ATTACHMENT II
SCOPE OF SERVICES - CORE PROVISIONS
EFFECTIVE: NOVEMBER 2024

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Section I. General Overview

A. Purpose

1. General Provisions

(a) Under the SMMC program, the Agency for Health Care Administration (Agency) contracts with the Managed Care Plan, as defined in **Section XVI.**, Definitions and Acronyms, to provide services to recipients.

(b) The Managed Care Plan shall comply with all provisions of this Contract, including all Attachments, applicable Exhibit(s), and any amendments and shall act in good faith in the performance of these Contract provisions.

2. Contract Structure

(a) The provisions in this Contract and the terms of the applicable federal waivers apply to all Managed Care Plan types unless specifically noted otherwise. Provisions unique to a specific type of Managed Care Plan are described in this Contract and its Exhibits specific to either the LTC managed care program or the MMA managed care program, respectively, and are depicted below in the General Contract Structure Table, **Table 1**, below.

TABLE 1
GENERAL CONTRACT STRUCTURE

Plan Type	Attachment I, Plan-Specific Scope of Service	Attachment II, Core Provisions	Exhibit II_A, MMA Services	Exhibit II-B, LTC Services
MMA Plan	✓	✓	✓	
MMA Plus Plan	✓	✓	✓+	
Select Comprehensive LTC Plans & Comprehensive LTC Plans	✓	✓	✓	✓
Comprehensive LTC Plus Plans	✓	✓	✓+	✓

(b) The following Managed Care Plan types shall be responsible for complying with the provisions of the Attachments and Exhibits as follows:

(1) The Comprehensive Long-Term Care Plan (Comprehensive Plan) shall comply with the provisions of:

- **Attachment II, Exhibit II-A**, and **Exhibit II-B** for enrollees receiving both MMA and LTC benefits.
- **Attachment II**, and **Exhibit II-A** for enrollees receiving only MMA benefits.

(2) The Comprehensive Long-Term Care Plus Plans (Comprehensive Plus Plan) shall comply with the provisions of:
- **Attachment II, Exhibit II-A, and Exhibit II-B for enrollees receiving both MMA and LTC benefits, and**
- **Attachment II and Exhibit II-A for enrollees receiving only MMA benefits, and**
- **Exhibit II-A** provisions specific to the Plan's Specialty product.

(3) The Select Comprehensive Long-Term Care Plans shall comply with the provisions of **Attachment II**, **Exhibit II-A**, and **Exhibit II-B** for all of its enrollees.

(4) Managed Medical Assistance Plans (MMA Plans) shall comply with the provisions of **Attachment II** and **Exhibit II-A** for enrollees receiving only MMA benefits.

(5) Managed Medical Assistance Plus Plans (MMA Plus Plans) shall comply with the provisions of:
- **Attachment II and Exhibit II-A for enrollees receiving only MMA benefits, as well as**
- **Exhibit II-A** provisions specific to the Plan's Specialty product.

(c) This Contract refers throughout to certain required forms, templates, reports, and submission requirements, all of which are posted on the Agency's website unless otherwise specified in this Contract.

B. Features: Florida First

Florida's Statewide Medicaid Managed Care (SMMC) program is committed to providing pathways to health and prosperity for individuals and families with low- or no-income. Following the Agency's mission of "Better Health Care for All Floridians," several enhancements to Florida Medicaid will be implemented for the 2025 – 2030 Contract term. Delivering high quality care is key to improving health outcomes, value of health care, and patient experience. New quality incentives and updated measures strengthen Florida Medicaid. The Agency has especially prioritized improvement of birth outcomes, mental health of children and adolescents, maximizing home and community-based placement and services for seniors, and support for Hope Florida.

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C. Prioritizing Autonomy and Self-Sufficiency through Community Partnerships

1. General Provisions

   a. The Managed Care Plan shall establish and maintain community partnerships with providers that create opportunities for reinvestment in community-based services. Community partners are public or private, non-governmental, nonprofit community-based organizations (CBOs) of demonstrated effectiveness that have principal address of operations in Florida, are representative of a Florida community or significant segments of a Florida community, and provide services to individuals in the community.

   b. In addition to the covered services specified in **Section V.**, Service Administration, of this Contract, the Managed Care Plan shall establish community partnerships, including, but not limited to, contract agreements between the Managed Care Plan and CBOs to provide services and supports for health-related social needs to the Managed Care Plan's enrollees. Contracted services and supports include, but are not limited to, case referrals, case planning, program development, information sharing and management, community awareness, group services, group education, individual services, and individual education. The Managed Care Plan is not reimbursed separately by the Agency for these services (409.966(3) and (4), F.S.).

      (1) The Managed Care Plan shall develop and maintain written procedures to implement community partnerships to improve outcomes (CPIO).

      (2) The Managed Care Plan senior executive leadership staff shall participate on boards, councils, and commissions of community organizations. The Managed Care Plan shall include members of community organizations in plan stakeholder and/or beneficiary advisory boards, councils, and commissions.

      (3) The Managed Care Plan shall contract annually with at least three (3) CBOs in each region of Plan operation for each of the Agency's CPIO priority areas described in this Section within the Plan's respective contract type(s).

      (4) The Managed Care Plan shall provide information in the enrollee and provider handbooks on CPIOs and how to access related services.

      (5) The Managed Care Plan and its provider network shall refer enrollees to community-based services.

      (6) The Managed Care Plan shall collaborate actively with community agencies and organizations, including, but not limited to, monetary support and in-kind donation of goods or services.

      (7) The Managed Care Plan shall document in the enrollee record any referrals to CBOs and follow up on the enrollee's receipt of services from the community program using a closed-loop referral system of record.

      (8) The Managed Care Plan shall report to the Agency annually on their list of

community agencies and organizations with written agreements in a manner and

format specified by the Agency. The list of community organizations should also include a description of the collaboration (maximum 250 words), an evaluation of the impact on enrollee quality performance outcomes, the amount of monetary support and in-kind donation from the Plan to the community-based organization, and the percent change in monetary support and in-kind donation to the previous fiscal year.

(9) The Agency reserves the right to identify and direct which Community Partner Network or CBOs to use.

c. In accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide, the Managed Care Plan shall report quarterly to the Agency on:

(1) The Managed Care Plan's participation on CBO boards, councils, and commissions, and

(2) Participation by CBOs on the Managed Care Plan's boards, councils, and commissions.

2. Community Partnerships to Improve Outcomes for MMA Enrollees

a. The Managed Care Plan shall establish community partnerships to provide services and supports in the following CPIO priority areas:

(1) Birth Outcomes. Examples of community organizations include, but are not limited to, the following.

- Florida Pregnancy Support Services Program and Florida Pregnancy Care Network
- Family Planning Partnerships
- Teenage Parent Program (TAPP) operated through school districts
- Pregnancy and Prenatal Partnerships
- Postpartum Partnerships
- Lactation Partnerships
- Parenting Partnerships
- Maternal Mental Health Partnerships
- Healthy Start Partnerships operated through the Florida Department of Health and County Health Departments

- Early Steps Partnerships operated through the Florida Department of Health and County Health Departments

(2) Mental Health of Children and Adolescents. Examples of community organizations include, but are not limited to, the following.

- School-Based Peer Support Programs
- Youth Mental Health and Awareness Partnerships
- Extended Day Enrichment Programs
- Youth Mentorship or Leadership Development Partnerships
- Partnerships to Assist Families in Screen Management for Youth
- School Readiness Partnerships
- Youth Tobacco Prevention and Cessation Partnerships such as Tobacco Free Florida and Area Health Education Centers
- Alcohol and Substance Use Prevention Partnerships

(3) Health Related Social Needs. Examples of community organizations include, but are not limited to, the following.

- State of Florida Centers for Independent Living
- Vocational Training and Job Placement Partnerships including, but not limited to, Workforce Development Organizations and Job Centers
- Academic Achievement Partnerships
- Intimate Partner Violence Partnerships
- Community Reentry for Justice-Involved People Partnerships
- Supportive Housing Partnerships including, but not limited to, Continuums of Care and Permanent Supportive Housing Organizations
- Literacy Partnerships

b. The Managed Care Plan offering a Specialty Product for enrollees with a Specialty condition shall establish community partnerships to provide services and supports in the following additional CPIO priority areas:

(1) Chronic Diseases. The Managed Care Plan shall contract with community organizations to improve the well-being of their special population. Examples of

community organizations include, but are not limited to, the following.

- Disease Awareness Partnerships
- Disease Progression Prevention Partnerships
- Disease Survivorship and Recovery Partnerships
- Foster Care Support Partnerships
- Adoption and Guardianship Support Partnerships
- Healthy Nutrition Partnerships
- Physical Activity and Fitness Partnerships

(2) Mental Health. Examples of community organizations include, but are not limited to, the following.

- School-Based Peer Support Programs
- Youth Mental Health and Awareness Partnerships
- Extended Day Enrichment Programs
- Youth Mentorship or Leadership Development Partnerships
- Partnerships to Assist Families in Screen Management for Youth
- School Readiness Partnerships
- Tobacco Prevention and Cessation Partnerships such as Tobacco Free Florida and Area Health Education Centers
- Alcohol and Substance Use Prevention Partnerships

(3) Health Related Social Needs. Examples of community organizations include, but are not limited to, the following.

- State of Florida Centers for Independent Living
- Vocational Training and Job Placement Partnerships including, but not limited to, Workforce Development Organizations and Job Centers
- Academic Achievement Partnerships

- Intimate Partner Violence Partnerships

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- Community Reentry for Justice-Involved People Partnerships
- Supportive Housing Partnerships including, but not limited to, Continuums of Care and Permanent Supportive Housing Organizations
- Literacy Partnerships

3. Community Partnerships to Improve Outcomes for Long-Term Care Enrollees

   a. The Managed Care Plan shall establish community partnerships to provide Home and Community-Based services and supports in the following CPIO priority areas:

      (1) Area Agencies on Aging (AAA) or Aging and Disability Resource Center (ADRC) Partnerships

      (2) Elder Abuse Prevention Partnerships

      (3) Healthy Aging Partnerships

      (4) Advanced Care Planning and End of Life Preparedness Partnerships

      (5) Partnerships that improve care transitions from institutional care to home and community-based settings

      (6) State of Florida Centers for Independent Living

      (7) Dementia Care & Cure Initiative Partnerships through the Florida Department of Elder Affairs and the AAAs

      (8) Partnerships that provide home modifications to increase safety, independence, and social connections

      (9) Caregiver Support Partnerships

      (10) Partnerships that Increase Social Engagement and Reduce Isolation

      (11) Community organizations that support Health Related Social Needs (e.g., Intimate Partner Violence Partnerships; Community Reentry for Justice-Involved People Partnerships; Supportive Housing Partnerships including, but not limited to, Continuums of Care and Permanent Supportive Housing Organizations, Vocational Training, and Job Placement Partnerships including, but not limited to, Workforce Development Organizations and Job Centers; and Literacy Partnerships)

(12) Chronic Diseases. Examples of community organizations include, but are not limited to, the following:

- Healthy Nutrition Partnerships
- Physical Activity and Fitness Partnerships
- Tobacco Prevention and Cessation Partnerships including, but not limited to, Tobacco Free Florida and Area Health Education Centers)

D. Prioritizing Florida's Families and Family Choice

1. The Agency has refined the delivery system structure to select Managed Care Plans with the ability to provide continuity of care and stability for both individuals and families. This all-in-one plan structure combines the convenience of managed medical assistance services, long-term care services, and a specialty product. This truly comprehensive plan structure enables an enrollee to move seamlessly between benefits without having to change their Managed Care Plan or health care providers.

   (a) **Comprehensive Long-Term Care Plan (herein referred to as a "Comprehensive Plan")** – A Managed Care Plan that is eligible to provide MMA services to any MMA-eligible recipients, may concurrently provide MMA and LTC services to recipients eligible for LTC services, and is eligible to provide LTC services to any recipient eligible only for LTC services.

   (b) **Comprehensive Long-Term Care Plus Plan (herein referred to as a "Comprehensive Plus Plan")** – A Managed Care Plan that is eligible to provide MMA services to any MMA-eligible recipients, may concurrently provide MMA and LTC services to recipients eligible for LTC services, and is eligible to provide LTC services to any recipient eligible only for LTC services. The Comprehensive Plus Plan also provides one (1) or more MMA Specialty products to Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

   (c) **Select Comprehensive Plan** – A Managed Care Plan that is eligible to provide concurrently MMA services and LTC services to eligible recipients enrolled in the LTC program. This plan type is not eligible to provide services to recipients who are eligible only for MMA services.

   (d) **Managed Medical Assistance (MMA) Plan** – A Managed Care Plan that is eligible to provide MMA services to recipients who are eligible only for MMA services. This plan type is not eligible to provide services to recipients who are eligible for LTC Services.

   (e) **Managed Medical Assistance (MMA) Plus Plan**– A Managed Care Plan that is eligible to provide MMA services to any MMA-eligible recipients and also provides one (1) or more MMA Specialty products to Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis. This plan type is not eligible to provide services to recipients who are eligible for LTC Services.

2. Provider Networks

   The Agency is dedicated to maintaining its current network monitoring activities, while enhancing select network requirements and innovating and leveraging the Contract to ensure the availability of strong provider networks.

   a. The Agency shall contract with an independent vendor to conduct network adequacy reviews for the purpose of auditing provider networks, including, but not limited to, conducting secret shopper activities and other activities to verify provider networks as identified by the Agency. The vendor will conduct systematic and continuous testing of the provider network databases maintained by the Managed Care Plan to confirm accuracy, confirm that providers are accepting enrollees, and confirm that enrollees have access to services, and provide the Agency with analytics, dashboard, and other reports as determined by the Agency. Payments shall include compensation of the vendor and necessary attendant administrative costs of the Agency directly related to the audit activities.

      (1) The Managed Care Plan shall pay to the Agency the expenses of the Agency's network review vendor at the rates established by the Agency proportionate to the Managed Care Plan's enrolled population.

      (2) The Managed Care Plan shall pay the Agency within twenty-one (21) days after presentation by the Agency of the detailed account of the charges and expenses.

      (3) The Managed Care Plan's failure to pay the Agency shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages.

E. Prioritizing Florida's Vulnerable Citizens

Chronic Disease Management (CDM) programs executed by the Managed Care Plan shall have proactive and organized interventions focused on defined populations with chronic diseases. The goal of CDM programs shall be to improve health outcomes of enrollees with chronic conditions by mitigating disease progression, reducing complications, preventing comorbidities, reducing potentially preventable events (PPEs), improving quality of life, and achieving cost savings to the enrollee, Managed Care Plan, and the state. With symptoms minimized and unnecessary hospitalizations prevented, there will be more opportunities for improved quality of life, social engagement, gainful employment, completing career education, and independence. At the population level, increasing the percentage of people with good physical and mental function lowers the demand for LTC resources.

1. Chronic Disease Management (CDM) Programs

   a. The Managed Care Plan shall provide CDM programs that include, but are not limited to, the following components:

      (1) Provide support to the Agency to improve quality of health care.

(2) Include interventions that exceed the Managed Care Plan's inherent care coordination and overall management of enrollees.

(3) Engage enrollees and care partners in the enrollee's care.

(4) Increase utilization of preventive services.

(5) Improve health outcomes by utilizing objective and measurable methods.

(6) Facilitate the scientific approach to improving health care services through the use of goals, specific interventions, reference populations, analysis plans, and quantifiable, measurable outcomes.

(7) Close the gaps on disparate access, utilization, or outcomes.

(8) Implement best practices informed by ongoing program evaluation.

b. Within the first ninety (90) days of contract implementation, the Managed Care Plan shall conduct a comprehensive analysis of its enrollees to develop meaningful CDM programs. As part of the comprehensive analysis, the Managed Care Plan shall develop a methodology to identify enrollees and providers of those enrollees with multiple or severe chronic conditions as a target population who would benefit from participating in the CDM. The Managed Care Plan shall offer CDM programs for the four chronic conditions listed below:

(1) Cancer and cancer prevention.

(2) Diabetes and diabetes prevention.

(3) Depression and depression prevention (including suicide prevention).

(4) Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and HIV prevention.

c. The Managed Care Plan shall offer two (2) additional CDM programs to be selected from the list below. The conditions chosen by the Managed Care Plan for its CDM programs shall match the needs of its enrollee population and shall be tied to the target population. Qualifying conditions include:

(1) Chronic Kidney Disease

(2) Dementia

(3) End Stage Renal Disease (ESRD)

(4) Hypertension

(5) Osteoporosis

(6) Parkinson's Disease

(7) For the Managed Care Plan not offering Enhanced Case Management or a Specialty product, one or more of the following:

- Anxiety disorders
- Attention deficit hyperactivity disorder (ADHD)
- Bipolar disorder
- Substance use disorders

d. The Managed Care Plan shall conduct a thorough analysis of each CDM target population to develop interventions. The Managed Care Plan shall use the following elements to design CDM programs:

(1) Provision of care coordination to ensure enrollees receive high quality care according to accepted standards of practice and clinical guidelines.

(2) Provision of case management services across the continuum of care to optimize health outcomes and reduce over and under-utilization of services.

(3) Use of preventive services to slow progression of disease and/or prevent complications and comorbidities.

(4) Promotion of lifestyle changes that slow progression of disease and/or prevent complications and comorbidities.

(5) Use of effective disease management toolkits, guidelines, and recommendations from associations and organizations with subject matter expertise.

(6) Implementation of strategies to address health disparities for target populations who are disproportionately impacted by the burden of chronic disease.

(7) Partnerships with providers, CBOs, and other stakeholders to leverage resources.

(8) Effective communication to enrollees and caregivers throughout the continuum of chronic disease from newly diagnosed to end of life.

(9) Provision of education and outreach interventions to engage enrollees and caregivers as partners in care.

The Agency shall use the above elements to assess the thoroughness of the Managed Care Plan's CDM program design.

e. The Managed Care Plan shall provide to the Agency before initiating the CDM programs the target chronic condition, the target population and methodology for identification, quality indicators that will be used to quantifiably measure progress, the

clinical knowledge or research that justify the quality indicators as credible progress measures, and data sources informing identification and progress (e.g., claims data or HEDIS). The Managed Care Plan will describe the clinical and demographic characteristics of the CDM target population, the opportunity for improvement, how the CDM will improve health outcomes for the target population, and the estimated number

of enrollees and providers in the target population. The CDM shall have target goals for the quality indicators that must be specific, quantifiable, appropriate for the chronic disease target population, and linked to planned interventions. Use of state or national standards or benchmarks shall be used for comparison purposes, if available. The Managed Care Plan in its CDM programs shall list and describe planned interventions and how they help achieve target goals. Interventions may include, but are not limited to, provider education, enrollee education, medication adherence, rewards and incentives program, care coordination, enrollee outreach, caregiver engagement, outreach to providers, home visits, case management, promotion of lifestyle changes, community partnerships.

2. The Managed Care Plan shall provide annual updates for each CDM program to the Agency including the following information:

   a. Total number of enrollees and/or providers in the target population.

   b. Total number of enrollees and/or providers who participated in the CDM program by receiving intervention(s).

   c. Clinical and demographic characteristics of the CDM participants compared to the CDM target population.

   d. List of implemented intervention types.

   e. Results of the CDM program including quantitative and qualitative data showing trends in quality indicators, comparison of quality indicators to target goal, and comparison of quality indicators to state or national standards or benchmarks, if available.

   f. Barriers encountered, such as healthcare team issues, communication issues, non-adherence, technology issues, medication issues, support system issues, transportation issues, financial issues, decline in clinical condition, external factors, knowledge deficit.

   g. Mitigation strategies used to address barriers such as culturally appropriate materials, new provider relationships or communication methods, new information technology solutions or new relationships with CBOs.

   h. Any changes to best practices producing positive health outcomes that the Managed Care Plan learned in conducting the CDM.

   i. Description of proposed changes to the CDM for the upcoming year.

   f. The Managed Care Plan shall provide quarterly updates for each CDM program to the

Agency reporting the results of the CDM program including:

(1) Quantitative and qualitative data showing trends in quality indicators.

(2) Comparison of quality indicators to target goal.

(3) Comparison of quality indicators to state or national standards or benchmarks, if available.

3. Chronic Disease Management Program for MMA Enrollees

a. The Managed Care Plan must offer CDM program interventions for the four chronic conditions listed below:

(1) Cancer and cancer prevention

(2) Depression and depression prevention (including suicide prevention)

(3) Diabetes and diabetes prevention

(4) Human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and HIV prevention

The Managed Care Plan offering a Specialty Product shall substitute a CDM program targeted to their entire specialty population in place of (4) of Item a. above.

b. The Managed Care Plan shall offer a minimum of two (2) additional CDM interventions to be selected from the list below. The conditions chosen by the Managed Care Plan for its CDM interventions shall match the needs of its enrollee population and shall be tied to the target population.

(1) Anxiety disorders

(2) Asthma

(3) Attention deficit hyperactivity disorder (ADHD)

(4) Bipolar disorder

(5) Cardiovascular Disease

(6) Chronic Kidney Disease

(7) Chronic Obstructive Pulmonary Disease (COPD)

(8) Dementia

(9) End Stage Renal Disease (ESRD)

(10) Hypertension

(11) Osteoporosis

(12) Parkinson's Disease

(13) Sickle Cell Disease

(14) Substance use disorders

4. The Managed Care Plan offering a Specialty Product shall offer a minimum of two (2) additional CDM interventions to be selected from the list below. The conditions chosen by the Managed Care Plan for the Specialty Product for its CDM interventions shall match the needs of its enrollee population and shall be tied to the target population.

   a. Enrollees who are hospitalized more than twice in six (6) months

   b. Enrollees with disparities in health outcomes due to demographic or socioeconomic status

   c. Enrollees with co-morbid conditions that complicate care

   d. Enrollees with medication non-adherence

   e. Enrollees with worse health outcomes due to disease refractoriness

   f. Enrollees with worse health outcomes due to issues with accessing or utilizing health care services

5. Chronic Disease Management Program for LTC Enrollees

   a. The Managed Care Plan must offer CDM program interventions for the four chronic conditions listed below:

      (1) Cancer and cancer prevention

      (2) Depression and depression prevention (including suicide prevention)

      (3) Diabetes and diabetes prevention

      (4) Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and HIV prevention

   b. The Managed Care Plan shall offer a minimum of two (2) additional CDM interventions to be selected from the list below. The conditions chosen by the Managed Care Plan for its CDM interventions shall match the needs of its enrollee population and shall be tied to the target population.

(1) Anxiety disorders

(2) Bipolar disorder

(3) Cardiovascular Disease

(4) Chronic Kidney Disease

(5) Chronic Obstructive Pulmonary Disease

(6) Dementia

(7) End Stage Renal Disease

(8) Hypertension

(9) Osteoporosis

(10) Parkinson's Disease

(11) Substance use disorders

F. Prioritizing Hope Florida

The Agency shall leverage the SMMC program to improve certain non-medical conditions through a closed-loop referral system that ensures the Managed Care Plan is accountable and incentivized to create Hope Florida. The Managed Care Plan shall develop and maintain procedures to assess enrollees who may be experiencing barriers to employment, economic self-sufficiency, and independence to gain access to care coordination/case management services and health-related social needs, such as housing assistance, food sustainability, vocational training, and educational support services.

1. Hope Florida

In 2021, the Department of Children and Families launched the Hope Florida initiative to Prosperity that uses Hope Navigators to guide Floridians on an individualized path to prosperity, economic self-sufficiency, and hope by focusing on community collaboration between the private sector, faith-based community, nonprofits, and government entities to break down traditional community silos, to maximize resources and uncover opportunities. It is the Agency's intention that the Managed Care Plan collaborates with the Hope Florida program to enable eligible enrollees to gain the necessary education, job, and life skills to achieve independence and "graduate" out of Medicaid.

a. The Managed Care Plan shall implement strategies, as directed by the Agency, to empower enrollees overcome barriers to employment, economic self-sufficiency, independence, and achieve inclusion and integration into society.

b. The Managed Care Plan may provide marketing information on its commercial line of business or its Individual Exchange Plan through the Health Insurance Marketplace as

part of the Managed Care Plan's Hope Florida program in support of assistance maintaining medical coverage after graduating from Medicaid.

c. The Managed Care Plan shall develop and maintain procedures to assess enrollees who may be experiencing barriers to employment, economic self-sufficiency, and independence to gain access to care coordination/case management services and health-related social needs, such as housing assistance, food sustainability, vocational training, and educational support services, as indicated.

d. The Managed Care Plan's procedures shall address the following minimum functions:

(1) How results of the Hope Florida screening are utilized by the Managed Care Plan to initiate access to care coordination/case management services.

(2) How findings of the Hope Florida screening ensure access to the array of expanded benefits that address barriers to overcoming barriers to employment, economic self-sufficiency, independence, and achieve inclusion and integration into society.

(3) How findings of the Hope Florida screening ensures referrals to the community partner network for housing assistance, food sustainability, vocational training, and educational support services through Hope Florida and other community resources.

(4) Appropriate support to case managers, enrollees, and caregivers, as needed, for referral and scheduling assistance to access community support services.

(5) Coordination between the Managed Care Plan's case managers and Hope Navigators to ensure effective use of resources.

(6) The interoperability of the Managed Care Plan's case management documentation system that will integrate information from providers, including their interface with the integrated data and tracking system for targeting services and supports to address health-related social needs.

(7) Documentation in the enrollee record of referrals to community programs and follow up on the enrollee's receipt of services from community programs (closed-loop referral system).

e. The Managed Care Plan shall exchange data, including leveraging the Florida Health Care Connections (FX) integration platform, in coordination with the Department of Children and Families' (DCF) Hope Florida program to enhance the integration of case management and coordination of service delivery.

f. The Managed Care Plan that achieves successful rates of graduation through its Hope Florida program may receive additional enrollee assignments at a factor and for duration to be determined by the Agency. The Agency reserves the right to establish a minimum threshold for successful rates of graduation.

g. In accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide, the Managed Care Plan shall report annually to the Agency:

(1) The number and percentage of enrollees who received a Hope Florida screening.

(2) Type, number, and value of community outreach services provided, including expanded benefits.

(3) Enrollees' receipt of community resources for Hope Florida -related referrals.

(4) Health care services utilized.

(5) Health outcomes post-services provided related to Hope Florida via case manager or Hope Navigator.

(6) Completion of vocational training of education programs, including participation and the number of enrollees successfully completing the program.

(7) Family members who received services from the Hope Florida program.

(8) Number of enrollees graduating out of Medicaid as defined by the Agency.

h. 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 XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

2. Additional Hope Florida Information

As additional Hope Florida program components are identified, the Managed Care Plan shall provide care coordination/case management to guide enrollees on an individual basis by focusing on community collaboration between the private sector, faith-based community, nonprofits, and government entities; break down traditional community silos; maximize resources; and uncover opportunities for enrollees to achieve independence.

G. Prioritizing Mental Wellness for Florida's Youth

The Agency is prioritizing mental health services to help enrollees function and live independently in the community. By ensuring that enrollees contending with serious mental illness or substance abuse issues receive access to the right care at the right time, the Managed Care Plan can promote the best outcomes and reduce the numbers of emergency department and inpatient admissions.

1. Care Coordination for Children with High Utilization of Crisis Stabilization Unit (CSU) and Inpatient Psychiatric Hospital Services

a. The Managed Care Plan shall assign a care coordinator to an enrollee under eighteen (18) years of age who are high utilizers of inpatient psychiatric hospitals, Baker Act receiving facilities, and/or CSUs (i.e., three (3) or more admissions within a six (6)-

month period). The Managed Care Plan's care coordinator shall assume a lead role in identifying services that can meet the enrollee's need even when there are multiple state agencies (e.g., DCF and Agency for Persons with Disabilities (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, including DCF regional Children's Care Coordinators and the local managing entities, to ensure access to Medicaid services and other related community resources. Such communication shall occur at the frequency warranted for the needs of the enrollee. The Managed Care Plan shall document coordination and communication efforts in the enrollee records.

b. The Managed Care Plan shall ensure that assigned care coordinators serving enrollees under the age of eighteen (18) years of age who are high utilizers of CSU and inpatient psychiatric hospital services receive training through DCF. Annual training topics shall include the following training at a minimum:

   (1) The Marchman Act (Chapter 397, F.S.)

   (2) The Baker Act (Part I of Chapter 394, F.S.)

   (3) Mental Health First Aid training.

c. The Managed Care Plan shall submit a completed training attestation, signed by the care coordinator/case manager's supervisor, to the Agency annually on June 1.

d. In addition to the provisions in **Attachment II**, **Exhibit II-A**, **Section V.**, Service Administration**, Sub-Section D.**, Coverage Provisions, **Item 3.**, Enrollee Screening and Education, the Managed Care Plan shall conduct quarterly education and outreach to promote resources on mental health services for children and adolescents.

e. The Managed Care Plan shall communicate and coordinate at least quarterly with DCF regional Children's Care Coordinators and the managing entities for enrollees under eighteen (18) years of age who are who are high utilizers of CSU and inpatient psychiatric hospital services to ensure access to Medicaid services and other related community resources. The Managed Care Plan shall document coordination and communication efforts in the enrollee records.

f. The Managed Care Plan shall report monthly on case management activities on enrollees under eighteen (18) years of age who have high utilization of CSU inpatient mental health services, in accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

2. High Utilizer Medical Record and Case Management File Review

   a. The Managed Care Plan shall perform medical record and case management file reviews for enrollees who are high utilizers of CSU and inpatient psychiatric hospital services, Baker Act receiving facilities, and/or CSUs within a six (6)-month period. The

Managed Care Plan must initiate the review within ninety (90) days of the third readmission and focus on inpatient evaluations, discharge planning, and identifying trends associated with:

(1) Communication between the inpatient facility, health plan, caregiver, and other providers.

(2) Seven (7) day follow up.

(3) Services scheduled.

(4) Completion of follow-up of services.

b. At a minimum, the review shall encompass three (3) enrollee records of the three (3) inpatient psychiatric hospitals, Baker Act receiving facilities, or CSUs with the highest readmission rates.

c. The results of the medical record and case management file reviews shall be utilized by the Managed Care Plan as part of its quality improvement activities and shall be made available to the Agency upon request.

d. If the Managed Care Plan fails to perform the medical record and case management file review for enrollees who are high utilizers of CSU and inpatient psychiatric hospital services, the Managed Care Plan shall be subject to fines or otherwise sanctioned in accordance with **Section XII.**, Sanctions and Corrective Action Plans.

3. Evidence-Based Practices for Children with Intense Behaviors

Under the authority of 42 U.S.C. 1396d(r)(5), the Managed Care Plan shall partner with DCF to offer the following evidence-based programs for children with intense behaviors, when medically necessary:

(1) Homebuilders

(2) Motivational Interviewing

(3) Multisystemic Therapy

(4) Parent-Child Interaction Therapy

(5) Functional Family Therapy

(6) Parents as Teachers

(7) Brief Strategic Family Therapy

(8) Healthy Families

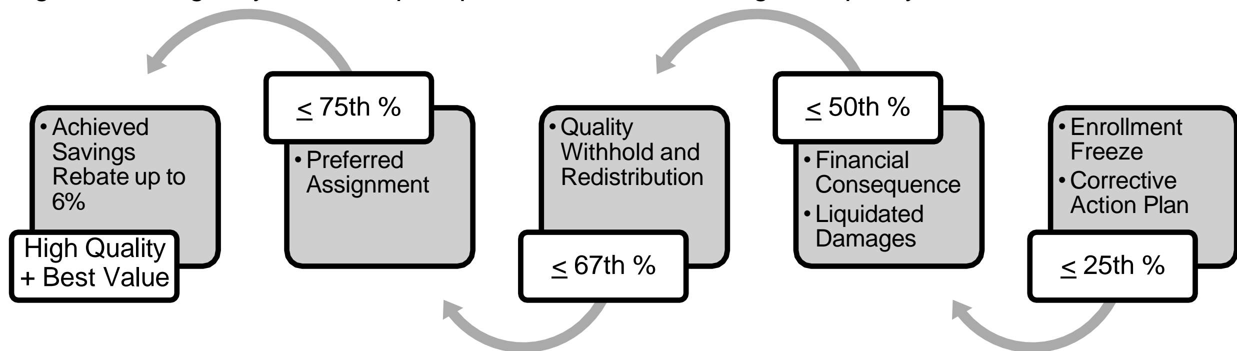
(9) Nurse Family Partnership

H. Prioritizing Quality and Value

The SMMC Quality Strategy details an array of quality components with balanced incentives and penalties to drive continual improvement in overall program quality. All quality components align to the three (3) core quality goals: promote healthy birth outcomes for mothers and infants, maximize home and community based (HCB) placement and services to improve independence, well-being and safety, and improve childhood and adolescent mental health. The quality structure aligns penalties and bonuses such that with each incremental improvement in performance, the Managed Care Plan will continue to have an incentive to continue to invest in improvement.

1. Layered Approach to Drive Continued Improvement

   The Agency has supplemented its Comprehensive Quality Strategy to include an array of quality components with balanced incentives and penalties to drive continual improvement in overall program quality. By tying performance incentives and penalties to the Agency's goals, the Agency will drive plan performance to the height of quality and best value.



   a. Achieved Savings Rebate One Percent Quality Incentive

      The Managed Care Plan operating at top tier performance levels may retain an additional one percent (1%) of revenue through the Achieved Savings Rebate.

      (1) Each year, to be eligible to retain up to an additional one percent (1%) of revenue, the Managed Care Plan must earn four (4) points or more for each reportable performance measure listed in the Quality Withhold Incentive as described in this Sub-Section. For example, a Managed Care Plan reporting all ten (10) measures to the Agency and earning four (4) points for each measure would score forty (40) Total Quality Points out of a maximum number of fifty (50) points possible, and consequently shall be eligible to retain an additional one percent (1%) of revenue.

      (2) The Agency reserves the right during the Contract term to change the Achieved Savings Rebate One Percent Quality Incentive methodology.

   b. Quality Preferred Assignment Incentive

      The Managed Care Plan with penultimate performance may receive preferred assignment incentives. In accordance with Section 409.977(1), F.S., the Agency may adjust enrollment through enhanced auto-assignments to high-performing plans as a performance incentive.

(1) In addition to the incentive payments available through the Quality Withhold Incentive as described in the below Item, the Managed Care Plan may be eligible for the Quality Preferred Assignment Incentive.

(2) Each year, to earn the Quality Preferred Assignment Incentive, the Managed Care Plan must have earned its full two percent (2%) withhold and be one of the three highest scoring plans, based on the percentage of Total Quality Points earned to maximum number of points possible, as described below, and have scored at least one (1) point for each reportable performance measure. If the Managed Care Plan earns the Quality Preferred Assignment incentive, the plan shall receive enrollee assignments at a factor of 1.5 for a six (6)-month period.

(3) The Agency reserves the right during the Contract term to change the Quality Preferred Assignment Incentive methodology.

c. Quality Withhold Incentive

The Quality Withhold Incentive creates a financial withhold from the capitation rates paid to the Managed Care Plan to use as an incentive payment to plans with high performance on certain quality measures. The Managed Care Plan may receive a payment higher or lower than their contribution based on performance.

(1) Each year, the Agency shall withhold two percent (2%) of the Managed Care Plan's capitation rate, with the withhold to be earned based on the Managed Care Plan's performance according to specific performance measures compared against national performance standards.

(2) The following Healthcare Effectiveness Data and Information Set (HEDIS) performance measures shall be used in the Quality Withhold Incentive, divided into two groups:

(a) Group A:

(i) Antidepressant Medication Management – Acute Phase (AMM-AP)

(ii) Controlling Blood Pressure (CBP)

(iii) Hemoglobin A1c Control for Patients with Diabetes (HBD) – Control (< 8.0%) (HBD)

(iv) Childhood Immunization Status – Combo 3 (CIS03)

(v) Well-Child Visits in the First 30 Months – First 15 Months (W30-15)

(vi) Child and Adolescent Well-Care Visits – Total (WCV)

(b) Group B:

(i) Follow-up after Hospitalization for Mental Illness – 7-day (FUH-7)

(ii) Follow-up after Emergency Department Visit for Mental Illness – 7-day (FUM-7)

(iii) Timeliness of Prenatal Care (PPC-Pre)

(iv) Postpartum Care (PPC-Post)

(3) The Managed Care Plan shall earn points for each measure based on the Managed Care Plan’s performance rate relative to the National Committee for Quality Assurance’s (NCQA’s) National Medicaid Percentile for the measure.

(a) For Group A measures, points will be earned as follows in the Points for Quality Withhold Incentive – Group A HEDIS Measures Table, **Table 2**, below:

TABLE 2 POINTS FOR QUALITY WITHHOLD INCENTIVE – GROUP A HEDIS MEASURES	
National Medicaid Percentile	**Points**
>= 90th percentile	5
>= 75th percentile and below 90th	4
>=60th percentile and below 75th	3
>= 50th percentile and below 60th	2
>= 40th percentile and below 50th	1
< 40th percentile	0

(b) For Group B measures, points will be earned as follows in the Points for Quality Withhold Incentive – Group B HEDIS Measures Table, **Table 3**, below:

TABLE 3 POINTS FOR QUALITY WITHHOLD INCENTIVE – GROUP B HEDIS MEASURES	
National Medicaid Percentile	**Points**
>= 75th percentile and below 90th	5
>=60th percentile and below 75th	4
>= 50th percentile and below 60th	3
>= 40th percentile and below 50th	2
>= 25th percentile and below 40th	1
< 25th percentile	0

(4) Earned points for the ten (10) measures will be added together to determine the Total Quality Points for the Managed Care Plan. The maximum number of Total Quality Points the Managed Care Plan may earn is five (5) multiplied by the total number of performance measures that the Managed Care Plan is obligated to

report to the Agency. For example, if the Managed Care Plan has reportable rates for all ten (10) measures, then the plan's maximum number of Total Quality Points is fifty (50). If the plan has reportable rates for eight (8) measures, then the plan's maximum number of Total Quality Points is forty (40).

(5) If the Managed Care Plan's Total Quality Points equals or exceeds an average of two (2) points per reportable performance measure, then the Managed Care Plan shall earn its full two percent (2%) withhold. For example, if the Managed Care Plan reports ten (10) measures to the Agency and earns twenty (20) Total Quality Points, then the Managed Care Plan shall earn its two percent (2%) withhold. If the Managed Care Plan reports eight (8) measures to the Agency and earns sixteen (16) Total Quality Points, then the Managed Care Plan shall earn its two percent (2%) withhold. If the Managed Care Plan's Total Quality Points are below an average of two (2) points per reportable performance measure, then the Managed Care Plan shall not receive its full withhold but may receive a portion of the withhold based on the percentage of Total Quality Points earned to maximum number of points possible.

(6) Withhold not earned back by the Managed Care Plan shall be directed to a Quality Bonus Pool.

   (a) Each year, if there is a Quality Bonus Pool created by the Managed Care Plans that has not earned its full withholds, then the Managed Care Plan that did earn its full 2% withhold may be eligible to earn an additional incentive payment from the Quality Bonus Pool based on the percentage of Total Quality Points earned to maximum number of points possible.

   (b) If every Managed Care Plan receives its full 2% withhold, then there will not be a Quality Bonus Pool available for distribution that year.

(7) The Agency reserves the right during the Contract term to change the Quality Withhold Incentive.

(8) The Managed Care Plan may use designations and rankings related to high performance on performance measures given by and as approved by the Agency.

(9) The below example is provided to illustrate the quality withhold incentive. The Managed Care Plan data in this example are fictitious. Identification with an actual Managed Care Plan is neither intended nor should be inferred.

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Example: Quality Withhold Incentive

After one (1) year of Contract implementation, three (3) Managed Care Plans were evaluated by quality performance measures described in **Section VIII.**, Quality, of the Contract. The three (3) Managed Care Plans' pertinent financial and quality performance data are presented in Table IV, Quality Withhold Incentive Results Example.

Table IV. Quality Withhold Incentive Results Example

Description	Row Label	Plan 1	Plan 2	Plan 3	Total
Total Revenue:	**A**	$750,000,000	$1,500,000,000	$1,450,000,000	**$3,700,000,000**
Withhold Percentage of Revenue:	**B**	2.00%	2.00%	2.00%	
Potential Quality Bonus Pool Percentage of Revenue:	**C**	2.00%	2.00%	2.00%	
Total Withhold:	**D: A x B**	$15,000,000	$30,000,000	$29,000,000	**$74,000,000**
Quality Points Available:	**E**	50	50	50	
Quality Points Earned:	**F**	29	21	17	
Quality Points Needed to Earn Back Total Withhold:	**G**	20	20	20	
	Withhold Earned Back				
Withhold Earned Back:	**H: If F ≥ G then D Else (F / G) x D**	$15,000,000	$30,000,000	$24,650,000	**$69,650,000**
Withhold % Returned:	**I: H / A**	2.00%	2.00%	1.70%	**1.88%**
	Quality Bonus Pool Distribution				
Funds Available in Quality Bonus Pool:	**J: D - H**	$0	$0	$4,350,000	**$4,350,000**
Maximum Quality Bonus Pool Earned Percentage:	**K: If F ≥ G, then C * (F - G)/(E - G) Else N/A**	0.600%	0.067%	N/A	
Maximum Quality Bonus Pool Eligible to Receive:	**L: K x A**	$4,500,000	$1,000,000	N/A	**$5,500,000**
Distribution % of Maximum Quality Bonus Pool:	**M: Minimum(100%, J_{TOTAL} / L_{TOTAL})**	79.09%	79.09%	N/A	**79.09%**
Total Distribution of Quality Bonus Pool:	**N: L x M**	$3,559,091	$790,909	N/A	**$4,350,000**
	Total Withhold Distribution				
Withhold Earned Back:	**O: H**	$15,000,000	$30,000,000	$24,650,000	**$69,650,000**
Quality Bonus Pool:	**P: N**	$3,559,091	$790,909	N/A	**$4,350,000**
Total Withhold Earned	**Q: O + P**	$18,559,091	$30,790,909	$24,650,000	**$74,000,000**
Total % Withhold Earned	**R: Q / A**	**2.47%**	**2.05%**	**1.70%**	**2.00%**

Step 1 – Withhold Return

With 2% of total revenue withheld for quality performance incentive, Plan 1 had $15,000,000 withheld, Plan 2 had $30,000,000 withheld, and Plan 3 had $29,000,000 withheld.

According to quality performance results, Plan 1 earned 29 of a maximum of 50 Quality Points, Plan 2 earned 21 of 50 Quality Points, and Plan 3 earned 17 of 50 Quality Points.

In the SMMC contract, 20 Quality Points or greater is required to earn back the entire 2% withhold amount. Since Plan 1 and Plan 2 earned more than 20 Quality Points, they earned back their entire withhold amounts. Plan 1 earned back $15,000,000. Plan 2 earned back $30,000,000.

Since Plan 3 earned less than 20 Quality Points, they earned back a percentage of their withhold amount. The amount earned back by Plan 3 ($24,650,000) was calculated by dividing their earned Quality Points (17) by the minimum threshold of Quality Points (20), and then multiplying that fraction (0.85) times their original quality withhold amount ($29,000,000).

Step 2 – Funds Available for Quality Bonus Pool

With Plans 1 and 2 earning back their entire 2% quality withhold amounts, they contributed no amount of money to the Quality Bonus Pool. However, since Plan 3 did not earn their entire withhold amount because of lower quality performance, their leftover amount of $4,350,000 was entered into a Quality Bonus Pool.

Step 3 – Distribution of Quality Bonus Pool

Since Plans 1 and 2 earned more than 20 Quality Points because of higher quality performance, they were eligible to receive distributions from the Quality Bonus Pool.

Based on quality performance, as calculated by earned Quality Points divided by maximum Quality Points possible, Plan 1 received more of the Quality Bonus Pool distribution compared to Plan 2.

Specifically, the maximum percentage that Plan 1 was eligible to receive from the Quality Bonus Pool was 0.60% of their total revenue

based on their performance of 29 Quality Points. If Plan 1 had earned 50 points of a maximum 50 points, then Plan 1 would have been eligible for a maximum of 2% of total revenue from the Quality Bonus Pool. However, with 29 of 50 points earned, the maximum amount eligible for Plan 1 was $4,500,000, assuming there was enough in the Quality Bonus Pool for all qualifying plans.

