197, F.S.; assisted living facilities reporting in accordance with s. 429.23, F.S.; nursing facilities reporting in accordance with s. 400.147, F.S.; and crisis stabilization units, residential treatment centers for children and adolescents, and residential treatment facilities reporting in accordance with s. 394.459, F.S., adverse incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.

2. Drug Utilization Review Program

a. The Managed Care Plan shall develop and operate a drug utilization review program that complies with the requirements described in section 1927(g) of the SSA and 42 CFR part 456, subpart K, as if such requirements applied to the Managed Care Plan instead of the state.

b. The Managed Care Plan shall provide a detailed description of its drug utilization review program activities to the Agency on an annual basis which shall include:

(1) Procedures for operating a Drug Utilization Review (DUR) program in compliance with 42 CFR 438.3(s)(4), including:

(2) A description of the Managed Care Plan's design and implementation of a DUR program to encourage coordination between an enrollee's PCP and a prescriber of a psychotropic or similar prescription drug for behavioral health problems.

(3) A process to identify those medications for other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems), where this is a significant risk to the enrollee posed by potential drug interactions between drugs for these conditions and behavioral-related drugs.

(4) A mechanism to notify all related prescribers, in a manner determined by the Managed Care Plan, that certain drugs may be contra-indicated due to the potential for drug interactions and shall encourage the prescribers to coordinate their care.

(5) A program to monitor and manage the appropriate use of antipsychotic medications by all children, in compliance with Section 1004 of the SUPPORT Act.

(6) A claims review automated process includes a prospective review of:

(a) The number of days' supply allowed, early refill requirements, duplicate fill requirements, and quantity limitations on opioids. The Managed Care Plan shall implement a claims review automated process that indicates fills of opioids in excess of limitations identified by the Agency;

(b) The maximum daily morphine equivalent for treatment of pain. The Managed Care Plan shall implement a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the Agency.

(c) When an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

c. The Managed Care Plan shall participate in the Medicaid Pharmaceutical and Therapeutics Committee and Drug Utilization Review Board by asking qualified plan administrators (MDs, DOs or pharmacists) to volunteer for committee appointment by the Governor's Office.

H. Continuity of Care in Enrollment

1. The Managed Care Plan shall provide continuation of services until the enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee's treatment plan, in accordance with **Attachment II**, Section IX.H., Continuity of Care in Enrollment.

2. The Managed Care Plan shall honor any written documentation of prior authorization of ongoing covered services for a period of up to sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.

3. For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services shall include the following, provided that the services were prearranged prior to enrollment with the Managed Care Plan:

    a. Prior existing orders;

    b. Provider appointments (e.g., transportation, dental appointments, surgeries, etc.);

    c. Prescriptions (including prescriptions at non-participating pharmacies);

    d. Prior authorizations;

    e. Treatment plan/plan of care.

4. The Managed Care Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Managed Care Plan is not required to approve claims for which it has received no written documentation.

5. The following services may extend beyond the sixty (60) day continuity of care period, and the Managed Care Plan shall continue the entire course of treatment with the recipient's current provider as described below:

    a. Prenatal and postpartum care – The Managed Care Plan shall continue to pay for services provided by a pregnant woman's current provider for the entire course of her pregnancy, including the completion of her postpartum care (six (6) weeks after birth), regardless of whether the provider is in the Managed Care Plan's network.

    b. Transplant services (through the first year post-transplant) – The Managed Care Plan shall continue to pay for services provided by the current provider for one (1) year post-transplant, regardless of whether the provider is in the Managed Care Plan's network.

    c. Oncology (Radiation and/or Chemotherapy services for the current round of treatment) – The Managed Care Plan shall continue to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in the Managed Care Plan's network.

    d. Full course of therapy for Hepatitis C treatment drugs.

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Section X. Administration and Management

A. General Provisions

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

B. Organizational Governance and Staffing

1. The Managed Care Plan shall have a designated employee, qualified by training and experience, to serve as a liaison with the Prepaid Dental Health Plan (PDHP) in in order to promote the most optimal outcomes in terms of integrating and coordinating the SMMC (medical, behavioral health, and long-term care) benefits with the pre-paid dental plan delivery system. This employee will serve as a point of contact for the PDHP in helping to resolve operational (i.e., sharing of data/information) and care coordination concerns/issues; and will work directly with the Agency on strategic planning efforts to advance the Agency's goals in coordinating dental and SMMC benefits, as well as reporting on any operational or care coordination issues.

If the Managed Care Plan fails to comply with the requirements of this section, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.

2. Case Management Staff Qualifications and Experience

a. The Managed Care Plan shall utilize case managers for enrollees under the age of twenty-one (21) years who are receiving services in a skilled nursing facility or private duty nursing services, and who possess the following qualifications:

(1) State of Florida licensed registered nurse with at least two (2) years of pediatric experience;

(2) State of Florida licensed practical nurse with four (4) years of pediatric experience; or

(3) Master's degree in social work with at least one (1) year of related professional experience.

b. The Managed Care Plan shall utilize case managers for enrollees under the age of twenty-one (21) years who are receiving medical foster care services, and who possess at least two (2) years of pediatric experience.