Plan 2 was eligible to receive a maximum of 0.067% of their total revenue based on their performance of 21 Quality Points. The maximum amount eligible for Plan 2 was $1,000,000, assuming there was enough in the Quality Bonus Pool for all qualifying plans.

Together, the maximum eligible amount for Plans 1 and 2 from the Quality Bonus Pool was $5,500,000. However, since only $4,350,000 was entered into the Quality Bonus Pool, then only 79.09% (calculated by $4,350,000 divided by $5,500,000 times 100%) of the maximum was available for distribution to the qualifying plans, Plan 1 and Plan 2. In specific, $3,559,091 was distributed from the Quality Bonus Pool to Plan 1 and $790,909 to Plan 2.

In total, because of Plan 1's higher performance, they earned 2.47% from the 2% quality withhold arrangement. Because of Plan 2's average performance, they earned 2.05% from the 2% quality withhold arrangement. And because of Plan 3's poor quality performance, they earned 1.70% from the 2% quality withhold arrangement.

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d. Financial Consequences and Liquidated Damages

(1) The Managed Care Plan agrees that failure to comply with any provisions of this Contract and 42 CFR 438.100 may result in the assessment of sanctions; temporary enrollment limitations, such as temporary enrollment freezes, enrollment algorithm reductions, and/or enrollment caps; and/or termination of this Contract, in whole or in part.

(2) If the Managed Care Plan's performance is not consistent with the Agency's expected minimum standards, as specified in this Sub-Section, 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 in **Attachment** II **Exhibit II-A, Section XII.**, Sanctions and Corrective Action Plans, **Sub-Section C.**, Performance Measure Sanctions, and temporary enrollment limitations, such as temporary enrollment freezes, enrollment algorithm reductions, and/or enrollment caps, in accordance with **Section XII.**, Sanctions and Corrective Action Plans, **Sub-Section A.**, Contract Violations and Non-Compliance, for poor performance, as specified in this Contract and its Exhibits.

e. Enrollment Freezes and Corrective Action Plans

Section 409.977(1), F.S., directs the Agency not to automatically enroll recipients in a plan that is deficient in performance or quality standards established by the Agency pursuant to Section 409.967, F.S.

(1) The Managed Care Plan shall be subject to enrollment limitations when the Managed Care Plan repeatedly fails to meet substantive requirements in **Section V.**, Service Administration; **Section VII.**, Provider Network and Services; and/or **Section VIII.**, Quality, of this Contract.

(2) If a CAP is required as determined by the Agency, the Managed Care Plan's proposed CAP shall be approved or disapproved by the Agency. If the Agency disapproves the CAP, the Managed Care Plan shall submit a new CAP within ten (10) business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency. The Managed Care Plan shall accept and implement an Agency-defined CAP if required by the Agency.

(3) The Agency may impose enrollment limitations on the Managed Care Plan until the Managed Care Plan implements, to the satisfaction of the Agency, the approved CAP.

(4) The Agency may impose temporary enrollment limitations, such as temporary enrollment freezes, enrollment algorithm reductions, and/or enrollment caps, in accordance with **Section XII.**, Sanctions and Corrective Action Plans, **Sub-Section A.**, Contract Violations and Non-Compliance, for poor performance, as specified in this Contract and its Exhibits.

2. Value-Based Purchasing (VBP) Programs

   a. The Managed Care Plan shall develop and implement a value-based purchasing (VBP) program to maximize high value care, reduce inappropriate care, and reward best-performing providers. The VBP program must comply with the Agency's value-based insurance design parameters described below in General VBP Agreement Requirements. The Managed Care Plan shall include VBP agreements between subcontracted provider networks and providers. The Managed Care Plan shall submit all encounter claims relevant to its VBP agreements in accordance with **Attachment II**, **Section IX.**, Administration and Management, of the Contract. The Agency reserves the right during the Contract term to modify the mandatory program parameters, performance metrics, data sharing, and reporting requirements.

   b. Value-Based Purchasing (VBP) Program Parameters

      (1) The goals of the VBP program are to maximize high value care, reduce inappropriate care, and reward best-performing providers.

      (2) The Managed Care Plan's VBP Program shall include contractual agreements with providers focused on defined populations.

   c. The Managed Care Plan shall use the following definitions of patient populations covered in VBP agreements between plans and providers.

      (1) Population-Based: Payments applied to a broad population for most of their care. Examples may include, but are not limited to, Accountable Care Organization (ACO) Models, Global Capitation, or Total Cost of Care Shared Savings/Risk.

      (2) Targeted Population-Based: Payments applied to a specific population based on chronic condition or diagnosis. Examples may include but are not limited to: Chronic Kidney Disease (CKD), Diabetes, Serious Mental Illness and Substance Use Disorder, Justice-Involved Individuals, HIV/AIDS, or people with intellectual disabilities and developmental disabilities.

      (3) Enhanced Primary Care: Primary care providers receive enhanced payment (e.g., Per Member Per Month (PMPM) care management fee or capitation payment) for providing enhanced set of primary care services to attributed patients. Examples may include, but are not limited to, Primary Care Medical Home (PCMH) Models, Comprehensive Primary Care Plus (CPC+), Primary Care First, or Acute Unscheduled Care Model (AUCM).

      (4) Targeted Enhanced Primary Care: Primary care providers receive enhanced payment (e.g., PMPM care management fee or capitation payment) for providing enhanced set of primary care services to a specific population of attributed patients with a chronic condition or diagnosis. Examples may include, but are not limited to, Integrated Care for Kids (InCK) Model, Patient-Centered Asthma Care Payment (PCACP), Patient-Centered Oncology Payment (PCOP), Patient-

Centered Payment for Care of Chronic Conditions, Patient-Centered Epilepsy Care Payment (PCECP), or Patient-Centered Headache Care Payment (PCHCP).

(5) Episode-Based: Payment applied to target population for episode care defined by a time period and/or specific diagnoses or procedures. Examples may include, but are not limited to, Asthma, Attention deficit and hyperactivity disorder (ADHD), Cancer, Cholecystectomy, Colonoscopy, congestive heart failure (CHF) exacerbation, chronic obstructive pulmonary disease (COPD) exacerbation, Dental emergency department visits, Esophagogastroduodenoscopy, Gastrointestinal bleed, Headache, Low back pain, Maternity, Mental Illness, Neonatal (low-risk), Osteoarthritis, Otitis media, Pediatric acute lower respiratory infection, Perinatal emergency department visits, Skin and soft tissue infections, Substance Use Disorders, Upper respiratory infection, Urinary tract infection, or Wound care.

(6) Quality: Bonus payments or penalties to providers for quality reporting or performance that align with the Agency's performance measures described in **Section VIII.**, Quality, of this Exhibit.

(7) Foundational Payments for Infrastructure & Operations: Payments to providers to support advancement toward value-based payment agreements. Examples may include, but are not limited to, Care Coordination Fees (PMPM or Lump Sum), Health Information Technology Investment, or Investment in Payment Reform or Supplemental Payments to Address Health-Related Social Needs.

d. The Managed Care Plan shall use the Learning Action Network (LAN)'s alternative payment framework to categorize its VBP agreements with providers. Agreements in categories LAN 3N or 4N are not considered value-based purchasing agreements and are not measured by the Agency. The Agency reserves the right during this Contract term to change the definitions of risk categories.

e. Provider Participation in VBP Agreements with the Managed Care Plan

(1) All providers in a Managed Care Plan's provider network, including subcontracted provider networks, shall be eligible for VBP agreements.

(2) Physicians who qualify for the MMA Physician Incentive Program (MPIP) shall be given the choice to participate in VBP agreements.

(3) If a physician qualifies for MPIP and chooses to participate in a VBP agreement, then the physician's choice must be documented.

(4) If the physician qualifies for the MPIP program and consents to participate in both the MPIP program and a VBP agreement, then payments in the VBP agreement shall be equal to or exceed MPIP payments for the patient populations included in the MPIP.

(5) MPIP agreements between the Managed Care Plan and Providers shall not be considered a VBP agreement but may be used to augment a VBP agreement.

f. General VBP Agreement Requirements

(1) The Managed Care Plan must include the following minimum value-based insurance design parameters in all VBP agreements between the Managed Care Plan and its providers:

(a) A detailed methodology used to attribute enrollees to providers. For primary care providers (PCP), it is recommended that the Managed Care Plan use the enrollees' PCP assignments described in **Section V.**, Service Administration, **Sub-Section D.**, Coverage Provisions, of this Exhibit.

(b) A detailed methodology used to calculate the VBP target budget. The Managed Care Plan is encouraged to use a percent of risk adjusted revenue for the target budget but should also consider the providers' own historical costs to assess adequacy of the target budget. When calculating target budgets, the Managed Care Plan is also encouraged to use the enrollees' area deprivation index or other social vulnerability index rankings to adjust provider risk.

(c) A detailed methodology of regularly sharing data, at a minimum quarterly, with providers that enables proactive care management to achieve performance targets. Shared data shall be in the forms of clinical (e.g., health care utilization, health outcomes, quality performance), financial (e.g., actual expenditures, bonus payments, withholds, shared savings, shared losses), provider's progress relative to achieving agreement targets (e.g., performance and budget), and others pertinent to the VBP agreement. The Managed Care Plan shall offer technical assistance to VBP-participating providers for visualizing and interpreting data.

(d) A list of quality measures used for calculating shared savings or losses, including at least one (1) Tier 1 quality performance measure listed in **Section VIII.**, Quality. The VBP agreement shall be clear on the performance period start and end dates. For providers who have no history of VBP contracting, the VBP agreement may include a ramp-up period prior to the first performance period to allow providers to put in place administrative systems and protocols needed under the VBP agreement.

(2) The VBP agreement shall be clear on the payment and reconciliation terms with providers, including remittance timeframes (for example, monthly, quarterly, or annually) and the process for appealing the payments.

(3) The VBP agreement shall require providers to participate in the Florida Health Information Exchange (HIE) Encounter Notification Service (ENS). The Managed Care Plan shall achieve and maintain ENS participation in one hundred percent (100%) of VBP arrangements.

(3) The VBP agreement shall require providers to participate in the Florida Health Information Exchange (HIE) Encounter Notification Service (ENS). The Managed Care Plan shall achieve and maintain ENS participation in one hundred percent (100%) of VBP arrangements.

(4) The Agency has the right to review any VBP agreement for compliance with minimum requirements.

(5) The Managed Care Plan shall expend a minimum percentage of payments to providers through VBP agreements in accordance with the Incremental Increase in Expenditures in Value-Based Purchasing Agreements with Providers Table, **Table 4**, below. The percentage of payments in various LAN risk levels are calculated by dividing the measured claim-based expenditures in VBP agreements by the total claim-based expenditures for all enrollees as reported in the Achieved Savings Rebate (ASR). If capitation is paid to providers in lieu of fee-for-service claim reimbursement, then the capitation payment amounts shall be included in the numerator and the denominator. If the Managed Care Plan falls below these minimum percentages, the Agency shall assess liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

TABLE 4 INCREMENTAL INCREASE IN EXPENDITURES IN VALUE-BASED PURCHASING AGREEMENTS WITH PROVIDERS*			
Contract Period	VBP LAN 3A+	VBP LAN 3B+	VBP LAN 4A+
Year 1	10%	5%	0%
Year 2	20%	10%	1%
Year 3	25%	15%	2.5%
Year 4	30%	20%	5%
Year 5	35%	25%	7.5%
Year 6	40%	30%	10%

*The percentages are minimum targets. The plus sign indicates the inclusion of greater risk levels. For example, “3A+” includes LAN risk levels 3A, 3B, 4A, 4B, 4C.

(6) VBP Reporting Requirements. The Managed Care Plan shall report quarterly reports to the Agency on its VBP program in accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

3. Stronger Performance Expectations for Specialty Product Enrollees

a. The Managed Care Plan offering a Specialty Product shall initiate a root cause analysis (RCA) within fourteen (14) days following each of the following events involving an enrollee of its Specialty product:

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(1) Suicide.

(2) Victim of Homicide.

(3) Baker Act of an enrollee aged twenty-one (21) years or younger.

(4) Death of an enrollee within one year of delivery or pregnancy termination.

(5) Death of an enrollee within one (1) year of life.

(6) Victim of abuse, neglect, or exploitation as defined by Section 415.102, F.S.

(7) Sexual battery or altercation requiring medical intervention.

(8) Resident elopement for enrollees in assisted care communities, as defined by Section 429.41, F.S.

b. The RCA shall include, at a minimum, a description of the event, health record review, case management investigation, and interviews to gather data that may not be present in health record documents, identification of causal factors, determination of root causes of causal factors, and actionable recommendations for the Managed Care Plan offering a Specialty Product to prevent the event at the individual level and the population level. The RCA for each event should be completed within thirty (30) days of RCA initiation.

c. The Managed Care Plan offering a Specialty Product shall provide a summary to the Agency each year of its RCA's involving enrollees of its Specialty product. The report must include the following information, at a minimum:

(1) Number and trend of each Serious Adverse Event (SAE) type.

(2) Number of RCAs initiated and completed for each SAE type.

(3) For each SAE type, a compilation of most frequent root causes.

(4) For each SAE type, a compilation of most frequent recommendations for the Managed Care Plan.

4. The Agency will collect and publicly report Managed Care Plan performance data in a manner and format to be determined by the Agency.

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Section II. Eligibility and Enrollment

A. General Provisions

1. The State has sole authority for determining eligibility for Medicaid. The DCF acts as the Agency's agent by enrolling recipients in the Medicaid program.

2. The Agency shall have the sole authority for determining whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Managed Care Plan, or are subject to annual open enrollment. The Agency or its enrollment broker shall be responsible for enrollment, including enrollment into the Managed Care Plan, disenrollment, and outreach and education activities. The Agency shall use an established algorithm to assign mandatory potential enrollees who do not select a Managed Care Plan during their choice period. The process may differ for the Managed Care Plan type as required by Section 409.977, F.S., and Section 409.984, F.S., and any other State law and federally approved State Plan amendments and/or waivers.

3. The Managed Care Plan shall accept Medicaid recipients without restriction in accordance with 42 CFR 438.3(d)(1) and Section 1903(m)(2)(A) of the Social Security Act. The Managed Care Plan shall not discriminate against potential enrollees on the basis of religion, sex, race, color, age or national origin, health status, pre-existing condition or need for health care services and shall not use any policy or practice that has the effect of such discrimination in accordance with 42 CFR 438.3(d)(3) and (4) and 438.3(q)(4). The Managed Care Plan shall coordinate with the Agency and its agent(s) as necessary for all enrollment and disenrollment functions.

4. The Managed Care Plan or its subcontractors, providers, or vendors shall not request enrollment or disenrollment of an enrollee, provide or assist in the completion of enrollment or disenrollment requests for an enrollee, or restrict the enrollee's right to disenroll voluntarily in any way (42 CFR 438.56(b)(1), (2), and (3)).

B. Eligibility

Medicaid recipients as defined in Section 409.965, F.S., shall receive Medicaid covered services through the SMMC program. The Agency shall determine eligibility for enrollment under this Contract. The Agency shall provide the Managed Care Plan a list of recipient aid categories that are eligible to enroll in the managed care program.

C. Enrollment

1. General Provisions

a. The Managed Care Plan shall coordinate with the Agency and its agent(s) for all enrollment functions.

b. The Managed Care Plan shall provide services to Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans.

c. The Agency or its agents shall notify the Managed Care Plan of an enrollee's selection or assignment to the Managed Care Plan by file transfer or other Agency prescribed method. Enrollment in the Managed Care Plan shall be effective at 12:01 a.m. on the effective date of enrollment provided on the Enrollment File.

2. Verification of Enrollment

a. The Managed Care Plan shall review its X12-834 enrollment files to ensure that all enrollees are eligible to receive services from the Managed Care Plan.

b. The Managed Care Plan shall notify the Agency of any discrepancies in enrollment, including enrollees not residing in the same region in which they were enrolled and enrollees not eligible for the Managed Care Plan, within five (5) business days of receipt of the enrollment file (42 CFR 438.608(a)(3)).

3. Temporarily Stopping, Limiting, or Adjusting Enrollment

a. The Managed Care Plan may ask the Agency to halt or reduce enrollment temporarily if continued enrollment would exceed the Managed Care Plan's capacity to provide required services under this Contract.

b. The Agency may limit Managed Care Plan enrollments when such action is in the Agency's or enrollees' best interest in accordance with the provisions of this Contract.

c. The Agency may adjust enrollment through enhanced auto-assignments to high-performing plans, as a performance incentive, as described in **Attachment II**, **Section VIII.** Quality.

d. See **Attachment II**, **Section I.,** General Overview, **Sub-Section H.,** Prioritizing Quality and Value, **Item 1.**, Layered Approach to Drive Continued Improvement, **Sub- Item e.**, Enrollment Freezes and Corrective Action Plans, for enhanced provisions on enrollment penalties.

D. Disenrollment

1. General Provisions

a. The Managed Care Plan shall ensure that it does not restrict the enrollee's right to disenroll voluntarily in any way.

b. The Managed Care Plan or its subcontractors, providers, or vendors shall not provide or assist in the completion of a disenrollment request, except as specified by the Agency (42 CFR 438.56(b)(1)).

c. The Agency shall notify enrollees of their right to request disenrollment. The Agency shall process all enrollee requests to disenroll from the Managed Care Plan. The Agency or its agent shall make final determinations about granting disenrollment requests and shall notify the Managed Care Plan by file transfer and the enrollee by surface mail of any disenrollment decision and the enrollee's right to request a Medicaid Fair Hearing if he or she is dissatisfied with an Agency determination.

d. The Agency shall make disenrollment requests effective no later than the first day of the second month following the month in which the enrollee requests disenrollment or the Managed Care Plan refers the request for involuntary disenrollment to the Agency.

   If the Agency fails to make a disenrollment determination within the specified timeframes, the disenrollment shall be considered approved for the same effective date that would have been established had the Agency made a determination in the specified timeframe (42 CFR 438.56(e)(1) - (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.3(q); 42 CFR 438.56(c)).

2. Voluntary Disenrollment

In addition to the reasons cited in Rule 59G-8.600, F.A.C., the following reason constitutes cause for disenrollment from the Managed Care Plan:

a. The enrollee is an American Indian or Alaskan Native as defined in 42 CFR 438.14(a).

b. The Agency has posed intermediate sanctions on the Managed Care Plan (42 CFR 438.3(q)(5); 42 CFR 438.56(c)(2)(iv)).

3. Involuntary Disenrollment

a. With proper written documentation, the Managed Care Plan may submit involuntary disenrollment requests to the Agency or its enrollment broker in a manner prescribed by the Agency and in accordance with 42 CFR 438.56(b)(1)-(3).

b. The following are acceptable reasons for which the Managed Care Plan may submit an involuntary disenrollment request:

   (1) Fraudulent use of the enrollee identification (ID) card.

   (2) Falsification of prescriptions by an enrollee.

c. The Managed Care Plan shall not request disenrollment of an enrollee due to:

   (1) Health diagnosis

   (2) Adverse changes in an enrollee’s health status

   (3) Utilization of medical services

   (4) Diminished mental capacity

   (5) Pre-existing medical condition

   (6) Attempt to exercise rights under the Managed Care Plan’s enrollee grievance and appeal system

   (7) Referral by a provider of an enrollee to a non-participating provider

(8) The enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Managed Care Plan's ability to furnish services to the enrollee or other enrollees).

(42 CFR 438.3(q)(5); 42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i) - (iii)).

d. The Managed Care Plan shall ensure that involuntary disenrollment documents are maintained in the enrollee record.

e. When the Managed Care Plan submits a request to the Agency for an involuntary disenrollment of an enrollee, the Managed Care Plan shall notify the enrollee in writing of the request for disenrollment, the reason for the request, and an explanation that the Managed Care Plan is requesting that the enrollee be disenrolled in the next Contract month, or earlier if necessary, pending an Agency decision. Until the enrollee is disenrolled, the Managed Care Plan shall be responsible for the provision of services to that enrollee.

f. The Agency shall review all disenrollment requests on a case-by-case basis, and it is at the sole discretion of the Agency to approve or deny such requests. Any request not approved is final and not subject to Managed Care Plan dispute or appeal. The Managed Care Plan shall notify the enrollee in writing of the decision.

E. Medicaid Redetermination Assistance

1. The Agency shall provide the Managed Care Plan with Medicaid recipient redetermination date information.

2. The Managed Care Plan shall provide Medicaid redetermination assistance to enrollees receiving nursing facility services and home and community-based services as described in the applicable Exhibit(s).

3. For all other enrollees, the Managed Care Plan shall request prior written approval from the Agency to assist with Medicaid eligibility redetermination to enrollees in order to promote continuous Medicaid eligibility.

4. A Managed Care Plan that chooses to participate in the use of this information shall provide its procedures regarding this Sub-Section to the Agency for its approval.

5. Should any complaint or investigation by the Agency result in a finding that the Managed Care Plan has violated this Sub-Section, the Agency may sanction the Managed Care Plan in accordance with **Section XII.**, Sanctions and Corrective Action Plans.

a. The Agency may impose a thirty (30)-day suspension of the Managed Care Plan's use of Medicaid redetermination dates for the first such violation.

b. The Agency may impose additional sanctions for additional or subsequent violations, up to and including the Agency's rescinding its approval to use redetermination date information.

Section III. Marketing

A. General Provisions

1. The Managed Care Plan shall ensure compliance with all State and federal marketing requirements and SMMC Marketing Guidelines, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the Managed Care Plan (42 CFR 438.104; Section 409.912, F.S.; s. 641.3901, F.S.; s. 641.3903, F.S.; s. 641.386, F.S.; s. 626.112, F.S.; s. 626.342, F.S.; s. 626.451, F.S.; s. 626.471, F.S.; s. 626.511, F.S.; s. 626.611, F.S.; s. 626.9541, F.S., and s. 626.9521, F.S.).

2. The Managed Care Plan shall not market nor distribute any marketing materials without first obtaining Agency approval (42 CFR 438.104(b)(1)(i)).

3. The Managed Care Plan shall ensure that marketing, including marketing plans and materials, is accurate and does not mislead, confuse, or defraud recipients or the Agency (42 CFR 438.104(b)(2)). The Managed Care Plan shall not distribute marketing materials that are materially inaccurate, misleading, or otherwise make material misrepresentations.

4. The Managed Care Plan may participate in social networking (e.g., Facebook, X (formerly Twitter), Scan Code, YouTube, LinkedIn, Instagram or QR Code) in accordance with the requirements of this Contract and federal and State law. Websites and social/electronic media posts that contain marketing content must be submitted to the Agency for review and approval.

5. The Managed Care Plan shall not engage in unfair methods of competition or unfair or deceptive acts or practices as defined in s. 641.3903, F.S., and s. 626.9541, F.S.

6. In accordance with Section 409.912, F.S., marketing to enrollees or potential enrollees in State offices or any location where eligibility is determined is prohibited. The Managed Care Plan shall not use any other State office or any location where eligibility is determined in the retention of enrollees or recruitment of potential enrollees, including Department of Children and Families community partner sites.

7. The Managed Care Plan must provide an opt-out process for enrollees and potential enrollees who previously voluntarily agreed to receive email or other electronic communications to no longer receive such communications.

B. Prohibited Statements and Claims

The Managed Care Plan shall not, whether orally or in writing:

1. Claim that a Medicaid recipient must enroll in the Managed Care Plan to obtain or to not lose Medicaid benefits or any other health or welfare benefits (42 CFR 438.104(b)(2)(i)).

2. Claim that the Managed Care Plan is recommended or endorsed by CMS, the federal or State government, or similar entity (42 CFR 438.104(b)(2)(ii)).

3. Claim that the State or the county recommends that a Medicaid recipient enroll with the Managed Care Plan.

4. Claim that marketing agents are employees of the federal, State, or county government, or of anyone other than the Managed Care Plan or the organization by whom they are reimbursed.

5. The Managed Care Plan may not compare itself to another Managed Care Plan, verbally or in writing, unless the Managed Care Plan can support the comparison and such comparisons are factually based and not misleading.

C. Prohibited Activities

1. The Managed Care Plan shall not enlist the assistance of any government employee, government officer, elected official, or the State's enrollment broker in recruitment of potential enrollees or the retention of enrollees.

2. The Managed Care Plan shall not provide any gift, commission, or any form of compensation to the enrollment broker, including its full-time, part-time, or temporary employees and subcontractors.

3. The Managed Care Plan shall not, directly or indirectly, engage in door-to-door, telephone, email, texting or other cold-call marketing activities or market through unsolicited contacts (42 CFR 438.104(b)(1)(v)).

4. If the Managed Care Plan receives permission to call or otherwise contact an enrollee or potential enrollee, the Managed Care Plan shall treat the permission as event-specific and shall not interpret the permission as an open-ended permission to contact the enrollee or potential enrollee after the enrollee or potential enrollee's inquiry or questions have been answered by the Managed Care Plan.

5. The Managed Care Plan shall not rent or purchase email lists to distribute information about its Medicaid Managed Care Plan to enrollees or potential enrollees.

6. The marketing agent shall not make unsolicited offers of business cards directly to attendees of marketing events.

7. The Managed Care Plan shall not treat social media interactions (e.g., like, comment, follow a Managed Care Plan, or participation in a virtual event) on social/electronic media as an agreement to receive Managed Care Plan communications outside the social media forum, unless there is a request for follow-up from the plan. The Managed Care Plan shall not address subjects beyond the question or statement initiated by the individual.

8. The Managed Care Plan marketing agents shall not visit a resident of a long-term care facility (e.g., nursing homes, assisted living facilities, board and care homes), or an individual receiving services from any other facility or organization that provides residential, temporary supervision and/or health care assistance, unless requested by the individual or the individual's guardian.

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D. Marketing of Multiple Lines of Business

1. The Managed Care Plan shall not influence enrollment in conjunction with the sale or offering of any private insurance (42 CFR 438.104(b)(1)(iv)).

2. The Managed Care Plan shall ensure that marketing materials requested by enrollees or potential enrollees describing other health-related lines of business contain instructions that describe how enrollees and potential enrollees may opt out of receiving such communications. The Managed Care Plan shall not send such communications to enrollees or potential enrollees who have asked to opt out of receiving future marketing communications about other lines of business.

3. If the Managed Care Plan advertises multiple lines of business within the same marketing material or at the same event, it shall keep the Managed Care Plan's other lines of business clearly and understandably distinct from the Medicaid Managed Care Plan.

4. The Managed Care Plan shall not include enrollment applications for other health-related lines of business in Medicaid managed care marketing materials.

E. Marketing Agents

1. The Managed Care Plan shall only use appointed and licensed insurance agents to conduct face-to-face and telephonic marketing in the State of Florida, to market to enrollees and potential enrollees. The Managed Care Plan shall ensure all such marketing agents or representatives comply with s. 626.112, F.S.

2. The Managed Care Plan shall report new marketing agents to the Agency as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

3. The Managed Care Plan shall ensure that all marketing agents (including employed agents) are trained annually on State and federal requirements and on details specific to the Managed Care Plan. The Managed Care Plan shall ensure that its training programs are made available to the Agency upon request.

4. The Managed Care Plan shall report to the Agency any marketing agent who violates any requirements of this Contract, within fifteen (15) days of knowledge of such violation. The Managed Care Plan shall submit reports to the Agency as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

5. The Managed Care Plan shall report the termination of any marketing agents to the Agency, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

6. The Managed Care Plan shall ensure that all marketing agents at marketing events display a Managed Care Plan nametag that includes the Managed Care Plan's name, logo, and agent's name. The Managed Care Plan shall have business cards available to attendees of events.

F. Telephonic Activities and Scripts

1. The Managed Care Plan may do the following activities:

   a. Call enrollees or potential enrollees who have expressly given permission for the Managed Care Plan to contact them.

   b. Return phone calls or messages from enrollees or potential enrollees, as these are not unsolicited.

   c. Transfer calls to a marketing agent only at the proactive request of the enrollee or potential enrollee.

   d. Clearly inform the enrollee or potential enrollee of any change in the nature of a call from informational to marketing. This shall be done with the full and active concurrence of the enrollee or potential enrollee with a yes/no question.

2. The Managed Care Plan shall not engage in the following activities:

   a. Including information about other lines of business in scripts.

   b. Conducting unsolicited calls about other business as a means of generating leads for the Managed Care Plan.

   c. Conducting calls based on referrals. If an enrollee would like to refer a friend or relative to the Managed Care Plan, the Managed Care Plan may provide contact information such as a business card that the enrollee may give to the friend or family member. In all cases, a referred individual needs to contact the Managed Care Plan directly.

   d. Conducting calls to former enrollees or to enrollees who are in the process of voluntarily disenrolling, for the purpose of marketing the Managed Care Plan or other products, except for marketing information provided as part of the Managed Care Plan's Hope Florida program.

   e. Conducting calls to enrollees or potential enrollees to confirm receipt of marketing material, with the exception of marketing information provided as part of the Managed Care Plan's Hope Florida program.

   f. Using language in scripts that imply the Managed Care Plan is endorsed by the Agency, calling on behalf of the Agency, or that the Agency asked the Managed Care Plan to call the recipient.

3. Any marketing scripts must be prior approved by the Agency. The Managed Care Plan shall submit all marketing scripts verbatim (bullets or talking points are unacceptable).

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G. Standards for Marketing Materials

The Managed Care Plan shall submit Medicaid marketing material or changes in marketing materials to the Agency for review and approval prior to use.

1. The following components constitute marketing material:

   a. Enrollment information.

   b. Benefit information.

   c. Plan-specific information (beyond allowable plan name, logo, tagline, phone number, or website).

   d. Verbiage intended to draw a potential enrollee's attention or retain an enrollee in the Managed Care Plan.

   e. Calls to action.

   f. Testimonials and endorsements.

2. The following types of marketing materials are subject to review by the Agency:

   a. Branding materials.

   b. Scripts, including marketing scripts (presentations), telephonic scripts, and broadcast scripts (television, radio, and social media).

   c. Written materials.

3. The Managed Care Plan shall submit marketing material to the Agency by the fifth (5th) of each month before the proposed use of the marketing material or revised material, or as prescribed by the Agency.

4. The Managed Care Plan shall submit all materials in "publication ready" form, including a sample of each version if the Managed Care Plan intends to use several versions. Each material must be submitted separately to the Agency for review.

5. The Managed Care Plan shall conduct a quality check and ensure that all materials are consistent with this Contract and State and federal requirements prior to submitting materials for review to the Agency. Generally, the Agency will not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.

6. The Managed Care Plan shall ensure that all marketing materials comply with the standards for written materials specified in **Section III.**, Marketing, **Sub-Section A.**, General Provisions. The Managed Care Plan shall submit readability scores with its marketing material, denote any redacted wording, and ensure that all materials submitted

for approval are at or near the fourth (4th) grade comprehension level. The Managed Care Plan may exclude the following from the readability score: addresses, phone numbers, PCP, department names, required disclaimers, medical terminology, medical conditions, proper names, legal terms, and words that cannot be easily substituted.

7. The Managed Care Plan shall include the following statements and disclaimers verbatim in any marketing materials that include information on benefits:

   a. “[insert Managed Care Plan’s legal or marketing name] is a Managed Care Plan with a Florida Medicaid Contract.”

   b. “The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the Managed Care Plan.”

   c. “[Limitations, copayments, and/or restrictions] may apply.”

   d. “[Benefits, formulary, pharmacy network, premium and/or co-payments/co- insurance] may change.”

8. The Managed Care Plan shall include a written statement on all marketing materials promoting drawings, prizes, or any promise of a free gift that there is no obligation to enroll in the Managed Care Plan. For example, “Eligible for a free drawing and prizes with no obligation.” or “Free drawing without obligation.”

9. The Managed Care Plan shall ensure that advertisements and invitations to marketing and enrollee educational events include the following two statements on marketing materials:

   a. “A health plan representative will be present with information.”

   b. “For accommodation of persons with special needs at marketing or enrollee educational events call <insert phone and TTY number>.”

10. The Managed Care Plan shall include a Teletypewriter Telephone (TTY) number in conjunction with the Managed Care Plan’s toll-free customer service number. This requirement does not apply to outdoor advertising, banner/banner-like ads, radio ads, or marketing and telephonic scripts.

11. The Managed Care Plan shall include the Enrollment Broker number and TTY/TDD number in any marketing materials that contain enrollment information.

12. The Managed Care Plan shall ensure all written marketing materials comply with non-discrimination requirements specified in **Section IX.**, Administration and Management, **Sub-Section B.**, Organizational Governance and Staffing, **Item 6.**, Non-discrimination Compliance Requirements. The Managed Care Plan shall include a statement on all marketing materials regarding their non-discrimination policies in accordance with the Nondiscrimination Final Rule, Section 1557 of the Affordable Care Act.

13. The Managed Care Plan shall make all written marketing materials available in multiple

languages, as prescribed by the Agency. Upon request, the Managed Care Plan shall notify enrollees or potential enrollees that information is available in alternative formats and how to access those formats (42 CFR 438.10(d)(3)).

14. The Managed Care Plan must include the following Long-Term Care enrollment information on Long-Term Care marketing materials that contain enrollment information, in additional to the Enrollment Broker's contact information:

    To become an LTC member, the following steps must be completed prior to selecting a LTC Plan:

    1. *Screening*
    2. *Eligibility*
    3. *Enrollment*

    The following link outlines the steps to become enrolled in the LTC program:
    https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/long-term-care-program

H. Use of Superlatives in Marketing Materials

1. The Managed Care Plan may use statements in its logos and in its product taglines (e.g., "Your health is our major concern," "Quality care is our pledge to you," "). The Managed Care Plan shall not use superlatives in logos/product taglines (e.g., "XYZ plan means the first in quality care" or "XYZ plan means the best in managed care").

2. The Managed Care Plan may not use absolute superlatives (e.g., "the best," "highest ranked," "rated number 1"), unless they are substantiated with supporting data provided to the Agency as a part of the marketing review process.

3. See **Attachment II**, **Section I.**, General Overview, **Sub-Section H.**, Prioritizing Quality and Value, **Item 1.**, Layered Approach to Drive Continued Improvement, **Sub-Item c.**, Quality Withhold Incentive, **Part (8)** for enhanced provisions on use of superlatives for high-performing plans.

I. Nominal Gifts

1. The Managed Care Plan may distribute nominal gifts as long as the gifts are provided regardless of enrollment. The Managed Care Plan shall obtain Agency approval before distributing any nominal gifts.

2. The Managed Care Plan shall adhere to the following requirements for nominal gift submissions.

    a. Ensure nominal gifts do not include more than the Managed Care Plan name, logo, product tagline, telephone contact number and/or website.

b. Include a cost verification sheet for each nominal gift submitted.

c. Submit all nominal gifts and indicate all plan information that will be included on the nominal gift.

3. The Managed Care Plan shall ensure the following for nominal gifts offered by the Managed Care Plan:

   a. If a nominal gift is one large gift that is available for all in attendance, the total retail cost must be fifteen dollars (**$15**) or less per person when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.

   b. Nominal gifts may not be in the form of cash, gift card/certificates, vouchers, or other monetary rebates.

4. The Managed Care Plan shall ensure that any nominal gifts provided by the Managed Care Plan:

   a. Are offered to all individuals regardless of enrollment and without discrimination.

   b. Are not items that are considered a health benefit (i.e., a free checkup).

   c. Do not consist of lowering or waiving co-payment.

   d. Are not used or included with the enrollee handbook.

   e. Do not inappropriately influence the enrollee's selection of a provider, practitioner, or supplier of any item or service.

   f. Are not tied directly or indirectly to the provision of any other covered item or service.

5. The Managed Care Plan shall track and document nominal gifts given to enrollees. The Managed Care Plan is not required to track nominal gifts distributed during marketing activities on a per person basis; however, the Managed Care Plan shall not structure event activities with the intent to give potential enrollees or enrollees gifts in excess of a maximum value of seventy-five dollars (**$75**) per person, per year.

6. The Managed Care Plan shall not provide meals (or have meals subsidized) at marketing events.

J. Regional Distribution of Marketing Materials

1. If the Managed Care Plan markets, it shall distribute marketing materials to the entire region served by the Managed Care Plan (42 CFR 438.104(b)(1)(ii)).

2. The Managed Care Plan shall not advertise outside of its contracted region(s) unless such

advertising is unavoidable. For situations in which this cannot be avoided (e.g., advertising in print or broadcast media with a statewide audience or with an audience that includes some individuals outside of the region), the Managed Care Plan shall clearly disclose all counties in the applicable region(s) in which the plan is contracted.

3. If the Managed Care plan is a joint enterprise, it shall market the Managed Care Plan under a single name throughout the region.

K. References to Studies

1. The Managed Care Plan may only compare itself to another Managed Care Plan by referencing an independent study. If the Managed Care Plan references a study in any marketing material, it must provide all the following information, either in the text or as a footnote, on the marketing material:

    a. Reference information (e.g., publication, date, page number).

    b. Information about the Managed Care Plan's relationship with the entity that conducted the study including funding source.

    c. The study sample size and number of Managed Care Plans surveyed (unless the study that is referenced is a CMS or Agency study).

    d. The name of the organization sponsoring the study.

    e. Statement that the study/survey or statistical data is not endorsed by the Agency.

2. The Managed Care Plan shall not compare itself to another Managed Care Plan by name unless it has written permission from all Managed Care Plans being compared and include this documentation with the Managed Care Plan's marketing submission.

3. The Managed Care Plan shall only use Plan-specific quality indicators to compare the plan's previous performance to the plan's current performance. Substantiating data must be provided to the Agency as a part of the marketing review process.

L. Product Endorsements/Testimonials

1. The Managed Care Plan shall ensure that all product endorsements and testimonials adhere to the following:

    a. The speaker must identify the Managed Care Plan by name.

    b. If an individual is paid to portray a real or fictitious situation, the ad must clearly state it is a "Paid endorsement."

2. An enrollee may offer endorsement of the Managed Care Plan, provided the enrollee is a current enrollee and voluntarily chooses to endorse the Managed Care Plan.

3. Any endorsement or testimonial by an individual shall not use any quotes by physicians or other health care providers.

4. The endorsement or testimonial shall not use negative testimonials about another Managed Care Plan.

5. The Managed Care Plan shall not pay or compensate enrollees or potential enrollees in any way to endorse or promote the Managed Care Plan.

6. Re-publication of an individual user's content or comment(s) that promote a Managed Care Plan from social/electronic media sites is considered a product endorsement/testimonial and must adhere to the requirements of this Section.

7. Materials containing testimonials and/or endorsements are subject to Agency approval prior to distribution or reproduction on social/electronic media sites. These materials must meet all applicable requirements of **Section III.**, Marketing.

M. Marketing Events

1. The Managed Care Plan shall obtain Agency approval prior to conducting any marketing events.

2. At a marketing event, the Managed Care Plan shall not:

   a. Conduct health screening or other like activities that could give the impression of "biased selection."

   b. Require enrollees or potential enrollees to provide any contact information as a prerequisite for attending the event. The Managed Care Plan shall clearly indicate on any sign-in sheets that completion of any contact information is optional.

3. The Managed Care Plan may use personal contact information to notify enrollees or potential enrollees of raffle or drawing winnings.

4. The Managed Care Plan shall notify the Agency of any change of plan attendance in advance of the scheduled event, including event cancellation and instances where the event is not cancelled but the Managed Care Plan has decided not to attend. The Managed Care Plan shall report any changes to an event via a variable report, as specified in **Section XV.**, Accountability, **Sub-Section B.**, Managed Care Plan Reporting Requirements, and the Managed Care Plan Report Guide.

5. If a marketing event is cancelled or the Managed Care Plan has decided not to attend less than forty-eight (48) hours before its originally scheduled date and time, the Managed Care Plan shall:

   a. Ensure a Managed Care Plan appointed and licensed marketing agent is present at the site of the event, at the time that the event was scheduled to occur, to inform enrollees and potential enrollees of the cancellation or decision not to attend and distribute information about the Managed Care Plan.

   b. Ensure a Managed Care Plan appointed and licensed marketing agent remains onsite at least fifteen (15) minutes after the scheduled start of the event. If the event was cancelled due to inclement weather, a Managed Care Plan marketing agent is not required to be present at the site.

6. If a marketing event is cancelled or the Managed Care Plan decides not to attend more than forty-eight (48) hours before the originally scheduled date and time, the Managed Care Plan shall notify enrollees and potential enrollees of the cancellation or decision by the Managed Care Plan not to attend through the same means the Managed Care Plan used to advertise the event. A Managed Care Plan's appointed and licensed marketing agent is not required to be present at the site.

7. All marketing events shall be reported to the Agency, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

N. Individual Marketing Appointments

1. All individual marketing appointments with enrollees or potential enrollees are considered marketing events.

2. The Managed Care Plan shall only discuss those products that have been agreed upon by the enrollee or potential enrollee for that appointment ("scope of appointment"). If other products need to be discussed at the request of the potential enrollee, the Managed Care Plan shall document a second scope of appointment for the new product type and then the marketing appointment may be continued.

3. Each scope of appointment for an individual marketing event must be documented either in writing, in the form of a signed, dated agreement by the enrollee or potential enrollee, or a recorded oral agreement. The Managed Care Plan is allowed and encouraged to use a variety of technological means to fulfill the requirement to document each scope of appointment requirement, including conference calls, fax machines, designated recording line, pre-paid envelopes, and email.

4. An enrollee or potential enrollee may set a scope of appointment at a marketing event for a future individual marketing appointment.

5. The Managed Care Plan shall submit all business reply cards for documenting enrollee or potential enrollee scope of appointment or agreement to be contacted to the Agency. The Managed Care Plan shall include a statement on the business reply card informing the enrollee or potential enrollee that a marketing agent will call as a result of the enrollee or potential enrollee returning a business reply card.

6. If the Managed Care Plan has a pre-scheduled appointment that becomes a "no-show," the Managed Care Plan may leave information at the no-show enrollee or potential enrollee's residence.

7. The Managed Care Plan shall not:

    a. Market non-health care related products (such as annuities or life insurance).

    b. Ask an enrollee or potential enrollee for referrals.

8. The Managed Care Plan shall report all individual marketing appointments to the Agency, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

O. Marketing in the Health Care Setting

1. The Managed Care Plan shall not conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

2. The Managed Care Plan shall not conduct marketing in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

P. Provider-Based Activities

1. If the Managed Care Plan chooses to utilize its provider network to distribute marketing materials, the Managed Care Plan shall ensure through its provider agreements that providers shall remain neutral.

2. The Managed Care Plan may permit providers to make available and/or distribute Managed Care Plan marketing materials as long as the provider does so for all Managed Care Plans with which the provider participates.

3. The Managed Care Plan may permit providers to display posters or other materials in common areas, such as the provider's waiting room.

4. The Managed Care Plan may permit LTC facilities to provide materials in admission packets announcing all Managed Care Plan contractual relationships.

5. The Managed Care Plan may not permit providers to:

   a. Offer marketing/appointment forms.

   b. Make phone calls or direct, urge, or attempt to persuade potential enrollees to enroll or enrollees to remain enrolled in the Managed Care Plan based on financial or any other interests of the provider.

   c. Mail marketing materials on behalf of the Managed Care Plan.

   d. Offer anything of value to retain enrollees or persuade potential enrollees to select them as their provider or to enroll in a particular Managed Care Plan.

   e. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.

6. Provider Affiliation Information

   a. Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).

   b. Providers may make new affiliation announcements within the first thirty (30) days of the new provider agreement.

   c. Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.

   d. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider has agreements.

7. Materials that indicate the provider has an affiliation with certain Managed Care Plans and that only list Managed Care Plan names, logos, product taglines, telephone contact numbers, and/or websites do not require Agency approval.

Q. Public Events

1. The Managed Care Plan may conduct, participate in, or sponsor public events. Such events must be held in a public venue. At such events, the Managed Care Plan may distribute public event materials. Public event materials do not require Agency review or approval.

2. The Managed Care Plan may conduct the following permissible activities at public events:

   a. Distribute public event material with the Managed Care Plan name, logo, product tagline, telephone contact number and/or website.

   b. Distribute approved nominal gifts at public events, as described in **Section III.**, Marketing, **Sub-Section I.**, Nominal Gifts.

   c. Display banners, posters, or other displays with the Managed Care Plan name, logo, product tagline, telephone contact number, and/or website.

   d. The Managed Care Plan must comply with cost and limitations associated with nominal gifts in **Section III.**, Marketing, **Sub-Section I.**, Nominal Gifts.