3. Caseload Ratio Requirements

a. The Managed Care Plan shall ensure that case manager caseloads for enrollees under the age of twenty-one (21) years who are receiving services in a skilled nursing facility or private duty nursing services do not exceed a ratio of:

(1) Fifteen (15) enrollees to one (1) care coordinator for enrollees who are receiving services in a skilled nursing facility.

(2) Forty (40) enrollees to one (1) case manager for enrollees under age twenty-one (21) years receiving private duty nursing services in their family home or other community-based setting, or receiving medical foster care services.

b. The Managed Care Plan may submit a request to the Agency to implement a mixed caseload of enrollees in the community and in nursing facilities. The Managed Care Plan shall receive authorization from the Agency prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established by the Managed Care Plan and do not require authorization. The Managed Care Plan shall submit any caseload exception requests to the Agency. The Agency may revoke the Managed Care Plan's authorization to exceed caseload ratios at any time.

C. Subcontracts

1. The Managed Care Plan may delegate any or all functions to one (1) or more PBMs. Before entering into a subcontract, the Managed Care Plan shall obtain the Agency's prior written approval of the delegation in accordance with Section X.C., Subcontracts.

   a. Pursuant to Executive Order 22-164 issued by Governor Ron DeSantis and effective on the date of execution of this amendment, all Managed Care Plan subcontracts with a PBM must be updated to prohibit the use of spread pricing. Contracts between the Managed Care Plan and the PBM responsible for coverage of covered outpatient drugs dispensed to individuals enrolled with the entity, shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the Managed Care Plan, be based on a Pass-Through Pricing model. All subcontracts must be updated within one hundred and eighty days following the execution of this amendment.

   A Pass-Through Pricing model is defined as the Managed Care Plan's payment to the PBM for such covered outpatient drug that are equivalent to the PBM payment to the dispensing pharmacy or provider which may include a contracted professional dispensing fee between the PBM and their network of pharmacies that would be paid if the Managed Care Plan was making the payment directly; and is passed through in its entirety by the Managed Care Plan or PBM to the pharmacy or provider that dispenses the drug; and paid in a manner that is not offset by any reconciliation; and remaining consistent with Section 1 of the State of Florida Office of the Governor Executive Order Number 22-164.

   Managed Care Plans found in violation of this are subject to liquidated damages, contractual sanctions, or other actions as deemed necessary by the Florida Agency for Health Care Administration

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b. As used in this subsection, the following terms are defined as:

- **Direct and indirect remuneration fees (DIR)**: Price concessions that are paid to the Managed Care Plan or PBM by the pharmacy retrospectively, which cannot be calculated at the point of sale. DIR can include discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, upfront payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits from manufacturers, pharmacies, or similar entities.

- **Dispensing fee:** Fee intended to cover reasonable costs associated with providing the drug to a Medicaid beneficiary. This cost includes the pharmacist's services and the overhead associated with maintaining the facility and equipment necessary to operate the pharmacy.

- **Brand or generic effective rate :** Contractual rate set forth by a PBM for the reimbursement of covered brand or generic drugs calculated using the total payments in the aggregate, by drug type, during the performance period. The effective rates are typically calculated as a discount off of industry benchmarks such as average wholesale price (AWP) or wholesale acquisition cost (WAC).

- **Monetary recoupments :** Rescinded or recuperated payments from a pharmacy or provider by the Managed Care Plan or PBM.

- **Network reconciliation offsets:** Process during annual payment reconciliation between a PBM or a Managed Care Plan and a provider which allows the PBM to offset over- or under-performance of contractual guarantees across guarantee line item, channel, network, and/or payer, as applicable.

- **Adjudication transaction fees:** Fee charged by the PBM to the pharmacy for electronic claim submissions. Fee may be charged for each claim submission that is accepted by the PBM regardless of transmission status.

- **Incentive payment:** A retrospective monetary payment made as a reward or recognition by the Managed Care Plan or PBM to a pharmacy for meeting and/or exceeding predefined pharmacy performance metrics as related to quality measures such as HEDIS.

- **Erroneous claims:** Pharmacy claims submitted in error including but not limited to unintended, incorrect, fraudulent or test claims.

- **Maximum allowable cost (MAC) appeal pricing adjustment:** A retrospective positive payment adjustment made to a pharmacy by the Managed Care Plan or PBM pursuant to an approved MAC appeal request submitted by the same

pharmacy to dispute the amount reimbursed for a drug based on the PBM's listed MAC price.

c. Pursuant to Executive Order 22-164 issued by Governor Ron DeSantis and effective on the date of execution of this amendment, all Managed Care Plan PBM subcontracts must be updated to prohibit the practice of financial clawbacks by PBMs. All subcontracts must be updated within one hundred and eighty days following the execution of this amendment.

Under the prohibition of "Financial Clawbacks" or Reconciliation Offsets, the Managed Care Plan or PBM shall not recuperate direct or indirect remuneration fees, dispensing fees, brand or generic effective rate adjustments via reconciliation, or any other monetary recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees and any other instance where a fee may be recuperated from a pharmacy and/or provider.

The following shall be excluded from being defined as Reconciliation Offsets or "Clawbacks": Any incentive payments provided by the Managed Care Plan or PBM to network pharmacy for meeting and/or exceeding predefined quality measures such as Healthcare Effectiveness Data and Information Set measures (HEDIS), recoupment due to erroneous claims, fraud waste and abuse, claims adjudicated in error, MAC appeal pricing adjustments, or any other any recoupment that is returned to the State of Florida.

Managed Care Plans found in violation of this are subject to liquidated damages, contractual sanctions, or other actions as deemed necessary by the Florida Agency for Health Care Administration

d. Within one hundred- and eighty-days (180) following execution of this amendment all Managed Care Plan PBM subcontracts must be updated to require PBMs to amend all contracts and/or agreements with participating network pharmacies to reflect that spread pricing and the use of financial clawbacks are not allowable under the Medicaid Managed Care Program. The language must read as follows:

"Pursuant to Executive Order 22-164 issued by Governor Ron DeSantis any PBM operating on behalf of a Medicaid Managed Care Plan must utilize pass-through pricing and is prohibited from instituting a spread pricing model and the practice of financial clawbacks against network pharmacies. Managed Care Plans found in violation of this are subject to liquidated damages, contractual sanctions, or other actions as deemed necessary by the Florida Agency for Health Care Administration."

Managed Care Plans found in violation of this are subject to liquidated damages, contractual sanctions, or other actions as deemed necessary by the Florida Agency for Health Care Administration.

e. The Managed Care Plan shall work with the Agency's fiscal agent to ensure that the transfer of accurate and complete Managed Care Plan encounter prescription data, including actual amounts paid to the provider, is initiated within forty-five (45) days of PBM implementation. The Managed Care Plan acknowledges that the transfer of prescription data is required by the ACA and that the Agency will invoice pharmaceutical manufacturers for federal rebates mandated under federal law, and for supplemental rebates negotiated by the Agency according to s. 409.912(5)(a)7, F.S.

The Managed Care Plan and PBM shall provide Annual and Quarterly Reconciliation Reports. The Quarterly Reconciliation Report shall be provided by the 25th of the first month following the last day of the prior quarter to the Agency. Both reports shall include a comparison of all adjudication and reconciliation costs and payments (if applicable) related to covered outpatient drugs and accompanying administrative services incurred, received, or made by the Managed Care Plan or the PBM, including ingredient costs, professional dispensing fees, administrative fees, post-sale and post-invoice fees, discounts, paid taxes or any related post-adjudication adjustments such as any incentive payments provided by the Managed Care Plan or PBM to network pharmacies for meeting and/or exceeding predefined quality measures such as HEDIS, recoupment due to erroneous claims, Fraud Waste and Abuse claims, claims adjudicated in error, MAC pricing adjustments, and any and all other remuneration.

Quarterly Reconciliation Report and Annual Reconciliation Report templates will be provided by the Agency to the Managed Care Plans.

f. Failure to provide the necessary data to the Agency will result in immediate action by the Agency that may include (but not be limited to) sanctions, application of liquidated damages, or reduction of capitation payments in the amount of estimated combined federal and supplemental rebates.

g. Failure to provide claim and provider information that assists the Agency in dispute resolution between the Agency and a drug manufacturer regarding federal drug rebates and that prevents the Agency from collecting drug rebates shall result in the Agency's recouping from the Managed Care Plan any determined uncollected rebates.

2. If there is a Managed Care Plan physician incentive plan, all model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall include a statement that the Managed Care Plan shall make no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care. (42 CFR 422.208(c)(1); 42 CFR 438.3(i)) If the physician incentive plan places a physician or physician group at substantial financial risk (pursuant to 42 CFR 422.208(a)(d)) for services that the physician or physician group does not furnish itself, the Managed Care Plan shall assure that all physicians and physician groups

at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(c)(2). The Managed Care Plan shall provide assurances to the Secretary of CMS that the requirements of 42 CFR 422.208 are met in accordance with 42 CFR 422.210(a).

3. The Managed Care Plan may delegate any or all functions relating to behavioral health services. Before entering into a subcontract, the Managed Care Plan shall develop and submit an analysis of the subcontractor's compliance with 42 CFR 438.3(n) with respect to quantitative and non-quantitative limits, and obtain the Agency's prior written approval of the delegation in accordance with Section X.C., Subcontracts.

D. Information Management and Systems

There are no additional information management and systems provisions unique to the MMA managed care program.

E. Encounter Data Requirements

1. The Managed Care Plan shall ensure all encounter data submissions include PPC information in order to meet the PPC identification requirements.

2. The Managed Care Plan shall comply with the Agency's encounter claims requirements for outpatient drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, in accordance with 42 CFR 438.3(s)(3).