3. The Managed Care Plan shall not do the following with regard to public events:

   a. Hold a public event at the home of an individual.

   b. Conduct one-on-one appointments.

   c. Conduct marketing, including the distribution of marketing material.

   d. Discuss Managed Care Plan-specific benefits.

   e. Distribute Managed Care Plan-specific materials.

4. The Managed Care Plan shall report participation in public events to the Agency, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

R. Enrollee Educational Events

1. Enrollee educational events may be hosted by the Managed Care Plan or an outside entity and must be held in a public venue. The Managed Care Plan shall ensure that events are not held at the home of an individual or as a one-on-one appointment. The Managed Care Plan shall not allow potential enrollees to participate in an educational event.

2. The Managed Care Plan may conduct the following permissible activities at enrollee educational events:

   a. Distribute public event material with the Managed Care Plan name, logo, product tagline, telephone contact number, and/or website.

   b. Distribute approved nominal gifts at educational events, as described in **Section III.**, Marketing, **Sub-Section I.**, Nominal Gifts, of this Contract.

   c. Display banners, posters or other displays with the Managed Care Plan name, logo, product tagline, telephone contact number, and/or website.

   d. Distribute or display business cards, scope of appointment forms and sign-up sheets.

   e. Set up individual marketing appointments.

   f. Provide meals at enrollee educational events. Managed Care Plans must comply with cost and limitations associated with nominal gifts in **Section III.**, Marketing, **Sub-Section I.**, Nominal Gifts.

3. The Managed Care Plan shall submit enrollee material for educational events to the Agency for review and approval prior to use. All enrollee educational events shall be reported to the Agency, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

4. The Managed Care Plan shall not do the following with regard to enrollee educational events:

   a. Conduct marketing activities.

   b. Distribute marketing materials.

   c. Advertise event to anyone other than enrollees.

   d. Conduct a marketing event immediately following an enrollee educational event in the same general location.

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Section IV. Enrollee Services

A. General Provisions

The Managed Care Plan shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities, as described in 42 CFR 438.100, and incorporated in the model enrollee handbook.

1. The Managed Care Plan shall have the capability to answer enrollee inquiries through written materials, telephone, electronic transmission, and face-to-face communication.

2. The Managed Care Plan shall provide written notice of changes affecting enrollees to those enrollees at least thirty (30) days before the effective date of change, unless otherwise specified in this Contract.

3. The Managed Care Plan shall develop and maintain processes, compliant with applicable federal and State laws (including, but not limited to, 42 CFR Part 435, and Chapters 709, 744, and 765 of the F.S.), which shall ensure that the Managed Care Plan possesses accurate and current information indicating who has legal authority to make health care decisions on behalf of an enrollee.

4. The Managed Care Plan may send notices to the enrollee's guardian or legally authorized responsible person as applicable.

5. In accordance with Title VI of the Civil Rights Act of 1964, the Managed Care Plan shall provide language assistance services, including the provision of foreign language interpreter and translation services, and auxiliary aids and services to enrollees to achieve effective communication (42 CFR 438.10(d)(3)).

B. Enrollee Material

1. General Provision

The Managed Care Plan shall submit enrollee material or changes in enrollee material related to this Contract to the Agency for review and approval prior to use.

a. The Managed Care Plan shall submit enrollee material to the Agency at least seventy-five (75) days before the proposed use of the enrollee material or revised material.

b. The Managed Care Plan shall conduct a quality check and ensure that all materials are consistent with this Contract and State and federal requirements prior to submitting materials for review to the Agency. Generally, the Agency will not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.

2. Requirements for Written Material

a. The Managed Care Plan shall provide enrollee information in accordance with 42 CFR

438.10(c)(1), 42 CFR 438.10(c)(7), 42 CFR 438.10(d)(6)(ii)-(iv), 42 CFR 438.10(f)(3), and 42 CFR 438.3(i), which addresses information requirements related to written and oral information provided to enrollees.

b. The Managed Care Plan shall provide all enrollee communications, including written materials, spoken scripts, and websites in an easily understood language and format. Enrollee communications shall be at or near the fourth (4th) grade comprehension level (42 CFR 438.10(d)(6)(i)). Readability tests to determine whether the written materials meet this requirement are:

    (1) Fry Readability Index

    (2) PROSE The Readability Analyst (software developed by Education Activities, Inc.)

    (3) Gunning FOG Index

    (4) McLaughlin SMOG Index

    (5) The Flesch-Kincaid Index

    (6) Other readability tests approved by the Agency

c. The Managed Care Plan shall make all written material available in multiple languages, as prescribed by the Agency. The Managed Care Plan shall notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats (42 CFR 438.10(d)(3)).

d. If the Managed Care Plan meets the five percent (5%) threshold for language translation, the Managed Care Plan shall place the following alternate language disclaimer on all enrollee materials, unless otherwise indicated in this Section:

    "This information is available for free in other languages. Please contact our customer service number at [insert enrollee help line and TTY/TTD numbers and hours of operation]."

    The Managed Care Plan shall include the alternate language disclaimer in both English and all non-English languages that meet the five percent (5%) threshold. The Managed Care Plan shall place the non-English disclaimer(s) below the English version and in the same font size as the English version. Information on language use may be found at https://www.census.gov/topics/population/language-use.html#tab2.

e. The Managed Care Plan shall include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. Information on the top fifteen (15) non-English languages is located at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf.

3. Requirements for Mailing Materials to Enrollees

a. The Managed Care Plan shall provide materials to enrollees by mail or consistent with the enrollee's preferred method of contact.

b. The Managed Care Plan shall display one of the following four (4) statements verbatim on the front of the envelope or, if no envelope is being sent, the mailing itself:

(1) Advertising pieces – "This is an advertisement."

(2) Managed Care Plan information – "Important Managed Care Plan information"

(3) Health and wellness information – "Health and wellness or prevention information"

(4) Hope Florida and Purpose related information – "Hope: Pathways"

(5) Non-health or non-Managed Care Plan information – "Non-health or non-Managed Care Plan related information"

The Agency does not require resubmission of envelopes based only on the envelope size.

c. The Managed Care Plan shall ensure that its Managed Care Plan name or logo is included in every mailing to enrollees.

d. The Managed Care Plan shall include a request for address correction in mailing envelopes for enrollee materials.

e. The Managed Care Plan shall not send emails unless the enrollee has agreed to receive those emails and shall provide an opt-out process for enrollees no longer to receive email communications.

4. Enrollee Procedures and Materials

a. The Managed Care Plan shall notify, in writing, within five (5) days following the receipt of the X12-834 enrollment file from the Agency or its designee, each person who is to be newly enrolled or reinstated with the Managed Care Plan.

b. The Managed Care Plan shall furnish enrollee materials to the new enrollee:

(1) An enrollment notice.

(2) An enrollee identification (ID) card.

(3) A current enrollee handbook.

(4) A current provider directory.

(5) Name, telephone number and address of the enrollee's PCP assignment, unless the enrollee is a full benefit dual eligible.

c. The Managed Care Plan shall furnish a reinstatement notice to a reinstated enrollee.

5. Required Enrollment Notice

The Managed Care Plan shall include in its enrollment notice:

a. The effective date of enrollment.

b. The enrollees' right to change their Managed Care Plan selections, subject to Medicaid limitations. The notifications shall distinguish between enrollees subject to open enrollment and those who are not and shall include information about change procedures for cause, or general Managed Care Plan change procedures through the Agency's enrollment broker website (www.flmedicaidmanagedcare.com) and toll-free enrollment broker telephone number as appropriate.

c. A notice that enrollees who lose eligibility and are disenrolled shall be automatically reinstated in the Managed Care Plan if eligibility is regained within the temporary loss period of one hundred eighty (180) days (42 CFR 438.56(g)).

d. A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Managed Care Plan and through DCF and/or the Social Security Administration.

e. A postage-paid, pre-addressed return envelope.

6. Reinstatement Notice

The Managed Care Plan shall include in its reinstatement notice:

a. The effective date of the reinstatement.

b. Instructions on how the enrollee can contact the Managed Care Plan if a new enrollee card, new enrollee handbook, and/or a new provider directory are needed.

c. A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Managed Care Plan and through DCF and/or the Social Security Administration.

d. A postage-paid, pre-addressed return envelope.

7. Enrollee ID Card Requirements

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

(1) The enrollee's name and Medicaid ID number.

(2) The Managed Care Plan's name, address, and enrollee help line number.

(3) A telephone number that a non-participating provider may call for billing information.

b. The Managed Care Plan shall provide replacement ID cards at the enrollee's request.

8. Enrollee Handbook Requirements

a. The Managed Care Plan shall furnish each new enrollee an enrollee handbook using the model enrollee handbook template provided by the Agency. The model enrollee handbook shall comply with the provisions of 42 CFR 438.3(j), 42 CFR 438.102(b)(2), 42 CFR 438.10(c)(4)(ii), 42 CFR 438.10(g). 42 CFR 438.62(b)(3), 42 CFR 489.102(a), and 45 CFR 147.200(a).

b. The Managed Care Plan shall provide the enrollee handbook through one of the following methods:

(1) Mailing a printed copy of the information to the enrollee's address.

(2) Providing the information by email, as permitted by this Contract.

(3) Advising the enrollee in paper or electronic form that the information is available on the Managed Care Plan's website and providing the applicable internet address.

(4) Providing the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

Prior to utilizing methods (2), (3), or (4) above, the Managed Care Plan shall submit a written description to the Agency Contract Manager of the process ensuring enrollees have access to a printed copy upon request.

9. Printed Provider Directory

a. The Managed Care Plan shall include in its printed provider directory the following information:

(1) Provider(s) names and group affiliations, including a designated section identifying "Essential Providers".

(2) Street address(es).

(3) Telephone number.

(4) Website URLs, if the provider has a website.

(5) Specialty credentials and other certifications, as applicable.

(6) Whether the provider will accept new enrollees.

(7) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

(8) Office hours (including after hours and weekend hours).

(9) Specific performance indicators.

(10) In accordance with s. 1932(b)(3) of the Social Security Act, a statement that some providers may choose not to perform certain services based on religious or moral beliefs.

(11) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment (42 CFR 438.10(h)(1)(viii)).

(12) Whether the provider offers covered services via telehealth.

b. The Managed Care Plan shall arrange the provider directory by county as follows:

(1) Providers listed by name in alphabetical order, showing the provider's specialty.

(2) Providers listed by specialty, in alphabetical order by name.

c. The Managed Care Plan shall provide a copy of the printed provider directory through one of the following methods:

(1) Mailing a printed copy to the enrollee's address.

(2) Providing the information by email, as permitted by this Contract.

(3) Advising the enrollee in paper or electronic form that the information is available on the internet and including the applicable internet address.

(4) Providing the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

d. The Managed Care Plan shall update the printable version of the provider directory at least monthly and include the date of revision (42 CFR 438.10(h)(3)).

e. When distributing printed provider directories, the Managed Care Plan shall include information stating that the most current listing of providers is available by calling the Managed Care Plan at its toll-free telephone number and at the Managed Care Plan's website. The letter shall include the telephone number and the internet address that links directly to the online provider database.

f. The Managed Care Plan is not required to include outpatient hospital-based specialty providers 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.

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10. Online Enrollee Materials

a. The Managed Care Plan shall make available electronically at the Managed Care Plan's website without requiring enrollee login, the enrollee handbook(s), the printed provider directory, and a searchable provider database.

(1) The Managed Care Plan must provide enrollee information electronically and meet the criteria as outlined in 42 CFR 438.10(c)(6)(i)-(v).

(2) The Managed Care Plan may provide a link to applications (smartphone applications, or "apps") for enrollee use that will take enrollees directly to existing Agency-approved materials (such as the Managed Care Plan's enrollee handbook and provider directory) on the Managed Care Plan's website.

(3) The online provider directory shall be made available in a machine-readable file and format in compliance with 42 CFR 438.10(h)(4).

b. The Managed Care Plan shall maintain an accurate and complete online provider database containing all the information required in the printed provider directory and as required by Section 409.967(2)(c)1, F.S. At a minimum, the online provider database must be searchable by:

(1) Name

(2) Provider type

(3) Distance from the enrollee's address

(4) County

(5) Zip code

(6) Whether the provider is accepting new patients

(7) After hours and weekend availability

c. The Managed Care Plan shall update the online provider database at least weekly to match the most recent provider network file submitted to the Agency.

d. The Agency reserves the right to publish the information specified in Section 409.967(2)(c)1, F.S.

11. Procedures for Provider Network Changes

a. The Managed Care Plan shall have procedures to inform potential enrollees and enrollees, upon request, of any changes to service delivery and/or the provider network including either of the following:

(1) Up-to-date information about any restrictions on access to providers, including providers who are not taking new patients.

(2) Any restrictions on counseling and referral services based on moral or religious grounds within thirty (30) days after adopting the policy with respect to any service (42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4)).

b. The Managed Care Plan shall have procedures to inform enrollees of adverse changes to its provider network.

C. Enrollee Services

1. General Provisions

a. The Managed Care Plan shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities.

b. The Managed Care Plan shall ensure language translation quality in all enrollee materials.

2. Translation and Interpretation Services

a. The Managed Care Plan is required to provide interpretation services at all points of contact to any potential enrollee or enrollee who speaks any non-English language regardless of whether the enrollee speaks a language that meets the threshold of a prevalent non-English language. This includes written translation, oral interpretation, and the use of auxiliary aids such as TTY/TDY and American Sign Language (42 CFR 438.10(d)(4); and 42 CFR 438.406(a)).

b. The Managed Care Plan is required to notify its enrollees of the availability of interpretation services and to inform them of how to access such services. Interpretation services are required for all Managed Care Plan information provided to enrollees, including notices of adverse action. There shall be no charge to the enrollee for translation services (42 CFR 438.10(d)(5)(i)-(iii), 42 CFR 438.10(d)(4)).
Upon request, the Managed Care Plan shall provide, free of charge, interpreters for potential enrollees or enrollees whose primary language is not English (42 CFR 438.10(d)(4)).

3. Enrollee Toll-Free Help Line

a. The Managed Care Plan shall operate a toll-free help line equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, a telecommunication device for the deaf (TTY/TDD), and access to the interpreter services for non-English speaking beneficiaries. The Managed Care Plan shall operate its enrollee help line as part of an inbound call center or similar functional arrangement where agents or operators staff telephones to field incoming calls.

b. The Managed Care Plan shall staff the enrollee help line twenty-four hours a day, seven days a week (24/7) to handle care related inquiries from enrollees and caregivers.

c. The enrollee help line agents/operators shall be trained to respond to enrollee questions in all areas.

d. The Managed Care Plan shall develop and implement an operational manual relevant to the call center. This manual shall provide information to agents/operators on how to

conduct various call center tasks and provide procedures for processing enrollee inquiries, including procedures, such as call scripts, call-handling procedures, first-call resolution, and escalation protocols.

e. If the Managed Care Plan utilizes an automated phone tree system, the Managed Care Plan's phone tree must include the option for enrollees to bypass options in the automated phone tree system and speak with an enrollee help line representative.

f. The Managed Care Plan may use a voice mail option in an automated phone tree system for callers to leave messages between the hours of 7:00 p.m. and 8:00 a.m., in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays. This phone tree must provide callers with clear instructions on what to do in case of an emergency and an option to speak to a Managed Care Plan representative.

g. If the Managed Care Plan utilizes a voice mailbox option, the Managed Care Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A Managed Care Plan representative shall respond to all messages on the next business day.

h. The Managed Care Plan shall have administrative procedures that include requirements for staffing, operations, technologies, and performance measurement. The administrative procedures shall address:

(1) Personnel management such as staff development and training, scheduling, and skill-based routing.

(2) Operational management of all call center activities such as call center shrinkage and schedule adherence, workload, and call load forecasting.

(3) Software and technologies, such as Automatic Call Distribution (ACD), telephone phone tree/Interactive Voice Response (IVR) technology and call recording systems.

(4) Call center quality control metrics and measurement for the performance of agents/operators.

i. The Managed Care Plan shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by the Agency before use, and comply with **Attachment II**, **Section XIII.**, Liquidated Damages, of this Contract. The Managed Care Plan shall measure its performance on a monthly basis and report on the following standards as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide:

(1) The Managed Care Plan shall ensure that at least ninety percent (90%) of calls are answered within thirty (30) seconds.

(2) The Managed Care Plan shall ensure that the rate of first-call resolution shall be at least eighty percent (80%).

(3) The Managed Care Plan shall ensure that the average hold time shall not exceed sixty (60) seconds.

(4) The Managed Care Plan shall ensure that the quality assurance monitoring score shall be ninety-five percent (95%) or greater.

(5) The Managed Care Plan shall ensure that the average speed of answer shall not exceed thirty (30) seconds.

(6) The Managed Care Plan shall ensure that the call abandonment rate shall not exceed three percent (3%).

(7) The Managed Care Plan shall ensure that the call blockage rate, as reported from the telecom provider, is no more than one-half percent (0.5%).

(8) The Managed Care Plan shall ensure that the call blockage rate, as reported by the ACD reporting software, is no more than zero percent (0.0%).

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 XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

j. The Managed Care Plan shall ensure that hold time messages do not include non-health related items (e.g., life insurance, disability), unless otherwise directed by the Agency. The Managed Care Plan shall submit hold time messages that promote the Managed Care Plan or include benefit information to the Agency for prior approval.

4. Cultural Competency Plan

As required by 42 CFR 438.206(c)(2), the Managed Care Plan shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.

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Section V. Service Administration

A. Required Benefits

1. General Provisions

a. The Agency shall be responsible for promulgating coverage requirements applicable to the Managed Care Plan through Florida Medicaid Coverage Policies, services listed in the associated Florida Medicaid fee schedules, and the Florida Medicaid State Plan, as well as plan communications specific to changes in federal and State law, rules or regulations and federal CMS waivers applicable to this Contract.

b. The Managed Care Plan shall ensure the provision of services defined and specified in this Contract and the applicable federal waivers in sufficient amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services defined and specified in this Contract (42 CFR 438.210(a)(3)(i)).

c. Nothing in this Contract waives the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) requirements of 42 U.S.C. § 1396d(r)(5). As such, in accordance with § 1396d(r) and all binding federal precedents interpreting it, the Managed Care Plan must, for Medicaid eligible children under the age of twenty-one (21) years, pay for any "other necessary health care, diagnostic services, treatment, and other measures described in Sub-Section (a) of this Section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." (42 U.S.C. 1396d(r)(5)). The Managed Care Plan shall not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21) years. The Managed Care Plan shall develop a special services process to authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary.

d. The Managed Care Plan shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the enrollee's diagnosis, type of illness or condition (42 CFR 438.210(a)(3)(i)). The Managed Care Plan may place appropriate limits on a service on the basis of medical necessity, as defined by the Agency, consistent with the terms of this Contract and as required by 42 CFR 438.210(a)(4)(i)-(ii) and 438.210(a)(1), provided the services furnished can be reasonably expected to achieve their purpose.

e. The Managed Care Plan shall provide the services identified in **Attachment II, and its Exhibits** in accordance with the Florida Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G-4, F.A.C., that include the Florida Medicaid Coverage and Limitations Handbooks, Florida Medicaid Coverage Policies, and services listed in the associated Florida Medicaid fee schedules, except where the provisions of this Contract or the applicable federal waivers alter the requirements set forth in the Handbooks, Coverage Policies, and Medicaid fee schedules.

(1) In no instance may the Managed Care Plan impose coverage and service limitations or exclusions more stringent than those specified in the aforementioned documents (42 CFR 438.210(a)(5)(i)).

(2) The Managed Care Plan may exceed specific coverage criteria included in the above and specific coverage exclusions specified in the aforementioned documents.

f. The Managed Care Plan is responsible for ensuring that all coverage and service requirements specified in the Florida Medicaid Services Coverage & Limitations Handbooks, Florida Medicaid Coverage Policies are incorporated into the Managed Care Plan's provider agreements. This includes professional licensure and certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in this Contract.

g. The Managed Care Plan may negotiate mutually agreed-upon rates with its providers, unless otherwise specified in State or Federal law or this Contract.

h. The Agency shall be responsible for accepting complaints directly from Medicaid recipients and providers, conducting Medicaid Fair Hearings, conducting appeals for MediKids enrollees, as well as reviewing complaints, grievances, and plan appeals reported by the Managed Care Plan to ensure appropriate resolution and monitor for contractual compliance, the Managed Care Plan performance, and trends that may reflect policy changes or operational changes needed.

i. This Contract shall prevail in any instance when compliance with provisions in the Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G, F.A.C. conflict with the terms of this Contract.

B. Expanded Benefits

1. General Provisions

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

b. The Managed Care Plan shall offer the approved expanded benefits to eligible enrollees in the applicable managed care program, subject to any Agency-agreed service limitations set forth in this Contract.

c. The Managed Care Plan shall inform new enrollees about its expanded benefits program and shall proactively engage in outreach and communication on a quarterly basis about the availability of such benefits to its enrollees.

d. The Managed Care Plan shall administer the expanded benefits of Medicaid covered services in accordance with any applicable service standards pursuant to this Contract, the applicable federal waivers, and any Florida Medicaid Coverage and Limitations Handbooks and Medicaid Coverage Policies.

e. A minimum utilization of eighty percent (80%) of the estimated actuarial value of the expanded benefit package is required. If the Managed Care Plan utilizes less than eighty percent (80%) of the actuarial value of an expanded benefit, the Managed Care Plan may submit to the Agency a replacement expanded benefit of equal or greater value. If the Managed Care Plan utilizes less than seventy percent (70%) of the actuarial value of an expanded benefit, the Managed Care Plan forfeits its right to have the expanded benefit published in enrollment materials.

2. Types of Expanded Benefits

The Managed Care Plan may offer the following expanded benefits:

a. Services in excess of the amount, duration, and scope of those listed in this Contract for its respective enrollees.

b. Other services and benefits not listed in the **Exhibit II-A-** MMA Exhibit and the **Exhibit II-B**, LTC Exhibit, upon approval of the Agency.

c. Services and benefits to advance Hope Florida in the following domains: housing assistance, food assistance, non-emergency transportation, life skills development, and K-12 tutoring.

3. Changes to Expanded Benefits Offered

a. The Managed Care Plan's expanded benefits may be changed on a Contract year basis in a manner and format approved by the Agency, if determined by the Agency to be beneficial to the enrollees.

b. The Managed Care Plan may increase its expanded benefits upon approval by the Agency.

c. The Managed Care Plan may exchange an expanded benefit for another, if determined to be actuarially equivalent by the Agency, upon approval by the Agency.

C. Excluded Services

1. General Provisions

a. The Managed Care Plan is not obligated to provide any services not specified in this Contract, except as federally required under EPSDT provisions.

b. Enrollees who require services not covered by this Contract shall receive the services through other appropriate Medicaid and non-Medicaid programs. In such cases, the Managed Care Plan's responsibility shall include care coordination/case management and referral (42 CFR 438.208(b)(2)(iii)-(iv)).

2. Moral or Religious Objections

a. The Managed Care Plan shall provide or arrange for the provision of all covered

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

(1) The Agency within one hundred twenty (120) days before implementing the policy with respect to any covered service (42 CFR 438.102(b)(1)(i)(A)(2)).

(2) Enrollees within ninety (90) days after adopting the policy for any covered service.

(3) Enrollees within sixty (60) days before implementing the policy with respect to any covered service.

b. In accordance with 42 CFR 438.10, if the Managed Care Plan chooses not to cover or furnish counseling or referral service information to enrollees due to moral or religious objections, the Agency shall be responsible for providing information on how and where to obtain the service (42 CFR 438.102(b)(1)(ii)(A)(1)).

D. Coverage Provisions

1. Service-Specific Requirements

The Managed Care Plan shall comply with additional provisions for covered services specified in the applicable Exhibit(s).

2. In Lieu of Services

a. The Managed Care Plan may cover services or settings that are in lieu of services or settings covered under the State plan (i.e., “in lieu of services”), as specified in this Contract and in accordance with 42 CFR 438.3(e)(2).

b. The Managed Care Plan shall use a clinical rationale for determining the benefit of the in lieu of service for the enrollee.

c. The Managed Care Plan shall develop educational materials for enrollees and providers that educate them about how these benefits will be administered and provide information about any administrative requirements (e.g., copayment or prior authorization requirements).

d. The Managed Care Plan shall ensure that the enrollee has a choice of whether to receive the Medicaid covered service or an in lieu of service and shall ensure that the choice is documented in the enrollee record.

e. The Managed Care Plan shall submit a copy of its procedures for in lieu of services to the Agency for approval in advance of implementation, unless otherwise specified in the applicable Exhibit.

3. Behavioral Health

The Managed Care Plan shall coordinate behavioral health services consistent with the care coordination requirements in this Section. Specific responsibilities of the Managed Care Plan as it relates to coordinating with other entities include:

a. Preadmission Screening and Resident Review (PASRR) Level II, if the PASRR Level II of an enrollee indicates a need for specialized services not included in the nursing facility per diem.

b. Assessment and treatment of mental health residents who reside in an assisted living facility that holds a limited mental health license, to ensure compliance with s. 394.4574, F.S.

E. Care Coordination/Case Management

1. General Provisions

a. The Managed Care Plan shall be responsible for care coordination/case management for enrollees as specified in this Contract and the applicable Exhibit(s) (42 CFR 438.208(b)(2)(ii)).

b. The Managed Care Plan shall have protocols in place to identify enrollees who require care coordination/case management services, and maintain written procedures for identifying, assessing, and implementing interventions for enrollees.

c. The Managed Care Plan shall ensure the following requirements are met when enrollees are admitted to or discharged from a nursing facility.

(1) The Managed Care Plan shall ensure DCF is notified when an enrollee is admitted to a nursing facility.

(a) The Managed Care Plan shall submit to DCF a properly completed DCF form CF-ES 2506A (Client Referral/Change) within ten (10) business days of an enrollee's admission to the nursing facility.

(b) The Managed Care Plan may delegate the submission of the DCF form CF-ES 2506A (Client Referral/Change) to the nursing facility, when the enrollee is under the age of 18. The Managed Care Plan must obtain a copy of the completed DCF form CF-ES 2506A (Client Referral/Change) that the facility submitted to DCF.

(2) The Managed Care Plan shall ensure DCF is notified when an enrollee is discharged from a nursing facility.

(a) The Managed Care Plan shall submit to DCF a properly completed DCF form CF-ES 2506 (Client Discharge/Change Notice) within ten (10) business days of an enrollee's discharge from the nursing facility.

(b) The Managed Care Plan may delegate submission of the DCF form CF-ES 2506 (Client Discharge/Change Notice) to the nursing facility.

d. The Managed Care Plan shall ensure case managers meet the appropriate experience and educational requirements.

e. The Managed Care Plan shall ensure access to case managers and back-up case managers as follows:

(1) The case manager shall be available for contact by the enrollee or the enrollee's authorized representative during business hours.

(2) When the enrollee's case manager is unavailable, the enrollee shall be provided the opportunity to be referred to a back-up case manager for assistance. The back-up case manager shall be available for contact by the enrollee or the enrollee's authorized representative during business hours.

(3) The enrollee shall be provided with access to an emergency back-up case manager through an after-hours telephone line.

(4) The Managed Care Plan shall ensure a mechanism to ensure enrollees, authorized representatives, and providers receive timely communication when messages are left for case managers.

f. The Managed Care Plan shall report monthly on enrollees under the age of twenty-one (21) years receiving nursing facility services or private duty nursing services, using a template provided by the Agency in accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

2. Case Management Program Description

The Managed Care Plan shall submit a Case Management Program Description to the Agency by June 1 of each Contract year. The Case Management Program Description shall address:

a. How the Managed Care Plan shall implement and monitor the case management program and standards outlined in this Contract.

b. A description of the methodology for assigning and monitoring case management caseloads and emergency preparedness plans.

c. A description of the Managed Care Plan's procedures for resolving conflict or disagreement in the care planning process, including guidelines for all participants.

d. A description of how the activities performed by the Managed Care Plan's care coordination, UM, and quality management/improvement departments interface in the development of the enrollee's plan of care, including how services that are managed and authorized through sub-contracted entities are incorporated into the workflow and support a person-centered care planning approach. Interface shall include electronic and written reports and verbal communication required for coordination of care planning activities.

e. A description of how the Managed Care Plan utilizes data provided by the Agency to provide enhanced care coordination for enrollees concurrently receiving services from or transitioning to or from one (1) or more of the following Florida agencies or their subcontractors:

   (1) Department of Veterans Affairs

   (2) Department of Children and Families (DCF)

      (a) Managing Entities

      (b) Community-Based Care Lead Agencies

   (3) Department of Education for School-based Services

   (4) Department of Juvenile Justice

   (5) Department of Corrections

   (6) Department of Elder Affairs for the Alzheimer's Disease Initiative, Home Care for the Elderly program, Community Care for the Elderly program, and Federal Older Americans Act program.

   (7) Agency for Persons with Disabilities

   (8) Department of Health Title XXI Children's Medical Services

f. An evaluation of the Managed Care Plan's case management program from the previous year, highlighting lessons learned and strategies for improvement.

g. All required elements of the case management program and responsibilities of the case manager/case manager supervisor as outlined in this Contract.

3. Freedom of Choice

The Managed Care Plan shall ensure the enrollee's or enrollee's authorized representative's completion and signature of the Agency-approved Freedom of Choice Certification Form as specified in the applicable Exhibit(s).

4. Pre-Admission Screening and Resident Review (PASRR)

The Managed Care Plan shall ensure that the care coordinator verifies that the PASRR required in Rule 59G-1.040, F.A.C. is in the enrollee's nursing facility's enrollee record.

5. Transition of Care

a. The Managed Care Plan shall develop and maintain transition of care procedures that address all transitional care coordination/case management requirements and submit these procedures for review and approval to the Agency (42 CFR 438.62(b)(1)-(2)). Transition of care procedures shall include the following minimum functions:

(1) Appropriate support to case managers, and to enrollees and caregivers as needed, for referral and scheduling assistance for enrollees needing specialty health care, transportation, or other service supports (42 CFR 438.208(b)(1)).

(2) Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting with assistance, as needed, by the Agency (42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164).

(3) Transfer of enrollee records in compliance with HIPAA privacy and security rules.

(4) Documentation of referral services in enrollee records, including follow up resulting from the referral.

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

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

c. The Managed Care Plan shall be responsible for coordination of care for enrollees transitioning to another Managed Care Plan or delivery system and ensure information for active services is shared with the new Managed Care Plan or delivery system within thirty (30) days following an enrollee's enrollment date.

6. Chronic Disease Management Program

See **Attachment II, Section I.**, General Overview, **Sub-Section H.**, Prioritizing Quality and Value, **Item 2.**, Value-Based Purchasing (VBP) Programs, for general provisions on VBP programs.

F. Community Partnerships to Improve Outcomes (CPIO)

See **Attachment II, Section I.**, General Overview, **Sub-Section C.**, Prioritizing Autonomy and Self-Sufficiency through Community Partnership, **Item 1.**, General Provisions, for general provisions on Community Partnerships to Improve Outcomes.

G. Authorization of Services

1. General Provisions

a. The Managed Care Plan shall establish and maintain an UM system to monitor utilization of services, including an automated service authorization system for denials, service limitations, and reductions of authorization. The Managed Care Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the enrollee's diagnosis, type of illness, or condition (42 CFR 438.210(a)(3)(ii)).

b. The Managed Care Plan shall ensure that applicable evidence-based guidelines are utilized with consideration given to characteristics of the local delivery systems available for specific enrollees as well as enrollee-specific factors, such as enrollee's age, co-morbidities, complications, progress in treatment, psychosocial situation and home environment.

c. The Managed Care Plan must provide that compensation to individuals or entities (including subcontractors) that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, in accordance with 42 CFR 438.210(e).

d. The Managed Care Plan shall develop a process for authorization of any medically necessary service to enrollees under the age of twenty-one (21) years, in accordance with Section 1905(a) of the Social Security Act, when:

(1) The service is not listed in the service-specific 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

(2) The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific Handbook or Coverage Policy, or the corresponding fee schedule.

e. The Managed Care Plan shall provide approval or denial of authorization in accordance with **Attachment II**, **Section VI.**, Enrollee Grievance and Appeal System, **Sub-Section G.**, Extension of Plan Appeal, for out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. The Managed Care Plan shall provide written follow-up documentation of the approval to the non-participating provider within one (1) business day after the approval.

f. The Managed Care Plan may utilize a national standardized set of criteria (e.g., Interqual) or other evidence-based guidelines approved by the Agency to approve services. Such criteria and guidelines shall not solely be used to deny, reduce, suspend, or terminate a good or service, but may be used as evidence of generally accepted medical practices that support the basis of a medical necessity determination.

2. Utilization Management Program Description

The UM program shall be consistent with 42 CFR Parts 438 and 456 (as applicable), reflected in a written Utilization Management Program Description and include, but not be limited to:

a. Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses.

b. Procedures for reporting fraud and abuse information identified through the UM program to the Agency's MPI as described in **Section IX.**, Administration and Management, and referenced in 42 CFR 455.1(a)(1).

c. Procedures for enrollees to obtain a second medical opinion at no expense to the enrollee and for the Managed Care Plan to authorize claims for such services in accordance with 42 CFR 438.236(c) and s. 641.51, F.S.

d. Protocols for prior authorization and denial of services.

e. The process used to evaluate initial and continuing authorization.

f. A detailed description of the Managed Care Plan's service authorization program for high-performing providers, including:

(1) The process for informing providers about the program.

(2) Provider eligibility criteria.

(3) Services that are included in the program.

(4) The process for notifying and educating approved providers about the program.

(5) The Managed Care Plan's oversight of approved high-performing providers.

(6) Criteria for inclusion of additional providers into the program.

g. Objective evidence-based criteria to support authorization decisions.

h. Mechanisms to ensure consistent application of review criteria for authorization decisions, including consultation with the requesting provider when appropriate.

i. Physician profiling.

j. Retrospective review, meeting the predefined criteria below. The Managed Care Plan shall be responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate (42 CFR 438.210(b)(1)-(2)(i)-(ii)).

3. Service Authorization System

a. The Managed Care Plan shall have automated authorization systems, as required in Section 409.967(2)(c)3., F.S., and may not require paper authorization in addition as a condition for providing treatment.

b. The Managed Care Plan's service authorization systems shall provide written notice of all denials, service limitations and reductions of authorization to providers and enrollees (42 CFR 438.210(c)).

c. The Managed Care Plan's service authorization systems shall provide the authorization number and effective dates for authorization to providers and non-participating providers.

d. 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.

e. The Managed Care Plan shall implement and maintain a program that reduces or eliminates service authorization requirements for high-performing providers that meet quality performance criteria, established by the Managed Care Plan.

(1) The Managed Care Plan may limit the services that qualify for inclusion in the program.

(2) The Agency reserves the right to prescribe the services that must be included in the Managed Care Plan's program in order to facilitate progress towards the Agency's goals.

(3) 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 XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

f. The Managed Care Plan shall provide the Agency with prior authorization denial data, upon request by the Agency and in a format specified by the Agency.

4. Practice Guidelines/Evidence-based Criteria

a. The Managed Care Plan shall adopt practice guidelines that meet the following requirements (42 CFR 438.236(c)):

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field (42 CFR 438.263(b)(1)).

(2) Consider the needs of the enrollees (42 CFR 438.236(b)(2)).

(3) Are adopted in consultation with providers (42 CFR 438.236(b)(3)).

(4) Are reviewed and updated periodically, as appropriate (42 CFR 438.236(b)(4)).

b. The Managed Care Plan shall disseminate any revised practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees (42 CFR 438.236(c)).

c. The Managed Care Plan shall ensure consistency with regard to all decisions relating to UM, enrollee education, covered services, and other areas to which the practice guidelines apply (42 CFR 438.236(d)).

d. If the Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C.

5. Clinical Decision-Making

a. The Managed Care Plan shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, must be:

(1) Made by a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency, who has the appropriate clinical expertise in treating the enrollee's condition or disease (42 CFR 438.210(b)(3)).

(2) Determined using the acceptable standards of care, State and federal laws, the Agency's medical necessity definition, and clinical judgment of a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency.

b. Inter-Rater Reliability

(1) The Managed Care Plan shall conduct inter-rater reliability audits on all clinical professionals who review service authorization requests under this Contract. The Managed Care Plan shall audit for consistency in decisions, which account for State and federal Medicaid requirements (e.g., EPSDT). At a minimum, the Managed Care Plan shall monitor one percent (1%) of service authorization decisions per reviewer per quarter.

(2) Each clinical reviewer must maintain an eighty-five percent (85%) accuracy rate.

(3) The Managed Care Plan shall submit a quarterly report of the results of the inter-rater reliability audit to the Agency as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

6. Service Authorization Standards for Decisions

The Managed Care Plan shall notify the provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (42 CFR 438.210(c); 42 CFR 438.404).

a. The Managed Care Plan shall comply with the following standards, measured on a monthly basis, for processing all service authorization requests and notifying providers and enrollees in a timely manner for:

(1) Standard Authorization Decisions

(i) The Managed Care Plan shall provide standard authorization decisions within no more than seven (7) days following receipt of the request for service.

(ii) The Managed Care Plan may extend the timeframe for standard authorization decisions up to four (4) additional days, if the enrollee or the provider requests an extension, or the Managed Care Plan justifies the need for additional information and how the extension is in the enrollee's interest (42 CFR 438.210(d)(1)).

(2) Expedited Authorization Decisions

(i) The Managed Care Plan shall provide expedited authorization decisions no later than two (2) days after receipt of the request for service.

(ii) The Managed Care Plan may extend the timeframe for expedited authorization decisions by up to one (1) additional day if the enrollee or the provider requests an extension or if the Managed Care Plan justifies the need for additional information and how the extension is in the enrollee's interest (42 CFR 438.210(d)(2)).

b. The Managed Care Plan shall submit a monthly report of the timeliness standards specified above to the Agency as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

c. If the Managed Care Plan extends the timeframe for a service authorization decision, in which case it shall:

(1) Notify the enrollee of the reason for extending the timeframe and advising of the right to file a grievance if the enrollee disagrees with the extension of time.

(2) Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires.

(3) Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.

d. The Managed Care Plan shall submit a monthly report on the outcome of service authorization decisions to the Agency as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide. At a minimum, the standards that shall be measured shall include:

(1) Number of service authorization requests received.

(2) Number and percentage of service authorization requests partially approved (this includes requests for continued authorization that were reduced).

(3) Number and percentage of service authorization requests denied (in whole).

(4) Number and percentage of requests referred to a physician reviewer or medical director.

(5) Number and percentage of requests that required a peer-to-peer review.

(6) Number and percentage of requests that required an extension in order to request/receive additional information.

7. Changes to Utilization Management Components

a. The Managed Care Plan shall obtain written approval from the Agency for its service authorization protocols and any changes.

b. The Managed Care Plan shall provide no less than sixty (60) days' written notice to the Agency before making any changes to the administration and/or management procedures and/or authorization, denial, or review procedures, including any delegations, as described in this Section.

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Section VI. Enrollee Grievance and Appeal System

A. General Provisions

1. The Managed Care Plan shall establish and maintain an enrollee grievance and appeal system for reviewing and resolving enrollee complaints, grievances, and appeals. Components must include a complaint process, a grievance process, a single plan appeal process, access to an applicable review outside of the Managed Care Plan, and access to a Medicaid Fair Hearing (s. 641.511, F.S.; 42 CFR 431, Subpart E; 42 CFR 438, Subpart F; and Rule 59G-1.100, F.A.C.)

2. The Managed Care Plan shall not delegate any aspect of the enrollee grievance and appeal system to its subcontractors, unless otherwise approved by the Agency subject to **Section IX.**, Administration and Management, **Sub-Section C.**, Subcontracts, of this Contract.

3. The Managed Care Plan shall ensure that all decisions on grievances and appeals are made by health care professionals in accordance with 42 CFR 438.406(b).

4. The Managed Care Plan shall refer all enrollees who are dissatisfied with the Managed Care Plan or its activities to the Managed Care Plan's enrollee grievance and appeal system.

5. In accordance with **Section IV.**, Enrollee Services, the Managed Care Plan shall assist the enrollee in completing forms and following the procedures for filing a grievance or plan appeal or requesting a Medicaid Fair Hearing.

6. Upon request, the Managed Care Plan shall provide the enrollee and his or her authorized representative the enrollee record, including all medical records and any other documents and records considered or relied upon by the Managed Care Plan regarding a plan appeal, Medicaid fair hearing, or MediKids State review, including the opportunity before and during the plan appeal or hearing process for the enrollee or an authorized representative to examine the record. The Managed Care Plan shall provide such records free of charge, within seven (7) calendar days of request (42 CFR 438.406(b)(5)).

7. The Managed Care Plan shall maintain a complete and accurate record of all complaints, grievances, and plan appeals. The Managed Care Plan shall maintain and make complaint, grievance, and plan appeal records available upon request of the Agency and CMS (42 CFR 438.416(c)).

   a. The Managed Care Plan shall address, log, track, and trend all complaints, regardless of the degree of seriousness or whether the enrollee or provider expressly requests filing the concern.

   b. The record of each grievance and appeal must contain, at a minimum, the information specified in 42 CFR 438.416(b)(1)-(6) and additional information as specified in the Managed Care Plan Report Guide.

8. The Managed Care Plan shall report on complaints, grievances, and plan appeals to the Agency as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency (42 CFR 438.416(a)).

B. Use of Independent Review Organization

1. The Managed Care Plan may elect to have all unresolved grievances and plan appeals subject to external review processes by an independent review organization.

2. The Managed Care Plan must notify the Agency in writing if it elects to have all its plan appeals subject to such external review.

C. Process for Complaints

1. The Managed Care Plan shall resolve complaints by close of business on the business day following receipt.

2. If a complaint is not resolved within one (1) business day following receipt, the Managed Care Plan shall enter the complaint as a grievance by close of business the following business day.

D. Process for Grievances

1. An enrollee may file a grievance with the Managed Care Plan, orally or in writing at any time (42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i)).

2. The Managed Care Plan's process for handling enrollee grievances must include acknowledgement in writing within five (5) business days of receipt of each grievance (42 CFR 438.406(b)(1); 42 CFR 438.406(a)).

3. The Managed Care Plan shall review the grievance and provide written notice of results to the enrollee, as expeditiously as the enrollee's health condition requires, but no later than thirty (30) calendar days from the date the Managed Care Plan receives the grievance (42 CFR 438.408(a) and (b)(1)).

4. The Managed Care Plan shall extend the timeframe for a grievance resolution up to fourteen (14) calendar days if the enrollee asks for an extension, or the Managed Care Plan documents that additional information is needed, and the delay is in the enrollee's interest (42 CFR 438.408(c)(1)(i) - (ii); 438.408(b)(1)).

   a. If the timeframe is extended other than at the enrollee's request, the Managed Care Plan shall provide the following notices to the enrollee:

      (1) Oral notice of the reason for the delay by close of business on the day of the determination.

      (2) Written notice of the reason for the delay and the enrollee's right to file a grievance if he or she disagrees with the Managed Care Plan's decision, within two (2) calendar days of the determination.

   b. If notified by the Agency of an enrollee's request for a for cause plan change pursuant to Rule 59G-8.600, F.A.C., the Managed Care Plan shall complete the grievance process within a timeframe prescribed by the Agency in accordance with 42 CFR 438.56(e). If the Managed Care Plan fails to provide the Agency with the outcome of the grievance process within the Agency-prescribed timeframes, the enrollee's request for a For Cause plan change is considered approved.

E. Notice of Adverse Benefit Determination

1. The Managed Care Plan shall give the enrollee written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or currently authorized under the fee-for-service delivery system or from the enrollee's immediate former managed care plan at the time of the enrollee's transition into the Managed Care Plan. The Managed Care Plan shall provide the enrollee with a written notice of adverse benefit determination for any service authorization decisions, using the template provided by the Agency (42 CFR 438.10(c)(4)(ii); 42 CFR 438.404(b); 42 CFR 438.402(b)-(c)).

2. The Managed Care Plan shall include an identifying number on each notice of adverse benefit determination in a manner prescribed by the Agency.

3. The Managed Care Plan shall mail the notice of adverse benefit determination as follows:

    a. For termination, suspension, or reduction of previously authorized Medicaid covered services no later than ten (10) days before the adverse benefit determination is to take effect (42 CFR 438.404(c)(1); 42 CFR 431.211). Certain exceptions apply under 42 CFR 431.213 and 214.

    b. By the date of the action when any of the following occur:

        (1) The enrollee has died.

        (2) The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result.

        (3) The enrollee has been admitted to an institution where he or she is ineligible under the Managed Care Plan for further services.

        (4) The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address.

        (5) The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

        (6) The enrollee's physician prescribes a change in the level of medical care.

        (7) The notice involves an adverse benefit determination with regard to PASSR under s.1919(e)(7) of the Social Security Act.

        (8) The enrollee's nursing facility has made a determination to transfer or discharge the enrollee.

        (42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); s. 1919(e)(7) of the Social Security Act).

c. For denial of payment, at the time of any adverse benefit determination affecting the clean claim; (42 CFR 438.404(c)(2)).

d. For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.

4. The Managed Care Plan may delegate completion and issuance of the notice of adverse benefit determination to a utilization management subcontractor, with approval of the Agency, when the Managed Care Plan:

   a. Conducts a comprehensive, quarterly audit of a sample of each delegated subcontractor's notice of adverse benefit determination letters (and associated service authorization decisions). The audit sample shall include ten (10) notices of adverse benefit determination, which shall be expanded to thirty (30) notices if issues are found in the initial sample.

   b. Conducts a quarterly review of the delegated subcontractor's adherence to the timeliness standards as established in **Section VI.**, Enrollee Grievance and Appeal System, **Sub-Section E.**, Notice of Adverse Benefit Determination, **Item 3.**, above.

5. The Managed Care Plan shall report to the Agency on its service authorization subcontractor monitoring within forty-five (45) days after completion of the reporting quarter, in a manner and format as specified by the Agency in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

F. Standard Resolution of Plan Appeals

1. The Managed Care Plan shall adhere to the following timeframes for processing plan appeals:

   a. An enrollee, authorized representative, or legal representative of the estate may file a plan appeal orally or in writing within sixty (60) calendar days from the date on the notice of adverse benefit determination (42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii)).

      An enrollee, authorized representative, or legal representative of the estate may follow an oral appeal with a signed, dated, written appeal within ten (10) calendar days of the oral filing, unless the enrollee requests an expedited resolution. However, oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and shall be confirmed in writing by the Managed Care Plan unless the enrollee or his or her authorized representative requests expedited resolution (42 CFR 438.402(c)(3)(ii); 42 CFR 438.406(b)(3)).

   b. The date of oral filing shall constitute the date of receipt.

   c. The Managed Care Plan shall acknowledge each plan appeal in writing within five (5) business days of receipt of each plan appeal unless the enrollee requests an expedited resolution (42 CFR 438.406(b)(1); 42 CFR 438.406(a)).

d. The Managed Care Plan shall ensure that enrollees who are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal on disenrollment except for the following reasons:

(1) Moving out of the region.

(2) Loss of Medicaid eligibility.

(3) Determination that an enrollee is in an excluded population, as defined in this Contract.

(4) Enrollee death.

e. The Managed Care Plan shall continue and pay for a Medicaid enrollee's benefits during the plan appeal if all of the following occur:

(1) The enrollee or the enrollee's authorized representative files the request for a plan appeal timely in accordance with 42 CFR 438.402(c)(2)(ii).

(2) The plan appeal involves the termination, suspension or reduction of a previously authorized course of treatment. This includes a reduction in services that were previously authorized under the fee-for-service delivery system or from the enrollee's immediate former managed care plan at the time of the enrollee's transition into the Managed Care Plan.

(3) The services were ordered by an authorized provider.

(4) The period covered by the original authorization has not expired at the time the plan appeal was filed.

(5) The enrollee timely files for continuation of benefits.

f. If, at the enrollee's request, the Managed Care Plan continues or reinstates the benefits while the plan appeal is pending, the benefits must continue until one (1) of the following occurs:

(1) The enrollee withdraws the plan appeal.

(2) The enrollee fails to request a fair hearing and continuation of benefits within ten (10) calendar days after the Managed Care Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.

g. The Managed Care Plan shall provide the enrollee a reasonable opportunity to present evidence and testimony and make allegations of fact or law in person as well as in writing (42 CFR 438.406(b)(4)).

h. The Managed Care Plan shall pay for disputed services received by the enrollee while the appeal was pending. The Managed Care Plan may require the enrollee to pay for the cost of those benefits if the Medicaid Fair Hearing upholds the Managed Care Plan's appeal resolution (42 CFR 438.424(a)-(b)).

i. If the final resolution of the plan appeal is adverse to the enrollee, the Managed Care Plan may recover the cost of services furnished to the enrollee while the plan appeal was pending to the extent they were furnished solely because of the requirements for continuation of benefits.

j. For resolution, a plan appeal shall be heard and notice of plan appeal resolution shall be sent to the enrollee no later than thirty (30) calendar days from the date the Managed Care Plan receives the plan appeal.

k. If the Managed Care Plan fails to adhere to the notice and timing requirements for resolution of the plan appeal, the Managed Care Plan shall give notice on the date that the timeframes expire. In such cases, the enrollee is deemed to have completed the Managed Care Plan's appeals process, and the enrollee may initiate a Medicaid fair hearing (42 CFR 438.408; 42 CFR 402(c)(1)(i)(A)).

l. The Managed Care Plan shall consider as parties to the plan appeal the enrollee or an authorized representative or, if the enrollee is deceased, the legal representative of the estate (42 CFR 438.406(b)(6)).

G. Extension of Plan Appeal

1. The timeframe for a plan appeal may be extended up to fourteen (14) calendar days if the enrollee asks for an extension, or the Managed Care Plan documents that additional information is needed and the delay is in the enrollee's interest (42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2)).

2. If the timeframe is extended other than at the enrollee's request, the Managed Care Plan must provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay to the enrollee within two (2) calendar days of the determination (42 CFR 438.408(c)(2)(i)-(iii); 42 CFR 438.408(b)(2)).

H. Expedited Resolution of Plan Appeals

1. The Managed Care Plan shall have an expedited review process for plan appeals for use when taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain or regain maximum function (42 CFR 438.410(a)).

2. The Managed Care Plan shall resolve each expedited plan appeal and provide written notice to the enrollee, as quickly as the enrollee's health condition requires, within State established timeframes not to exceed forty-eight (48) hours after the Managed Care Plan receives the plan appeal request, whether the plan appeal was made orally or in writing (42 CFR 438.210(d)(2)).

3. The Managed Care Plan shall inform the enrollee of the limited time available to present evidence and allegations of fact or law, in the case of expedited plan appeal resolution, and ensure that the enrollee understands any time limits that may apply.

4. If the Managed Care Plan denies the request to expedite the plan appeal, it shall immediately transfer the plan appeal to the timeframes for standard resolution and so notify the enrollee (42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2); 42 CFR 438.410(c)).

5. If an enrollee asks for an extension, the Managed Care Plan shall treat the request as a denial to expedite the plan appeal, immediately transfer the plan appeal to the timeframe for standard resolution, and so notify the enrollee. Nothing in this Section relieves the plan of its obligation to resolve the enrollee's appeal as expeditiously as the enrollee's health condition requires, in accordance with 42 CFR 438.408(b)(2).

6. In the case where the Managed Care Plan denies a request to expedite the plan appeal, the Managed Care Plan shall also provide oral notice to the enrollee by close of business on the day of resolution, and written notice to the enrollee within two (2) calendar days of the disposition.

I. Notice of Plan Appeal Resolution

1. The Managed Care Plan shall provide the enrollee with a written notice using the notice of plan appeal resolution template provided by the Agency (42 CFR 438.10(c)(4)(ii)).

2. The Managed Care Plan shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the plan appeal.

J. Process for Medicaid Fair Hearings

1. The Managed Care Plan must comply with Rule 59G-1.100, F.A.C., and all terms and conditions set forth in any orders and instructions issued by the Office of Fair Hearing or a hearing officer.

2. An enrollee may request a Medicaid Fair Hearing after completing the Managed Care Plan's appeal process. An enrollee has completed the plan appeal process after receiving a notice of plan appeal resolution indicating that the Managed Care Plan is upholding, in whole or in part, the adverse benefit determination or after the Managed Care Plan fails to adhere to the notice and timing requirements applicable to plan appeals (42 CFR 438.402(c)(1); 42 CFR 438.408).

3. An enrollee, or his or her authorized representative, who has completed the Managed Care Plan's appeal process may file for a Medicaid Fair Hearing in accordance with Rule 59G-1.100, F.A.C.

4. Parties to the Medicaid Fair Hearing include the Managed Care Plan as well as the enrollee, or the enrollee's authorized representative.

5. The Managed Care Plan shall attend fair hearings as scheduled. The Managed Care Plan shall attend hearings with the necessary witnesses and evidentiary materials.

6. The Managed Care Plan shall submit an evidence packet to the Agency and to the enrollee, free of charge, within ten (10) business days from the time the Managed Care Plan receives notification of the hearing and must be submitted to the Agency in accordance with any prehearing instructions. The evidence packet must include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents/records considered or relied upon by the Managed Care Plan, supporting the Managed Care Plan's adverse benefit determination and plan appeal resolution.

7. Within two (2) business days of notification of the fair hearing request, the Managed Care Plan shall provide the corresponding Notice of Adverse Benefit Determination and the Notice of Plan Appeal Resolution that relate to the fair hearing request to the Agency (42 CFR 438.228(b)).

8. The Managed Care Plan must designate an email address with the Agency for Health Care Administration Office of Fair Hearings for all fair hearing-related communications from the Office and any party to the fair hearing.

9. The Managed Care Plan shall provide transportation to the enrollee and/or, the enrollee's authorized representative upon request and if the enrollee has no other means of transportation to and from the nearest hearing call-in center in accordance with **Section IV.**, Enrollee Services, of this Contract and its Exhibits.

10. The Managed Care Plan shall continue the enrollee's benefits while the fair hearing is pending if the enrollee timely files for continuation of benefits within ten (10) calendar days after the Managed Care Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.

11. If, at the enrollee's request, the Managed Care Plan continues or reinstates the benefits while fair hearing is pending, the benefits must continue until one (1) of the following occurs:

    a. The enrollee withdraws the fair hearing request.

    b. The enrollee fails to request a fair hearing and continuation of benefits within ten (10) calendar days after the Managed Care Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.

    c. The fair hearing office issues a hearing decision adverse to the enrollee.

12. If the Managed Care Plan's action is sustained by the hearing decision, the Managed Care Plan may recover the cost of services furnished to the enrollee while the plan appeal and fair hearing were pending, to the extent they were furnished solely because of the requirements for continuation of benefits.

13. If the Managed Care Plan's action is reversed by the hearing decision and services were not furnished while the plan appeal was pending, the Managed Care Plan shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Managed Care Plan receives the notice reversing the determination.

K. Appellate Responsibilities

1. Should an enrollee appeal a Medicaid Fair Hearing final order to the appropriate DCA or Florida Supreme Court, the Managed Care Plan shall fully participate as a party in the appellate process and shall be responsible for defending both its actions and the Hearing Officer's final order, to the extent that position on appeal is consistent with the rules governing The Florida Bar and Florida law. The Agency may choose whether or not to participate in the appellate proceeding as a party and/or whether or not to participate in briefing.

2. The Managed Care Plan shall file all appropriate document(s) with the DCA or Florida Supreme Court to participate in the appeal as a party and defend both its actions and the Hearing Officer's final order to the extent that position on appeal is consistent with the rules governing The Florida Bar and Florida law.

3. The Managed Care Plan shall bear all costs associated with completing the record and transmitting it to the DCA or Florida Supreme Court, including transcribing the audio recording of the Medicaid Fair Hearing proceedings. The Managed Care Plan shall ensure that a copy of the record is provided to all of the following:

   a. The enrollee, or enrollee's authorized representative.

   b. The enrollee's attorney, if applicable.

   c. The Agency's Appellate Section.

4. The Managed Care Plan shall contact the Agency's Appellate Section to coordinate the appeal within five (5) business days after receipt of notification that an appeal of a Medicaid Fair Hearing has been filed with the DCA or Florida Supreme Court.

5. The Managed Care Plan shall provide the Agency's Appellate Section with a copy of its draft brief(s) for review no later than ten (10) business days in advance of the filing deadline(s) set by the DCA or Florida Supreme Court.

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Section VII. Provider Network and Services

A. Network Adequacy Standards

1. General Provisions

a. The Managed Care Plan shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements in **Section VII.**, Provider Network and Services of this Contract. The Managed Care Plan shall submit model provider agreement templates to the Agency for review as specified in **Section VII.**, Provider Network and Services.

b. Pursuant to Section 409.967(2)(c)(1), F.S. and in accordance with 42 CFR 438.68(c), the Managed Care Plan shall maintain a region-wide network of providers in sufficient numbers to meet the network capacity and geographic access standards for services with respect to the applicable SMMC program.

c. The Agency shall be responsible for establishing standards and requirements for provider networks, reviewing Managed Care Plan's provider networks, and monitoring the Managed Care Plan to ensure provider networks are capable of meeting the needs of their enrollees and are sufficient to serve the number of enrollees in the Managed Care Plan in accordance with this Contract and its Exhibits.

d. The Managed Care Plan shall enter into provider agreements with a sufficient number of providers to provide all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided to the enrollee with reasonable promptness (within the meaning of that term as set forth in 42 U.S.C. §1396a(a)(8)). (42 CFR 438.3(q)(1) and (3)). The Managed Care Plan shall take any and all necessary action to ensure that all medically necessary covered services are provided to enrollees with reasonable promptness, including, but not limited to, the following:

   (1) Utilizing out-of-network providers (42 CFR 438.206(b)(4)).

   (2) Using financial incentives to induce network or out-of-network providers to accept an enrollee as a patient/client and provide all medically necessary covered services with reasonable promptness.

e. The Agency reserves the right to change Provider Qualifications and Minimum Network Adequacy Requirements.

f. The Managed Care Plan shall perform ongoing monitoring activities, including Agency-prescribed activities.

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

h. The Managed Care Plan shall require non-participating providers to coordinate with respect to payment and must ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network (42 CFR 438.206(b)(5)).

i. The Managed Care Plan must maintain sufficient Indian Health Care Providers (IHCPs) in the network to ensure timely access to services available under the Contract for Indian enrollees who are eligible to receive services from such providers, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR 438.4(b)(3), and must permit out-of-network or out-of-state IHCPs to provide covered services and make referrals to network providers for Indian enrollees.

2. Network Capacity and Geographic Access Standards

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

b. The Managed Care Plan shall have the provider capacity to provide covered services to all enrollees, by region, as indicated in this Contract.

c. The Managed Care Plan may provide transportation services directly through its own network of transportation providers or through a subcontractor. The Managed Care Plan shall ensure a transportation network of sufficient size to ensure the ability to provide the services required in this Contract.

3. Demonstration of Network Adequacy

The Managed Care Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) on a weekly basis and at any time upon request of the Agency with sufficient evidence that the Managed Care Plan has the capacity to provide covered services to all enrollees, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide (42 CFR 438.207(b)(1)).

a. Maintains a region-wide network of providers offering an appropriate range of services in sufficient numbers to meet the access standards established by the Agency, pursuant to Section 409.967(2)(c)(1), F.S.

b. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients as specified in s. 1932(b)(5) of the Social Security Act, as enacted by Section 4704(a) of the Balanced Budget Act of 1997.

4. Timely Access Standards

a. The Managed Care Plan shall contract with and maintain a provider network sufficient to comply with timely access standards as specified in this Contract and the applicable Exhibit(s).

b. In accordance with 42 CFR 438.206(c)(1), the Managed Care Plan shall establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply.

c. Transportation Timeliness

(1) The Managed Care Plan shall ensure that enrollees arrive on time at pre-arranged times for appointments and are picked up on time at pre-arranged times for the return trip if the covered service follows a reliable schedule. The pre-arranged times may not be changed by the transportation provider or driver without prior permission from the enrollee.

(2) The Managed Care Plan shall comply with the following transportation standards. Items (a) through (e) below shall be measured on a monthly basis, for processing transportation requests in a timely manner. Item (f) will be measured per occurrence.

(a) The Managed Care Plan shall ensure that at least ninety percent (90%) of trips resulted in the enrollee arriving to their scheduled appointment on time.

(b) The Managed Care Plan shall ensure that no more than two-tenths percent (0.2%) of transportation requests resulted in a missed trip.

(c) The Managed Care Plan shall ensure that at least eighty-five percent (85%) of unscheduled trips are fulfilled within three (3) hours of the request.

(d) The Managed Care Plan shall ensure that at least ninety percent (90%) of the total scheduled Leg A trip requests were fulfilled within fifteen (15) minutes of the scheduled time for pick-up.

(e) The Managed Care Plan shall ensure that at least ninety percent (90%) of the total scheduled Leg B trip requests were fulfilled within thirty (30) minutes of the scheduled time for pick-up.

(f) The Managed Care Plan shall ensure that no enrollee with a Standing Order misses an appointment due to late pick-up, missed trip, or cancellation by the transporter. Examples of Standing Orders include persons receiving Dialysis, Cancer, and Methadone treatments. Item (f) will be measured by occurrence as determined from complaints received by the Agency. If liquidated damage is assessed, the corresponding missed trip will be removed from the performance calculation of items (a)-(e) above.

(g) If an enrollee who does not have a Standing Order misses an appointment due to late pick up, missed trip, or cancellation by the transporter, the Managed Care Plan must work expeditiously with the appointment provider and enrollee to coordinate and reschedule the appointment for the nearest available time slot as possible.

If the Managed Care Plan fails to comply with the requirements of this provision, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

(3) The Managed Care Plan shall report to the Agency on transportation timeliness as specified in **Section XV.**, Accountability, and in the Managed Care Plan Report Guide.

5. Waiver

a. If the Managed Care Plan is unable to demonstrate network adequacy for any network access standards and provides evidence that a certain provider(s) is not available to meet the network standard, the Managed Care Plan may submit a waiver request for review and approval by the Agency. The Managed Care Plan shall augment its network as such providers become available to meet the network adequacy requirements.

b. The Managed Care Plan may submit a waiver request in a manner and format approved by the Agency.

c. Nothing in this Section relieves the plan of its obligation to provide adequate and timely access to medically necessary services for its enrollees with reasonable promptness.

B. Network Management

1. General Provisions

a. The Managed Care Plan shall develop and maintain procedures to evaluate the Managed Care Plan's provider network to ensure that covered services are available and accessible, at a minimum, in accordance with the access standards in this Contract (42 CFR 438.207(b); 42 CFR 438.206).

b. If the Managed Care Plan declines to include individual or group providers in its provider network, the Managed Care Plan shall provide written notice to the affected provider(s) of the reason for its decision (42 CFR 438.12(a)(1)).

c. The Agency shall contract with an independent vendor to conduct network adequacy reviews for the purpose of auditing provider networks, including, but not limited to, conducting secret shopper activities and other activities to verify provider networks as identified by the Agency. The vendor will conduct systematic and continuous testing of the provider network databases maintained by the Managed Care Plan to confirm accuracy, confirm that providers are accepting enrollees, and confirm that enrollees have access to services, and provide the Agency with analytics, dashboard, and other reports as determined by the Agency. Payments shall include compensation of the vendor and necessary attendant administrative costs of the Agency directly related to the audit activities.

(1) The Managed Care Plan shall pay to the Agency the expenses of the Agency's network review vendor at the rates established by the Agency proportionate to the Managed Care Plan's enrolled population.

(2) The Managed Care Plan shall pay the Agency within twenty-one (21) days after presentation by the Agency of the detailed account of the charges and expenses.

(3) The Managed Care Plan's failure to pay the Agency shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages.

2. Annual Network Development Plan

a. The Managed Care Plan shall develop and maintain an annual network development plan. The Managed Care Plan shall submit this plan by September 1 of each Contract year, to the Agency.

b. The Managed Care Plan's annual network development plan shall include:

(1) The Managed Care Plan's processes and methods to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.

(2) The Managed Care Plan's annual network development plan must include a description of network design by region and county for each population served by the Managed Care Plan.

c. 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) Immediate short-term interventions to address network gaps, including the process for enrollees to access services.

(2) Long-term interventions to resolve network gaps and an evaluation of the effectiveness of those interventions to resolve network gaps and barriers.

(3) Method for accessing a non-participating provider to address any potential gaps, including a description of the Managed Care Plan's provider outreach strategy.

(4) The extent to which the Managed Care Plan utilizes telemedicine services to resolve network gaps.

(5) Ongoing activities for network development, including network management functions delegated to subcontractors.

d. The Managed Care Plan's annual network development plan must include an organizational flowchart that outlines relationships between internal departments, including all committees and committee membership, by department/area, where this coordination occurs.

e. The Managed Care Plan's annual network development plan shall include the results of "secret shopper" activities, including those prescribed by the Agency, and how those results are used to monitor and maintain the provider network.

f. The Managed Care Plan's annual network development plan shall include a description of coordination with provider associations and other outside organizations.

g. The Managed Care Plan's annual network development plan shall include a description of the overall monitoring strategy of subcontractors delegated for network management functions, including how those monitoring results are used to ensure continuous oversight across all provider network functions between the Managed Care Plan and its subcontractors.

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

3. Regional Network Changes

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

b. The Managed Care Plan shall provide the Agency with documentation of compliance with access requirements at any time there has been a significant change in the Managed Care Plan's regional network that would affect adequate capacity and services.

c. The Managed Care Plan shall notify the Agency within seven (7) business days of any adverse changes to its regional provider network, including:

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

(2) As defined in the Exhibits.

C. Provider Credentialing and Contracting

1. General Provisions

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

b. If the Managed Care Plan has delegated credentialing and/or recredentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Managed Care Plan's and the Agency's credentialing requirements as found in **Section VII.**, Provider Network and Services, **Sub-Section C.**, Provider Credentialing and Contracting.

c. The Agency reserves the right to require the Managed Care Plan to utilize the Agency's provider enrollment and/or credentialing vendor in coordinating Managed Care Plan onboarding and credentialing. The FX Provider Enrollment System includes a streamlined credentialing process in which the Managed Care Plan is required to participate to lower the administrative burden to providers.

d. The Managed Care Plan shall participate in workgroups with other Managed Care Plans, the Agency, and additional stakeholders to focus on reducing SMMC program redundancies in the provider onboarding process.

e. 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 XII.** Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

2. Credentialing and Recredentialing

a. The Managed Care Plan shall ensure that all providers are eligible for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements (42 CFR 455.100-106; 42 CFR 455.400-470).

b. The Managed Care Plan shall ensure all providers have a current provider agreement with Agency, as prescribed by the Agency. The Managed Care Plan shall continuously verify all providers have a current provider agreement with Agency at regular intervals to ensure payments are not made to ineligible providers.

c. The Managed Care Plan shall fully enroll/on-board all providers it chooses to contract within sixty (60) days. The Managed Care Plan shall submit the date it receives full and complete provider applications to the Agency on the Provider Network Verification (PNV) file when requested.

d. If the Managed Care Plan fails to comply with the requirements of this provision, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.** Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

e. The Managed Care Plan may execute network provider agreements, pending the outcome of the enrollment and onboarding process of up to sixty (60) days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of the sixty (60)-day period without enrollment of the provider, and notify affected enrollees. [42 CFR 438.602(b)(2)]

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

g. The Managed Care Plan shall deem providers with a valid Limited Enrolled or Fully Enrolled agreement with the Agency as having met all requirements described below:

(1) Proof of each provider's current license or authority to do business, including documentation of provider qualifications, as specified in the service-specific policy; if the provider is located in Georgia or Alabama, the provider's license and permit must be current and applicable to the respective state in which the provider is located.

(2) No revocation, moratorium, or suspension of the provider's license by the licensing authority in this or any state, if applicable.

(3) No sanctions imposed on the provider by Medicare or Medicaid, without proof of reinstatement or other documentation that all obligations under the sanction have been met.

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

(5) A level II background check pursuant to Section 409.907, F.S.

h. In order to receive payment for covered services, non-participating providers must have a Medicaid provider identification number in the FMMIS.

i. The Managed Care Plan shall ensure providers not known to Florida Medicaid that rendered services during a disaster or emergency declared by a Governor's Executive Order, as confirmed by the Agency, complete the Agency's provisional (temporary) enrollment process to obtain a provider identification number for services rendered to enrollees.

j. The Managed Care Plan is authorized to recoup any payments made under this Contract if the provider does not successfully complete the onboarding process within sixty (60) days and the delay is not caused by the Managed Care Plan.

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

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

(2) A designated credentialing committee.

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

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

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

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

l. The Managed Care Plan shall establish and verify additional provider credentialing and recredentialing criteria with respect to the applicable SMMC program in accordance with the applicable Exhibit(s).

m. If a provider is currently suspended or terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. Suspension and termination are described further in Rule 59G-9.070, F.A.C.

n. The Managed Care Plan shall submit provider disclosures and notifications to the federal DHHS OIG and to MPI in accordance with s. 1128, s. 1156, and s. 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in **Section IX.**, Administration and Management, **Sub-Section F.**, Fraud and Abuse Prevention, **Item 6.**, Reporting and Disclosure Requirements.

o. The Managed Care Plan shall report suspected unlicensed ALF's and AFCH's to the Agency, and shall require its providers to do the same pursuant to Section 408.812 F.S.

p. Managed Care Plan credentialing and recredentialing processes must include verification of the following additional requirements for transportation providers and shall ensure all transportation providers (excluding transportation network companies):

(1) Comply with standards set forth in Chapter 427, F.S., and Rules 41-2 and 14-90, F.A.C. These standards include drug and alcohol testing, safety standards, driver accountability, and driver conduct.

(2) Maintain vehicles and equipment in accordance with State and federal safety standards and the manufacturers' mechanical operating and maintenance standards for any and all vehicles used for transportation of Medicaid recipients.

(3) Comply with applicable State and federal laws, including, but not limited to, the ADA and the Florida Transportation Association (FTA) regulations.

(4) Immediately remove from service any vehicle that does not meet the Florida Department of Highway Safety and Motor Vehicles licensing requirements, safety standards, ADA regulations, or Contract requirements and re-inspect the vehicle before it is eligible to provide transportation services for Medicaid enrollees under this Contract. Vehicles shall not carry more passengers than the vehicle was designed to carry. All lift-equipped vehicles must comply with ADA regulations.

(5) Maintain sufficient liability insurance to meet requirements of Florida law.

(6) Ensure adequate seating for paratransit services for each enrollee and escort, child, or personal care attendant, and shall ensure that the vehicle meets the following requirements and does not transport more passengers than the registered passenger seating capacity in a vehicle at any time:

(a) Enrollee property that can be carried by the passenger and/or driver, and can be stowed safely on the vehicle, shall be transported with the passenger at no additional charge. The driver shall provide transportation of wheelchairs, child seats, stretchers, secured oxygen, personal assistive devices, and/or intravenous devices, as applicable, within the capabilities of the vehicle.

(b) Each vehicle shall have posted inside the Managed Care Plan's toll-free telephone number for enrollee complaints.

(c) The interior of all vehicles shall be free from dirt, grime, oil, trash, torn upholstery, damaged or broken seats, protruding metal, or other objects or materials which could soil items placed in the vehicle or cause discomfort to enrollees.

(d) Smoking, eating, and drinking are prohibited in any vehicle, except in cases in which, as a medical necessity, the enrollee requires fluids or sustenance during transport.

(e) All vehicles must be equipped with two-way communications, in good working order and audible to the driver at all times, by which to communicate with the transportation services hub or base of operations.

(f) All vehicles must have working air conditioners and heaters.

(7) Comply with the minimum liability insurance requirement of two hundred thousand dollars **($200,000)** per person and three hundred thousand dollars **($300,000)** per incident for all transportation services purchased or provided for the transportation disadvantaged through the Managed Care Plan (s. 768.28(5), F.S.). The Managed Care Plan shall indemnify and hold harmless the local, State, and federal governments and their entities and the Agency from any liabilities arising out of or due to an accident or negligence on the part of the Managed Care Plan and/or all transportation providers under contract to the Managed Care Plan.

(8) Maintain a passenger/trip database that includes information for each enrollee it transports and the details of the driver providing the trip (name, driver's license number). Information in the Managed Care Plan's passenger/trip database must be maintained in a reproduceable format and available to the Agency upon request.

(9) Providing the enrollee with boarding assistance, if necessary or requested, to the seating portion of the vehicle, including but not be limited to: opening the vehicle door, fastening the seat belt or wheelchair securing devices, storing mobility assistive devices, and closing the vehicle door. In the door-through-door paratransit service category, the driver shall open and close doors to buildings, except in situations in which assistance in opening and/or closing building doors would not be safe for passengers remaining in the vehicle. The driver shall provide assisted access in a dignified manner.

(10) Provide shelter, security, and safety of enrollees at vehicle transfer points.

(11) Provide pick up from and return to a mutually agreed-upon location for the enrollee and enrollee's attendant/escort.

q. The Managed Care Plan shall ensure that all vehicles used for transportation services have received annual safety inspections, and all drivers providing transportation services have passed background checks and meet all qualifications specified in law and in rule.

3. Minority Recruitment and Retention Plan

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

4. Prohibition Against Discriminatory Practices

a. The Managed Care Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of the provider's license or certification under applicable State law.

b. The Managed Care Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments (42 CFR 438.12(a)(2); 42 CFR 438.214(c)).

c. The Managed Care Plan shall not discriminate or take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal (42 CFR 438.410(b)).

5. Provider Agreement Requirements

a. The Managed Care Plan shall submit all provider agreement templates for Agency review to determine compliance with Contract requirements. The Managed Care Plan shall submit to the Agency, upon request, individual provider agreements as required by the Agency. If the Agency determines, at any time, that a provider agreement is not in compliance with a Contract requirement, the Managed Care Plan shall promptly revise the provider agreement to bring it into compliance. In addition, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.** Sanctions and Corrective Action Plans, and/or liquidated damages pursuant to **Section XIII.**, Liquidated Damages.

b. The Managed Care Plan shall ensure all provider agreements comply with Chapter 641.315, F.S., 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.

c. The Managed Care Plan shall take any and all necessary action to promote eligible provider participation in the ENS and include such requirements in its provider agreements.

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

(1) Not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient regarding:

(a) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(b) Any information the enrollee needs to decide among all relevant treatment options.

(c) The risks, benefits, and consequences of treatment or non-treatment.

(d) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions (42 CFR 438.102(a)(1)).

(2) Not prohibit a provider from advocating on behalf of the enrollee in any part of the enrollee grievance and appeal system or UM process, or individual authorization process to obtain necessary services (42 CFR 438.402(c)(1)(i)-(ii); 42 CFR 438.408).

(3) Prohibit a provider from offering anything of value (including reduction of room and board costs) to retain enrollees or persuade potential enrollees to select them as their provider or to enroll in a particular Managed Care Plan.

(4) Require providers to offer hours of operation that are no less than the hours of operation offered to commercial Managed Care Plan members or comparable Medicaid FFS recipients if the provider serves only Medicaid recipients (42 CFR 438.206(c)(1)).

(5) Require providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with special health care needs, including physical or mental disabilities in accordance with 42 CFR 438.206(c)(3).

(6) Specify covered services, including applicable prior authorization requirements, acceptable billing codes, and populations to be served under the provider agreement.

(7) Require primary care providers to conduct screening of at least ninety-five percent (95%) of enrollees for health-related social needs using an Agency-approved screening tool and record the identified ICD-10 codes (Z55-Z65) in the enrollee's electronic health record.

(8) Specify the Managed Care Plan's process and timing for updating its claim processing system when the Agency's fee schedules are updated, whether based upon the effective date or promulgated date of the fee schedule change, and for reprocessing claims.

(9) Require providers to immediately notify the Managed Care Plan of an enrollee's pregnancy, including the mechanism of doing so, whether identified through medical history, examination, testing, claims, or otherwise.

(10) Require providers to meet timely access standards pursuant to this Contract.

(11) Require all direct service providers to complete abuse, neglect, and exploitation training, including training to identify victims of human trafficking.

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

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

(14) Provide for continuity of care for the course of treatment in the event a provider agreement terminates during the course of an enrollee’s treatment.

(15) Require the provider to look solely to the Managed Care Plan for compensation for services rendered, with the exception of cost sharing and patient responsibility (if applicable).

(16) Establish requirements for ICP, Hospice, and ALFs regarding collection of patient responsibility, including prohibiting the assessment of late fees.

(17) Require the provider to participate with the Managed Care Plan’s peer review, grievance, QI, and UM activities, as directed by the Managed Care Plan.

(18) Include the monitoring and oversight activities the plan will follow, including monitoring of services rendered to enrollees, by the Managed Care Plan.

(19) Identify the measures, metrics, and frequency of measurement that shall be used by the Managed Care Plan to monitor the quality and performance of the provider.

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

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

(22) Require that records be maintained for a period not less than ten (10) years from the close of this Contract and retained further if the records are under review or audit until the review or audit is complete (42 CFR 438.3(u)). Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the provider agreement is continuous.

(23) Require providers to cooperate fully with the Agency (or its designee), CMS, the OIG, the Comptroller General, and Attorney General’s Office for the inspection, evaluation, and auditing of any records or documents (medical or financial) of the Managed Care Plan or its subcontractors at any time, related to this Contract (42 CFR 438.3(h)).

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

(25) Include the specific reports and clinical information required by the Managed Care Plan for QI or other administrative purposes out of claims processing.

(26) Require providers to submit timely, complete, and accurate claims to the Managed Care Plan in accordance with the requirements of **Section IX.**, Administration and Management, **Sub-Section D.**, Information Management and Systems, at a minimum.

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

(28) Require compliance with HIPAA privacy and security provisions (42 CFR 438.224).

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

(30) Specify that any provider whose participation is terminated pursuant to the provider agreement for any reason shall utilize the applicable appeals procedures outlined in the provider agreement. No additional or separate right of appeal to the Agency or the Managed Care Plan is created as a result of the Managed Care Plan's act of terminating, or decision to terminate, any provider under this Contract.

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

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

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

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

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(35) Specify the process for a network provider to report to the Managed Care Plan when the network provider has received an overpayment, to return the overpayment to the Managed Care Plan within sixty (60) days after the date on which the overpayment was identified, and to notify the Managed Care Plan in writing of the reason for the overpayment (42 CFR 438.608(d)(2)).

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

(37) If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount, less any applicable copayments.

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

f. The Managed Care Plan may execute provider agreements pending the outcome of the provider enrollment process. The Managed Care Plan must terminate a network provider immediately upon notification from the Agency that the network provider cannot be enrolled, or upon expiration of the sixty (60) day period without enrollment of the provider and notify affected enrollees in accordance with 42 CFR 438.602(b)(2).

6. Network Performance Management

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

b. The Managed Care Plan shall monitor participating providers on performance measures specified and collected by the Agency, as well as additional measures agreed upon by the provider and the Managed Care Plan as documented in the provider agreement.

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

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

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

7. Provider Termination and Continuity of Care

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

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

c. At least sixty (60) days before the effective date of the suspension or termination of a provider from the network, unless otherwise specified in this Section, the Managed Care Plan shall:

   (1) Notify the provider and enrollees that received services from the provider within the past six (6) months.

   (2) Provide reason(s) to the Agency of a for-cause termination.

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

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

f. The Managed Care Plan shall allow enrollees to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the enrollees select another provider, for a minimum of sixty (60) days after the termination of the provider's Contract. Notwithstanding the provisions in this Section, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

g. For continuity of care under this Section, the Managed Care Plan and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated Contract.

h. The Managed Care Plan shall report provider terminations, suspensions, and denials of a provider's request to participate in the Managed Care Plan's network, including documentation of enrollee notification and additions as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide (42 CFR 438.608).

i. The Managed Care Plan shall notify the Agency at least ninety (90) days prior to the termination effective date of a participating hospital agreement, or within seven (7) days of notification from the participating hospital; whichever occurs first. The notification must include the Agency-prescribed hospital termination checklist located at https://ahca.myflorida.com/Medicaid/statewide_mc/app_contract_materials.shtml.

D. Provider Services

1. General Provisions

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

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

c. The Managed Care Plan shall monitor provider compliance with Contract requirements, provide technical support and training, and take Contract action when needed to ensure compliance.

2. Provider Engagement Approach

a. The Managed Care Plan shall employ regional provider engagement staff whose primary jobs are to respond timely and adequately to inquiries, questions, and concerns from participating providers. This staff shall ensure that providers receive prompt resolution to their problems or inquiries, as well as appropriate education about participation in the SMMC program. Sufficient regional staffing under this position must be in place to ensure providers receive assistance and timely and accurate responses.

b. The Agency reserves the right to establish minimum ratios of provider engagement staff to participating providers.

c. The Managed Care Plan shall implement mechanisms to track interactions with providers (electronic, hard copy, in person, and telephonic) that result in the production of meaningful data the Managed Care Plan will use to address both clinical and administrative problem areas with participating providers. Such mechanisms shall include the collection of data demonstrating the Managed Care Plan's responsiveness to provider-initiated interactions.

3. Provider Handbook and Bulletin Requirements

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

b. The Managed Care Plan may choose to distribute the provider handbook from the Managed Care Plan's website. This notification shall detail how to obtain the handbook from the Managed Care Plan's website and how the provider can request a hard copy from the Managed Care Plan at no charge.

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

d. The Managed Care Plan shall provide at least thirty (30) days' advance notice to providers of changes to its provider handbooks that impact service authorization, claims payment, or grievance and appeals processes.

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

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

(2) Emergency service responsibilities.

(3) Provider responsibilities.

(4) Requirements regarding background screening.

(5) Requirements regarding the recredentialing process.

(6) Description of where to obtain service-specific coverage requirements and medical necessity criteria.

(7) Description of how to obtain service authorization and referral procedures, including required forms.

(8) Information on the Managed Care Plan's CPIO programs.

(9) Enrollee record standards for providers.

(10) Description of where to obtain claims submission protocols and standards, including instructions and all information required for a clean or complete claim.

(11) Protocols for submitting claims data.

(12) Requirements regarding marketing activities and marketing prohibitions.

(13) Procedures that address the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Managed Care Plan to file a provider complaint, including complaints about claims issues, and the complaint review process.

(14) Information on identifying and reporting abuse, neglect, and exploitation of enrollees, including information on identifying victims of human trafficking.

(15) Enrollee rights and responsibilities (42 CFR 438.100).

(16) Required procedural steps in the Managed Care Plan's enrollee grievance process, including the address, telephone number, and office hours of the

grievance staff; the enrollee's right to request continuation of benefits while utilizing the enrollee grievance and appeal system in accordance with 42 CFR 438.414. The Managed Care Plan shall specify telephone numbers to call to present a complaint, grievance, or appeal on behalf of an enrollee. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the Managed Care Plan without undue delays.

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

4. Provider Education and Training

a. The Managed Care Plan shall make available training to all providers and their staff regarding the requirements of this Contract, including any Contract amendments and special needs of enrollees.

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

c. For a period of at least twelve (12) months following the implementation of this Contract, the Managed Care Plan shall conduct monthly education and training for the top five (5) specific provider types identified by the Managed Care Plan through its monitoring and QI processes, and claims submission and payment processes, which shall include, but not be limited to, an explanation of common claims submission errors and how to avoid those errors. Such period may be extended as determined necessary by the Agency.

d. The Managed Care Plan shall conduct analysis of provider complaint reasons at a frequency to be determined by the Agency to determine the greatest areas of need for provider communication and/or training.

e. The Managed Care Plan shall meet regularly with provider organizations to maintain a proactive approach to resolving and preventing issues.

f. The Managed Care Plan shall ensure sufficient in-person and on-demand training availability to meet the needs of its providers.

g. The Managed Care Plan shall provide ongoing training to providers addressing the following topics at a minimum:

(1) Minimum service coverage guidelines

(2) Service authorization requirements

(3) Billing procedures

(4) Claims processing, including claim denial reason codes and billing solutions

(5) Payment timeframes

(6) Dispute resolution process and timeframes

(7) Agency contract requirements

h. The Managed Care Plan shall ensure all participating and direct service providers required to report abuse, neglect, or exploitation of vulnerable adults under Section 415.1034, F.S., obtain training on these subjects.

5. Toll-Free Provider Help Line

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

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

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

d. This provider help line shall have staff to respond to provider questions in all other areas, including, but not limited to, the provider complaint system and provider responsibilities, between the hours of 8 a.m. and 7 p.m. in the provider's time zone, Monday through Friday, excluding State holidays. The Managed Care Plan shall ensure that, after regular business hours, the provider help line (not the prior authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for an enrollee with an emergency or urgent medical condition. This requirement shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

e. The Managed Care Plan's (or its subcontractor's) call center systems shall measure its performance on a monthly basis and report on these standards as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

f. The Managed Care Plan shall maintain provider call center metrics at the following levels through the SMMC Contract term:

(1) The Managed Care Plan shall ensure that at least ninety percent (90%) of calls are answered within thirty (30) seconds.

(2) The Managed Care Plan shall ensure that the rate of first-call resolution shall be at least seventy-five percent (75%).

(3) The Managed Care Plan shall ensure that the average hold time shall not exceed ninety (90) seconds.

(4) The Managed Care Plan shall ensure that the quality assurance monitoring score shall be ninety-five percent (95%) or greater.

(5) The Managed Care Plan shall ensure that the average speed of answer shall not exceed thirty (30) seconds.

(6) The Managed Care Plan shall ensure that the call abandonment rate shall not exceed three percent (3%).

(7) The Managed Care Plan shall ensure that the blockage rate, as reported from the telecom provider, is no more than one-half of a percent (0.5%).

(8) The Managed Care Plan shall ensure that the call blockage rate, as reported by the ACD reporting software, is no more than zero percent (0.0%).

If the Managed Care Plan fails to comply with the requirements of the above provisions, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

6. Provider Complaint System

The Managed Care Plan shall establish and maintain a provider complaint system that permits a provider to dispute the Managed Care Plan’s policies, procedures, or any aspect of a Managed Care Plan’s administrative functions, including proposed actions, claims/billing disputes, and service authorizations.

a. Upon an effective date to be determined by the Agency, the Managed Care Plan shall not delegate any aspect of the provider complaint system to its subcontractors unless otherwise specified in provisions below.

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

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

(2) Identify staff specifically designated to receive and process provider complaints.

(3) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider agreement provisions, collecting all pertinent facts from all parties and applying the Managed Care Plan’s written procedures.

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

c. The Managed Care Plan’s process for provider complaints concerning claims issues shall be in accordance with s. 641.3155, F.S.

d. For provider complaints concerning non-claims issues, the Managed Care Plan shall:

(1) Allow providers forty-five (45) days from the date the issue occurred to file a complaint for issues that are not about claims.

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

(3) Within thirty (30) days of receipt of a non-claim complaint, document the reason the complaint is unresolved and provide written notice of the status to the provider. Written notice of the status of the complaint must be provided to the provider every thirty (30) days thereafter until the complaint is resolved, using the Notice of Status Letter Template provided by the Agency.

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

e. For provider complaints concerning claims issues, the Managed Care Plan shall:

(1) Allow providers ninety (90) days from the date of final determination of the primary payer to file a complaint for claims issues.

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

(3) Within thirty (30) days of receipt of a claim complaint, document the reason the complaint is unresolved and provide written notice of the status to the provider. Written notice of the status of the complaint must be provided to the provider every thirty (30) days thereafter until the complaint is resolved, using the Notice of Status Letter Template provided by the Agency.

(4) Provide written notice of the status of Agency submitted claim issues to the Agency within fifteen (15) business days of receipt. For Agency submitted claims issues that require additional time to research, the Managed Care Plan must submit a written request to the Agency within three (3) business days of receipt of the complaint, and shall include:

(a) An explanation for the need of an extension.

(b) Expected time needed beyond the initial fifteen (15) business days for research and response.

Approval of extension is contingent upon Agency review.

(5) Resolve all denied claims complaints within sixty (60) days of receipt in accordance with s. 641.3155, F.S., and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

(6) Resolve all other claim related complaints within ninety (90) days from the date of receipt and provide written notice of the disposition and the basis of resolution to the provider within three (3) business days of resolution.

f. The Managed Care Plan shall utilize the Agency's contracted dispute resolution vendor, as described in Section 408.7057, F.S., for managing, addressing, and resolving provider complaints related to claims issues. The process shall comply with s. 641.3155, F.S. The Managed Care Plan shall comply with all terms and conditions set forth in any orders and instructions issued by the Agency or its designee as a result of the claim dispute resolution process.