3. The Managed Care Plan shall report drug utilization data that is necessary for the Agency to bill manufacturers for rebates in accordance with 42 CFR 438.3(s)(2).

4. The Managed Care Plan agrees to enter into a coordination of benefits agreement with the Prepaid Dental Health Plans that includes data sharing requirements and coordination protocols to support the provision of dental services and reduction of potentially preventable events. The Managed Care Plan shall ensure that the agreement complies with and includes the minimum requirements and guidelines established by the Agency.

F. Fraud and Abuse Prevention

In compliance with Section 1004 of the SUPPORT Act, the Managed Care Plan's written fraud and abuse prevention program shall have internal controls and procedures in place that are designed to identify potential fraud or abuse of controlled substances by enrollees, providers, and pharmacies.

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Section XI. Method of Payment

A. General Provisions

The Managed Care Plan's financial responsibility ends for post-stabilization care services it has not prior authorized when:

1. A physician in the Managed Care Plan's network who has privileges at the treating hospital assumes responsibility for the enrollee's care;

2. A physician in the Managed Care Plan's network assumes responsibility for the enrollee's care through transfer;

3. A Managed Care Plan representative and the treating physician reach an agreement concerning the enrollee's care; or

4. The enrollee is discharged.

(42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)-(iv))

B. Fixed Price Unit Contract

There are no additional fixed price unit Contract provisions unique to the MMA managed care program.

C. Payment Provisions

1. Capitation Rates

a. The Agency shall pay the Managed Care Plan a retroactive capitation rate for each newborn enrolled in a Managed Care Plan retroactive to the month of birth. (s. 409.977(3), F.S.)

b. The Managed Care Plan shall be responsible for payment of all covered services provided to newborns.

c. The Agency shall be responsible for administration of the Medicaid prescribed drug program, including negotiating rebates on all drugs. During the time that the Managed Care Plan is required to utilize the Agency's PDL, the Managed Care Plan shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs reimbursed under this Contract. The Agency will be the sole negotiator of pharmaceutical rebates for all prescribed drugs, and all rebate payments for prescribed drugs will be made to the Agency.

2. Rate Adjustments and Reconciliations

a. The Agency shall be responsible for adjusting applicable capitation rates to reflect

budgetary changes in the Medicaid program.

b. Pursuant to s. 409.976(2), F.S., the Managed Care Plan's actual payments to SIPP providers shall be reconciled for enrollees with MMA benefits to ensure actual claim payments are, at a minimum, the same as Medicaid FFS claim payments. The Managed Care Plan accepts and assumes all risks of excess payments as a cost of doing business.

3. Kick Payments

a. LTC Eligible Kick Payment

(1) The Managed Care Plan shall be paid one kick payment for each enrollee who is eligible for the LTC program but not yet enrolled in an LTC plan.

(2) The Managed Care Plan shall receive a kick payment, instead of the capitation rate as described in **Attachment II**, Section XI., on a daily basis for each LTC eligible enrollee as determined by the Agency and in the amount specified in **Attachment I**, **Exhibit I-C**, Managed Care Plan Rates.

(3) The Agency shall conduct quarterly reconciliations to funds previously paid to bring payments in line with above reimbursement methodology.

b. Obstetrical Delivery Kick Payment

(1) The Managed Care Plan shall be paid one kick payment for each obstetrical delivery service for enrollees who are not also eligible for Medicare or other third-party coverage

(2) The Managed Care Plan shall receive kick payments for obstetrical delivery services specified in this Section in the amounts specified in the Contract. For kick payment purposes, an obstetrical delivery includes all births resulting from the delivery; therefore, if an obstetrical delivery results in multiple births, the Agency will make only one kick payment. This includes still births. The kick payment amount is the same, regardless of the delivery outcome (live or still birth), the mode of delivery (vaginal or cesarean), or the setting in which the delivery occurs (hospital, birth center, or in the home).

(3) To receive a kick payment for covered services specified in this Section, the Managed Care Plan must adhere to the specific requirements listed in subsection d. below and adhere to the following requirements:

(a) The Managed Care Plan must have provided the covered service while the recipient was enrolled in the Managed Care Plan;

(b) The Managed Care Plan must submit corresponding encounters for these services in accordance with **Attachment II**, Section X.E., Encounter Data Requirements; and

(c) The Managed Care Plan shall submit any required documentation to the Agency upon its request in order to receive the kick payment.

(4) In addition to subsection c. above, to receive a kick payment for covered services specified in this Section, provided to an enrollee without Medicare, the Managed Care Plan shall comply with the following requirements:

(a) The Managed Care Plan shall submit an X12 837 Professional (837P) (non-encounter) transaction or through the direct data entry or trade files option on the Medicaid Provider Web Portal, within the required Medicaid FFS claims submittal timeframes;

(b) The Managed Care Plan shall use the following list of obstetrical delivery procedure codes relative to the type of delivery performed when completing transactions or claims:

CPT CODE	DESCRIPTION
59410	Vaginal Delivery with Post-Delivery Care
59515	Cesarean Delivery with Post-Delivery Care

(c) The Managed Care Plan shall list itself as both the pay-to and the treating provider on the transaction or claim; and

(5) The Managed Care Plan shall receive kick payments for obstetrical delivery services in the amounts indicated in **Attachment I**, **Exhibit I-D** Kick Payment Rates for Covered Obstetrical Delivery Services.