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

h. The Managed Care Plan shall maintain a complete and accurate record of all complaints and shall make such records available upon request of the Agency.

i. The Managed Care Plan is prohibited from discriminating or taking punitive action against a provider for making a complaint to the Agency in good faith. Punitive actions include harassment or retaliation of any kind, and the Agency may investigate reports of such misconduct.

j. The Managed Care Plan shall report provider complaints as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

E. Claims and Provider Payment

1. General Provisions

a. The Managed Care Plan shall process claims and pay providers in compliance with the federal and State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent (Section 409.967(2)(j), F.S.).

b. The Managed Care Plan shall have claims payment performance metrics, including those for quality, accuracy, and timeliness. The Managed Care Plan shall also include a process for measurement and monitoring, and for the development and implementation of interventions for improvement in regard to claims processing and claims payment. The Managed Care Plan shall make documentation of such metrics available for Agency review upon request.

c. The Managed Care Plan shall use electronic transmission of claims, transactions, notices, documents, forms, and payments to the greatest extent possible by the Managed Care Plan.

d. Pursuant to Section 409.967(2)(m), F.S., the Managed Care Plan must provide an itemized accounting of the individual claims included in the payment to a provider, including the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Managed Care Plan.

e. The Managed Care Plan shall ensure at least eighty-five percent (85%) of all personal care services and home health services visits paid are verified using EVV technology, without the need to override exceptions to submit the claims or to process the claims through manual data entry. The Managed Care Plan shall submit to the Agency reports regarding EVV as specified in Section XV., Accountability, and the Managed Care Plan Report Guide.

f. The Managed Care Plan shall not reimburse for claims for nursing facility services provided prior to the date of completion of PASRR requirements.

g. The Managed Care Plan shall pay nursing facility providers in compliance with 42 CFR 488.417 and enforce any denial of payment for new admissions issued by CMS and as provided by the Agency.

h. The Managed Care Plan shall comply with Rule 59G-1.052, F.A.C. with regard to payment of third-party liability and Medicare co-insurance and deductibles for covered services.

i. The Managed Care Plan shall enter into a coordination of benefits agreement with Medicare and participate in the automated claims crossover process (42 CFR 438.3(t)).

j. The Managed Care Plan shall pay all deductibles and coinsurance for Medicare-covered services provided to Medicare-eligible enrollees by ambulances licensed pursuant to chapter 401 according to the corresponding procedure codes for such services, pursuant to Section 409.908(13)(c)4, F.S.

k. The Managed Care Plan shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three (3) years.

l. The Managed Care Plan shall not pay for the following:

(1) Home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

(2) Items or services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend payments (42 CFR 438.608(a)(8); 42 CFR 455.23).

(3) Any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (Section 1903(i) of the Social Security Act) and

(4) Items or services furnished by a provider during a period where the Agency has determined there is reliable evidence of circumstances giving rise to the need for a withholding of payments, which involves, fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients (Section 409.913(25)(a), F.S.).

m. The Managed Care Plan shall not pay for prescriptions, including refills, written by individuals that have had their Medicaid prescribing rights suspended by the Agency, as identified by the Agency.

n. The Managed Care Plan that is operating as a Provider Service Network shall comply with the following Fair Payment Provisions:

   (1) Fully comply with the provisions of Section 409.967(2)(l), F.S.

   (2) Ensure that any health care provider entity that the PSN controls and/or in which the PSN has an ownership interest, regardless of whether that entity is licensed under Chapter 395, F.S., does not charge any other managed care plan more than the amount paid to that provider by the PSN for the same service.

   (3) Ensure that any health care provider entity that has controlling interest and/or an ownership interest in the PSN, regardless of whether that entity is licensed under Chapter 395, F.S, does not charge any other managed care plan more than the amount paid to that provider by the PSN for the same service.

   If the Managed Care Plan fails to comply with the requirements of these provisions, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

o. The Managed Care Plan shall incorporate into its claim processing and claims payment system the NCCI editing programs for the HCPCS/CPT codes to promote correct coding and control coding errors, except for allowable NCCI edits exclusions in accordance with the claims processing requirements of 42 CFR 433.116 and 45 CFR 95, subpart F.

p. For provider network agreements relying on fee-for-service fee schedules, the Managed Care Plan shall program the new or updated codes in its claim processing systems based upon the effective date of the code change as posted on the Agency's website. The Managed Care Plan shall pay claims correctly based upon the code effective date to ensure there are no gaps in covered services or payment.

q. For dually eligible enrollees residing in a nursing facility and receiving hospice services, the Managed Care Plan shall not pay for hospice services and shall pay for hospice room and board.

r. For dually eligible enrollees, the Managed Care Plan shall not require an explanation of benefits prior to payment for services that are not covered by Medicare (e.g., hearing aids, refractory examinations for prescription glasses, room and board payments for enrollees residing in a nursing facility and receiving hospice services pursuant to s. 1812(d) of the SSA). Exceptions to this requirement may be approved by the Agency.

s. The Agency shall ensure that no payment is made to a provider other than by the Managed Care Plan for services available under this Contract, except when these payments are specifically provided for in Title XIX of the Social Security Act, in 42 CFR Chapter IV, or when the Agency has adjusted the capitation rates paid under this Contract to make payments for graduate medical education (42 CFR 438.60).

t. In the event the Agency establishes systems and processes to collect submitted claims data, including denied claims, from the providers directly, the Managed Care Plan must be capable of sending and receiving any claims information directly to the Agency in standards and timeframes specified by the Agency within sixty (60) days' notice. The Managed Care Plan shall also work cooperatively with the Agency during any transition period for network providers to move to submitting claims through the State instead of directly to the Managed Care Plan.

2. Timely Claims Payment

For claims for services:

a. For all electronically submitted claims for services, the Managed Care Plan shall:

(1) Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.

(2) Pursuant to Section 409.982(5), F.S., within ten (10) business days of receipt of nursing facility and hospice clean claims, pay or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

(3) Within fifteen (15) days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of denial reasons or codes and additional information or documents necessary to process the claim.

(4) Pay or deny the contested claim within ninety (90) days after receipt of the claim. Failure to pay or deny the claim within one hundred twenty (120) days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim (s. 641.3155(3)(e), F.S.).

b. For all non-electronically submitted claims for services, the Managed Care Plan shall:

(1) Within fifteen (15) days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.

(2) Within twenty (20) days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

(3) Pay or deny the contested claim within one hundred twenty (120) days after receipt of the claim. Failure to pay or deny the claim within one hundred forty (140) days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim.

c. The Managed Care Plan shall comply with the following standards regarding timely claims processing for all providers:

   (1) The Managed Care Plan shall pay eighty-five percent (85%) of all clean claims submitted within seven (7) days.

   (2) The Managed Care Plan shall pay ninety-five percent (95%) of all clean claims submitted within ten (10) days.

   (3) The Managed Care Plan shall pay ninety-eight percent (98%) of all clean claims submitted within twenty (20) days.

d. The Managed Care Plan shall reimburse providers for the delivery of authorized services as described in s. 641.3155, F.S., including but not limited to:

   (1) The provider must mail or electronically transfer (submit) the claim to the Managed Care Plan within six (6) months after:

      (a) The date of service or discharge from an inpatient setting; or

      (b) The date that the non-participating provider was furnished with the correct name and address of the Managed Care Plan, if applicable.

   (2) When the Managed Care Plan is the secondary payer and the primary payer is an entity other than Medicare, the Managed Care Plan shall require the provider to submit the claim to the Managed Care Plan within ninety (90) days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook. When the Managed Care Plan is the secondary payer and the primary payer is Medicare, the Managed Care Plan shall require the provider to submit the claim to the Managed Care Plan in accordance with timelines established in the Medicaid Provider General Handbook.

3. Accurate Claims Payment

a. The Managed Care Plan shall maintain a claim payment accuracy percentage of ninety-five percent (95%) or higher for each measure of accuracy established by the Agency.

b. The Managed Care Plan shall submit a claim payment accuracy report as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

4. Multipayer Claims Database

Pursuant to Section 409.967(2)(o), the Managed Care Plan shall contribute all claims data from the Managed Care Plan and its affiliates for services provided to all enrollees and other covered individuals to the Agency's contracted vendor authorized under Section 408.05(3)(c), F.S., in a manner specified by the Agency.

5. Directed Payment Programs

a. Public Emergency Medical Transportation Fee Schedule

The Managed Care Plan shall make monthly uniform increase payments as specified in the Plan-specific **Attachment I** , **Section III.**, Method of Payment, to qualified public emergency medical transportation providers. The payment amount shall be the per-member, per-month amount multiplied by the Managed Care Plan's monthly enrollment in the applicable region.

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Section VIII. Quality

A. Quality Improvement

1. General Provisions

a. The Managed Care Plan shall have a QI program that ensures enhancement of quality of care and emphasizes improving the quality of patient outcomes, including establishing metrics for monitoring the quality and performance of each participating provider. The Managed Care Plan shall evaluate the provider's performance and determine continued participation in the network as specified in **Section VIII.**, Quality.

b. The Agency shall be responsible for establishing standards and requirements for QI, including performance measures, targets, improvement plans, satisfaction surveys and enrollee record reviews, and providing instructions to the Managed Care Plan through the Managed Care Plan Report Guide referenced in **Section XV.**, Accountability and Performance Measures Specifications Manual. The Agency may change these targets and/or change the timelines associated with meeting the targets. The Agency shall make these changes with sixty (60) days' advance notice to the Managed Care Plan.

c. The Agency shall be responsible for contracting with an EQRO and conducting other QI activities, including, but not limited to, audits of enrollee records, enrollee plans of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under this Contract and its Exhibits.

d. The Agency shall be responsible for establishing incentives to high-performing Managed Care Plans in accordance with 42 CFR 438.6(b) and take appropriate action in accordance with the terms of this Contract if the Managed Care Plans do not meet acceptable QI and performance indicators.

e. The Managed Care Plan shall identify and track adverse or critical incidents and shall review and analyze adverse or critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. The Managed Care Plan shall make such tracking available to the Agency upon request.

f. The Managed Care Plan shall submit performance measure data as specified by the Agency and in a manner and format prescribed by the Agency.

2. Performance Incentives

The Agency may offer incentives to high-performing the Managed Care Plan in accordance with 42 CFR 438.6(b). The Agency will notify the Managed Care Plan annually on or before December 31 of the incentives that will be offered the following year. Incentives may be awarded to all high-performing Managed Care Plans or may be offered on a competitive basis. Incentives may include, but are not limited to, quality designations, quality awards, and enhanced auto-assignments. The Agency, at its discretion, may

disqualify a Managed Care Plan for any reason the Agency deems appropriate, including, but not limited to, the Managed Care Plan that received a monetary sanction for performance measures or any other sanctionable offense. In accordance with Section 409.967(3)(g), F.S., as part of the achieved savings rebate process, a Managed Care Plan that exceeds Agency-defined quality measure targets as specified in **Section X**, Method of Plan Payment, in the reporting period may retain an additional one percent (1%) of revenue.

3. Accreditation

a. Pursuant to Section 409.967(2)(f)3., F.S., the Managed Care Plan must be accredited by a nationally recognized accrediting body or have initiated the accreditation process within one (1) year after this Contract was executed.

   (1) If the Managed Care Plan is not accredited or has not initiated the accreditation process within one (1) year, all enrollee auto-assignments to the Managed Care Plan shall be suspended until the Managed Care Plan is accredited by a nationally recognized body (42 CFR 438.332(a)).

   (2) If the Managed Care Plan is not accredited within eighteen (18) months after executing this Contract, the Agency may terminate this Contract for failure to comply with this Contract.

b. In accordance with 42 CFR 438.332, the Managed Care Plan shall authorize its accrediting body to provide the Agency a copy of its most recent accreditation review, including: its accreditation status, survey type, and level (as applicable); recommended actions or improvements, CAPs, and summaries of findings; and the expiration date of accreditation.

4. Quality Improvement Program

a. The Managed Care Plan shall have an ongoing QI program that objectively and systematically monitors and evaluates access to care and the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees (42 CFR 438.330(a)(1) and (3); 42 CFR 438.330(b)(4); 42 CFR 438.340).

b. The Managed Care Plan's governing body shall oversee and evaluate the impact and effectiveness of its QI program (42 CFR 438.330(e)(2); 42 CFR 438.310(c)(2)). The role of the Managed Care Plan's governing body shall include providing strategic direction to the QI program, as well as ensuring the QI plan is incorporated into processes throughout the Managed Care Plan.

c. The Managed Care Plan shall cooperate with the Agency and the EQRO. The Managed Care Plan shall use the methodology and standards for QI set by the Agency.

5. Quality Improvement Program Committee

a. The Managed Care Plan shall have a QI program committee, which includes:

(1) The Medical Director, as chair or co-chair.

(2) Provider representation (either through providers serving on the committee or through a provider liaison position, such as a representative from the network management department).

(3) Other committee representatives shall be selected to meet the needs of the Managed Care Plan.

Individual staff members may serve in multiple roles on the committee if they also serve in multiple positions within the Managed Care Plan.

b. At a minimum, the committee must meet quarterly. The Managed Care Plan shall maintain minutes of all QI program committee and sub-committee meetings and make the minutes available for Agency review on request.

c. The Managed Care Plan's QI program committee shall be responsible for development and implementation of a written QI plan, which incorporates the strategic direction provided by the Managed Care Plan's governing body.

6. Quality Improvement Plan

a. The Managed Care Plan shall develop and maintain a written QI plan and submit its QI plan to the Agency by November 1 of each year.

b. The QI plan must include a description of:

(1) The Managed Care Plan positions assigned to the QI program committee, including a description of why each position was chosen to serve on the committee and the roles each position is expected to fulfill. The resumes of QI program committee members shall be made available upon the Agency's request.

(2) The QI program committee structure, including development of subcommittees and task forces, and the committee's role in monitoring and evaluation of quality and appropriateness of care provided to enrollees.

(3) The mechanism within the Managed Care Plan for the governing body to provide strategic direction for the QI program, and for the QI program committee to communicate with the governing body.

(4) Specific training about quality that shall be provided by the Managed Care Plan to staff serving in the QI program committee. At a minimum, the training shall include protocols developed by CMS regarding quality. CMS protocols may be obtained from:

https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

(5) The Managed Care Plan's guiding philosophy for quality management, including any nationally recognized, standardized approach that is used (e.g., PDCA, Rapid Cycle Improvement, FOCUS-PDCA, Six Sigma). Selection of performance indicators and sources for benchmarking also shall be included in addressing the following specific components of the QI plan:

(a) Methods for assessment of the quality and appropriateness of care provided to enrollees with timely resolution of problems and new or continued improvement activities, including but not limited to:

(i) Service availability and accessibility.

(ii) Quality of services in accordance with acceptable professional practice standards.

(iii) Network quality.

(iv) Care planning and care coordination.

(v) Enrollee safety.

(vi) Utilization review processes.

(vii) Grievance and appeals.

(viii) Adverse/critical incident reporting

(b) The process to direct and analyze periodic review of enrollee service utilization patterns (including detection of underutilization and overutilization of services) (42 CFR 438.330(b)(3)).

(c) Monitoring and evaluation of provider network quality, including but not limited to:

(i) Credentialing and recredentialing processes.

(ii) Provider performance measurement.

(iii) Metrics for monitoring the quality and performance of participating providers related to their continued participation in the network.

(6) The process for selecting evaluation and study design procedures.

(7) A standard describing the process the QI program shall use to review and suggest new and/or improved QI activities.

(8) The Managed Care Plan's QI plan shall describe the process for annual QI activities evaluation, the evaluation results of the prior year's QI activities, and any subsequent revisions to the QI plan.

(a) The Managed Care Plan's program description and program evaluation shall identify priority areas for improvement that align with the Agency's goals and priorities.

(b) The Managed Care Plan shall conduct an analysis of the degree to which improvement was achieved for each priority area, including an analysis of the effectiveness.

c. The Managed Care Plan shall submit its updated QI plan, including the findings from its annual QI program evaluation to the Agency by November 1 of each Contract year.

7. EQRO Coordination Requirements

The Managed Care Plan shall cooperate with and provide all information requested by the EQRO (42 CFR 438.350).

8. Florida Medical School Quality Network Initiatives

In accordance with Section 409.975(2), F.S., the Managed Care Plan shall have a cooperative agreement with the FMSQN as directed by the Agency.

B. Performance Measures

1. General Provisions

a. The Managed Care Plan shall meet Agency-specified performance targets for all PMs as specified in this Contract and the applicable Exhibit(s).

b. The Agency may add or remove PM requirements with sixty (60) days' advance notice.

2. Required Performance Measures

a. The Managed Care Plan shall collect statewide data on enrollee PMs, as defined by the Agency and as specified in the SMMC Performance Measure Tables in the applicable Exhibits, the Managed Care Plan Report Guide, and Performance Measures Specifications Manual.

b. The Managed Care Plan shall report results of PMs to the Agency as specified in **Section XV.**, Accountability, the Managed Care Plan Report Guide, and Performance Measures Specifications Manual.

3. Quality Assessment and Performance Improvement Program

a. By July 1 of each Contract year, the Managed Care Plan shall deliver to the Agency a report on performance measure data and a certification by a NCQA certified HEDIS auditor that the performance measure data reported for the previous year are fairly and accurately presented. The HEDIS auditor shall certify the report, and the auditor must certify the actual file submitted to the Agency.

b. The Agency may grant extensions to the due date for up to thirty (30) days and require a signed, dated, written request by the Managed Care Plan CEO or designee. The Agency must receive the request before the report due date and the delay must be due to unforeseen and unforeseeable factors beyond the Managed Care Plan's control. Extensions shall not be granted on oral requests.

c. The Managed Care Plan shall use a software vendor who has achieved full HEDIS Measure Certification Status from NCQA for the current reporting year to calculate its PM rates each year.

d. The Agency shall consider deficient a report that contains a "not reportable" (NR) designation due to bias for any or all measures by the HEDIS auditor, or that contains a "false" designation.

4. Publication of Performance Measures

Pursuant to Section 409.967(2)(f)2., F.S., the Managed Care Plan shall publish its results for HEDIS measures on the Managed Care Plan's website in a manner that allows recipients to reliably compare the performance of Managed Care Plans. The Managed Care Plan may meet this requirement by including information about the comparison of performance measures conducted by the Agency and providing a link to the Agency's applicable website page.

C. Performance Improvement Projects

1. General Provisions

a. The Managed Care Plan shall develop, implement, and monitor PIPs in accordance with 42 CFR 438.240(d)(1). The Managed Care Plan shall achieve significant improvement to the quality of care and service delivery, through ongoing measurement of performance using objective quality indicators and ongoing interventions, sustained over time.

b. By January 1 of each Contract year, the Agency shall determine and notify the Managed Care Plan if there are changes in the number and types of PIPs the Managed Care Plan shall perform for the coming Contract year.

c. The Managed Care Plan's PIP methodology must comply with the most recent protocol set forth by CMS, Implementation of PIPs. CMS protocols may be obtained from:

https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/quality-of-care-external-quality-review/index.html

1. The Managed Care Plan shall include a statistically valid sample size for each PIP.

2. Populations selected for study under the PIP shall be specific to this Contract and shall not include Medicaid recipients from other states, or enrollees from other lines of business.

3. If the Managed Care Plan contracts with a separate entity for management of particular services, PIPs conducted by the separate entity shall not include enrollees for other Managed Care Plans served by that entity.

d. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at the ninety-five percent (95%) confidence level and must be sustained for two (2) additional re-measurement periods.

e. The Agency shall consider PIPs that have successfully achieved sustained improvement, as approved by the Agency, to be complete, and such PIPs shall not meet the requirement for one (1) of the number of PIPs required by the Agency, although the Managed Care Plan may wish to continue to monitor the performance target as part of its overall QI program. In this event, the Managed Care Plan shall select a new PIP and submit it to the Agency for approval (42 CFR 438.330(d)(2); 42 CFR 438.330(d)(2)(iv)).

2. PIP Proposals

a. The Managed Care Plan shall submit its measurement periods and methodologies to the Agency for approval before initiation of the PIP. Within thirty (30) days of Contract execution, the Managed Care Plan shall submit to the Agency, in writing:

(1) The initial proposed PIP topics and their indicators.

(2) A brief summary of the baseline data and time period that the Managed Care Plan shall use for each indicator for each of the proposed PIPs.

(3) An estimate of how many plan members will be in the eligible/affected population for each PIP.

(4) A brief rationale for why the Managed Care Plan has selected each proposed PIP topic.

b. The Managed Care Plan shall submit to the Agency in writing, a final proposal for each planned PIP no later than ninety (90) days after the execution of this Contract.

c. Each initial PIP proposal shall be submitted using the most recent version of the EQRO PIP validation form. The Managed Care Plan may obtain instructions for using the form to submit PIP proposals and updates from the Agency.

d. Activities 1 through 6 of the EQRO PIP validation form must be addressed in the PIP proposal. These activities are listed at http://www.myfloridaeqro.com/pips.aspx.

e. In the event the Managed Care Plan elects to modify a portion of the PIP proposal after initial Agency approval, the Managed Care Plan must submit a written request to the Agency for prior approval.

f. The Agency reserves the right to mandate specific PIP topics and performance indicators and will provide the Managed Care Plan with information required to complete their PIPs as needed.

3. Annual PIP Submission

a. The Managed Care Plan shall submit ongoing PIPs October 1 of each Contract year to the Agency for review and approval (42 CFR 438.330(c)(1) and (2)).

b. The Managed Care Plan shall update the EQRO PIP validation form in its annual submission to reflect the Managed Care Plan's progress. The Managed Care Plan is not required to transfer ongoing PIPs to a new, updated EQRO form.

c. The Managed Care Plan shall submit the Agency-approved EQRO PIP validation form to the EQRO upon its request for validation. The Managed Care Plan shall not make changes to the Agency-approved PIP being submitted to the EQRO unless expressly permitted and approved by the Agency in writing.

4. Quarterly PIP Progress Reports

In addition to annual submissions, the Managed Care Plan shall submit quarterly updates on PIP progress to the Agency on January 1, April 1, and July 1 of each Contract year. Fourth quarter updates should be submitted as part of the Managed Care Plan's annual PIP submission. Quarterly updates should, at a minimum, include the following elements:

a. Progress on intervention activities

b. Preliminary data results

c. Evaluations of effectiveness

5. EQRO Validation

The Managed Care Plan's PIPs shall be subject to review and validation by the EQRO. The Managed Care Plan shall comply with any recommendations for improvement requested by the EQRO, subject to approval by the Agency.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

a. The Managed Care Plan shall conduct an annual Enrollee Satisfaction survey. The Managed Care Plan shall submit a written proposal for survey administration and reporting to the Agency, by December 1 of each Contract year.

b. The proposal shall include the following:

(1) Identification of survey administrator and evidence of the survey administrator's NCQA certification as a CAHPS survey vendor

(2) Sampling methodology

(3) Administration protocol

(4) Analysis plan

(5) Reporting description

(6) Copy of the survey tool

(7) Cover letters and/or postcards

c. The Managed Care Plan shall provide the survey results to the Agency, in accordance with the survey results reporting templates and instructions from the Agency, along with an action plan in accordance with the applicable Exhibit(s).

d. The Managed Care Plan shall contract with a qualified, Agency-approved, NCQA-certified vendor to conduct annual enrollee satisfaction surveys required under this Contract (42 CFR 438.66(c)(5)).

e. The Agency will specify the survey requirements including survey specifications, applicable supplemental item sets and Agency-defined survey items. Annually, by January 1 of each Contract year, the Agency shall determine and notify the Managed Care Plan if there are changes in survey requirements.

f. The Managed Care Plan shall have its sample validated by a NCQA-certified HEDIS Auditor.

g. The Managed Care Plan shall report CAHPS survey results, starting with the July 1, 2019, submission, to the NCQA and the Agency. The submission to NCQA must be made by the NCQA deadline.

h. By October 1 of each Contract year, the Managed Care Plan shall submit its CAHPS survey vendor's final report to the Agency, along with the plan's action plan to address the results of the CAHPS survey.

i. The Managed Care Plan shall submit a CAP, as required by the Agency, within sixty (60) days of the request from the Agency to address any deficiencies identified in the annual CAHPS survey.

j. 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.

2. Provider Satisfaction Survey

a. The Managed Care Plan shall conduct an annual Provider Satisfaction Survey. The Managed Care Plan shall submit a written provider satisfaction survey plan to the Agency for written approval within ninety (90) days after initial Contract execution and by January 1 of each Contract year, thereafter (42 CFR 438.66(c)(5)).

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b. The proposal shall include the following:

(1) Copy of the survey tool, using a four-point Likert scale and including the following domains:

(a) Provider relations and communication

(b) Authorization processes, including denials and appeals.

(c) Timeliness of claims payment and assistance with claims processing

(d) Complaint resolution process

(e) Care coordination/case management support.

(2) Sampling methodology

c. The Agency reserves the right to require a specific survey tool, survey questions and/or survey methodology and to provide for minimum qualifications for survey vendors.

d. The Managed Care Plan shall conduct the survey, compile, and analyze its survey results, and provide the survey results to the Agency with an action plan to address the results of the Provider Satisfaction survey by September 1 each Contract year for the previous calendar year, beginning with the September 1, 2025, reporting.

E. Enrollee Record Requirements

1. General Provisions

The Managed Care Plan shall ensure maintenance of an enrollee record for each enrollee in accordance with this Section and with 42 CFR 431 and 42 CFR 456. Enrollee records shall include documents related to the quality, quantity, appropriateness, and timeliness of services performed under this Contract.

2. Enrollee Record Review Strategy

a. By June 1 of each Contract year, the Managed Care Plan shall submit a written strategy for conducting enrollee record reviews for Agency approval. The strategy shall include, at a minimum:

(1) Designated staff to perform this duty.

(2) Process for establishing inter-rater reliability with internal and external enrollee record reviews.

(3) Method for identifying enrollee records.

(4) Anticipated number of reviews for a statistically significant sample of enrollee records maintained by the Managed Care Plan, its subcontractors, and providers.

(5) The tool that the Managed Care Plan shall use to review each record.

(6) Record review deficiencies and how results will be utilized in process improvement(s).

(7) How the Managed Care Plan will link the information compiled during the review to other Managed Care Plan functions (e.g., QI, recredentialing, peer review).

b. The Managed Care Plan shall conduct enrollee record reviews of all providers with a pattern of complaints regarding poor quality of service and providers with poor quality outcomes.

c. The Managed Care Plan shall distribute the standards, which must include all enrollee record documentation requirements addressed in this Contract, to all providers.

3. Standards for Managed Care Plan Enrollee Records

a. The Managed Care Plan shall develop and maintain enrollee records meeting the documentation standards set forth in Rule 59G-1.054, F.A.C., below, and in the program-specific Exhibit(s):

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

(2) Include information relating to the enrollee's use of tobacco, alcohol, and drugs/substances.

(3) Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up.

(4) Reflect the primary language spoken by the enrollee and any translation needs of the enrollee.

(5) Identify enrollees needing communication assistance in the delivery of health care services.

b. The Managed Care Plan shall maintain written procedures for enrollee advance directives that address how the Managed Care Plan shall access copies of any advance directives executed by the enrollee. The Managed Care Plan's procedure shall be updated to reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change (42 CFR 438.3(j)(4)).

(1) All enrollee records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether or not the enrollee has executed an advance directive (42 CFR 438.3(j)(3)).

(2) Neither the Managed Care Plan, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)).

c. If the Managed Care Plan is not yet fully accredited by a nationally recognized accrediting body, the Managed Care Plan shall establish processes for enrollee record review that meet or exceed nationally recognized accrediting body enrollee record review standards.

4. Standards for Provider-Specific Enrollee Records

The Managed Care Plan shall ensure that its network of providers follow the enrollee record standards set forth in Rule 59G-1.054, F.A.C.

F. Provider-Specific Performance Monitoring

1. General Provision

The Managed Care Plan shall monitor the quality and performance of each participating provider. At the beginning of this Contract period, the Managed Care Plan shall notify all its participating providers of the metrics used by the Managed Care Plan for evaluating the provider's performance and determining continued participation in the network (Section 409.975(3), F.S.)

2. Peer Review

a. The Managed Care Plan shall have a peer review process that results in:

(1) Review of a provider's practice methods and patterns, morbidity/mortality rates, and all complaints and grievances filed against the provider.

(2) Evaluation of the appropriateness of care rendered by providers.

(3) Implementation of corrective action(s) when the Managed Care Plan deems it necessary to do so.

(4) Development of policy recommendations to maintain or enhance the quality of care provided to enrollees.

(5) Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider's enrollee records, adherence to standards generally accepted by a provider's peers and the process and outcome of a provider's care.

(6) Education of enrollees and Managed Care Plan staff about the peer review process, so that enrollees and the Managed Care Plan staff can notify the peer review authority of situations or problems relating to providers.

3. Monitoring Activities

The Managed Care Plan shall comply with monitoring activities requirements as specified in the applicable Exhibit(s).

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G. Additional Quality Management Requirements

1. Incident Reporting Requirements

a. As part of the Managed Care Plan's quality management requirements, the Managed Care Plan shall implement and maintain a risk management program.

b. The Managed Care Plan shall develop and implement an incident reporting and management system for adverse or critical incidents.

c. The Managed Care Plan shall require participating service providers and direct service providers to report adverse or critical incidents to the Managed Care Plan.

d. The Managed Care Plan shall provide appropriate training and take corrective action as needed to ensure its staff, participating providers, and direct service providers comply with critical incident requirements.

e. The Managed Care Plan shall immediately report to DCF's Central Abuse Hotline any suspected cases of abuse, neglect or exploitation of enrollees, in accordance with s. 39.201 and Chapter 415, F.S. The Managed Care Plan shall maintain documentation related to the reporting of such events in a confidential file, separate from the enrollee record. Such file shall be made available to the Agency upon request.

f. The Managed Care Plan shall report a summary of adverse and critical incidents to the Agency, as specified in **Section XV.**, Accountability, and in the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

2. Agency Monitoring

The Managed Care Plan shall furnish specific data requested by the Agency in order to conduct monitoring of the Managed Care Plan's compliance with this Contract.

H. Continuity of Care in Enrollment

The Managed Care Plan shall be responsible for continuity of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, including those services previously authorized under the fee-for-service delivery system or by the enrollee's immediate former managed care plan, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers for at least ninety (90) days after the effective date of enrollment. The Managed Care Plan shall reimburse non- participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for at least sixty (60) days, unless said provider agrees to an alternative rate.

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Section IX. Administration and Management

A. General Provisions

1. The Agency is responsible for administering the Medicaid program. The Agency shall administer contracts, monitor Managed Care Plan performance, and provide oversight in all aspects of Managed Care Plan processes.

2. The Agency shall be responsible for the administration of the FMMIS and contracting with the State's fiscal agent to exchange data with the Managed Care Plan and enroll Medicaid providers. The Agency is responsible also for the administration of programs for Florida's Medicaid Electronic Health Record Incentive Program, the Florida Health Information Network and other efforts to provide information and resources relating to HIT and HIE, as well as collecting data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information through http://www.floridahealthfinder.gov/index.html.

3. The Agency shall be responsible for establishing standards and requirements to ensure receipt of complete and accurate data for program administration as required to determine compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, F.S. The Agency shall be responsible for establishing systems, processes, standards and requirements, including, but not limited to, encounter data collection and submission, and providing instructions to the Managed Care Plan through the Medicaid Companion Guides and Pharmacy Payer Specifications. The Agency shall be responsible for validating and reporting encounter data in accordance with 42 CFR 438.818.

4. The Agency shall be responsible for coordinating Medicaid overpayment and abuse prevention, detection, and recovery efforts. The Attorney General's office is responsible for investigating and prosecuting Medicaid fraud. The Agency shall operate the MPI program, which includes but is not limited to such monitoring as may be done by desk reviews or on site as determined by the Agency. These reviews may be conducted by various Agency bureaus and the Agency shall provide appropriate notice for requesting documents as needed and for conducting on-site reviews, as well as providing the Managed Care Plan with the result of such reviews. The Agency, Bureau of MPI, audits and investigates providers suspected of overbilling or defrauding the Florida Medicaid Program, recovers overpayments, issues administrative sanctions and refers cases of suspected fraud for criminal investigation to the MFCU. The Agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.

5. The Managed Care Plan shall be responsible for the administration and management of all aspects of this Contract, including, but not limited to, delivery of services, provider network, provider education, claims resolution and assistance, and all subcontracts, employees, agents and services performed by anyone acting for or on behalf of the

Managed Care Plan. The Managed Care Plan shall ensure all services provided directly or indirectly under this Contract are performed within the borders of the forty-eight (48) contiguous U.S. states.

6. The Managed Care Plan shall have a centralized executive administration and must ensure adequate staffing and information systems capability to ensure the Managed Care Plan can appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter data, or other information required by this Contract.

7. The Agency reserves the right to publish any data or information regarding Managed Care Plan performance under this Contract.

B. Organizational Governance and Staffing

1. General Provisions

a. The Managed Care Plan shall be responsible for the administration and management of all aspects of this Contract, including all subcontracts, employees, agents, and services performed by anyone acting for or on behalf of the Managed Care Plan.

b. The Managed Care Plan shall have a centralized executive administration, which shall serve as the contact point for the Agency, except as otherwise specified in this Contract.

c. The Managed Care Plan must ensure adequate staffing and information systems capability to ensure the Managed Care Plan can appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter data, or other information required by the Agency, and to comply with the HIPAA and HITECH Acts.

d. The Managed Care Plan shall be located in the U.S (42 CFR 438.602(c)).

e. The Managed Care Plan shall meet all requirements for doing business in the State of Florida.

f. The Managed Care Plan shall submit any changes to its approved organizational chart to the Agency for prior approval. If any member of the minimum staffing is terminated or becomes unavailable for any reason, the Managed Care Plan shall submit to the Agency the resume of the proposed replacement(s) and offer the Agency to review the qualifications of the proposed applicant(s).

g. The Agency reserves the right to disapprove proposed applicant(s) with reason.

2. Minimum Staffing

The positions described below represent the minimum management staff required for the Managed Care Plan. The Managed Care Plan shall notify the Agency of changes in the staff positions indicated below, within five (5) business days of the changes in staffing. The Managed Care Plan shall not delegate minimum staffing positions.

a. The Managed Care Plan shall designate a full-time Contract Manager to work directly with the Agency. The Contract Manager shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to this Contract. The Contract Manager shall have the authority to administer the day-to-day business activities of this Contract, including revising processes or procedures and assigning additional resources as needed to maximize the efficiency and effectiveness of services required under this Contract. The Managed Care Plan shall meet in person, or by telephone, at the request of Agency. The Contract Manager shall be located in the State of Florida.

b. The Managed Care Plan shall designate a full-time Medical Director who is a physician licensed in the State of Florida with experience providing services to the populations served under this Contract. The Medical Director shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to this Contract. The Medical Director shall oversee and be responsible for the proper provision of covered services to enrollees, the quality management program, and the enrollee grievance and appeal system.

c. The Managed Care Plan shall designate a full-time Compliance Officer, qualified by knowledge, training, and experience in health care or risk management, to promote, implement, and direct the overall compliance program and to oversee the Managed Care Plan's compliance with non-discrimination requirements in this Contract. The Compliance Officer shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to this Contract. The Compliance Officer shall exhibit knowledge of relevant regulations, provide expertise in compliance processes, and be qualified to design, implement, and oversee a fraud and abuse program designed to ensure program integrity through fraud and abuse prevention and detection, which identifies and addresses emerging trends of fraud, abuse, and waste pursuant to this Contract and State and federal law.

d. The Managed Care Plan shall designate a Special Investigations Unit (SIU) Manager, qualified by training and experience in health care fraud and abuse prevention and detection. The SIU Manager shall oversee the Medicaid health plan's fraud and abuse detection and prevention efforts and work with Medicaid Program Integrity and the Medicaid Fraud Control Unit as needed with regard to any audits and investigations of providers.

e. The Managed Care Plan shall designate a staff for each of the following functional areas within the Agency:

    (1) Medicaid Quality

    (2) Medicaid Recipient/Provider Assistance

    (3) Medicaid Policy

    (4) Medicaid Data Analytics

(5) Medicaid Finance

(6) Claims and Encounter Data

(7) Program Integrity

(8) Subcontractor Oversight

f. The Managed Care Plan shall establish a staffing model that maintains a staff-to-enrollee ratio as prescribed by the Agency. At a minimum, the following positions are required in the staffing model:

(1) Claims Resolution Staff

(2) Provider Relations Staff

(3) Recipient Relations Staff

(4) Utilization and Authorization Staff

(5) Quality Initiative Staff

The staff in these positions shall be full-time employees of the Managed Care Plan, dedicated one hundred percent (100%) to this Contract, and located in the State of Florida.

g. The Managed Care Plan shall submit a staff-to-enrollee ratio report in the manner and format determined by the Agency, specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

3. Medical and Professional Support Staff

The Managed Care Plan shall have an adequate number of medical and professional support staff, sufficient to conduct daily business in an orderly manner, including having enrollee services staff directly available during business hours for enrollee services consultation, as determined through management and medical reviews. The Managed Care Plan shall maintain and adequate number sufficient medical and professional support staff, available twenty-four hours a day, seven days a week (24/7), to handle emergency services and care inquiries from enrollees and caregivers.

4. Care Coordination/Case Management Staff

The Managed Care Plan shall have sufficient care coordination/case management staff, qualified by training, experience, and certification/licensure to conduct the Managed Care Plan's care coordination/case management functions.

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5. Staff Training and Education

a. The Managed Care Plan shall educate its staff about its procedures and all applicable provisions of this Contract (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)).

b. The Managed Care Plan shall make available to the Agency the Managed Care Plan's schedule and curriculum for all internal staff, subcontractor, provider, and enrollee training sessions (via web-based or in person) and agrees to allow Agency staff to attend each training session.

6. Non-discrimination Compliance Requirements

a. The Managed Care Plan shall comply with all applicable federal and State civil rights laws, regulations, rules and policies, including, but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the ADA of 1990, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and the Age Discrimination Act of 1975.

b. The Managed Care Plan shall develop a non-discrimination compliance plan. The Managed Care plan shall be responsible for initial and ongoing training regarding the non-discrimination compliance plan to all Managed Care Plan staff. The Managed Care Plan shall maintain documented proof of such training and provide such proof to the Agency upon request.

c. The Managed Care Plan's non-discrimination compliance plan shall include written procedures that demonstrate non-discrimination in the provision of services to enrollees. The policy shall also demonstrate non-discrimination in the provision of language assistance services for members with limited English proficiency and those requiring communication assistance in alternative formats. See **Section IV.**, Enrollee Services, **Sub-Section B.**, Enrollee Material.

7. Emergency Management Plan

a. Before implementation of this Contract and May 1 of each Contract year, the Managed Care Plan shall submit to the Agency an emergency management plan specifying what actions the Managed Care Plan shall conduct to ensure the ongoing provision of covered services in a disaster, public health emergency, or man-made emergency, including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. The emergency management plan shall include risk assessment, procedures to comply with this Contract during disasters, a communication plan specific to enrollees and providers during disasters, and training schedules for plan staff.

b. The Managed Care Plan shall perform at least one mock-disaster exercise per Contract year and report the result to the Agency when requested.

c. The Managed Care Plan shall comply with the provisions of s. 252.358, F.S., which allows for early prescription refills due to a Governor's Executive Order declaring a State of Emergency for Florida counties.

d. The Managed Care Plan shall comply with the following provisions when a disaster or emergency is declared by a Governor's Executive Order and confirmed by the Agency:

(1) Furnish covered services to an enrollee without any form of authorization, without regard to whether such services are provided by a participating or non-participating provider, without regard to service limitations, and whether or not the enrollee has temporarily relocated to a different region or state.

(2) Implement a readily-available claims payment process to ensure providers are paid for services rendered before, during, and after the disaster or emergency, as medically necessary.

(3) Publish guidance via website for enrollees and providers before, during, and after the disaster on how to receive services, contact information for emergencies, payment processes and any other information required by the Agency.

The Managed Care Plan shall continue to comply with the above provisions during and after an emergency, until otherwise directed by the Agency.

e. 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 XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIV.**, Liquidated Damages, as determined by the Agency.

C. Subcontracts

1. General Provisions

a. The Managed Care Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract and may delegate performance of work required under this Contract to a subcontractor. The Managed Care Plan shall submit any proposed delegation to the Agency for prior written approval. The Managed Care Plan shall submit all subcontracts for Agency review at least ninety (90) days before the proposed effective date of the subcontract or change. If the submission is for management of a covered service, the Managed Care Plan shall include the following in its submission to the Agency in a manner prescribed by the Agency:

(1) A draft subcontract that complies with subcontract requirements specified in this Section, the Agency **Standard Contract**, 42 CFR 438.230(c)(1)(i), and 42 CFR 438.3(k).

(2) A test PNV file as proof of provider network adequacy.

(3) A copy of applicable licensure, if appropriate.

(4) Enrollee materials.

(5) The population covered by the subcontract.

(6) Provider materials.

(7) A model provider agreement template as specified in **Section VII.**, Provider Network and Services.

(8) An approximate number of impacted enrollees.

If the Agency determines, at any time, that a subcontract is not in compliance with a Contract requirement, the Managed Care Plan shall promptly revise the subcontract into compliance. In addition, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, and/or liquidated damages pursuant to **Section XIII.**, Liquidated Damages.

b. All subcontracts must comply with 42 CFR 438.230, 42 CFR 438.3(k), 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106 and all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and Contract provisions, and any other applicable State or federal law.

c. The Managed Care Plan shall identify the service(s) and/or goods covered by the subcontract, as applicable.

d. All subcontracts must contain provisions wherein the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with **Section XV.**, Accountability, and the SMMC Report Guide.

e. No subcontract that the Managed Care Plan enters into with respect to performance under this Contract shall, in any way, relieve the Managed Care Plan of any responsibility for the performance of duties under this Contract. The Managed Care Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract and shall provide the Agency with its monitoring schedule for all Agency-approved subcontractors by December 1 of each Contract year.

f. All executed subcontracts and amendments used by the Managed Care Plan under this Contract shall be in writing, signed, and dated by the Managed Care Plan.

g. The Managed Care Plan shall immediately advise the Agency of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor.

h. Upon implementation of the Contract, the Managed Care Plan agrees to maintain arrangements with its Agency-approved subcontractors for the first two (2) full years of the Contract period. The Managed Care Plan may seek the Agency's written permission to waive this provision of the Contract and provide documentation and evidence that the subcontractor no longer meets eligibility requirements to deliver services under this Contract or the subcontractor's authorization, administrative, or reimbursement practices are jeopardizing enrollees' access to care. The Agency may grant written permission at its sole discretion.

i. The Managed Care Plan agrees to prohibit the blanket use of case rate (i.e., flat rate) payment arrangements in agreements between subcontractors and providers. Prohibition against the blanket use of case rates does not prohibit payment

arrangements that implement the value-based purchasing guidelines as described in **Attachment II**., Scope of Services-Core Provisions, Section I., Florida First, Sub-Section H., Prioritizing Quality and Value; Item 2. Value-Based Purchasing (VBP) Programs. The Managed Care Plan shall require subcontractors to utilize value-based purchasing arrangements to the fullest extent.

j. The Managed Care Plan shall have a contingency plan for each subcontract to provide for continuity of care should the subcontractor cease to provide services that are the subject of the subcontract.

2. Subcontractor Eligibility

a. All subcontractors must be eligible for participation in the Medicaid program; however, the subcontractor is not required to participate in the Medicaid program as a provider.

b. If a subcontractor was involuntarily terminated from the Medicaid program other than for purposes of inactivity, that entity is not considered an eligible subcontractor.

c. The Managed Care Plan shall not delegate provider network management to a subcontractor that meets both of the following:

(2) The subcontractor is owner or has controlling interest in any provider(s) included in the network.

(3) The subcontractor limits enrollee choice of network providers through a requirement for a referral/authorization process to access network providers.

3. Subcontract Content Requirements

a. Payment - The Managed Care Plan agrees to make payment to all subcontractors pursuant to all State and federal laws, rules, and regulations, including Section 409.967, F.S., Section 409.975(6), F.S., Section 409.982, F.S., s. 641.3155, F.S., 42 CFR 238.230, 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (5) and (6), in addition to sub regulatory guidance and the provisions of this Contract.

(1) All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall meet the following requirements:

(a) Identify conditions and method of payment.