4. Enrollee Payment Liability Protection

The Managed Care Plan shall not hold an enrollee liable for payment of subsequent screening and treatment needed to diagnose or stabilize an emergency medical condition, as long as the enrollee utilizes a provider in the Managed Care Plan's network. (42 CFR 438.114(d)(2))

5. Achieved Savings Rebate

In order to be eligible to retain up to an additional one percent (1%) of revenue, the Managed Care Plan shall achieve performance measure rates at or above the seventy-fifth (75^{th}) percentile for five (5) of the ten (10) performance measures listed below, with none of the rates below the fiftieth (50^{th}) percentile. The performance measures are as follows:

a. Antidepressant Medication Management – Effective Acute Phase Treatment;

b. Adherence to Antipsychotic Medications for Individuals With Schizophrenia;

c. Comprehensive Diabetes Care – HbA1c Control (<8%);

d. Controlling High Blood Pressure;

e. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Day – Total;

f. Follow-Up After Emergency Department Visit for Mental Illness – 7 Day;

g. Follow-Up After Hospitalization for Mental Illness – 7 Day;

h. Human Immunodeficiency Virus (HIV) Viral Load Suppression;

i. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total; and

j. Asthma Medication Ratio – 75% Compliance – Total.

6. The Managed Care Plan shall submit dual eligible enrollees identified with an HIV/AIDS diagnosis to the Agency in a report format and transmittal method approved by the Agency and as specified in the Agency's Managed Care Plan Report Guide. See Section XVI., Reporting Requirements, of this Exhibit.

7. The Managed Care Plan shall only receive a monthly capitation payment for an enrollee aged twenty-one (21) to sixty-four (64) years receiving inpatient treatment in an Institution for Mental Diseases (IMD), so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care, or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short-term stay of no more than fifteen (15) days during the period of the monthly capitation payment. (42 CFR 438.6(e))

8. Value Based Purchasing Programs. The Managed Care Plan shall develop and implement a value-based purchasing program to reduce costs associated with potentially preventable events and improved birth outcomes. The Agency reserves the right to develop mandatory program parameters, performance metrics, and alternative payment methodologies at a later date.

9. Prescribed Drugs High Risk Pool (PDHRP)

The Managed Care Plan shall participate in and comply with the Prescribed Drugs High Risk Pool (PDHRP), which recognizes the disproportionate enrollment of enrollees with high drug costs, exceeding a specific threshold defined by the Agency, during the Contract year. Year 1 of the PDHRP shall be effective from February 1, 2019 through September 30, 2019, with subsequent years operating on a Contract year basis. The PDHRP operates as a revenue neutral redistribution of plan reimbursement associated with enrollees with high drug costs. The risk pool is funded through a small withhold amount applied to the capitation rates. Encounter data submissions are required in accordance with **Attachment II**, Section X., Administration and Management, of the Contract.

10. Home Health Withhold Arrangement

a. The Managed Care Plan shall participate in and comply with the home health withhold arrangement, to ensure the delivery of medically necessary, authorized home health services to eligible enrollees. For Rate Year (RY) 2020/2021, the amount of the withhold is determined by a small withhold amount applied to the private duty nursing (PDN) rate cell capitation rate. Subsequent years shall be subject to Legislative approval. The Managed Care Plan may earn up to one hundred percent (100%) of the amount of their withhold based on the level of PDN utilization achieved, as defined by the Agency.

b. The Managed Care Plan shall report quarterly on the utilization of PDN services, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

11. COVID-19 Vaccine Supplemental Payment

The Agency shall pay the Managed Care Plan a supplemental, non-risk payment for eligible vaccine administration services provided to enrollees covered under this Contract between April 1, 2021 through the last day of the calendar quarter beginning one (1) year after the Federal COVID-19 Public Health Emergency (PHE) ends.

a. The Agency shall identify enrollees having received the COVID-19 vaccination, based upon the Managed Care Plan's encounter data submissions.

b. The Agency, through its fiscal agent, shall make quarterly payment(s) to the Managed Care Plan based upon verified encounter data.

c. Unless otherwise specified in this Contract, the Managed Care Plan shall accept the supplemental payment(s) received as payment in full by the Agency for COVID-19 vaccine administration services provided to enrollees.

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Section XII. Financial Requirements

A. General Provisions

The Managed Care Plan shall not avoid costs for services covered in this Contract by referring MediKids enrollees to publicly supported health care programs for services that are covered under this Contract. (42 CFR 457.1201(p))

B. Insolvency Protection

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

C. Surplus

There are no surplus provisions unique to the MMA managed care program.

D. Interest

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

E. Third Party Resources

There are no additional third party resources provisions unique to the MMA managed care program.