(b) Provide for prompt submission of information needed to make payment.

(c) Provide for full disclosure of the method and amount of compensation or other consideration to be received from the Managed Care Plan.

(d) Require any claims processing vendors to maintain accurate enrollee and provider information, including provider agreements reflecting the correct reimbursement rate and provider specialty, to ensure the correct adjudication of claims and proper payment to providers.

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

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

(g) Specify that the Managed Care Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with **Section XI.**, Financial Requirements.

(2) If the Managed Care Plan delegates claims processing and payment or enters into a risk-bearing contract, the Managed Care Plan shall:

(a) Require the subcontractor(s) to submit quarterly unaudited and annual audited financial statements to the Managed Care Plan. The quarterly unaudited financial statements shall be submitted to the Managed Care Plan within sixty (60) days of the end of the quarter and annual audited financial statements shall be submitted within one hundred twenty (120) days of the end of the year.

(b) Provide to the Agency, upon request, copies of the financial statements, including documentation of the Managed Care Plan's financial review. Failure to obtain required financial statements shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages

(c) Notify the Agency within two (2) days of discovery, if based on the Managed Care Plan's review of financial statements or other information, the Managed Care Plan has reason to believe that the subcontracted vendor is insolvent or becoming insolvent. Failure to notify the Agency within two days shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages.

(d) For subcontracts delegating only claims processing and payment, require the subcontractor to maintain either:

i. An insolvency account to meet its obligations. The insolvency account shall be funded in an amount equal to two percent (2%) of the annual contract value. In the event that the subcontractor has filed for bankruptcy or has otherwise been determined to be insolvent by a regulating entity, the insolvency account may be drawn upon solely by the Managed Care Plan to disburse funds to meet Medicaid financial obligations incurred by the subcontractor under the contract between the Managed Care Plan and subcontractor. Documentation of the insolvency account, including account balances and governing agreements, shall be provided to the Agency upon request.

ii. An Irrevocable Standby Letter of Credit, with the Managed Care Plan as the beneficiary. The issuing bank shall be a federally guaranteed financial institution, licensed to do business in Florida and shall be an entity that is acceptable to the Agency. The value of the Irrevocable Standby Letter of Credit shall be at least two percent (2%) of the annual subcontract value and shall allow the Managed Care Plan to draw upon the Irrevocable Standby Letter of Credit to disburse funds to meet Medicaid financial obligations incurred by the subcontractor under the contract between the Managed Care Plan and the subcontractor. Copies of the Irrevocable Standby Letter of Credit shall be provided to the Agency.

The requirements of this provision do not apply when the Managed Care Plan pays claims processed by the subcontractor directly from the Managed Care Plan's account and/or prints checks for payment on Managed Care Plan check stock; and at no time is the subcontractor in control of Managed Care plan funds prior to performing under the subcontract agreement.

(e) Require that, if the Managed Care Plan delegates claims processing and payment, the subcontractor shall require the subcontractor shall maintain a surplus account to meet its obligations if the subcontractor is at financial risk and/or is delegated to process and pay claims.

If the Managed Care Plan fails to comply with the requirements of the above provisions, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

b. Monitoring and Inspections - All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall meet the following requirements with respect to provisions for monitoring and inspections:

(1) Provide that the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate, or inspect the subcontractor's premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's subcontractor, pertaining to any aspect of services and activities performed, or determination of amounts payable under the Managed Care Plan's Contract with the State. In accordance with 42 CFR 438.230(c)(3)(iii), the subcontractor shall agree that the right to audit exists through ten (10) years from the final date of this Contract period or from the date of completion of any audit, whichever is later.

(2) Provide that the subcontractor shall make available for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Medicaid enrollees pertinent to this Contract by the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS; (42 CFR 438.3(h); s. 1903(m)(2)(A)(iv) of the Social Security Act).

(3) Require full cooperation in any investigation by the Agency, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, DOEA, or other State or federal entity or any subsequent legal action that may result from such an investigation.

(4) In addition to record retention requirements for practitioner or provider licensure, require subcontractors to retain, as applicable, the following information in accordance with 42 CFR 438.3(u): base data in 42 CFR 438.5(c); MLR reports in 42 CFR 438.8(k); and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period not less than ten (10) years from the close of this Contract and retained further if the records are under review or audit until the review or audit is complete (Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the subcontract is continuous.) (42 CFR 438.3(h)).

(5) Provide for monitoring and oversight by the Managed Care Plan and the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the Managed Care Plan's and the Agency's credentialing requirements as found in **Section VII.**, Provider Network and Services, if the Managed Care Plan has delegated the credentialing to a subcontractor.

(6) Provide for monitoring of services rendered to Managed Care Plan enrollees through the subcontractor.

c. Protective Clauses - All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall meet the following requirements with respect to protective clauses:

(1) Require safeguarding of information about enrollees according to 42 CFR Part 438.224.

(2) Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that enrollees or the Agency shall not be held liable for any debts of the subcontractor.

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

(4) Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this Contract unless such employees are covered by the

protection afforded by the Managed Care Plan. Such insurance shall comply with Florida's Workers' Compensation Law.

(5) Specify that if the subcontractor delegates or subcontracts any functions of its contract with the Managed Care Plan, that the subcontract or delegation shall include all the requirements of this Contract, unless otherwise exempted in this Section of the Contract or its Exhibits.

(6) Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract.

(7) Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate.

(8) Provide that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee (42 CFR 438.210(e)).

(9) Provide that the subcontractor shall establish, enforce, and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

(10) Require that the subcontractor timely notify the Managed Care Plan of changes in directory information.

(11) Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:

(a) The False Claims Act.

(b) The penalties for submitted false claims and statements.

(c) Whistleblower protections.

(d) The entity's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

(42 CFR 438.608(a)(6); s. 1902(a)(68) of the Social Security Act).

(12) Managed Care Plan subcontracts with providers shall ensure that providers are obligated to cooperate with recovery efforts, including participating in audits and repay overpayments.

d. The Managed Care Plan shall require its subcontractors to co-brand all communications with enrollees and providers to ensure it is clear that the Managed Care Plan is aware of and endorses the content contained within the communication.

e. All subcontracts for claims adjudication activities shall comply with 42 CFR 438.8(k)(3).

f. Termination Procedures - In accordance with the requirements of the **Standard Contract**, **Section III.**, THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE, **Sub-Section A.**, Termination, all provider agreements and subcontracts shall contain termination procedures.

g. Marketing - All subcontracts specify that the subcontractor shall comply with the marketing requirements specified in **Section III.**, Marketing.

h. All subcontracts shall require subcontractors to submit notice of termination at least ninety (90) days before the effective date of such withdrawal.

i. Encounter Data - All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall require subcontractors to submit timely, complete, and accurate encounter data to the Managed Care Plan in accordance with the requirements of **Section IX.**, Administration and Management, **Sub-Section D.**, Information Management and Systems.

j. 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 XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

4. Other Contract Requirements

Subcontractors are subject to background checks. The Managed Care Plan shall consider the nature of the work a subcontractor or agent shall perform in determining the level and scope of the background checks in accordance with Section 408.809, F.S.

5. Minority Business Enterprises

The State supports and encourages supplier diversity and the participation of small and minority business enterprises in State contracting, both as vendors and subcontractors. The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this Contract enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of Florida. Respondents can contact the Office of Supplier Diversity online at http://osd.dms.state.fl.us/ for information on minority vendors who may be considered for subcontracting opportunities.

D. Information Management and Systems

1. General Provisions

The Managed Care Plan shall have information management processes and information systems of sufficient capacity that enable it to meet Agency and federal -, other Contract requirements, and all applicable Agency policies, State and federal laws, rules and regulations, including HIPAA. The Managed Care Plan shall be responsible for establishing connectivity to the Agency's/State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency and/or State policies, standards and guidelines, as well as coordinating activities and developing cohesive systems strategies across vendors and agencies.

a. Systems Functions – The Managed Care Plan shall have information management processes and information systems that collect, analyze, integrate, and report data, enabling the Managed Care Plan to meet Agency and federal reporting requirements (42 CFR 438.242(a) and (b); s. 6504(a) of the ACA).

b. Systems Capacity – The Managed Care Plan's system(s) shall possess capacity sufficient to handle the workload projected for the begin date of implementation of this Contract and shall be scalable and flexible as to be adapted as needed, within negotiated timeframes, in response to changes including but not limited to Contract requirements and increases in enrollment estimates.

c. Email System – The Managed Care Plan shall provide a continuously available electronic mail communication link (email system) with the Agency. This system shall be:

    (1) Available from the workstations of the designated Managed Care Plan contacts.

    (2) Capable of attaching and sending documents created using software products other than the Managed Care Plan's systems, including the Agency's currently installed version of Microsoft Office and any subsequent upgrades as adopted. The electronic mail system shall include encryption capabilities compliant with FIPS 140-2.

d. HIPAA Compliance – The Managed Care Plan must ensure it meets all federal regulations regarding required standard electronic transactions and standards for privacy and individually identifiable health information as identified in the HIPAA of 1996 and the HITECH Act of 2009 and associated regulations.

e. Data Security – The Managed Care Plan shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with FIPS, and/or the NIST publications regarding cryptographic standards.

f. The Agency shall conduct an initial IT security rating score scan on the Managed Care Plan, as well as periodic or continuous security monitoring through an information security rating service, at the Agency's expense, to enable the Agency to effectively measure and mitigate the Managed Care Plan's security risks. The Managed Care Plan shall work with the Agency's Security Rating Score Provider to define the relevant Managed Care Plan assets providing Agency services. If the Managed Care Plan fails to maintain a B or higher security rating score, the Agency will impose liquidated damage(s) and/or other applicable sanction(s).

g. Participation in Information Systems Work Groups/Committees – The Managed Care Plan shall meet as requested by the Agency, to coordinate activities and develop cohesive systems strategies across vendors and agencies.

h. Connectivity to the Agency/State Network and Systems – The Managed Care Plan shall be responsible for establishing connectivity to the Agency's/State's wide area data communications network, and the relevant information systems attached to this

network, in accordance with all applicable Agency and/or State policies, standards, and guidelines. The Managed Care Plan shall notify the Agency of termination of any staff with access to the Agency's network within twenty-four (24) hours of the termination.

i. Security Training – Managed Care Plan staff that have access connectivity to the Agency's data communications network shall be required to complete Agency Security Awareness Training and Agency HIPAA Training. The Managed Care Plan shall sign an Acceptable Use Acknowledgement Form and submit the completed form to the Agency's Information Security Manager. The requirements described in this Item must be completed before access to the Agency's network is provided.

j. The Managed Care Plan shall adhere and comply with the Agency's Division of IT standards regarding Secure Sockets Layer (SSL) Web interface(s) and Transport Layer Security (TLS).

k. The Managed Care Plan shall adhere to the Driver Privacy Protection Act rules that address a memorandum of understanding and security requirements as well as other requirements contained in Rule.

l. The Managed Care Plan shall conform to current and updated publications of the principles, standards, and guidelines of the FIPS, the NIST publications, including, but not limited to, Cybersecurity-Framework and NIST.SP.800-53r5.

m. The Managed Care Plan, its employees, subcontractors and agents shall provide immediate notice to the Agency Information Security Manager ("ISM") in the event it becomes aware of any security breach and any unauthorized transmission or loss of any or all of the data collected or created for or provided by the Agency ("State Data") or, to the extent the Managed Care Plan is allowed any access to the Agency's information technology ("IT") resources, provide immediate notice to the ISM, of any allegation or suspected violation of security procedures of the Agency. Except as required by law and after notice to the Agency, the Managed Care Plan shall not divulge to third parties any confidential information obtained by the Managed Care Plan or its agents, distributors, resellers, subcontractors, officers or employees in the course of performing this Contract work according to applicable rules, including, but not limited to, Rule 60GG-2, Florida Administrative Code (FAC) and its successor regulation, security procedures, business operations information, or commercial proprietary information in the possession of the State or the Agency. After the conclusion of this Contract unless otherwise provided herein, the Managed Care Plan shall not be required to keep confidential information that is publicly available through no fault of the Managed Care Plan, material that the Managed Care Plan developed independently without relying on the State's confidential information, or information that is otherwise obtainable under State law as a public record.

n. The Managed Care Plan shall report to the Agency in the manner and format obtained from the Agency, within twenty-four (24) of discovery of any security incident, as defined in Section XVI., Definitions, of this **Attachment**.

If the Managed Care Plan fails to comply with the security incident reporting requirements of this Contract, the Managed Care Plan shall be subject to sanctions pursuant to Section XII., Sanctions and Corrective Action Plans.

o. The Managed Care Plan shall employ traffic and network monitoring software and tools on a continuous basis:

(1) To identify obstacles to optimum performance.

(2) To identify email and Internet spam and scams and restrict or track user access to appropriate websites.

(3) To identify obstacles to detect and prevent hacking, intrusion, and other unauthorized use of the Managed Care Plan's resources.

(4) To prevent adware or spyware from deteriorating system performance.

(5) To update virus blocking software daily and aggressively monitor for and protect against viruses.

(6) To monitor bandwidth usage and identify bottlenecks that impede performance.

(7) To provide methods to flag recipient data to exclude PHI from data exchanges as approved by the State, and to comply with recipient rights under the HIPAA privacy law for: 1) Requests for restriction of the uses and disclosures on PHI (45 CFR 164.522(a)); 2) Requests for confidential communications (45 CFR 164.522(B)); and (3)). Requests for amendment of PHI (45 CFR 164.526). The Managed Care Plan shall also enter into a BAA with the Agency. The provisions of the BAA apply to HIPAA requirements and in the event of a conflict between the BAA and the provisions of this Sub-Section, the BAA shall control. (See **Standard Contract**, **Attachment III**, Business Associate Agreement).

2. Data and Document Management Requirements

a. Adherence to Data and Document Management Standards

(1) The Managed Care Plan's systems shall conform to the standard transaction code sets specified in this Contract.

(2) The Managed Care Plan's systems shall conform to HIPAA and HITECH standards for data and document management.

(3) The Managed Care Plan shall collaborate with the Agency in the management of standard transaction code sets specific to the Agency. Furthermore, the Managed Care Plan shall collaborate with the Agency in the development and implementation planning of future standard code sets not specific to HIPAA or other federal efforts and shall conform to these standards as stipulated in the plan to implement the standards.

b. Data Model and Accessibility. Managed Care Plan systems shall be SQL and/or ODBC compliant. Alternatively, the Managed Care Plan's systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system to operate and maintain them.

c. Data and Document Relationships. The Managed Care Plan shall house indexed images of documents used by enrollees and providers to transact with the Managed Care Plan in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data.

d. Information Retention. Information in the Managed Care Plan's systems shall be maintained in electronic form for three (3) years in live systems and for an additional ten (10) years in archival systems. Enrollee grievance and appeal records (42 CFR 438.416), base data (42 CFR 438.5(c)), MLR reports (42 CFR 438.8(k)), and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 shall be maintained for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u) in live and/or archival systems, or longer for audits or litigation as specified elsewhere in this Contract.

e. Information Ownership. All information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract is owned by the Agency. The Managed Care Plan is expressly prohibited from sharing or publishing the Agency information and reports without the prior written consent of the Agency. In the event of a dispute regarding the sharing or publishing of information and reports, the Agency's decision on this matter shall be final and not subject to change.

3. System and Data Integration Requirements

a. Adherence to Standards for Data Exchange

(1) The Managed Care Plan's systems shall be able to transmit, receive and process data in HIPAA-compliant formats.

(2) The Managed Care Plan's systems shall be able to transmit, receive and process data in the Agency-specific formats and/or methods.

(3) The Managed Care Plan's systems shall conform to future federal and/or Agency-specific standards for data exchange, including HIPAA-compliant data formats, within one hundred twenty (120) days of the standard's effective date or, if earlier, the date stipulated by HHS, CMS, or the Agency. The Managed Care Plan shall partner with the Agency in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the Managed Care Plan shall conform to these standards as stipulated in the Agency agreed-upon plan to implement such standards.

b. HIPAA Compliance Checker. All HIPAA-conforming transactions between the Agency and the Managed Care Plan shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application. Data and Report Validity and Completeness. The Managed Care Plan shall institute

processes to ensure the validity and completeness of the data, including reports, it submits to the Agency. At the Agency's discretion, the Managed Care Plan shall be subject to general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that shall be audited include, but are not limited to: enrollee ID, date of service, assigned Medicaid provider ID, category and subcategory (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and (if and when applicable) date of claim payment. Control totals shall also be reviewed and verified.

c. State/Agency Website/Portal Integration. Where deemed that the Managed Care Plan's web presence shall be incorporated to any degree to the Agency's or the State's web presence (also known as a portal), the Managed Care Plan shall conform to any applicable Agency or State standard for website structure, coding, and presentation.

d. Functional Redundancy with Agency Systems. The Managed Care Plan's systems shall be able to transmit and receive transaction data to and from Agency Systems as required for the appropriate processing of claims and any other transaction that could be performed by either system.

e. Data Exchange in Support of the Agency's Program Integrity and Compliance Functions. The Managed Care Plan's systems shall be capable of generating files in the prescribed formats for upload into Agency systems used specifically for program integrity and compliance purposes.

f. Address Standardization. The Managed Care Plan's system(s) shall possess mailing address standardization functionality in accordance with U.S. Postal Service conventions.

g. Eligibility and Enrollment Data Exchange Requirements

(1) The Managed Care Plan shall receive process and update enrollment files sent daily by the Agency or its agent(s).

(2) The Managed Care Plan shall update its eligibility/enrollment databases within twenty-four (24) hours after receipt of said files.

(3) The Managed Care Plan shall transmit to the Agency or its agent, in a periodicity schedule, format, and data exchange method to be determined by the Agency, specific data it may garner from an enrollee including third party liability data.

(4) The Managed Care Plan shall be capable of uniquely identifying a distinct Medicaid recipient across multiple systems within its span of control.

4. Systems Availability, Performance and Problem Management Requirements

a. Availability of Critical Systems Functions. The Managed Care Plan shall ensure that critical systems functions available to enrollees and providers, functions that if unavailable would have an immediate detrimental impact on enrollees and providers, are available twenty-four hours per day, seven days per week (24/7), except during periods of scheduled system unavailability agreed upon by the Agency and the Managed Care Plan. Unavailability caused by events outside of a Managed Care

Plan's span of control should be addressed in a Business Continuity plan. The Managed Care Plan shall make the Agency aware of the nature and availability of these functions prior to extending access to these functions to enrollees and/or providers.

b. Availability of Data Exchange Functions. The Managed Care Plan shall ensure that the systems and processes within its span of control associated with its data exchanges with the Agency and/or its agent(s) are available and operational according to specifications and the data exchange schedule.

c. Availability of Other Systems Functions. The Managed Care Plan shall ensure that at a minimum, all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., in the time zone where the user is located, Monday through Friday.

d. Problem Notification

(1) Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the Managed Care Plan and the Agency and/or its agent(s), the Managed Care Plan shall notify the applicable Agency staff via phone, fax, and/or electronic mail within one (1) hour of such discovery. In its notification, the Managed Care Plan shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes.

(2) The Managed Care Plan shall provide to appropriate Agency staff information on system unavailability events, as well as status updates on problem resolution. At a minimum, these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

e. Recovery from Unscheduled System Unavailability. Unscheduled system unavailability caused by the failure of systems and telecommunications technologies within the Managed Care Plan's span of control shall be resolved, and the restoration of services implemented, within forty-eight (48) hours of the official declaration of system unavailability.

f. Exceptions to System Availability Requirement. The Managed Care Plan shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Managed Care Plan's span of control.

g. Information Systems CAP. If at any point there is a problem with a critical systems function, at the request of the Agency, the Managed Care Plan shall provide to the Agency full written documentation that includes a CAP that describes how problems with critical systems functions shall be prevented from occurring again. The CAP shall be delivered to the Agency within five (5) business days of the problem's occurrence. Failure to submit a CAP and to show progress in implementing the CAP shall make the Managed Care Plan subject to sanctions, in accordance with **Section XII.**, Sanctions and Corrective Action Plans.

h. Business Continuity-Disaster Recovery (BC-DR) Plan

(1) Regardless of the architecture of its systems, the Managed Care Plan shall develop, maintain, and be continually ready to invoke a BC-DR plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed. The BC-DR plan shall limit service interruption to a period of twenty-four (24) hours and shall ensure compliance with all contractual requirements. The records backup standards and BC-DR plan shall be developed and maintained for the entire Contract period.

(2) The BC-DR plan shall include a strategy for restoring day-to-day operations, including alternative locations for the Managed Care Plan to operate. The BC-DR plan shall maintain database backups in a manner that eliminates service disruptions or data loss due to system or program failures or destruction.

The Managed Care Plan's BC-DR plan shall be submitted to the Agency. If the approved plan is unchanged from the previous year, the Managed Care Plan shall submit a certification to the Agency that the prior year's plan is still in place May 1 of each Contract year. Changes in the plan are due to the Agency within ten (10) business days after the change.

(3) At a minimum, the Managed Care Plan's BC-DR plan shall address the following scenarios:

(a) The central computer installation and resident software are destroyed or damaged.

(b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage.

(c) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system.

(d) System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability.

(e) Malicious acts, including malware or manipulation.

(4) The Managed Care Plan shall perform comprehensive tests of its BC-DR plan at least annually, by April 30 through simulated disasters and lower-level failures in order to demonstrate to the Agency that it can restore system functions by being ISO22301 certified (Business Continuity Management) or comparable standard (contingent upon Agency approval) certified.

(5) Outbound mail gateways used by the Managed Care Plan must be configured to only send e-mails to the Agency over an encrypted connection (currently, TLS). Additionally, all incoming mail gateways must be configured to accept encrypted connections (TLS) as the Agency shall only be transmitting mail across such connections.

(6) In the event that the Managed Care Plan fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Managed Care Plan shall be required to submit to the Agency a CAP in accordance with **Section XII.**, Sanctions and Corrective Action Plans, that describes how the failure shall be resolved. The CAP shall be delivered within ten (10) business days of the conclusion of the test.

i. Data Security

(1) The Managed Care Plan, its employees, subcontractors, and agents shall provide immediate notice within one hour to the Agency ISM in the event it becomes aware of any security breach and any unauthorized transmission or loss of any or all of the data collected or created for or provided by the Agency (State Data) or, to the extent the Managed Care Plan is allowed any access to the Agency's IT resources, provide immediate notice to the ISM, of any allegation or suspected violation of security procedures of the Agency. Except as required by law and after notice to the Agency, the Managed Care Plan shall not divulge to third parties any confidential information obtained by the Managed Care Plan or its agents, distributors, resellers, subcontractors, officers, or employees in the course of performing contract work according to applicable rules, including, but not limited to, Rule 74-2, F.A.C., and its successor regulation, security procedures, business operations information, or commercial proprietary information in the possession of the State or the Agency. After the conclusion of this Contract unless otherwise provided herein, the Managed Care Plan shall not be required to keep confidential information that is publicly available through no fault of the Plan, material that the Managed Care Plan developed independently without relying on the State's confidential information, or information that is otherwise obtainable under State law as a public record.

(2) In the event of loss of any State Data or record where such loss is due to the negligence of the Managed Care Plan or any of its subcontractors or agents, the Managed Care Plan shall be responsible for recreating such lost data in the manner and on the schedule set by the Agency at the Managed Care Plan's sole expense, in addition to any other damages the Agency may be entitled to by law or this Contract. In the event lost or damaged data is suspected, the Managed Care Plan shall perform due diligence and report findings to the Agency and perform efforts to recover the data. If it is unrecoverable, the Managed Care Plan shall pay all the related costs associated with the remediation and correction of the problems engendered by any given specific loss. Further, failure to maintain security that results in certain data release shall subject the Managed Care Plan to liquidated damages for failure to comply with Section 501.171, F.S., together with any costs to the Agency of such breach of security caused by the Managed Care Plan. If State Data will reside in the Managed Care Plan's system, the Agency may conduct, or request the Managed Care Plan conduct at the

Managed Care Plan's expense, an annual network penetration test or information security audit of the Managed Care Plan's system(s) on which State Data resides. State-owned Data shall be processed and stored in data centers that are located only in the forty-eight (48) contiguous U.S. states. All successful Managed Care Plan personnel who will have access to State-owned Data shall undergo the background checks and screenings described in this Contract. Within the first year of this Contract term, the Managed Care Plan must obtain a NIST compliant information security risk assessment conducted by an independent third party unless one has been completed within the year prior to Contract execution.

5. System Testing and Change Management Requirements

a. Notification and Discussion of Potential System Changes. The Managed Care Plan shall notify the Agency of the following changes to systems within its span of control at least ninety (90) days before the projected date of the change. If so directed by the Agency, the Managed Care Plan shall discuss the proposed change with the applicable Agency staff. This includes: (1) software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment, and data management; and (2) conversions of core transaction management systems.

b. Response to Agency Reports of Systems Problems not Resulting in System Unavailability

(1) The Managed Care Plan shall respond to Agency reports of system problems not resulting in system unavailability according to the following timeframes:

(a) Within seven (7) days of receipt, the Managed Care Plan shall respond in writing to notices of system problems.

(b) Within twenty (20) days, the correction shall be made, or a requirements analysis and specifications document shall be due.

(2) The Managed Care Plan shall correct the deficiency by an effective date to be determined by the Agency.

c. Valid Window for Certain System Changes. Unless otherwise agreed to in advance by the Agency as part of the activities described in this Section, scheduled system unavailability to perform system maintenance, repair, and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.

d. Testing

(1) The Managed Care Plan shall work with the Agency pertaining to any testing initiative as required by the Agency.

(2) Upon the Agency's written request, the Managed Care Plan shall provide details of the test regions and environments of its core production information systems, including a live demonstration, to enable the Agency to corroborate the readiness of the Managed Care Plan's information systems.

(3) The Managed Care Plan shall be required to complete system integration testing with the Agency for enhancements and future initiatives, when needed.

6. Information Systems Documentation Requirements

a. Types of Documentation. The Managed Care Plan shall develop, prepare, print, maintain, produce, and distribute distinct system process and procedure manuals, user manuals, and quick-reference guides, and any updates thereafter, for the Agency and other applicable Agency staff.

b. Content of System Process and Procedure Manuals. The Managed Care Plan shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

c. Content of System User Manuals. The system user manuals shall contain information about, and instructions for, using applicable system functions and accessing applicable system data.

d. Changes to Manuals

(1) When a system change is subject to the Agency's written approval, the Managed Care Plan shall draft revisions to the appropriate manuals prior to Agency approval of the change.

(2) Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) business days of the update's taking effect.

e. Availability of/Access to Documentation. All of the aforementioned manuals and reference guides shall be available in printed form and/or online. If so prescribed, the manuals shall be published in accordance with the appropriate Agency and/or State standard.

7. Reporting Requirements

The Managed Care Plan shall extract and upload data sets, upon request, to an Agency-hosted Secure File Transfer Protocol (SFTP) site to enable authorized Agency personnel, or the Agency's agent, on a secure and read-only basis, to build and generate reports for management use. The Agency and the Managed Care Plan shall arrange technical specifications for each data set as required for completion of the request.

8. Community Health Record/Continuity of Care Document/Electronic Enrollee Record and Related Efforts

a. At such times that the Agency requires, the Managed Care Plan shall participate and cooperate with the Agency to implement, within a reasonable timeframe, secure, web-accessible, community health records for enrollees.

b. The design of the vehicle(s) for accessing the community health record/continuity of care document, the health record format, and design shall comply with all HIPAA and related regulations.

c. The Managed Care Plan shall also cooperate with the Agency in the continuing development of the State's health care data site (www.FloridaHealthFinder.com).

d. The Managed Care Plan shall provide to its staff and volunteers, initial and ongoing/periodic training on this Contract, including, but not limited to, HIPAA and the HITECH Act regarding the use and safeguarding of PHI.

9. Compliance with Standard Coding Schemes

a. Compliance with HIPAA-Based Code Sets. Managed Care Plan systems that are required to or otherwise contain the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed; for example:

(1) LOINC

(2) HCPCS

(3) Home Infusion Electronic Data Interchange (EDI) Coalition Product Codes

(4) NDC

(5) NCPDP

(6) ICD

(7) DRG

(8) CARC

(9) RARC

b. Compliance with Other Code Sets. Managed Care Plan systems that are required to or otherwise contain the applicable data type shall conform to the following non-HIPAA-based standard code sets:

(1) As described in all Agency Medicaid reimbursement handbooks, for all "covered entities," as defined under HIPAA, and which submit transactions in paper format (non-electronic format).

(2) As described in all Agency Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

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10. Data Exchange and Formats and Methods Applicable to the Managed Care Plan

a. HIPAA-Based Formatting Standards. Managed Care Plan systems shall conform to the following HIPAA-compliant standards for EDI of health care data effective the first day of implementation in the applicable region. The Managed Care Plan shall submit and receive transactions, ASC X12N or NCPDP (for certain pharmacy transactions), including claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits, and premium payment. The implementation specifications for ASC X12N standards may be obtained from the Washington Publishing Company on the Internet at http://www.wpc-edi.com/. Florida specifications may be obtained on the Florida Medicaid provider portal at: http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/default.aspx

   Transaction types include, but are not limited to:

   (1) ASC X12N 820 Payroll Deducted & Other Premium Payment

   (2) ASC X12N 834 Enrollment and Audit Transaction

   (3) ASC X12N 835 Claims Payment Remittance Advice Transaction

   (4) ASC X12N 837I Institutional Claim/Encounter Transaction

   (5) ASC X12N 837P Professional Claim/Encounter Transaction

   (6) ASC X12N 270/271 Eligibility/Benefit Inquiry/Response

   (7) ASC X12N 276 Claims Status Inquiry

   (8) ASC X12N 277 Claims Status Response

   (9) ASC X12N 278 Utilization Review Inquiry/Response

   (10) NCPDP D.0 Pharmacy Claim/Encounter Transaction

b. Methods for Data Exchange

   (1) The Managed Care Plan and the Agency and/or its agent shall make predominant use of SFTP and EDI in their exchanges of data.

   (2) The Managed Care Plan shall encourage network providers to participate in the Agency's DSM service.

c. Agency-Based Formatting Standards and Methods. Managed Care Plan systems shall exchange the following data with the Agency and/or its agent in formats specified by the Agency:

   (1) Provider network data

(2) Case management fees

(3) Payments

11. Smartphone Applications

a. The Managed Care Plan must develop and maintain procedures regarding the use of social networking or smartphone applications (apps).

b. If the Managed Care Plan uses apps to allow enrollees direct access to Agency-approved member materials, the Managed Care Plan shall comply with the following:

(1) The smartphone application shall disclaim that the app being used is not private and that no PHI or personally identifying information should be published on this application by the Managed Care Plan or end user.

(2) The Managed Care Plan shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines.

12. Social Networking

a. The Managed Care Plan shall adhere to the following user requirements for procedure development, permitted uses of apps, and acceptable content for social networking applications/tools in performance of this Contract. These requirements shall apply to all interactions/communications by the Managed Care Plan or its subcontractors with enrollees, providers, and website requirements, when conducted through social networking applications.

b. The Managed Care Plan is vicariously liable for any social networking violations of its employees, agents, volunteers, providers, or subcontractors.

c. User Requirements

(1) The Managed Care Plan's presence on such social networking sites must include an avatar and/or a username that clearly indicates the Managed Care Plan that is being represented and cannot use any Agency logo or State of Florida seal. When registering for social networking applications, the Managed Care Plan shall use its email address. If the application/tool requires a username, the following syntax shall be used: http://X.com/<Managed Care Plan_identifier><username>.

(2) The enrollee or prospective enrollee, or friend/follower, and not the Managed Care Plan, must initiate all Social Networking interactions/communications. Any communication resulting from such a subscription shall include a link/method to opt-out of the subscription.

(3) The Managed Care Plan shall place photographs on pages that are hosted on the site and not linked from outside Web pages. The Managed Care Plan shall not post information, photos, links/URLs, or other items online that would reflect negatively on any individual(s), its enrollees, the Agency, or the State.

(4) The Managed Care Plan shall not tag photographic or video content and must remove all tags placed by others upon discovery.

d. Functionalities

The following functionalities are prohibited:

(1) Authoring – The ability to create and update content leads to the collaborative work of many rather than just a few Web authors such as in wikis and/or blogs. In wikis, users may extend, undo, and redo each other's work. In blogs, posts and the comments of individuals build up over time.

(2) Tags – Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories.

(3) Extensions – Software that makes the Web an application platform as well as a document server.

(4) Forums – Sites hosted by a company that allow users to create topics (threads) and post information including but not limited to comments and questions, that are available for public conversation among all members in the forum.

E. Encounter Data Requirements

1. General Provisions

a. Encounter data collection and submission is required from the Managed Care Plan for all services, including other benefits and expanded benefits, rendered to its enrollees (excluding services paid directly by the Agency on a FFS basis). The Managed Care Plan shall submit encounter data that meets established Agency data quality standards as defined herein. These standards are defined by the Agency as the receipt of complete, timely, and accurate data and are needed for program administration and to set actuarially sound capitation rates. These standards are closely monitored and enforced (42 CFR 438.242(b)(1); 42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818).

b. The Managed Care Plan shall receive amended standards with advance notice as described in this Section for the purposes of continuous QI. The Managed Care Plan shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with the Agency's data quality standards. The Managed Care Plan shall receive:

(1) No notice for Medicaid Companion Guide updates that are informational, limited to clarification of existing standards, or setting an edit from deny to pay.

(2) Thirty (30) days' notice for setting a pay edit to deny or informing the plan of new CARC and RARC combinations.

(3) Sixty (60) days' notice for adding a new and unique plan-related edit.

(4) Ninety (90) days' notice of a system change resulting in a process change for the Managed Care Plan.

The Managed Care Plan must be capable of sending and receiving any claims information directly to the Agency meeting the above standards and timeframes.

c. The Managed Care Plan must certify all data to the extent required in 42 CFR 438.606. Such certification must be submitted to the Agency concurrently with the data and must be based on the knowledge, information and belief of the CEO, CFO, Chief Medical Officer or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO that all data submitted in conjunction with the encounter data and all documents requested by the Agency are accurate, truthful, and complete (42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c)).

d. The Managed Care Plan shall have the capacity to identify encounter data anomalies and shall provide a description of that process to the Agency for review and approval.

e. The Managed Care Plan shall designate sufficient IT and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.

f. The Managed Care Plan shall retain submitted encounter data for a period not less than ten (10) years (42 CFR 438.3(u)).

g. The Managed Care Plan shall participate in Agency-sponsored workgroups directed at continuous improvements in encounter data quality and processes.

2. Requirements for Complete, Timely, and Accurate Encounters

The Managed Care Plan shall establish and maintain a comprehensive automated and integrated encounter data system capable of capturing, storing, and transmitting complete, accurate and timely encounter data to the Agency.

a. All Managed Care Plan encounters shall be submitted to the Agency in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P — Professional; I — Institutional; D — Dental), and, for pharmacy services, in the current NCPDP format. The Managed Care Plan's encounters shall also follow the standards in

the Agency's 5010 Companion Guides, the Florida D.0 Payer Specification – Encounters and in this Section. Encounters must include Managed Care Plan amounts paid to the providers and shall be submitted for all providers (capitated and non-capitated).

b. The Managed Care Plan shall follow the instructions in the User Guide and Report Guide regarding the reporting of pharmacy encounter data using the NCPDP standard D. 0. Format and field definitions. Additionally, the Managed Care Plan shall submit all denied pharmacy encounter data and the reason code(s) for denial of prescriptions.

c. The Managed Care Plan shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.

d. For any services in which a Managed Care Plan has entered into capitation reimbursement arrangements with providers, the Managed Care Plan shall comply with all encounter data submission requirements in this Section. The Managed Care Plan shall require timely submissions from its providers as a condition of the capitation payment.

e. The Managed Care Plan shall implement and maintain review procedures to validate encounter data submitted by providers.

f. The Managed Care Plan shall ensure all encounter data submissions include the actual amount paid to providers.

   (1) Fee-for-Service encounters must include Managed Care Plan amounts paid to the providers and shall be submitted for all providers even if the amounts paid are zero dollars.

   (2) Capitated encounters where a claim is submitted by the rendering provider back to the Managed Care Plan must include Managed Care Plan amounts paid to the provider and shall be submitted for all providers even if the amounts paid are zero dollars.

   (3) Capitated encounters where the Managed Care Plan has contracted with another capitated provider, such as a physician group or network, where no claim was submitted by the contracted group or network back to the Managed Care Plan directly, must include the Managed Care Plan calculated amounts paid and shall be submitted for all providers even if the calculated amounts paid are zero dollars.

g. For all services rendered to its enrollees (excluding services paid directly by the Agency on a FFS basis), the Managed Care Plan shall submit encounter data, without alteration or omission of provider submitted data. The Managed Care Plan shall append to the provider-submitted data the Managed Care Plan data required by the Agency as described in the Medicaid Companion Guides.

h. For Non-Pharmacy Encounters (X12):

   (1) Complete: The Managed Care Plan shall submit encounters for no less than one hundred percent (100%) of the covered services provided by participating and non-participating providers, as defined in **Section IX.**, Administration and Management, **Sub-Section D.**, Information Management and Systems, **Item 1.**, General Provisions, of this Sub-Section, including services denied by the Managed Care Plan. Encounters for which Agency system acceptance is not available are excluded.

   (2) Timely: The Managed Care Plan shall submit no less than ninety-five percent (95%) of encounter data no later than seven (7) days following the date on which the Managed Care Plan adjudicated the claim.

   (3) Accurate: No less than ninety-five percent (95%) of the Managed Care Plan’s encounter lines submission shall pass FMMIS system edits as specified by the Agency.

(4) Resubmission: The Managed Care Plan shall correct one hundred percent (100%) of encounters that posted denial edits and resubmit within thirty (30) days.

i. Pharmacy Encounters (NCPDP)

(1) Complete: The Managed Care Plan shall submit encounters for one hundred percent (100%) of the covered services provided by participating and nonparticipating providers, as defined in **Section IX.**, Administration and Management, **Sub-Section E.**, Encounter Data Requirements, **Item 1.**, General Provisions, of this Sub-Section, including services denied by the Managed Care Plan. Encounters for which Agency system acceptance is not available are excluded.

(2) Timely: The Managed Care Plan shall submit no less than ninety-five (95%) of encounter data no later than seven (7) days following the date on which the Managed Care Plan adjudicated the claim.

(3) Accurate: No less than ninety-five percent (95%) of the Managed Care Plan's encounter lines submission shall pass NCPDP edits and pharmacy benefits system edits as specified by the Agency. The NCPDP edits are described in the NCPDP Telecommunications Standard Guides. Pharmacy benefits system edits are defined on the following website:

http://portal.flmmis.com/flpublic/Provider_ManagedCare/Provider_ManagedCare_Encounter/Provider_ManagedCare_Pharmacy/tabid/82/desktopdefault/+/Default.aspx.

(4) Resubmission: The Managed Care Plan shall correct one hundred percent (100%) of encounters that posted denial edits and resubmit within thirty (30) days.

j. For encounter data acceptance purposes, the Managed Care Plan must submit valid HIPAA compliant transactions to the Agency, which include active, valid Medicaid provider NPIs or Medicaid IDs.

k. The Managed Care Plan shall work with the Agency to establish an Encounter Claims Clearinghouse to enable Florida providers to submit claims and other EDI transactions directly to the Agency, in addition to, or instead of direct submission to the Managed Care Plan.

3. Encounter Data Submission

a. The Managed Care Plan shall collect and submit encounter data to the Agency's fiscal agent. The Managed Care Plan shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on its behalf.

b. The encounter data submission standards required to support encounter data collection and submission are defined by the Agency in the Medicaid Companion Guides, Pharmacy Payer Specifications and this Section. In addition, encounter data reporting requirements shall be posted on the following websites:

http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx

http://portal.flmmis.com/flpublic/Provider_ManagedCare/Provider_ManagedCare_Encounter/Provider_ManagedCare_Pharmacy/tabid/82/desktopdefault/+/Default.aspx.

c. The Managed Care Plan shall implement and maintain review procedures to validate the successful loading of encounter files by the Agency's fiscal agent's EDI clearinghouse. The Managed Care Plan shall use the EDI response (acknowledgement) files to determine if files were successfully loaded. Within seven (7) days of the original submission attempt, the Managed Care Plan shall correct and resubmit files that fail to load.

d. Encounter Resubmission – Adjustments, Reversals or Corrections

(1) Within thirty (30) days after encounters fail NCPDP edits, X12 (EDI) edits or FMMIS system edits, the Managed Care Plan shall correct and resubmit all encounters for which errors can be remedied.

(2) The Managed Care Plan shall correct and resubmit one hundred percent (100%) of previously submitted X12 encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.

(3) The Managed Care Plan shall correct and resubmit one hundred percent (100%) of previously submitted NCPDP encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within seven (7) days of the respective action.

e. If the Managed Care Plan fails to comply with the encounter data reporting requirements of this Contract, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages.

F. Fraud and Abuse Prevention

1. General Provisions

a. The Managed Care Plan shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all State and federal program integrity requirements, including, but not limited to, the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 75; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S., and Rules 59A-12.0073, 59G and 69D-2, F.A.C.; 2 CFS Part 200 and 2 CFR 300.1.

b. The Managed Care Plan shall have adequate Florida-based staffing and resources to enable the Compliance Officer to investigate indicia of fraud, abuse, waste and develop and implement CAPs relating to fraud, abuse, waste and overpayment.

c. The Managed Care Plan's written fraud and abuse prevention program shall have internal controls and procedures in place that are designed to prevent, reduce, detect, investigate, correct and report known or suspected fraud, abuse, and waste activities. This shall include reporting instances of fraud and abuse pursuant to 42 CFR 438.608, Section 409.91212, 409.920, 626.989, and 641.3915, F.S.

d. In accordance with s. 6032 of the federal Deficit Reduction Act of 2005, the Managed Care Plan shall make available written fraud and abuse policies to all employees. If the Managed Care Plan has an employee handbook, the Managed Care Plan shall include specific information about s. 6032, the Managed Care Plan's policies, and the rights of employees to be protected as whistleblowers.

e. The Managed Care Plan shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect, exploitation, and overpayment issues.

f. The Agency may impose sanctions and/or liquidated damages for failure to timely comply with the provisions of this Section.

2. Compliance Officer

The Managed Care Plan's Compliance Officer as described in **Section IX.**, Administration and Management, shall have unrestricted access to the Managed Care Plan's governing body for compliance reporting, including fraud, abuse, waste and overpayment.

3. Special Investigations Unit

a. The Managed Care Plan shall establish and maintain a special investigations unit to investigate possible acts of fraud, abuse, waste, or overpayment, or may subcontract such functions.

b. If a Managed Care Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Managed Care Plan shall file the following with the Bureau of MPI for approval at least sixty (60) days before subcontract execution:

   (1) The names, addresses, telephone numbers, e-mail addresses and fax numbers of the principals of the entity with which the Managed Care Plan wishes to subcontract.

   (2) A description of the qualifications of the principals of the entity with which the Managed Care Plan wishes to subcontract.

   (3) The proposed subcontract.

c. The Managed Care Plan shall submit to MPI such executed subcontracts, attachments, exhibits, addendums or amendments thereto, within thirty (30) days after execution.

4. Compliance Plan and Anti-Fraud Plan

a. The Managed Care Plan shall submit its compliance plan and anti-fraud plan, including its fraud and abuse procedures, and any changes to these items, to MPI for written approval at least forty-five (45) days before those plans and procedures are implemented (Sections 409.91212, F.S., and 409.967(2)(g), F.S.). The Managed Care Plan shall submit these documents via the MPI-MC SFTP site. Failure to implement an MPI approved anti-fraud plan within ninety (90) days may result in liquidated damages. MPI may reassess the implementation of the anti-fraud plan every ninety (90) days until MPI deems the Managed Care Plan to be in compliance (**Section XIII.**, Liquidated Damages).

b. At a minimum the Managed Care Plan shall submit its compliance plan to MPI by September 1 of each Contract year. The compliance plan shall comply with 42 CFR 438.608 and include:

(1) Written policies, procedures and standards of conduct that articulate the Managed Care Plan's commitment to comply with all applicable federal and State standards.

(2) The designation of a Compliance Officer and a compliance committee accountable to senior management.

(3) Effective training and education of the compliance officer and the Managed Care Plan's employees.