F. Assignment

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

G. Financial Reporting

1. Medical Loss Ratio

a. The Managed Care Plan shall maintain an annual (January 1 – December 31) medical loss ratio (MLR) of a minimum of eighty-five percent (85%) for the first full year of MMA program operation and subsequent years, beginning January 1, 2019.

b. The Agency will calculate the MLR in a manner consistent with 42 CFR 438.8, 45 CFR Part 158, 42 CFR 438.8(k), and s. 409.9122(9)(a), (b), and (c), F.S., To demonstrate ongoing compliance, the Managed Care Plan shall complete and submit appropriate financial reports, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

c. The Managed Care Plan shall submit an attestation with its MLR reporting, in compliance with 42 CFR 438.8(k) and (n).

d. The federal Centers for Medicare & Medicaid Services will determine the corrective action for non-compliance with this requirement.

H. Inspection and Audit of Financial Records

As used in this section, the term "Dispensing Fee" is defined as:
- Dispensing fee: Fee intended to cover reasonable costs associated with providing the drug to a Medicaid beneficiary. This cost includes the pharmacist's services and the overhead associated with maintaining the facility and equipment necessary to operate the pharmacy.

Upon request of the Agency and at a minimum on an annual basis, the Managed Care Plan shall disclose to the Agency all financial terms and arrangements for payment of any kind that apply between the Managed Care Plan or the Managed Care Plan's Pharmacy Benefits Manager and any provider of outpatient drugs, any prescription drug manufacturer, prescription drug wholesaler, or labeler. Such financial terms and arrangements include: formulary/PDL management; drug-switch programs; educational support; claims processing; discounts, including but not limited to end of period discounts, pharmacy network fees, data sales fees, dispensing fees paid to pharmacy providers and dispensing fees billed to the Managed Care Plan, and any other fees.

a. The Managed Care Plan must disclose copies of its PBM pharmacy provider agreement and note any differences between the agreement among commercial, preferred, or independently owned pharmacies.

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Section XIII. Sanctions

A. Contract Violations and Non-Compliance

There are no additional Contract violations and non-compliance provisions unique to the MMA managed care program.

B. Corrective Action Plans

There are no additional CAP Contract provisions unique to the MMA managed care program.

C. Performance Measure Sanctions

1. The Agency may sanction the Managed Care Plan for failure to achieve minimum scores on HEDIS performance measures after the first year of poor performance. The Agency may impose monetary sanctions as described below in the event that the plan's performance is not consistent with the Agency's expected minimum standards, as specified in this subsection.

2. Performance measures shall be assigned a point value by the Agency that correlates to the National Committee for Quality Assurance HEDIS National Means and Percentiles for Medicaid plans. The scores will be assigned according to the HEDIS National Means and Percentiles for Medicaid Plans Table, Table 8 below. Individual performance measures will be grouped, and the scores averaged within each group.

TABLE 8: HEDIS NATIONAL MEANS AND PERCENTILES FOR MEDICAID PLANS	
PM Ranking	**Score**
>= 90th percentile	6
75th – 89th percentile	5
60th – 74th percentile	4
50th – 59th percentile	3
25th-49th percentile	2
10th – 24th percentile	1
< 10th percentile	0

3. The Agency may require the Managed Care Plan to complete a Performance Measure Action Plan (PMAP) after the first year of poor performance.

4. The Managed Care Plan may receive a monetary sanction of up to ten thousand dollars **($10,000.00)** for each performance measure group where the group score is below three (3). Performance measure groups are as follows:

   a. Mental Health and Substance Abuse

      (1) Antidepressant Medication Management – Effective Acute Phase Treatment

(2) Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase

(3) Follow-up after Hospitalization for Mental Illness – 7 Day

(4) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total

(5) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Day – Total

(6) Follow-Up After Emergency Department Visit for Mental Illness – 7 Day

b. Well-Child

(1) Child and Adolescent Well Care Visits

(2) Childhood Immunization Status – Combination 3

(3) Immunizations for Adolescents – Combination 1

(4) Lead Screening in Children

c. Other Preventive Care

(1) Adults' Access to Preventive/Ambulatory Health Services – Total

(2) Breast Cancer Screening

(3) Cervical Cancer Screening

(4) Chlamydia Screening in Women – Total

d. Prenatal/Perinatal

(1) Prenatal and Postpartum Care (includes two (2) measures)

e. Diabetes – Comprehensive Diabetes Care measure components

(1) HbA1c Testing

(2) HbA1c Control (< 8%)

(3) Eye Exam

f. Other Chronic and Acute Care

(1) Controlling High Blood Pressure

(2) Asthma Medication Ratio – 75 % Compliance – Total

(3) Annual Monitoring for Patients on Persistent Medications – Total

The Agency may amend the performance measure groups with sixty (60) days' advance notice.

D. Other Sanctions

There are no additional other sanctions provisions unique to the MMA managed care program.

E. Notice of Sanctions

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

F. Dispute of Sanctions

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

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Section XIV. Liquidated Damages

A. Damages

Additional damages issues and amounts unique to the MMA managed care program are specified below.

B. Issues and Amounts

If the Managed Care Plan fails to perform any of the services set forth in the Contract, the Agency may assess liquidated damages for each occurrence listed in the MMA Issues and Amounts Table, Table 9, below.

TABLE 9
LIQUIDATED DAMAGES ISSUES AND AMOUNTS

#	MMA Program Issues	Damages
1.	Failure to comply with the enrollee records documentation requirements pursuant to the Contract.	One thousand dollars **($1,000.00)** per enrollee record that does not include all of the required elements.
2.	Failure to comply with the federal and/or State well-child visit eighty percent (80%) screening rate and/or federal eighty percent (80%) well-child visit participation rate requirements described in the Contract.	Fifty thousand dollars **($50,000.00)** per occurrence in addition to ten thousand dollars **($10,000.00)** for each percentage point less than the target.
3.	Failure to attend scheduled or ad hoc CMAT staffing(s) for their assigned enrollees receiving private duty nursing, receiving medical foster care services, or receiving services in a skilled nursing facility.	One thousand dollars **($1,000.00)** per occurrence
4.	Failure to convene an MDT meeting focused on transition planning, as required in the Contract, for enrollees receiving services in a skilled nursing facility.	Five hundred dollars **($500.00)** per occurrence

Section XIV. Liquidated Damages

TABLE 9 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
5.	Failure to develop and maintain a person centered individualized service plan, as required in the Contract, for enrollees receiving private duty nursing services or receiving services in a skilled nursing facility.	Five hundred dollars **($500.00)** per occurrence
6.	Failure to develop and maintain a plan of care, as required in the Contract, for enrollees receiving medical foster care services.	One thousand dollars **($1,000.00)** per occurrence
7.	Failure to provide early intervention services within thirty (30) days from the date the IFSP was completed for children enrolled in the Early Steps Program.	One thousand dollars **($1,000.00)** per occurrence
8.	Failure to provide coordination of aftercare services at least thirty (30) days prior to discharge from a residential treatment setting for enrollees receiving residential psychiatric treatment.	One thousand dollars **($1,000.00)** per occurrence
9.	Failure to pay physician payment rates equal to or in excess of Medicare rates for services provided as part of a physician incentive plan approved by the Agency in accordance with s. 409.967(2)(a), F.S.	One thousand dollars **($1,000.00)** per occurrence, plus one hundred dollars **($100.00)** per day for each day the physician has not received payment.
10.	Failure to develop and document a treatment or service plan for an enrollee with complex medical issues, high service utilization, intensive health care needs, or who consistently accesses services at the highest level of care, that shall be documented in writing as described in the Contract.	Five hundred dollars **($500.00)** per deficient/missing treatment or service plan.

TABLE 9 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
11.	Failure to make referrals per the requirements and timeframes indicated in the Contract to complete the clinical eligibility process for members turning eighteen years (18) if residing in a nursing facility, or twenty-one (21) years if receiving private duty nursing services, when the enrollee or their authorized representative has expressed a desire to enroll in the LTC program.	One thousand dollars **($1,000.00)** per occurrence, plus one hundred dollars (**$100.00)** per day for each day after the six (6) month requirement.
12.	Failure to comply with standards for the completion of health risk assessments.	Two thousand five hundred dollars **($2,500.00)** per occurrence.

C. Performance Measure Liquidated Damages

1. The Agency may impose liquidated damages for performance measures as described below in the event that the Managed Care Plan fails to perform at the level of the Agency's expected minimum standards, as specified in sub-item 2 of this item.

2. The Managed Care Plan's performance measure rates shall be compared to the NCQA HEDIS National Means and Percentiles for Medicaid plans. For each measure where the Managed Care Plan's rate falls below the fiftieth (50^{th}) percentile, the Managed Care Plan may receive liquidated damages. Liquidated damages will be calculated based on the number of members eligible for the measure who did not receive the service being measured up to the fiftieth (50^{th}) percentile rate. For measures calculated using a sample, liquidated damages will be calculated based on the extrapolated number of eligible members who did not receive the service being measured, not just those in the sample, up to the fiftieth (50^{th}) percentile rate.

3. For performance measures in Tier 1 where the Managed Care Plan's rate falls below the fiftieth (50^{th}) percentile, liquidated damages may be assessed at one hundred fifty dollars (**$150.00**) per eligible member not receiving the service being measured up to the fiftieth (50^{th}) percentile rate for the measure.

4. For performance measures in Tier 2 where the Managed Care Plan's rate falls below the fiftieth (50^{th}) percentile, liquidated damages may be assessed at one hundred dollars (**$100.00**) per eligible member not receiving the service being measured up to the fiftieth (50^{th}) percentile rate for the measure.

5. For performance measures in Tier 3 where the Managed Care Plan's rate falls below the fiftieth (50^{th}) percentile, liquidated damages may be assessed at eighty dollars (**$80.00**) per eligible member not receiving the service being measured up to the fiftieth (50^{th}) percentile rate for the measure.