(4) Effective lines of communication between the compliance officer and the Managed Care Plan's employees.

(5) Enforcement of standards through well-publicized statutory and contractual requirements and related disciplinary guidelines.

(6) Provision for internal monitoring and auditing.

(7) Provisions for prompt response to detected offenses and for development of corrective action initiatives.

c. At a minimum, the Managed Care Plan shall submit its anti-fraud plan to MPI September 1 of each Contract year. The anti-fraud plan shall comply with Section 409.91212, F.S., and, at a minimum, must include:

(1) A written description or chart outlining the organizational arrangement of the Managed Care Plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse or fraud.

(2) A description of the Managed Care Plan's procedures for detecting and investigating possible acts of fraud, abuse and overpayment.

(3) A description of the Managed Care Plan's procedures for the mandatory reporting of possible overpayment, abuse or fraud to MPI.

(4) A description of the Managed Care Plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse, waste and overpayment, including

(a) At a minimum, training shall be conducted within thirty (30) days of new hire and annually thereafter.

(b) The Managed Care Plan shall have a methodology to verify training occurs as required.

(c) The Managed Care Plan shall also include Deficit Reduction Act requirements in the training curriculum.

(5) The name, address, telephone number, e-mail address and fax number of the individual responsible for carrying out the anti-fraud plan.

(6) A summary of the results of the investigations of fraud, abuse, waste, or overpayment which were conducted during the previous fiscal year by the Managed Care Plan's Special Investigations Unit. For purposes of this summary, a case includes any action, whether an investigation, audit, provider payment review, provider on-site review, or other provider-specific evaluation. This summary shall include information pertaining to the State fiscal year that concluded immediately prior to the submission of this report. This summary shall include:

(a) Total number of cases opened.

(b) Total number of cases closed.

(c) Total number of cases that remain open as of the last day of the previous fiscal year.

(d) Total of overpayments identified for recovery which were identified as waste.

(e) Total amount of overpayments identified for recovery which were identified as fraud or abuse.

(f) Total amount of overpayments identified as waste which were actually recovered.

(g) Total amount of overpayments identified as fraud or abuse that was actually recovered.

(42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i)-(vii); 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3)).

d. At a minimum, the Managed Care Plan's compliance plan, anti-fraud plan, and fraud and abuse procedures shall comply with Section 409.91212, F.S., and with the following:

(1) Ensure that all officers, directors, managers and employees know and understand the provisions.

(2) Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. Nothing in this Contract shall require that the Managed Care Plan assure that non-participating providers are compliant with this Contract, but the Managed Care Plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected.

(3) Describe the Managed Care Plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols. Such internal investigational methodology and reporting protocols shall ensure the unit's primary purpose is for the investigation (or supervision of the investigation) of suspected insurance/Medicaid fraud and fraudulent claims.

(4) Describe the method(s), including detailed procedures, for verifying enrollees' identity and if services billed by providers were actually received.

(a) The Managed Care Plan shall describe procedures that include provisions to verify, by sampling or other methods, delivery of services by network providers to enrollees. Such methods include, but are not limited to, electronic verification, biometric technology, sending enrollee explanations of Medicaid benefits, contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses (42 CFR 438.608(a)(5)).

(b) Notwithstanding the above provisions, the Managed Care Plan shall describe the process by which the delivery of personal care services and home health services shall be monitored and validated via an EVV system (as required by federal law in the "21st Century Cures Act"). The description shall include details on EVV system reports and costs. The Managed Care Plan may use any EVV vendor and/or proprietary EVV system; however, the EVV system shall offer inter-operability and compatibility among EVV platforms and be compatible with the Agency's EVV system as prescribed by the Agency.

(5) Incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:

(a) An effective pre-payment and post-payment review process, including, but not limited to, data analysis, claims and other system edits, and auditing of participating providers (Section 409.967(2)(g), F.S.).

(b) Provider profiling, credentialing, and recredentialing, and ongoing provider monitoring including a review process for claims and encounters that shall include providers and non-participating providers who:

(i) Demonstrate a pattern of submitting falsified encounter data or service reports.

(ii) Demonstrate a pattern of overstated reports or up-coded levels of service.

(iii) Alter, falsify, or destroy enrollee record documentation.

(iv) Make false statements related to credentials.

(v) Misrepresent medical information to justify enrollee referrals.

(vi) Fail to render medically necessary covered services they are obligated to provide according to their provider agreements.

(vii) Charge enrollees for covered services.

(viii) Bill for services not rendered.

(c) Prior authorization.

(d) UM.

(e) Subcontract and provider agreement provisions.

(f) Provisions from the provider and the enrollee handbooks.

(g) Standards for a code of conduct.

(42 CFR 438.608(a)(7)).

(6) Contain provisions pursuant to this Section for the confidential reporting of Managed Care Plan violations to MPI and other agencies as required by law.

(7) Include provisions for the investigation and follow-up of any reports.

(8) Ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud and abuse.

(9) Require all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, Managed Care Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under State and/or federal law be reported to MPI within fifteen (15) days of detection, as specified in Section 409.91212, F.S., and in **Section XV.**, Accountability, and the Managed Care Plan Report Guide. Additionally, any final resolution reached by the Managed Care Plan shall include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter.

(10) Require all potential instances of fraud relating to the provision of and payment for Medicaid services including, but not limited to, Managed Care Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees be reported to the Medicaid Fraud Control Unit as required in 42 CFR 438.608 and this Contract.

(11) Ensure that the Managed Care Plan and all providers and subcontractors, upon request and as required by State and/or federal law, shall:

(a) Make available to all authorized federal and State oversight agencies and their agents, including, but not limited to, the Agency, the Florida Attorney General, and DFS any and all administrative, financial and enrollee records and data relating to the delivery of items or services for which Medicaid monies are expended (42 CFR 438.242(b)(4)).

(b) Allow access to all authorized federal and State oversight agencies and their agents, including, but not limited to, the Agency, the Florida Attorney General, and DFS to any place of business and all enrollee records and data, as required by State and/or federal law. Access shall be during Normal Business Hours, except under special circumstances when the Agency, the Florida Attorney General, and DFS shall have After Hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances.

(12) Ensure that the Managed Care Plan shall cooperate fully in any investigation by federal and State oversight agencies and any subsequent legal action that may result from such an investigation.

(13) Ensure that the Managed Care Plan does not retaliate against any individual who reports violations of the Managed Care Plan's fraud and abuse procedures or suspected fraud and abuse.

(14) Not knowingly employ or contract with individuals or entities debarred or excluded from participation in any federal health care program under ss. 1128 and 1128A of the Social Security Act, nor with an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610 (a)(1); or subcontractors on the discriminatory vendor list maintained by the Department of Management Services in accordance with s. 287.134, F.S.; (42 CFR 438.808(a) and (b)(2); 42 CFR 431.55(h); 42 CFR 438.610(b); ss. 1128(b)(8) and 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b); State Medicaid Director Letters 6/12/08 and 1/16/09; Executive Order No. 12549)

(15) On at least a monthly basis check current staff, subcontractors and providers against the federal LEIE and the federal SAM (includes the former EPLS) or their equivalent, to identify excluded parties. The Managed Care Plan shall also check monthly the Agency's listing of suspended and terminated providers at the Agency website below, to ensure the Managed Care Plan does not include any non-Medicaid eligible providers in its network: http://apps.ahca.myflorida.com/dm_web.

The Managed Care Plan shall also conduct these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. The Managed Care Plan shall not employ or contract with an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act (42 CFR 438.214(d)(1)).

(16) Provide details and educate employees, subcontractors and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:

(a) The Federal False Claims Act.

(b) The penalties and administrative remedies for submitting false claims and statements.

(c) Whistleblower protections under federal and State law.

(d) The entity's role in preventing and detecting fraud, waste, and abuse.

(e) Each person's responsibility relating to detection and prevention.

(f) The toll-free State telephone numbers for reporting fraud and abuse.

(17) If the Managed Care Plan provides telemedicine, the Managed Care Plan shall include procedures specific to prevention and detection of potential or suspected fraud and abuse of telemedicine in its fraud and abuse detection activities.

5. Retention Policy for the Treatment of Fraud, Abuse, and Waste Recoveries

a. The Managed Care Plan shall engage in efforts to recover overpayments. Overpayments may be in the form of fraud, abuse, or waste.

b. The Agency's retention and distribution policies only apply to recoveries made through Agency investigations, and do not include non-Agency investigations and recoveries. Distribution of recoveries to a Managed Care Plan pursuant to these provisions may be limited if prohibited by State or federal law.

c. The Managed Care Plan shall timely report to the Agency's Bureau of MPI the identification of suspected or confirmed fraud, abuse, and waste (42 CFR 438.608 and Section 409.91212, F.S.).

d. The Managed Care Plan shall fully participate as directed by the Agency in fraud investigations, prosecutions, and civil actions pursued by MFCU or other law enforcement/prosecutorial entities.

e. The Managed Care Plan may be entitled to a portion of the recoveries made through Agency investigations when:

(1) The Managed Care Plan has timely reported the suspected fraud, abuse, or waste to the Agency.

(2) The Managed Care Plan has participated in the investigation, prosecution, and/or civil action regarding such.

(3) The recovery efforts are not time limited by the provisions of s. 641.3155, F.S.

f. The Agency may share recoveries made by the Agency with the Managed Care Plan when the Managed Care Plan has timely reported the suspected fraud, abuse, or waste to the Agency and the recovery efforts are time limited by the provisions of s. 641.3155, F.S.

g. The Managed Care Plan shall not be entitled to recoveries related to overpayments under any of the following circumstances:

(1) The recovery of overpayments is time limited by the provisions of s. 641.3155, F.S., and:

(a) The Agency's Bureau of MPI identifies and recovers overpayments related to abuse and waste, except as permitted in Sub-item e. above.

(b) The Managed Care Plan has not properly reported to the Agency the suspected fraud, abuse, or waste.

(2) The Agency identifies and recovers overpayments that are not time limited by the provisions of s. 641.3155, F.S., the Agency has provided notice to the Managed Care Plan of the identification of overpayments, and the Managed Care Plan does not engage in recovery efforts.

(3) The recovery of overpayments is made by MFCU.

6. Reporting and Disclosure Requirements

a. The Managed Care Plan shall comply with all reporting requirements as set forth below and in 42 CFR 438.608 and Section 409.91212, F.S.

b. The Managed Care plan shall submit disclosures of suspected or confirmed provider fraud through the following process:

(1) Within five (5) days of the date of detection of suspected or confirmed provider fraud, the Managed Care Plan shall provide advanced notice to MPI of the details of the investigative subject (provider), potential fraud scheme, and estimated exposed amount in a manner and format specified by the Agency.

(2) Within ten (10) days of submission of advanced notice to MPI, the Managed Care Plan shall submit a supplemental referral attachment to MPI in a format specified by the Agency.

(3) Within the statutorily required reporting period, unless otherwise advised by MPI in writing, the Managed Care Plan shall report incidents of suspected/confirmed fraud as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

(4) The Managed Care Plan shall refer incidents of suspected/confirmed fraud to MFCU within ten (10) calendar days following submission of the suspected/confirmed fraud report to MPI and submit a copy of the MFCU referral to MPI.

(a) The Managed Care Plan shall temporarily cease any further activities, not limited to overpayment recovery or witness interviews, which could obstruct or impede a criminal investigation, unless MFCU advises the Managed Care Plan and MPI that the referral is not accepted.

(b) The Managed Care Plan shall resume its activities after the forty-five (45) day period unless otherwise agreed upon between the Managed Care Plan and MFCU. In such case, MFCU will provide routine investigative updates to the Managed Care Plan and MPI.

c. The Managed Care Plan shall achieve or exceed the Agency-specified performance target for reporting suspected provider fraud cases each State Fiscal Year to the Medicaid Fraud Control Unit following the required processes as outlined in this Contract and applicable federal and state regulations. The Medicaid Fraud Performance Target Formula is available at: https://ahca.myflorida.com/Medicaid/statewide_mc/app_contract_materials.shtml.

d. The Managed Care Plan shall report on a quarterly basis a comprehensive fraud and abuse prevention activity report regarding its investigative, preventive and detective activity efforts, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

e. The Managed Care Plan shall, by September 1 of each year, report to MPI its experience in implementing an anti-fraud plan, and on conducting or subcontracting for investigations of possible fraudulent or abusive acts during the prior State fiscal year, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide. The report must include, at a minimum:

(1) The dollar amount of Managed Care Plan losses and recoveries attributable to overpayment, abuse and fraud.

(2) The number of Managed Care Plan referrals to MPI.

f. The Managed Care Plan shall notify DHHS OIG and MPI within ten (10) business days of discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per s. 1128, s. 1156, and s.1892 of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1.

g. In accordance with 42 CFR 455.106, the Managed Care Plan shall disclose to DHHS OIG, with a copy to MPI within ten (10) business days after discovery, the identity of any person who:

(1) Has ownership or control interest in the Managed Care Plan, or is an agent or managing employee of the Managed Care Plan.

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

h. In addition to the disclosure required under 42 CFR 455.106, the Managed Care Plan shall also disclose to DHHS OIG with a copy to MPI within ten (10) business days after discovery, the identity of any person described in 42 CFR 1002.3 and 42 CFR 1001.1001(a)(1), and to the extent not already disclosed, to additionally disclose any person who has ownership or control interest in a Managed Care Plan participating provider, or subcontractor, or is an agent or managing employee of a Managed Care Plan participating provider or subcontractor, and meets at least one of the following requirements:

(1) Has been convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

(2) Has been denied entry into the Managed Care Plan's network for program integrity-related reasons.

(3) Is a provider against whom the Managed Care Plan has taken any action to limit the ability of the provider to participate in the Managed Care Plan's provider network, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program or Managed Care Plan provider network to avoid a formal sanction.

i. The Managed Care Plan shall submit the written notification referenced above to DHHS OIG as instructed by the Agency. Document information examples include, but are not limited to, court records such as indictments, plea agreements, judgments and conviction/sentencing documents.

j. The Managed Care Plan shall notify MPI and provide a copy of any corporate integrity or corporate compliance agreements within thirty (30) days after execution of such agreements.

k. The Managed Care Plan shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI.

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Section X. Method of Plan Payment

A. General Provisions

1. The Agency shall deny payments to the Managed Care Plan for new enrollees when payment for those enrollees is denied by CMS based on the Agency's recommendation in accordance with 42 CFR 438.726(b) and 42 CFR 438.730(e).

2. In accordance with Section 409.967(3), F.S., the Agency shall be responsible for verifying the Managed Care Plan's ASR as specified in **Section X.**, Method of Plan Payment in this Contract. The Agency shall contract with independent certified public accountants (CPAs) to conduct compliance audits for the purpose of auditing Managed Care Plan financial information in order to determine and validate the Managed Care Plan's ASR.

B. Fixed Price Unit Contract

This is a fixed price (unit cost) Contract awarded through procurement. The Agency, through its fiscal agent, shall make payment to the Managed Care Plan on a monthly basis for the Managed Care Plan's satisfactory performance of its duties and responsibilities as set forth in this Contract.

C. Payment Provisions

1. Capitation Rates

a. The Managed Care Plan shall be paid the applicable capitation rate for each Medicaid-eligible enrollee whose name appears on the HIPAA-compliant X12 820 file for each month. The total payment amount to the Managed Care Plan shall depend upon the number of enrollees in each eligibility category and each rate group, as provided for by this Contract, or as adjusted pursuant to this Contract when necessary. The Managed Care Plan is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the Managed Care Plan has received capitation payment or for whom the Agency has assured the Managed Care Plan that capitation payment is forthcoming (42 CFR 438.3(c)(2)).

b. In accordance with Section 409.968, 409.976 and 409.983, F.S., the capitation rates reflect historical utilization and spending for covered services projected forward and shall be risk adjusted for enrollees in each Managed Care Plan. During the Contract term, the Agency may change the Risk Adjustment Model to reflect the risk of the Managed Care Plan's membership mix.

c. Utilization and expenditures for services by providers outside the U.S. shall not be included in the development of capitation rates.

d. The rates shall be actuarially sound in accordance with 42 CFR 438.6(c).

e. The base capitation rates prior to risk adjustment shall be included in this Contract.

f. The Agency may use, or may amend and use these rates, only after certification by its actuary and approval by CMS. Inclusion of these rates is not intended to convey or imply any rights, duties or obligations of either party, nor is it intended to restrict, restrain or control the rights of either party that may have existed independently of this Section of this Contract.

g. By signature on this Contract, the parties explicitly agree that this Section shall not independently convey any inherent rights, responsibilities, or obligations of either party, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by either party. In the event that the rates certified by the actuary and approved by CMS are different from the rates included in this Contract, the Managed Care Plan agrees to accept a reconciliation performed by the Agency to bring payments to the Managed Care Plan in line with the approved rates. The Agency may amend and use the CMS-approved rates by notice to the Managed Care Plan through an amendment to this Contract.

h. Unless otherwise specified in this Contract, the Managed Care Plan shall accept the capitation payment received each month as payment in full by the Agency for all services provided to enrollees covered under this Contract and the administrative costs incurred by the Managed Care Plan in providing or arranging for such services. Any and all costs incurred by the Managed Care Plan in excess of the capitation payment shall be borne in total by the Managed Care Plan.

i. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Managed Care Plan must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Managed Care Plan works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Managed Care Plan will not be paid for that work. If the state paid the Managed Care Plan in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work must be returned to the State.

2. Rate Adjustments and Reconciliations

a. The Managed Care Plan and the Agency acknowledge that the capitation rates paid under this Contract are subject to approval by the federal government.

b. The Managed Care Plan and the Agency acknowledge that adjustments to funds previously paid, and to funds yet to be paid, may be required. Funds previously paid shall be adjusted when capitation rate calculations are determined to have been in error, or when capitation rate payments have been made for enrollees who are determined not to have been eligible for Managed Care Plan membership during the period for which the capitation rate payments were made. In such events, the Managed Care Plan and any subcontractor shall report to the State within sixty (60) days when

it has identified capitation payments or other payments in excess of amounts specified in this Contract. The Managed Care Plan agrees to refund any overpayment and the Agency agrees to pay any underpayment (42 CFR 438.608(c)(3)).

c. Capitation rates shall be adjusted to reflect budgetary changes in the Medicaid program. The rate of payment and total dollar amount may be adjusted with a properly executed amendment when Medicaid expenditure changes have been established through the appropriations process and subsequently identified in the Agency's operating budget. Legislatively-mandated changes shall take effect on the dates specified in the legislation. The Agency may not approve any Managed Care Plan request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act (Section 409.968(3), F.S.).

d. In accordance with Section 409.967(3) and 42 CFR 438.8(k) and (m) F.S., the Managed Care Plan's ASR shall be verified as specified in this Contract.

3. Errors

The Managed Care Plan shall carefully prepare all reports and monthly payment requests for submission to the Agency. If after preparation and electronic submission, the Managed Care Plan discovers an error, including, but not limited to, errors resulting in capitated payments or other payments in excess of amounts specified in this Contract, either by the Managed Care Plan or the Agency, the Managed Care Plan has sixty (60) days from its discovery of the error, or sixty (60) days after receipt of notice by the Agency, to correct the error and re-submit accurate reports. Failure to respond within the sixty (60)-day period shall result in a loss of any money due to the Managed Care Plan for such errors and/or sanctions against the Managed Care Plan pursuant to **Section XII.**, Sanctions and Corrective Action Plans.

4. Enrollee Payment Liability Protection

a. Pursuant to s. 1932(b)(6), Social Security Act (as enacted by Section 4704 of the Balanced Budget Act of 1997), the Managed Care Plan shall not hold enrollees liable for debts of the Managed Care Plan, in the event of the Managed Care Plan's insolvency (42 CFR 438.106(a)).

b. The Managed Care Plan shall not hold enrollees liable for payment of covered services provided by the Managed Care Plan if the Managed Care Plan has not received payment from the Agency for the covered services, or if the provider, under contract or other arrangement with the Managed Care Plan, fails to receive payment from the Agency or the Managed Care Plan (42 CFR 438.106(b)(1)-(2); 42 CFR 438.3(k); 42 CFR 438.230).

c. The Managed Care Plan shall not hold enrollees liable for payments to a provider, including referral providers, that furnished covered services under a contract or other arrangements with the Managed Care Plan, that are in excess of the amount that normally would be paid by the enrollee if the covered services had been received directly from the Managed Care Plan (42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230).

5. Quality Withhold Incentive

a. Each year, the Agency shall withhold two percent (2%) of the Managed Care Plan's capitation rate, with the withhold to be earned based on the Managed Care Plan's performance according to specific performance measures compared against national performance standards.

b. The following Healthcare Effectiveness Data and Information Set (HEDIS) performance measures shall be used in the Quality Withhold Incentive, divided into two groups:

(1) Group A:

(a) Antidepressant Medication Management – Acute Phase (AMM-AP)

(b) Controlling Blood Pressure (CBP)

(c) Hemoglobin A1c Control for Patients with Diabetes (HBD) – Control (< 8.0%) (HBD)

(d) Childhood Immunization Status – Combo 3 (CIS03)

(e) Well-Child Visits in the First 30 Months – First 15 Months (W30-15)

(f) Child and Adolescent Well-Care Visits – Total (WCV)

(2) Group B:

(a) Follow-up after Hospitalization for Mental Illness – 7-day (FUH-7)

(b) Follow-up after Emergency Department Visit for Mental Illness – 7-day (FUM-7)

(c) Timeliness of Prenatal Care (PPC-Pre)

(d) Postpartum Care (PPC-Post)

c. The Managed Care Plan shall earn points for each measure based on the Managed Care Plan's performance rate relative to the National Committee for Quality Assurance's (NCQA's) National Medicaid Percentile for the measure.

(1) For Group A measures, points will be earned as follows in the Points for Quality Withhold Incentive – Group A HEDIS Measures Table, **Table 5**, below:

TABLE 5 POINTS FOR QUALITY WITHHOLD INCENTIVE – GROUP A HEDIS MEASURES	
National Medicaid Percentile	**Points**
>= 90th percentile	5
>= 75th percentile and below 90th	4
>=60th percentile and below 75th	3
>= 50th percentile and below 60th	2
>= 40th percentile and below 50th	1
< 40th percentile	0

(2) For Group B measures, points will be assigned as follows in **Table 6**, Points for Quality Withhold Incentive – Group B HEDIS Measures:

TABLE 6 POINTS FOR QUALITY WITHHOLD INCENTIVE – GROUP B HEDIS MEASURES	
National Medicaid Percentile	**Points**
>= 75th percentile and below 90th	5
>=60th percentile and below 75th	4
>= 50th percentile and below 60th	3
>= 40th percentile and below 50th	2
>= 25th percentile and below 40th	1
< 25th percentile	0

d. Earned points for the ten (10) measures will be added together to determine the Total Quality Points for the Managed Care Plan. The maximum number of Total Quality Points the Managed Care Plan may earn is five (5) multiplied by the total number of performance measures that the Managed Care Plan reports to the Agency. For example, if the Managed Care Plan has reportable rates for all ten (10) measures, then the plan's maximum number of Total Quality Points is fifty (50). If the plan has reportable rates for eight (8) measures, then the plan's maximum number of Total Quality Points is forty (40).

e. If the Managed Care Plan's Total Quality Points equals or exceeds an average of two (2) points per reportable performance measure, then the Managed Care Plan shall earn its full two percent (2%) withhold. For example, if the Managed Care Plan reports ten (10) measures to the Agency and earns twenty (20) Total Quality Points, then the Managed Care Plan shall earn its two percent (2%) withhold. If the Managed Care Plan reports eight (8) measures to the Agency and earns sixteen (16) Total Quality Points, then the Managed Care Plan shall earn its two percent (2%) withhold. If the Managed Care Plan's Total Quality Points are below an average of two (2) points per reportable performance measure, then the Managed Care Plan shall not receive its full withhold but may receive a portion of the withhold based on the percentage of Total Quality Points earned to maximum number of points possible.

f. Withhold not earned back by the Managed Care Plan shall be directed to a Quality Bonus Pool.

g. Each year, if the Managed Care Plan earns its full 2% withhold and there is a Quality Bonus Pool created by other Managed Care Plans that have not earned their full withholds, then the Managed Care Plan may be eligible to earn an additional incentive payment from the Quality Bonus Pool based on the percentage of Total Quality Points earned to maximum number of points possible.

h. If every Managed Care Plan receives its full two percent (2%) withhold, then there will not be a Quality Bonus Pool available for distribution that year.

i. The Agency reserves the right to change the Quality Withhold Incentive methodology in the future.

6. Achieved Savings Rebate

a. In accordance with 42 CFR 438.6(b)(3)(i)-(iv), 42 CFR 438.340, Section 409.967(3), F.S., and as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide, the Managed Care Plan shall submit:

(1) Quarterly and annual unaudited ASR Financial Reports, and an annual financial statement audit conducted by an independent CPA.

(2) Quarterly and annual NAIC Financial Statements filed with the OIR and prepared in accordance with statutory accounting principles.

b. In accordance with Section 409.967(3)(g), F.S., as part of the ASR process, a Managed Care Plan that exceeds Agency-defined quality measures as specified in **Section X.**, Method of Plan Payment, in the reporting period may retain an additional one percent (1%) of revenue.

c. The Managed Care Plan shall pay to the Agency the expenses of the Agency's ASR audit at the rates established by the Agency. Expenses shall include actual travel expenses, reasonable living expense allowances, compensation of the CPA, and necessary attendant administrative costs of the Agency directly related to the audit/examination. The Managed Care Plan shall pay the Agency within twenty-one (21) days after presentation by the Agency of the detailed account of the charges and expenses. Failure to pay shall result in liquidated damages as specified in **Section XIII.**, Liquidated Damages.

d. The Managed Care Plan shall make available all books, accounts, documents, files and information that relate to the Managed Care Plan's Medicaid transactions at a Florida location by the Agency's contracted CPA.

(1) The Managed Care Plan shall cooperate in good faith with the Agency and the CPA.

(2) Records not in the Managed Care Plan's immediate possession must be made available to the Agency or the CPA in the Florida location specified by the Agency or the CPA within three (3) days after a request is made by the Agency or the CPA. If original records are required, and they cannot be made available in a Florida location as specified herein, the Managed Care Plan shall make the records available for the CPA to review at the applicable location and shall pay any expenses related to the CPA's review at that location.

(3) Failure to comply with such record requests, including failure to provide records, reports, and documentation to the Agency or CPA by the dates requested, shall be deemed a breach of Contract, and the Managed Care Plan shall be subject to sanctions as specified in **Section XII.**, Sanctions and Corrective Action Plans.

e. In accordance with Section 409.967(3)(g), F.S., and as specified below, if the Managed Care Plan exceeds the Agency-defined quality measures as specified in the applicable Exhibit(s), the Managed Care Plan may retain up to an additional one percent (1%) of its revenue.

(1) The Managed Care Plan that meets the quality standards for only one program component (LTC or MMA), may retain up to one percent (1%) of ASR-allowed revenue associated with the component for which they meet the quality standards.

(2) The Agency may amend the performance measures and the thresholds required for a Managed Care Plan to retain up to an additional one percent (1%) of revenue with sixty (60) days' advance notice.

f. The Agency CPA shall validate the ASR, and the results shall be provided to the Agency. If the CPA validates the ASR submitted by the Managed Care Plan in accordance with the Managed Care Plan Report Guide, these results shall be final and dispositive. If the CPA fails to validate the ASR submitted by the Managed Care Plan, the Managed Care Plan shall receive written notice of the CPA's findings and be provided with the opportunity to review and respond to the CPA's findings in writing within the timeframe specified by the Agency. The CPA shall review the Managed Care Plan's response and issue final results. These results are dispositive.

g. The Managed Care Plan shall receive the final results of the audit, and the Managed Care Plan shall pay the rebate to the Agency within thirty (30) days after the results are provided.

h. The ASR is established by determining pretax income as a percentage of revenues and applying the following income ratios:

(1) One hundred percent (100%) of income up to and including five percent (5%) of revenue shall be retained by the Managed Care Plan.

(2) Fifty percent (50%) of income above five percent (5%) and up to ten percent (10%) shall be retained by the Managed Care Plan, and the other fifty percent (50%) refunded to the State.

(3) One hundred percent (100%) of income above ten percent (10%) of revenue shall be refunded to the State.

i. As further specified in the Managed Care Plan Report Guide, for purposes of the ASR:

Pretax income is defined as pre-tax revenue minus those expenses permitted in the Managed Care Plan Report Guide.

j. Revenue includes but is not limited to all capitation premium payments made by the State to the Managed Care Plan. Revenue is to be reduced by the State premium tax or other State assessments based on the premium.

k. Expenses generally include reasonable and appropriate medical expenses and general and administrative expenses, as determined by the Agency, other than interest expense, of operating the Managed Care Plan in accordance with the requirements of this Contract. Any State premium tax or other State assessment based on premium that is treated as a reduction to premium revenue cannot be included in the allowable expenses.

l. In accordance with Section 409.967(3)(h), F.S., the following expenses are not allowable expenses for purposes of determining the pre-tax income subject to the ASR:

   (1) Payment of ASRs.

   (2) Any financial incentive payments made to the Managed Care Plan outside of the capitation rate.

   (3) Expenses associated with any lobbying or political activities.

   (4) Cash value or equivalent cash value of bonuses of any type paid or awarded to the Managed Care Plan's executive staff other than base salary.

   (5) Reserves and reserve accounts other than those expressly permitted by the Managed Care Plan Report Guide.

   (6) Administrative costs in excess of actuarially sound maximum amounts set by the Agency.

   (7) Other costs excluded in accordance with 42 CFR 438.6.

m. The actuarially sound maximum amount for administrative costs shall be set by the Agency in consultation with the actuary developing the capitation rates as part of the rate setting process.

n. In accordance with Section 409.967(3)(i), F.S., if the Managed Care Plan incurs a loss in the first year of operation subject to the achieved saving rebate, it may apply the full amount of such loss as an offset to income in the second year. If the Managed Care Plan elects to carry forward such a loss, then the life-years of coverage for the first year of coverage shall also carry over to the second year.

o. In accordance with Section 409.967(3)(j), F.S., if the Agency later determines that the Managed Care Plan owes an additional rebate, the Managed Care Plan shall have thirty (30) days after notification by the Agency to make payment. If the Managed Care Plan fails to pay the rebate, future payments shall be withheld until the entire amount of the rebate is recouped. If the Agency determines that the Managed Care Plan made an overpayment, the Managed Care Plan shall be returned the overpayment within thirty (30) days of such determination.

p. If the Managed Care Plan purchases or acquires part or all of the business of another Managed Care Plan, the Managed Care Plan's information and reports regarding its ASR shall include information for the purchased business, including for that part of the reporting period that was prior to the purchase. If the Managed Care Plan is unable to include information for the purchased business prior to the purchase date, the Managed Care Plan shall pay for the cost of the audit for the reporting period prior to the purchase date.

q. If the Managed Care Plan's enrollment in a reporting period is fewer than five thousand (5,000) life-years, the Managed Care Plan shall not owe a rebate for the reporting

period. However, the information from that reporting period shall be carried over and included with information for the next reporting period. When the cumulative life-years of such combined reporting periods equal or exceed five thousand (5,000) life-years, the achieved saving rebate calculation shall be performed.

r. If the Agency determines that payment of an ASR by the Managed Care Plan would result in the Managed Care Plan being put at significant risk of insolvency, the Agency may defer all or a portion of the rebate payment owed by the Managed Care Plan.

s. The ASR shall be calculated in accordance with Section 409.967(3)(f), F.S., as illustrated in the Achieved Savings Rebates Table – Effective 01/01/2025 – 12/31/2030 Table, **Table 7**, below.

Note: The following three (3) increments shall be applied to the Managed Care Plan's (Plan's) pre-tax income (AKA: net operating income [NOI])

TABLE 7: ACHIEVED SAVINGS REBATES TABLE – EFFECTIVE 01/01/2025 – 12/31/2030			
	NOI Range Category	**Amount the Managed Care Plan shall retain**	**Amount the Managed Care Plan shall be required to refund to the Agency**
I	NOI ranging from Zero (0) up to and including five percent (5%) of the Managed Care Plan's premium revenue:	The Managed Care Plan shall retain one hundred percent (100%) of NOI within this range.	The Managed Care Plan shall not be required to refund any of their NOI within this range.
II	NOI above five percent (5%) and up to and including ten percent (10%) of the Managed Care Plan's premium revenue:	The Managed Care Plan shall retain fifty percent (50%) of the NOI within this range.	The Managed Care Plan shall be required to refund fifty percent (50%) of the NOI within this range.
III	NOI above ten percent (10%) of the Managed Care Plan's premium revenue:	The Managed Care Plan shall not be allowed to retain any of the NOI within this range.	The Managed Care Plan shall have to refund to the Agency one hundred percent (100%) of the NOI within this range.

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Example: If the Managed Care Plan's premium revenues are one million dollars (**$1,000,000)** and allowed expenses are eight hundred fifty thousand dollars (**$850,000)**, the Managed Care Plan has a pre-tax net operating income (NOI) of one hundred fifty thousand dollars (**$150,000).** The NOI is calculated to be fifteen percent (15%) of premium revenue (NOI/Revenue):

NOI Range as Percent of Revenue	**Plan Retains**		**Plan Refunds to the State**	
0.00% to 5.00% = **$50,000**	One hundred percent (100%) of NOI within this range	**$50,000**	Zero percent (0%) of NOI within this range:	**$0**
5.00% to 10.00% = **$50,000**	Fifty percent (50%) of NOI within this range	**$25,000**	Fifty percent (50%) of NOI within this range:	**$25,000**
above 10.00% = **$50,000**	Zero percent (0%) of NOI within this range	**$0**	One hundred percent (100%) of NOI within this range:	**$50,000**
TOTAL = **$150,000**		**$75,000**		**$75,000**

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Section XI. Financial Requirements

The Managed Care Plan shall meet all financial requirements established by this Contract and report financial information, including, but not limited to, quarterly and annual financial statements, in accordance with **Section XV.**, Accountability, the Managed Care Plan Report Guide and other Agency instructions. The Managed Care Plan shall certify that information it submits to the Agency is accurate, truthful, and complete in accordance with 42 CFR 438.606.

A. Insolvency Protection

1. Insolvency Protection Requirements

a. Insolvency Protection Requirements for the PSN

(1) The PSN shall furnish to the Agency a performance bond in an amount equal to the greater of five hundred thousand dollars **($500,000)**, ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the PSN's prepaid revenues for all regions in which the PSN is awarded a Contract. If the PSN is awarded more than one (1) region, the PSN shall furnish a single bond for the total amount of the foregoing.

(2) The bond must be furnished to the Agency within thirty (30) calendar days after execution of the Contract and prior to commencement of any work under this Contract. Thereafter, the bond shall be furnished on an annual basis, thirty (30) calendar days prior to the new Contract year for the same amount as required for the initial performance bond. A copy of all performance bonds shall be submitted to the Agency's Contract Manager. The performance bond must not contain any provisions that shorten the time for bringing an action to a time less than that provided by the applicable Florida Statute of Limitations. See Section 95.03, F.S. No payments shall be made to the PSN until an acceptable performance bond is furnished to the Agency.

(3) The PSN shall maintain an effective performance bond for the full term of this Contract, including any renewal period. The Agency shall be named as the beneficiary of the PSN's bond. The bond shall provide that the insurer or bonding company(s) pay losses suffered by the Agency directly to the Agency.

(4) The PSN shall bear cost of the performance bond.

(5) In the event that a determination is made by the Agency that the PSN is insolvent or this Contract terminates, an assessment against the bond shall be made by the Agency to pay any outstanding debts the PSN owes the Agency, including, but not limited to, overpayments made to the PSN, such amounts as may be required to protect enrollees in the event the PSN is unable to meet its obligations, and fines imposed under this Contract or Florida law. In addition, an assessment against the bond shall be made by the Agency to cover the costs of issuing a new solicitation and selecting a new PSN. The PSN agrees that the Agency's damages in the event of a termination by the PSN shall be considered to be in excess of the full amount of the bond. The Agency need not prove the damage amount or provide notice to the PSN in exercising its right of recourse against the bond.

(6) If the Contract is not renewed, the Agency shall release the bond to the PSN upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.

b. Insolvency Protection Requirements for Eligible Plans excluding PSNs

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

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

https://ahca.myflorida.com/Medicaid/statewide_mc/app_contract_materials.shtml.

The Managed Care Plan shall submit all such agreements or other signature cards to the Agency for prior approval.

(3) In the event that the Agency determines the Managed Care Plan is insolvent, the Agency may draw upon the amount solely with the two (2) authorized signatures of representatives of the Agency, and the Agency may disburse funds to meet financial obligations incurred by the Managed Care Plan under this Contract. A statement of account balance shall be provided by the Managed Care Plan within fifteen (15) days of the request from the Agency.

(4) If the Agency terminates or does not renew this Contract, the Agency shall release the account balance to the Managed Care Plan upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.

(5) In the event the Agency terminates or does not renew this Contract and the Managed Care Plan is insolvent, the Agency may draw upon the insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency, including, but not limited to, overpayments made to the Managed Care Plan and fines imposed under this Contract or, for HMOs, s. 641.52, F.S., for EPOs, Chapter 627, F.S., and for health insurers, Chapter 624, F.S., for which a final order has been issued. The Managed Care Plan authorizes the Agency to file one or more financial statements or similar records covering the insolvency protection account where filing is deemed to be necessary or desirable by the Agency. The Managed Care Plan shall execute and deliver, or cause to be executed and delivered, such other documents as the Agency may from time to time request to perfect or further evidence the pledge, security interest and assignment created in the insolvency protection account by this Contract. No financial statement or similar record covering all or any portion of the insolvency protection account shall be on file in any public office unless the Agency has approved that filing. In addition, if the Agency terminates or does not renew this Contract, and the Managed Care Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Managed Care Plan shall agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

2. Insolvency Protection Account Waiver for Eligible Plans excluding PSNs

The Agency may waive the insolvency protection account in writing when evidence of adequate insolvency insurance and reinsurance are on file with the Agency to protect enrollees in the event the Managed Care Plan is unable to meet its obligations (42 CFR 438.6(b)(1)).

3. Insolvency Protection Investment Option for Eligible Plans excluding PSNs

a. At the discretion of and upon written permission granted by the Agency, a Managed Care Plan that has fully funded their restricted insolvency protection account in accordance with this Section, and has met surplus requirements in accordance with this Section for the previous six (6) consecutive quarters may invest the full value of the required insolvency protection account balance in U.S. Treasury Securities (Securities) which are backed by the full faith and credit of the U.S. government through the utilization of a custodial account at a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by Section 4706 of the Balanced Budget Act of 1997), and Section 409.912, F.S. A listing of approved Securities is specified in the table below. Securities held in the custodial account shall not be pledged to any entity other than the Agency, and trading on margin shall be prohibited.

b. The Managed Care Plan shall safeguard against potential losses in value by depositing an additional amount equal to the estimated decrease in account value that would occur for a one hundred (100) basis points (1%) increase in the Federal Funds rate. The amount of this deposit shall be approved by the Agency upon account inception and can be held in either Securities or cash.

c. The custodial investment insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by the Managed Care Plan and two (2) representatives of the Agency. The Multiple Signature Verification Agreement for Custody Arrangements Form shall be submitted to the Agency within thirty (30) calendar days of account execution and resubmitted within thirty (30) calendar days after a change in authorized Managed Care Plan personnel occurs. If the authorized persons remain the same, the Managed Care Plan shall submit an attestation to this effect April 1 of each Contract year to the Agency along with a copy of the latest bank statement and summary of transactions for the month prior.

d. The Managed Care Plan assumes sole responsibility for monitoring the custodial investment insolvency account to ensure the total value of all Securities shall not fall below the required insolvency protection account balance pursuant this Section. The Managed Care Plan shall submit to the Agency a monthly account valuation within fifteen (15) calendar days after the end of each reporting month. The monthly account valuation shall include a complete transaction history of purchased and/or sold Securities within the reporting period, the custodial investment insolvency protection account balance, and shall take into consideration all factors that may affect the total value of the custodial investment insolvency protection account. In the event that the total value of the custodial investment insolvency protection account is less than the required insolvency protection account balance at any time, the Managed Care Plan shall make a capital contribution in the form of cash and/or Securities within five (5) business days equal to the difference between the current value and the required insolvency protection account balance. Documentation evidencing this contribution shall be included with the monthly valuation. Should the Managed Care Plan fail to maintain the required insolvency protection account balance, the Agency, at its sole discretion, reserves the right to require the Managed Care Plan to re-establish a restricted insolvency protection account in accordance with Section X.A.1 (42 CFR 438.604(a)(4); 42 CFR 438.606).

e. The Agency, at its sole discretion, may require the plan to re-establish a restricted insolvency protection account in accordance with this Section. The re-established account shall be funded by the liquidated proceeds of all Securities held in the insolvency protection investment account at the time the Agency required its re-establishment, plus any additional cash required to fully fund the account on its opening.

   Upon receipt of the executed Multiple Signature Verification Agreement for Custody Arrangements, the Managed Care Plan may initiate the purchase or sale of Securities with only the Managed Care Plan's authorized representatives' signatures, provided that the Securities sold or purchased are in accordance with the Agency's guidelines of approved Securities as listed in the table below, and the transaction results in an equal amount of incoming cash or Securities on the same day of the transaction.

   Withdrawals from the investment insolvency protection account that do not result in an equal amount of incoming cash or Agency-approved Securities on the same day of the transaction requires the authorized signatures of two (2) Managed Care Plan representatives and two (2) Agency representatives.

f. In the event that the Agency determines the Managed Care Plan is insolvent, the Agency may, in the Agency's sole discretion and without any requirement or obligation, draw upon or initiate the sale of Securities from the custodial investment insolvency protection account solely with the two (2) authorized signatures of representatives of the Agency and funds may be disbursed to meet financial obligations incurred by the Managed Care Plan under this Contract. The Managed Care Plan shall not initiate any transactions subsequent to notification by the Agency that the Agency has determined the Managed Care Plan to be insolvent. The Managed Care Plan shall provide a statement of account balance within fifteen (15) calendar days of request of the Agency.

g. If this Contract is terminated or not renewed, the custodial investment insolvency protection account balance shall be released by the Agency to the Managed Care Plan upon the receipt of proof of satisfaction for all outstanding obligations incurred under this Contract.

h. In the event this Contract is terminated, not renewed, and/or the Managed Care Plan is declared insolvent, the Agency may, in the Agency's sole discretion and without any requirement or obligation, draw upon or initiate the sale of Securities from the investment insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency, including, but not limited to, overpayments made to the Managed Care Plan, and fines imposed under this Contract or, for HMOs, s. 641.52, F.S., for EPOs, s. 627, F.S., and for health insurers, s. 624, F.S. **Table 8**, Custodial Investment Insolvency Protection Account Approved Securities Table, below, lists the maturity term and guarantee for the respective Security. The Managed Care Plan authorizes the Agency to file one or more financing statements or similar records covering the investment insolvency protection account where filing is deemed to be necessary or desirable by the Agency. The Managed Care Plan shall execute and deliver, or cause to be executed and delivered, such other documents as the Agency may from time-to-time request to perfect or further evidence the pledge, security interest and assignment created in the investment insolvency protection account by this Contract. No financing statement or similar record covering all or any portion of the investment insolvency protection account shall be on file in any public office unless the Agency has approved that filing. In addition, if the above occurs and the Agency, in its sole discretion, determines that it would be in the best interest of the providers for the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the custodial or controlled account, the Managed Care Plan shall agree to the appointment. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

TABLE 8: CUSTODIAL INVESTMENT INSOLVENCY PROTECTION ACCOUNT APPROVED SECURITIES		
Security	**Maturity Term**	**Guarantee**
U.S Treasury Bills	All	Full Faith & Credit of the U.S. Government
U.S. Treasury Notes	Not to Exceed Three (3) Years	Full Faith & Credit of the U.S. Government

B. Surplus for Eligible Plans excluding PSNs

1. Surplus Requirement

a. The Managed Care Plan shall maintain at all times in the form of cash and investments allowable as admitted assets by the DFS and restricted funds of deposits controlled by the Agency (including the Managed Care Plan's insolvency protection account) or the DFS, a surplus amount equal to the greater of one and one-half million dollars **($1.5 million)**, ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the Managed Care Plan's prepaid revenues. If the Managed Care Plan's surplus (as defined in **Section XVI.**, Definitions and Acronyms) falls below the amount specified in this paragraph, the Managed Care Plan is prohibited from engaging in marketing activities, shall not receive new enrollments until the required balance is achieved, or may have its Contract terminated statewide.

b. In lieu of the surplus requirements under this Section, the Agency may consider any of the following:

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

(2) The State guarantees the solvency of the organization.