6. The Agency may reduce the liquidated damage amount for Tier 1 by fifty dollars (**$50.00**), Tier 2 by thirty dollars (**$30.00**), and Tier 3 by twenty dollars (**$20.00**) per eligible enrollee when:

   a. The rate for a performance measure has improved three (3) percentage points or more compared to the previous reporting period; and

   b. The rate for the performance measure is between the fortieth (40^{th}) and fiftieth (50^{th}) percentiles.

7. The Agency may assess liquidated damages for each of the following measures:

   a. Tier 1:

      (1) Antidepressant Medication Management – Effective Acute Phase Treatment

      (2) Adherence to Antipsychotic Medications for Individuals with Schizophrenia

      (3) Comprehensive Diabetes Care – HbA1c Control (<8%)

      (4) Controlling High Blood Pressure

      (5) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 day – Total

      (6) Follow-Up After Emergency Department Visit for Mental Illness – 7 day

      (7) HIV Viral Load Suppression

      (8) Initiation and Engagement of Alcohol and Other drug Dependence Treatment – Initiation – Total

      (9) Asthma Medication Ratio – 75% Compliance – Total

   b. Tier 2:

      (1) Child and Adolescent Well-Care Visits

      (2) Adults' Access to Preventive/Ambulatory Health Services – Total

      (3) Childhood Immunization Status – Combination 3

(4) Immunizations for Adolescents – Combination 1

(5) Timeliness of Prenatal Care

c. Tier 3:

(1) Annual Monitoring for Patients on Persistent Medications – Total*

(2) Breast Cancer Screening

(3) Cervical Cancer Screening

(4) Chlamydia Screening in Women – Total

(5) Comprehensive Diabetes Care – HbA1c Testing

(6) Comprehensive Diabetes Care – Eye Exam

(7) Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase

(8) Lead Screening in Children

(9) Postpartum Care

8. The Agency may amend the performance measure listing with sixty (60) days' advance notice.

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Section XV. Special Terms and Conditions

The special terms and conditions in **Attachment II**, Section XV., Special Terms and Conditions, apply to all Managed Care Plans covering MMA services.

A. Applicable Laws and Regulations

The Mental Health Parity and Addictions Equity Act

1. The Managed Care Plan shall comply with all applicable federal and State laws, rules and regulations including 42 CFR part 438, Subpart K, and the MHPAEA.

2. The Managed Care Plan shall conduct an annual review of its administrative, clinical, and utilization management practices to assess its compliance with the MHPAEA under this Contract.

3. The Managed Care Plan shall submit to the Agency an attestation of the Managed Care Plan's compliance with the MHPAEA no later than November 1 of each year, in a manner and format to be specified by the Agency.

B. The Managed Care Plan agrees to participate in meetings with the Agency and the PDHP to foster enhanced communication, strategic planning, and collaboration in coordinating benefits provided through the SMMC and PDHP delivery system and to address any major organizational challenges and/or barriers during the implementation process.

If the Managed Care Plan fails to comply with the requirements of this section, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.

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Section XVI. Reporting Requirements

A. Required Reports

The Managed Care Plan shall comply with all reporting requirements set forth in this Contract, including reports specific to the MMA managed care program as specified in the Summary of Reporting Requirements Table, Table 10, below, and the Managed Care Plan Report Guide.

TABLE 10
SUMMARY OF REPORTING REQUIREMENTS

Report Name	Program Type	Frequency
Actual Value of Enhanced Payment (AVEP) MMA Physician Incentive Payment (MPIP) Report	MMA Program	Semi-Annual
Appointment Wait Times Report	MMA Program	Quarterly
Child Staffing Attendance Report	MMA Program	Monthly
ER Visits for Enrollees without PCP Appointment Report	MMA Program	Annually
Estimated Value of Enhanced Reimbursement (EVREVER)/Qualified Provider MMA Physician Incentive Program (MPIP) Report	MMA Program	Annually
Health Risk Assessment Report	MMA Program	Quarterly
Healthy Behaviors	MMA Program	Quarterly
HSA Ombudsman Log	MMA Program	Quarterly
HSA Survey	MMA Program	Annually
Institution for Mental Diseases (IMD) Reimbursement	MMA Program	Semi-Annual
Medical Foster Care Services Report	MMA Program	Monthly
Nursing Facility Services Report	MMA Program	Monthly
PCP/PDP Appointment Report	MMA Program	Annually

Section XVI. Reporting Requirements

TABLE 10 **SUMMARY OF REPORTING REQUIREMENTS**		
Report Name	**Program Type**	**Frequency**
PDN Utilization Report	MMA Program	Quarterly
Reconciliation Report	MMA Program	Quarterly Annually
Residential Psychiatric Treatment Report	MMA Program	Monthly
Service Authorization Timeliness Performance Outcome Report	MMA Program	Monthly
Supplemental HIV/AIDS Report	MMA Program	Monthly
Well Child Health Check-Up Visit (CMS-416) and FL 80% Screening	MMA Program	Annually

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