(3) The organization is a FQHC or is controlled by one (1) or more FQHCs and meets the solvency standards established by the State for such organization pursuant to Section 409.912(4)(b), F.S.

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

C. Interest for Eligible Plans excluding PSNs

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

D. Third Party Resources for All Eligible Plans

1. Covered Third Party Collections

a. The Managed Care Plan shall identify and seek recovery up to the Managed Care Plan's full legal ability from any third party, as defined by 409.901(27), F.S., to pay for services rendered to enrollees under this Contract and notify the Agency of when any third party was identified and when recovery was made.

b. The Managed Care Plan shall have exclusive recovery rights for all third party recovery actions within fifteen (15) months from the Managed Care Plan's date of payment on the claim. The Managed Care Plan shall maintain exclusive recovery rights on a claim if the initial recovery request is issued to the liable third party within the fifteen (15) months from the Managed Care Plan's date of payment on the claim.

   Any claims for which the Managed Care Plan has not issued a recovery request to the liable third party within fifteen (15) months of the Managed Care Plan's date of payment may be pursued by the Agency, at the Agency's sole discretion. All funds recovered from the Agency's efforts shall be retained by the Agency.

c. The following standards govern third party recoveries:

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

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

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

e. The Managed Care Plan shall provide necessary data for third party identification and recoveries in a format prescribed by the Agency.

2. Optional Third-Party Recovery Services

a. The Agency may, at its sole discretion, offer to provide third party recovery services to the Managed Care Plan for covered third party collections.

b. If the Managed Care Plan elects to authorize the Agency to recover covered third party collections on its behalf, the Managed Care Plan shall be required to provide the necessary data for recovery in the format prescribed by the Agency.

c. If the Managed Care Plan elects to authorize the Agency to recover covered third party collections on its behalf, all recoveries, less the Agency's cost to recover, shall be income to the Managed Care Plan. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the Managed Care Plan elects to authorize the Agency to recover on its behalf.

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

3. Patient Responsibility

a. The Managed Care Plan shall be responsible for collecting patient responsibility as determined by DCF and shall have policies and procedures to ensure that, where applicable, enrollees are assessed for and pay their patient responsibility. Some enrollees have a patient responsibility amount of zero dollars (**$0**) either because of their limited income or the methodology used to determine patient responsibility.

b. The Managed Care Plan may transfer the responsibility for collecting its enrollees' patient responsibility to residential providers and compensate these providers net of the patient responsibility amount. The Managed Care Plan shall either collect patient responsibility from all of its residential providers or transfer collection to all of its residential providers.

c. The Managed Care Plan shall have a system in place to track the receipt of patient responsibility at the enrollee level irrespective of which entity collects the patient responsibility. This data shall be available upon request by the Agency. The Managed Care Plan or its providers shall not assess late fees for the collection of patient responsibility from enrollees.

E. Assignment

1. General Assignment Provisions for the Managed Care Plan

a. In compliance with Section 409.969(1), F.S., the Agency shall not approve the assignment or transition of all enrollees within a region to a single Managed Care Plan.

b. The Agency may approve assignment of a Contract if all of the following conditions are met:

(1) After three (3) full Contract years have passed.

(2) If the purchasing entity was awarded a Contract pursuant to the ITN and is in good standing.

(3) If, following the merger, the number of plans in each impacted region remains at or above the statutory minimum.

c. Good standing:

To be in good standing, a Managed Care Plan shall:

(1) Not have failed accreditation.

(2) Not have committed any material violation of the requirements of s. 641.52, F.S.

(3) Meet the requirements of this Contract.

(4) Not have been subject to an enrollment freeze at any time under this Contract or a Corrective Action Plan during the past eighteen (18) month period.

d. Notice to the Agency and Transition plan:

(1) When a merger or acquisition of a Managed Care Plan has been approved by the regulatory entity (DFS or OIR), and the conditions listed in (b) and (c) have been met, the Agency may approve assignment or transfer of the appropriate Contract upon the request of the surviving entity of the merger or acquisition if the Managed Care Plan and the surviving entity have been in good standing with the Agency for the most recent twelve (12) month period, unless the Agency determines that the assignment or transfer would be detrimental to Medicaid recipients or the Medicaid program.

(2) To request assignment or transfer of its enrollees, the Managed Care Plan shall notify the Agency at least one hundred eighty (180) days before the anticipated effective date in compliance with Section 409.967(2)(i), F.S. The Managed Care Plan shall provide the following documentation with its notice. Notice will not be considered complete if all the following are not included concurrent with the notice.

(a) Proof of DFS or OIR approval of the acquisition.

(b) A list of subcontractors to be utilized by the acquiring entity, if approved.

(c) Updated ownership information for the acquiring entity.

(d) A detailed transition plan as described by the Agency.

(e) Additional documentation as identified by the Agency.

(3) The Managed Care Plan requesting the assignment or transfer of its enrollees and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, particularly those hospitalized, those requiring care coordination/case management and those with complex medical needs. The notice to enrollees shall contain the same information as required for a notice of termination according to **Section XIV.**, Special Terms and Conditions, **Sub-Section G.**, Termination Procedures. The Managed Care Plan requesting assignment or transfer of its enrollees shall perform as follows:

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

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

e. Payment of Associated Costs:

Pursuant to Section 409.967(2)(i)1., F.S., the Managed Care Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities associated with the assignment of a contract following a merger or acquisition. If more than one (1) Managed Care Plan providing services under the same program component leaves a region at the same time, the exiting Managed Care Plan shall share the costs in a

manner proportionate to their enrollments. Costs include, but are not limited to, changes to printed materials and staffing associated with increased call volume.

f. Additional Assignment Provisions:

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

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

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

F. Financial Reporting

1. The Managed Care Plan shall submit to the Agency quarterly and annual NAIC Health Statements, quarterly and annual Achieved Savings Rebate Financial Reports, and annual audited financial statements.

2. The Managed Care Plan shall submit to the Agency the annual NAIC Health Statement and annual audited financial statements no later than three (3) calendar months after the end of the calendar year. The Managed Care Plan shall submit the quarterly NAIC Health Statements no later than forty-five (45) days after the end of each calendar quarter. A quarterly NAIC Health Statement is not required for the quarter ending December 31. The quarterly and annual NAIC Health Statement, as well as the annual audited financial statements, shall be prepared using statutory accounting principles. The quarterly and annual Achieved Savings Rebate Financial Report shall be submitted in accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

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

4. The Managed Care Plan shall submit all financial reports to the Agency in accordance with **Section XV.**, Accountability, and the instructions for Achieved Savings Rebate Financial Reports in the Managed Care Plan Report Guide (42 CFR 438.3(m)).

G. Inspection and Audit of Financial Records

The State, CMS, and DHHS may inspect and audit any financial records of the Managed Care Plan or its subcontractors, as well as financial records from parent companies relating to corporate or administrative charges included on financial reports submitted by the Managed Care Plan to the Agency. Pursuant to s. 1903(m)(4)(A) of the Social Security Act and the State Medicaid Manual 2087.6(A-B), a non-federally qualified Managed Care Plan shall report to the State, upon request, and to the Secretary and the Inspector General of DHHS, a

description of certain transactions with parties of interest as defined in s. 1318(b) of the Social Security Act. The Managed Care Plan shall make any reports of transactions between the Managed Care Plan and parties in interest that are provided to the State or other agencies to its enrollees, upon reasonable request (Section 1903(m)(4)(A)-(B) of the Social Security Act).

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Section XII. Sanctions and Corrective Action Plans

A. Contract Violations and Non-Compliance

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

2. See **Attachment II, Section I.,** General Overview, **Sub-Section H.**, Prioritizing Quality and Value, **Item 1.**, Layered Approach to Drive Continued Improvement, **Sub-Item d.**, Financial Consequences and Liquidated Damages, for enhanced provisions on contract violations and non-compliance.

3. The Agency shall be responsible for imposing sanctions for Contract violations or other non-compliance and requiring corrective actions for a violation of or any other non-compliance with this Contract and its Exhibits.

4. In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Managed Care Plan pursuant to any of the following, as allowable: Section 409.912(4), F.S., Section 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; Section 409.967; F.S., 42 CFR Part 438, Subpart I (Sanctions) and ss.1905(t), 1932 and s. 1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to **Section XIII.**, Liquidated Damages.

a. The Agency may impose temporary management in accordance with 42 CFR 438.706(a) only if it finds any of the following:

(1) There is continued egregious behavior by the Managed Care Plan, including, but not limited to, behavior described in 42 CFR 438.700 or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act.

(2) There is substantial risk to enrollees' health.

(3) The sanction is necessary to ensure the health of the Managed Care Plan's enrollees while improvements are made to remedy violations or until there is an orderly termination or reorganization of the Managed Care Plan.

b. The Managed Care Plan shall be subject to mandatory temporary management when the Managed Care Plan repeatedly fails to meet substantive requirements in ss. 1903(m) or 1932 of the Social Security Act or 42 CFR 438. The imposition of such temporary management must not be delayed to provide a pre-termination hearing and may not be terminated until it is determined that the Managed Care Plan can ensure the sanctioned behavior shall not reoccur (42 CFR 438.706(b)-(d); s. 1932(e)(2)(B)(ii) of the Social Security Act).

c. The Managed Care Plan may be subject to temporary management and enrollees shall be notified by the Agency of the right to terminate enrollment without cause, when the Managed Care Plan repeatedly fails to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act, or 42 CFR 438.706 (42 CFR 438.706(b)).

d. See **Attachment II, Section I.**, General Overview, **Sub-Section H.**, Prioritizing Quality and Value, **Item 1.**, Layered Approach to Drive Continued Improvement, **Sub- Item e.**, Enrollment Freezes and Corrective Action Plans, for enhanced provisions on enrollment limitations.

e. If the Agency imposes a civil monetary penalty on the Managed Care Plan pursuant to 42 CFR 438.704 for charging premiums or charges in excess of the amounts permitted under Medicaid, the amount of the overcharge shall be deducted from the penalty and return it to the affected enrollee (42 CFR 438.704(c)).

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

6. In addition to imposing sanctions for a Contract violation or other non-compliance, the Agency may require the Managed Care Plan to submit to the Agency a CAP within a timeframe specified by the Agency. In the event the Agency identifies a violation of, or other non-compliance with this Contract, to include failure to meet performance standards, the Agency may sanction the Managed Care Plan pursuant to any of the following, as allowable: Section 409.912(4), F.S., Section 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; Section 409.967; F.S., 42 CFR Part 438, Subpart I (Sanctions) and ss.1905(t), 1932 and s. 1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to **Section XIII.**, Liquidated Damages.

7. If the Agency imposes monetary sanctions, the Managed Care Plan must pay the monetary sanctions to the Agency within thirty (30) days from receipt of the notice of sanction, regardless of any dispute in the monetary amount or interpretation of policy that led to the notice. If the Managed Care Plan fails to pay, the Agency reserves the right to recover the money by any legal means, including, but not limited to, the withholding of any payments due to the Managed Care Plan. If the Secretary or designee determines that the Agency should reduce or eliminate the amount imposed, the appropriate amount shall be returned to the Managed Care Plan within sixty (60) days from the date of a final decision rendered.

8. The Agency may terminate the Managed Care Plan Contract and place enrollees into a different Managed Care Plan or provide Medicaid benefits through other State plan authority, if the Agency determines that the Managed Care Plan has failed to carry out the substantive terms of its Contract or meet the applicable requirements of ss. 1932, 1903(m), or 1905(t) of the Social Security Act (42 CFR 438.708(a)-(b)).

B. Corrective Action Plans

1. See **Attachment II, Section I.**, General Overview, **Sub-Section H.**, Prioritizing Quality and Value, **Item 1.**, Layered Approach to Drive Continued Improvement, **Sub-Item e.**, Enrollment Freezes and Corrective Action Plans, for enhanced provisions on Corrective Action Plans.

2. The Agency may impose a monetary sanction of two hundred dollars **($200)** per day on the Managed Care Plan for each day the Managed Care Plan does not implement, to the satisfaction of the Agency, the approved CAP.

C. Performance Measure Sanctions

1. The Managed Care Plan may be subject to sanctions for failure to achieve minimum performance scores on performance measures specified by the Agency after the first year of poor performance, as specified in this Contract and its Exhibits, as applicable. The Agency shall develop performance measures and may impose monetary sanctions for some or all performance measures. The Agency shall develop performance targets for each performance measure with a methodology for application of the sanction specified by the Agency.

2. The Agency may sanction the Managed Care Plan for failure to achieve minimum scores on performance measures after the first year of poor performance on any measure as specified in this Section. The Agency may impose monetary sanctions and/or CAPs as described above.

3. The Managed Care Plan shall be subject to sanction by the Agency for failure to achieve minimum scores on additional performance measures after the first year of poor performance on any measure specified in this Contract and its Exhibits.

D. Additional Sanctions

1. Pursuant to Section 409.967(2)(i)2., F.S., if the Managed Care Plan fails to comply for thirty (30) days with the encounter data reporting requirements as specified in this Contract, the Managed Care Plan shall be subject to the following actions on the thirty-first (31st) day:

   (a) The Managed Care Plan shall be assessed a fine of five thousand dollars **($5,000**) per day for each day of noncompliance.

   (b) The Managed Care Plan shall be notified that the Agency shall initiate Contract termination procedures on the ninetieth (90th) day unless the Managed Care Plan comes into compliance before that date.

2. Fraud and Abuse – See **Section X.**, Methods of Plan Payment, **Sub-Section F.**, Fraud and Abuse Prevention.

3. Pursuant to 42 CFR 438.702(a)(4), after the date the Secretary of DHHS or the Agency notifies the Managed Care Plan of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Act the Managed Care Plan may be subject to suspension of all new enrollment, including default enrollment.

4. Pursuant to 42 CFR 438.702(a)(5), the Managed Care Plan may be subject to suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the Agency is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

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E. Notice of Sanctions

1. Except as noted in 42 CFR Part 438, Subpart I (Sanctions), before imposing any of the sanctions specified in this Section, the Agency shall provide written notice to the Managed Care Plan that explains the basis and nature of the sanction, cites the specific Contract section(s) and/or provision of law and the methodology for calculation of any fine, and the process to dispute sanctions (42 CFR 438.710(a)(1)).

2. If the Managed Care Plan fails to carry out any substantive terms of this Contract or fails to meet applicable requirements in Sections 1932, 1903(m), or 1905(t) of the Social Security Act, the Agency may terminate the Managed Care Plan's Contract for cause.

   a. Before terminating this Contract, the Agency must provide to the Managed Care Plan a pre-termination hearing and give advance written notice of intent to terminate, which includes the reason for termination and the time and place of the hearing.

   b. After the hearing, Managed Care Plan shall receive written notice of the decision affirming or reversing the proposed termination of this Contract and, if affirmed, the effective date of termination.

   c. The Agency must notify Managed Care Plan enrollees of the termination and provide information on their options for receiving Medicaid services following the effective date of termination, which may include disenrolling from the Managed Care Plan immediately and without cause.

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

F. Dispute of a Corrective Action Plan or Sanction

1. To dispute a CAP or a sanction, the Managed Care Plan must request that the Agency's Secretary or designee hear and decide the dispute.

   a. The Managed Care Plan must submit a written dispute of the CAP or sanction directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

      (1) The Managed Care Plan shall submit each written request for dispute to an SFTP site in a file and format specified by the Agency.

      (2) Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

         (a) A Managed Care Plan appeal letter that is addressed to the Secretary or designee, and which includes the case and file number from the original compliance action related to the issue being disputed.

         (b) Exhibit A – the original action letter received from the Agency.

(c) Exhibit B – the Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

(3) The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M., EST on the twenty-first (21st) day after the date of issuance of any CAP or sanction. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

b. The Managed Care Plan waives any dispute not raised within twenty-one (21) days of receiving the CAP or sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving the CAP or sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission submitted within the twenty-one (21) days following its receipt of the CAP or sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

(1) The Secretary, or designee, shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Managed Care Plan. This written decision shall be final.

(2) The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Secretary, or designee, shall be Circuit Court in Leon County, Florida; in any such action, the Managed Care Plan agrees to waive its right to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Managed Care Plan shall receive notice of the appropriate administrative remedy.

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Section XIII. Liquidated Damages

The Agency shall be responsible for imposing liquidated damages as a result of failure to meet any aspect of the responsibilities of this Contract and its Exhibits.

The Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with **Section XIII.**, Liquidated Damages.

A. Damages

1. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach. The Agency may impose liquidated damages in addition to any sanctions imposed pursuant to **Section XII.**, Sanctions and Corrective Action Plans.

2. The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty but are intended to be reasonable estimates of the Agency's projected financial loss and damage resulting from the Managed Care Plan's nonperformance, including financial loss as a result of project delays. Accordingly, in the event the Managed Care Plan fails to perform in accordance with this Contract, the Agency may assess liquidated damages as provided in this Section.

3. If the Managed Care Plan fails to perform any of the services described in this Contract, the Agency may assess liquidated damages for each occurrence listed in **Table 9**, Liquidated Damages Issues and Amounts Table. Any liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. The Agency shall have sole authority to determine the application of an occurrence (e.g., per unit of service, per date of service, per episode of service, per complaint, or per enrollee).

4. The Agency may elect to collect liquidated damages:

    a. Through direct assessment and demand for payment delivered to the Managed Care Plan.

    b. By deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Managed Care Plan or that become due at any time after assessment of the liquidated damages. The Managed Care Plan shall be subject to

deductions until the Agency has collected the full amount payable by the Managed Care Plan.

5. The Managed Care Plan shall not pass through liquidated damages imposed under this Contract to a provider and/or subcontractor, unless the provider and/or subcontractor caused the damage through its own action or inaction. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.

6. All liquidated damages imposed pursuant to this Contract, whether paid or due, shall be paid by the Managed Care Plan out of administrative costs and profits.

7. Subject to legislative approval, the Agency reserves the right to redirect any amounts assessed as liquidated damages towards QI activities that target and support Agency goals or initiatives.

8. To dispute the imposition of liquidated damages, the Managed Care Plan must request that the Agency's Secretary, or designee, hear and decide the dispute.

   a. The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Agency via an electronic submission process; the Agency will not accept deliveries by U.S. mail, commercial courier service, or hand.

      (1) The Managed Care Plan shall submit each written request for dispute to an SFTP site in a file and format specified by the Agency.

      (2) Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

         (a) A Managed Care Plan appeal letter that is addressed to the Secretary and which includes the case and file number from the original compliance action related to the issue being disputed.

         (b) Exhibit A – the original action letter received from the Agency.

         (c) Exhibit B – the Managed Care Plan's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

      (3) The Managed Care Plan shall submit its dispute request to the Agency by 5:00 P.M., EST on the twenty-first (21st) day after the date of issuance of any liquidated damage. The Agency will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Agency.

   b. The Managed Care Plan waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments

it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

9. The Secretary, or designee, shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Managed Care Plan. This written decision shall be final.

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

B. Issues and Amounts

The Managed Care Plan shall pay the Agency up to the amount for each issue as specified in the Liquidated Damages Issues and Amounts Table, **Table 9**, below. In addition, the Managed Care Plan shall pay the Agency an additive liquidated damage that shall not be passed down to the Managed Care Plan's subcontractor(s) in the amount of one thousand dollars (**$1,000**) for every occurrence where a contract action is assessed by the Agency for a subcontractor-related issue.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
1.	Failure to provide covered services with reasonable promptness.	Two thousand five hundred dollars **($2,500)** per occurrence.
2.	Failure by the Managed Care Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach as described in this Contract. See also ancillary BAA between the parties.	Five hundred dollars **($500)** per enrollee per occurrence, not to exceed ten million dollars **($10,000,000)**.
3.	Failure to meet plan readiness goals set by the Agency.	Five thousand dollars **($5,000)** per occurrence.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
4.	Failure to submit a timely notice of involuntary disenrollment to the enrollee as described in this Contract.	One thousand dollars **($1,000)** per occurrence.
5.	Failure to comply with marketing requirements as described in this Contract.	Two thousand five hundred dollars **($2,500)** per occurrence.
6.	Failure to timely report staff or marketing agent violations as described in this Contract.	Two thousand five hundred dollars (**$2,500**) per
7.	Failure to obtain approval of enrollee materials, as required by this Contract.	One thousand dollars (**$1,000**) per occurrence.
8.	Failure to withhold payment to providers ineligible for payment under 42 CFR 455.23 or payment withhold under Section 409.913(25)(a) F.S., or providers with new admissions under a denial of payment for new admissions issued by CMS in accordance with 42 CFR 488.417.	Five hundred dollars (**$500**) per occurrence, in addition to two hundred fifty dollars (**$250**) for each day that the Agency determines that the Managed Care Plan is not in compliance.
9.	Failure to comply with enrollee notice requirements as described in this Contract (excluding denials, reductions, terminations or suspensions of services).	Two hundred fifty dollars (**$250**) per occurrence.
10.	Failure to comply with time frames for providing Enrollee Handbooks, I.D. cards and Provider Directories, as required in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
11.	Failure to update online and printed provider directory as described in this Contract.	Two thousand five hundred dollars (**$2,500**) per occurrence.
12.	Failure to comply in any way with the toll-free enrollee help line requirements as described in this Contract (excluding the failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as required by the Agency).	Ten thousand dollars (**$10,000**) per month, for each month that the Agency determines that the Managed Care Plan is not in compliance.
13.	Failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as described this Contract.	Five hundred (**$500**) per day, per occurrence.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
14.	Failure to timely submit any complete plan as described in this Contract, including, but not limited to a CCP. Note: The Anti-Fraud plan liquidated damages listed in this table is separate and not included in this program issue.	Two hundred fifty dollars (**$250**) per day for every day plans are late.
15.	Failure to comply with the grievance and appeal notice requirements described in this Contract.	Two hundred fifty dollars (**$250**) per occurrence
16.	Failure to comply with timeframes for the enrollee grievance and appeal system.	Five hundred dollars (**$500**) per occurrence.
17.	Failure to comply with all orders/official decisions relating to claim disputes, grievances, appeals and/or fair hearings, as they are issued.	Ten thousand dollars (**$10,000**) per occurrence.
18.	Failure to provide continuation of services during the pendency of a Medicaid fair hearing and/or the Managed Care Plan's appeal process where the enrollee has challenged a reduction or elimination of services as required by this Contract, applicable State or federal law, and all court orders governing appeal procedures as they become effective.	The value of the reduced or eliminated services as determined by the Agency for the timeframe specified by the Agency and five hundred dollars (**$500**) per day for each day the Managed Care Plan fails to provide continuation or restoration as required by the Agency.
19.	Failure to submit a fair hearing evidence packet within the timeframe and/or include all required materials described in this Contract and prehearing instructions.	One thousand dollars (**$1,000**) per occurrence.
20.	Failure to provide necessary witnesses for fair hearings in accordance with this Contract.	One thousand dollars (**$1,000**) per occurrence.
21.	Failure to attend fair hearings as scheduled in accordance with this Contract.	Two thousand five hundred dollars (**$2,500**) per occurrence.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS

#	CORE PROGRAM ISSUES	DAMAGES
22.	Failure to provide restoration of services after the Managed Care Plan receives an adverse determination as a result of a Medicaid fair hearing or the Managed Care Plan's appeal process as required by this Contract, applicable State or federal law and all court orders governing appeal procedures as they become effective.	The value of the reduced or eliminated services as determined by the Agency and five hundred dollars (**$500**) per day for each day the Managed Care Plan fails to provide continuation or restoration as required by the Agency.
23.	Failure to provide medically necessary services to enrollees under the age of twenty-one (21) years in accordance with this Contract.	Two thousand five hundred dollars (**$2,500**) per occurrence.
24.	Failure to comply with one (1) or more non-emergency transportation timeliness standards as specified by this Contract.	Five thousand dollars (**$5,000**) per occurrence
25.	Failure to transport an enrollee to a pre-scheduled appointment on time which results in a missed appointment for the enrollee.	Two thousand five hundred dollars (**$2,500**) per occurrence.
26.	Failure to use telemedicine coverage provisions as described in this Contract.	One thousand dollars (**$1,000**) per occurrence.
27.	Failure to submit the annual healthy behavior program evaluation as described in this Contract.	Five hundred dollars (**$500**) per occurrence, in addition to Two hundred fifty dollars (**$250**) for each day that the Agency determines that the Managed Care Plan is not in compliance.
28.	Imposition of arbitrary utilization guidelines or other quantitative coverage limits as prohibited in this Contract.	Twenty-five thousand dollars (**$25,000**) per occurrence.
29.	Failure to complete a comprehensive assessment, develop a treatment or service plan or plan of care, or authorize and initiate all services specified in the plan for an enrollee within specified timelines as described in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
30.	Failure to maintain case manager caseload ratios pursuant to this Contract.	One thousand dollars (**$1,000**) per occurrence.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
31.	Failure to facilitate transfers between health care settings as described in this Contract.	One thousand five hundred dollars (**$1,500**) per occurrence.
32.	Failure to develop and/or implement a transition plan for recipients including the provision of data to the Agency, as specified in this Contract.	Ten thousand dollars (**$10,000**) per occurrence.
33.	Failure to develop and document a treatment or service plan for an enrollee, that shall be documented in writing as described in this Contract.	Five hundred dollars (**$500**) per deficient/missing treatment or service plan.
34.	Failure to ensure compliance with PASRR requirements prior to reimbursement for nursing facility services as described in this Contract.	Five hundred dollars (**$500**) per occurrence.
35.	Failure to comply with provider network requirements specified in this Contract.	Two thousand five hundred dollars (**$2,500**) per occurrence.
36.	Failure to submit a Provider Network File that meets the Agency's specifications as described in this Contract.	Five hundred dollars (**$500**) per occurrence.
37.	Failure to timely report, or provide notice for, significant network changes as described in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
38.	Failure to meet provider credentialing requirements, including background screening requirements, specified in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
39.	Failure to comply with licensure or background screening requirements for Managed Care Plan principals in this Contract.	Five thousand dollars (**$5,000**) per occurrence that owner/staff is not licensed or qualified as required by applicable State or local law plus the amount paid to the owner/staff during that period.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
40.	Failure to comply with licensure or background screening requirements for subcontractors in this Contract.	Five thousand dollars (**$5,000**) per occurrence that subcontractor/ driver/agent is not licensed or qualified as required by applicable State or local law plus the amount paid to the subcontractor/ driver/agent during that period.
41.	Failure to report notice of provider termination, suspension, or denial of participation in the Managed Care Plan as described in this Contract.	Five hundred dollars (**$500**) per day, per occurrence.
42.	Failure to timely report notice of terminated providers due to imminent danger/impairment as described in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
43.	Failure to timely report termination or suspension of providers for cause as described in this Contract.	Two hundred fifty dollars (**$250**) per occurrence.
44.	Failure to suspend or terminate providers who become ineligible for Medicaid participation.	Five hundred dollars (**$500**) per occurrence, in addition to two hundred fifty dollars (**$250**) per day until the provider is suspended or terminated.
45.	Failure to obtain and/or maintain national accreditation as described in this Contract.	One thousand dollars (**$1,000**) per day for every day beyond the day accreditation status must be in place as described in this Contract.
46.	Failure to cooperate with the Agency's contracted EQRO as described in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
47.	Failure to comply with the quality requirements specified in this Contract under **Section VIII.**, Quality, of **Attachment II and its Exhibits**.	One thousand dollars (**$1,000**) per occurrence.
48.	Failure to submit audited HEDIS, CAHPS, and Agency-defined measures results timely as described in this Contract.	Two hundred fifty dollars (**$250**) per day for every day reports are late.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
49.	Failure to timely submit appropriate PIPs as described in this Contract.	One thousand dollars (**$1,000**) per day for every day PIPs are late.
50.	Failure to accurately report PIP data, interventions, or evaluation methods.	Five thousand dollars (**$5,000**) per occurrence.
51.	Failure to address previous PIP feedback from the Agency/EQRO prior to subsequent submissions.	Five thousand dollars (**$5,000**) per occurrence.
52.	Failure to timely submit enrollee records within time frames requested by the Agency or the EQRO.	One thousand dollars (**$1,000**) per occurrence.
53.	Failure to allow an enrollee to obtain a second medical opinion at no expense and regardless of whether the provider is participating or not, as described in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
54.	Failure to acknowledge or act timely upon a request for prior authorization in accordance with this Contract.	Two thousand five hundred dollars (**$2,500**) per occurrence. *Currently $1,000*
55.	Failure to comply with any of the standards for timely service authorization as specified in this Contract.	Five thousand dollars (**$5,000**) per month, per standard
56.	Failure to comply with enrollee notice for denials, reductions, terminations, or suspensions of services within the timeframes specified in this Contract as described in this Contract.	Two thousand five hundred dollars (**$2,500**) per occurrence.
57.	Failure to provide continuity of care and a seamless transition consistent with the services in place prior to the new enrollee’s enrollment in the Managed Care Plan as described in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
58.	Failure to comply in any way with Managed Care Plan staffing requirements as specified in this Contract.	One thousand dollars (**$1,000**) per day for each day that staffing requirements are not met.
59.	Failure to timely report changes in Managed Care Plan staffing as described in this Contract.	One thousand dollars (**$1,000**) per occurrence.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
60.	Failure to provide no less than thirty (30) days' written notice before making any changes to the administration and/or management procedures and/or authorization, denial, or review procedures, including any delegations, as described in this Contract.	Twenty-five thousand dollars (**$25,000**) per occurrence.
61.	Failure of a provider agreement to comply with a requirement of this Contract.	One thousand dollars (**$1,000**) per failure per provider agreement
62.	Failure to receive prior written Agency approval of delegation to a subcontractor.	Twenty-five thousand dollars (**$25,000**) per occurrence
63.	Failure of a subcontract to comply with a requirement of this Contract.	Five thousand dollars (**$5,000**) per failure per subcontract
64.	Failure to maintain and/or provide proof of required insurance as described in this Contract.	Five hundred dollars (**$500**) per day.
65.	Failure to comply with subcontract requirements for providers dually offering UM and service provision.	Twenty-five thousand dollars (**$25,000**) per occurrence.
66.	Failure to maintain and/or provide proof of the Managed Care Plan's fidelity bond as required in this Contract.	Five hundred dollars (**$500**) per day.
67.	Failure by the Managed Care Plan to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, BAA or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to this Contract. See also ancillary BAA between the parties.	Five hundred dollars (**$500**) per enrollee per occurrence.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
68.	Failure by the Managed Care Plan to ensure that all data containing PHI, as defined by HIPAA, is secured through commercially reasonable methodology in compliance with the HITECH Act, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Agency enrollee's PHI as specified in this Contract. See also ancillary BAA between the parties.	One thousand dollars (**$1,000**) per enrollee per occurrence. If the State determines credit monitoring and/or identity theft safeguards are needed to protect those enrollees whose PHI was placed at risk by Managed Care Plan's failure to comply with the terms of this Contract, the Managed Care Plan shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
69.	Failure to complete or comply with CAPs as described in this Contract.	Five hundred dollars (**$500**) per day for each day the corrective action is not completed or complied with as required.
70.	Failure to provide notice of noncompliance to the Agency within five (5) days or other Contract-specified period of time in accordance with this Contract.	Five hundred dollars (**$500**) per day beginning on the next day after default by the Managed Care Plan.
71.	Failure to provide proof of compliance to the Agency within five (5) days of a directive from the Agency or within a longer period of time that has been approved by the Agency	Five hundred dollars (**$500**) per day beginning on the next day after default by the Managed Care Plan.
72.	Failure to comply with claims processing as described in this Contract.	Ten thousand dollars (**$10,000**) per month, for each month that the Agency determines that the Managed Care Plan is not in compliance.
73.	Failure to comply with encounter data submission requirements as described in this Contract (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency).	Twenty-five thousand dollars (**$25,000**) per occurrence.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	CORE PROGRAM ISSUES	DAMAGES
74.	Failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency and described in this Contract.	Five hundred dollars (**$500**) per day, per occurrence.
75.	Failure to comply with fraud and abuse provisions, including failure to cooperate with the Agency or Law Enforcement entities during investigations, as described in this Contract.	Two thousand dollars (**$2,000**) per day per occurrence/issue.
76.	Failure to establish an investigative unit as required in this Contract, by the time the Managed Care Plan has enrolled its first recipient.	Ten thousand dollars (**$10,000**) per occurrence.
77.	Failure to staff the Compliance Officer or Special Investigations Unit Manager position with a qualified individual in accordance with this Contract.	Five thousand dollars (**$5,000**) per day starting ninety (90) days from the date of the position vacancy.
78.	Failure to implement an anti-fraud plan as required by this Contract, within ninety (90) days of its approval by the Agency.	Ten thousand dollars (**$10,000**) per occurrence.
79.	Failure to cooperate fully with the Agency and/or State during an investigation of fraud or abuse, complaint, or grievances as described in this Contract.	Five hundred dollars (**$500**) per incident for failure to fully cooperate during an investigation.
80.	Failure to timely report, or report all required information for, all suspected or confirmed instances of provider or recipient fraud or abuse as required by this Contract.	One thousand dollars (**$1,000**) per day, until MPI deems the Managed Care Plan to be in compliance.
81.	Failure to timely submit an acceptable anti-fraud plan, quarterly fraud and abuse report or the annual report required by this Contract.	Two thousand dollars (**$2,000**) per day, until MPI deems the Managed Care Plan to be in compliance.
82.	Failure to comply with the requirement to pay the expenses of the Agency's Achieved Savings Rebate Audit as described in this Contract.	One hundred dollars (**$100**) per day.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
83.	Failure to achieve and/or maintain insolvency or Irrevocable Standby Letter of Credit (LOC) requirements in accordance with this Contract.	One thousand dollars (**$1,000**) per day for each day that insolvency or Irrevocable Standby LOC requirements are not met.
84.	Failure to submit timely to the Agency all items of the monthly account valuation.	Two hundred fifty dollars (**$250**) per day.
85.	Failure to purchase Securities in accordance with Agency guidelines.	Two thousand five hundred dollars (**$2,500**) per day for every unapproved security purchased until the Security is replaced with an approved Security.
86.	Failure to achieve and/or maintain financial surplus requirements as described in this Contract.	One thousand dollars (**$1,000**) per day for each day Contract requirements are not met.
87.	Failure to timely submit complete and accurate quarterly unaudited and audited annual financial statements as described in this Contract.	Five hundred dollars (**$500**) per day for each day that reporting requirements are not met.
88.	Failure to require and ensure compliance with ownership and disclosure requirements as required in this Contract.	Five thousand dollars (**$5,000**) per provider disclosure/attestation for each disclosure/attestation that is not received timely or is not in compliance with the requirements outlined in 42 CFR Part 455, Subpart B.
89.	Failure to timely report changes in ownership and control as described in this Contract.	Five thousand dollars (**$5,000**) per occurrence.
90.	Failure to timely initiate a background screening via the Clearinghouse for newly hired principals as described in this Contract.	One thousand dollars (**$1,000**) per occurrence.
91.	Failure to timely report information about offenses listed in Section 435.04, F.S., as described in this Contract.	One thousand dollars (**$1,000**) per occurrence.
92.	Failure to comply with conflict of interest or lobbying requirements as described in this Contract.	Ten thousand dollars (**$10,000**) per occurrence.
93.	Failure to disclose lobbying activities and/or conflict of interest as required by this Contract.	One thousand dollars (**$1,000**) per day that disclosure is late.

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
94.	Failure to meet plan readiness review deadlines set by the Agency	Two thousand dollars (**$2,000**) per day per occurrence
95.	Failure to comply with public records laws, in accordance with s. 119.0701, F.S.	Five thousand dollars (**$5,000**) per occurrence.
96.	Submission of inappropriate report certifications and/or failure to submit report attestations as described in this Contract.	Five hundred dollars (**$500**) per occurrence.
97.	Failure to file required reports timely as described in this Contract.	Five hundred dollars (**$500**) per occurrence.
98.	Failure to file accurate reports as described in this Contract.	Two thousand five hundred dollars (**$2,500**) per occurrence.
99.	Failure to respond to an Agency request or ad-hoc report for documentation within the time prescribed by the Agency as described in this Contract.	One thousand dollars (**$1,000**) per day.
100.	Failure to process enrollment files as specified in the Contract.	One thousand dollars (**$1,000**) per occurrence.
101.	Failure to comply with Fair Payment Provisions as described in the Contract.	Five hundred dollars (**$500**) per occurrence, in addition to two hundred fifty dollars (**$250**) for each day that the Agency determines that the Managed Care Plan is not in compliance.
102.	Failure to resolve claims and non-claim complaints within the timeframes described in the Contract.	Five hundred dollars (**$500**) per occurrence.
103.	Failure to adhere to Contract timeframes with providers or the Agency as outlined in the Contract.	Five hundred dollars (**$500**) per occurrence.
104.	Failure to pay non-participating providers as specified in the Contract.	Five hundred dollars (**$500**) per occurrence.
105.	Failure to comply with the provider complaint system notice requirements as outlined in the Contract.	Two hundred fifty dollars (**$250**) per occurrence

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
106.	Failure to terminate providers who become ineligible for Medicaid participation.	Five thousand dollars (**$5,000**) per occurrence, in addition to two hundred fifty dollars (**$250**) per day until the provider is terminated.
107.	Failure to submit subcontracts for Agency review at least ninety (90) days before the proposed effective date of the subcontract.	Ten thousand dollars (**$10,000**) per occurrence.
108.	Failure by the Managed Care Plan to revise a subcontract into compliance with Contract amendments	Five thousand dollars (**$5,000**) per occurrence.
109.	Failure to monitor subcontractors pursuant to the requirements of the Contract	Ten thousand dollars (**$10,000**) per occurrence.
110.	Failure to timely notify the Agency of subcontractor insolvency or petition of bankruptcy	One thousand dollars (**$1,000**) per occurrence.
111.	Failure by the Managed Care Plan to notify the Agency of problems with systems functions within one (1) hour and/or update hourly until resolved, as described in the Contract.	One thousand dollars (**$1,000**) per occurrence.
112.	Failure to submit to the Agency an Emergency Management Plan as described in the Contract.	One thousand dollars (**$1,000**) per occurrence.
113.	Failure to comply with emergency management plan requirements as described in the Contract.	Two thousand five hundred dollars (**$2,500**) per occurrence.
114.	Failure to comply with inter-rater reliability requirements to ensure consistent application of review criteria for authorization decisions.	One thousand dollars (**$1,000**) per month for each month the Agency determines that the Managed Care Plan is not in compliance.
115.	Failure to participate in the Agency's dispute resolution process for provider complaints.	Two thousand five hundred dollars (**$2,500**) per occurrence

TABLE 9: LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**CORE PROGRAM ISSUES**	**DAMAGES**
116.	Failure to comply with timeframes for submission of disclosures of suspected or confirmed fraud within five (5) days of the date of detection to Medicaid Program Integrity, as outlined in the Contract.	Five hundred dollars (**$500**) per occurrence
117.	Failure to maintain a claim payment accuracy percentage of ninety-five percent (95%) or higher for each measure of accuracy established by the Agency.	Ten thousand dollars (**$10,000**) per occurrence
118.	Failure to implement a plan-specific commitment without approval from the Agency.	Five thousand dollars (**$5,000**) per occurrence
119.	Failure to obtain Agency approval prior to alteration, discontinuation, or non-performance of a plan-specific commitment.	Five thousand dollars (**$5,000**) per occurrence
120.	Failure to submit performance measures as specified in the Report Guide and file layout instructions.	Five thousand dollars (**$5,000**) per occurrence
121.	Failure to comply with any requirements set by the Agency to implement or achieve compliance with the Order of Injunction (ECF No. 1171) or other court orders issued in United States v. Florida, No. 12 cv-60460 (S.D. Fla.)	Ten thousand dollars (**$10,000**) per occurrence

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Section XIV. Special Terms and Conditions

A. Applicable Laws and Regulations

1. The Managed Care Plan shall comply with all applicable federal and State laws, rules and regulations including but not limited to:

   a. Title IX of the Education Amendments of 1972

   b. Title IX of the Education Amendments of 1972 (regarding education programs and activities)

   c. Title 42 CFR 422.208 and 422.210 on Physician Incentive Plans

   d. The Rehabilitation Act of 1973, as amended, 29 USC 794 (which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance)

   e. Medicare - Medicaid Anti-Fraud and Abuse Amendments of 1977

   f. 42 CFR part 438

   g. Section 1557 of the ACA

   h. 2 CFR part 200; and 2 CFR 300.1; and 45 CFR part 75

   i. Section 508 of the Federal Water Pollution Control Act as amended (33 U.S.C. 1251, et seq.)

   j. Executive Order 11738 as amended

   k. Environmental Protection Agency regulations 40 CFR 30, as applicable

   l. Title 2 CFR part 200 and Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR part 60, if applicable

   m. The Pro-Children Act of 1994 (20 U.S.C. 7183)

   n. Title 2 CFR parts 180 and 376 and Executive Orders 12549 and 12689 “Debarment and Suspension

   o. Title 2 CFR part 175 relating to trafficking in persons

   p. Title 2 CFR part 170, relating to the Transparency Act, as applicable

   q. Section 501.171, F.S., the Florida Information Protection Act of 2014

r. Sections 1903(i)(16)-(17) and 1903(i)(2)(A)-(C) of the Social Security Act

s. Chapter 409, F.S.

t. Section 403.7065, F.S.

u. Rule 62-730.160, F.A.C. pertaining to standards applicable to generators of hazardous waste

v. All applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 USC 7401 et seq.

w. 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin

x. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended

y. 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation, or beliefs

z. Other federal omnibus budget reconciliation acts.

aa. All regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

In addition to the above, the terms of the applicable federal waivers shall apply.

2. The Managed Care Plan is subject to any changes in federal and State law, rules or regulations and federal CMS waivers applicable to this Contract and shall implement such changes in accordance with the required effective dates upon notice from the Agency without waiting for an amendment to this Contract. However, an amendment to this Contract shall be processed to incorporate the changes.

B. Entire Agreement

This Contract, including all Attachments and Exhibits, represents the entire agreement between the Managed Care Plan and the Agency and supersedes all other contracts between the parties when it is executed by duly authorized signatures of the Managed Care Plan and the Agency. Correspondence and memoranda of understanding do not constitute part of this Contract. In the event of a conflict of language between this Contract and the Attachments (which includes the ITN), the provisions of this Contract shall govern, unless otherwise noted. The Agency reserves the right to clarify any contractual relationship in writing and such clarification shall govern. Pending final determination of any dispute over any Agency decision, the Managed Care Plan shall proceed diligently with the performance of its duties as specified under this Contract and in accordance with the direction of the Agency's Division of Medicaid. The Parties, notwithstanding any other term of this Contract, do not intend to create through this Contract, and hereby disclaim and reject, any rights enforceable by third-parties or non-parties to this Contract, through a third party beneficiary cause of action or under any other contractual claim in equity or in law.

C. Ownership and Management Disclosure

1. The Managed Care Plan shall fully disclose any business relationships, ownership, management, and control of disclosing entities in accordance with State and federal law. A Managed Care Plan providing SMMC services shall not contract with the Agency to operate as a Managed Care Plan that has a business relationship with another Managed Care Plan providing SMMC services and operating in the same region (Section 409.966(3)(b), F.S.).

2. The Managed Care Plan shall be located in the United States (42 CFR 438.602(i)).

3. If the Managed Care Plan fails to disclose a business relationship or is considering a business relationship with a Managed Care Plan that has a Contract with the Agency under the SMMC program, the Managed Care Plan shall immediately disclose such business relationship to the Agency pursuant to Section 409.966(3)(b), F.S., within five (5) days after discovery. The disclosure shall include but not be limited to the identifying information for each Managed Care Plan, the nature of the business relationship, the regions served by each Managed Care Plan, and the signature of the authorized representative for each Managed Care Plan. In addition, PSNs must disclose changes in the percentages of provider ownership interest and changes in the provider make-up of the board of directors or members and/or managers if structured as a limited liability company.

4. The Managed Care Plan shall submit the following for the areas of ownership and control interest information in compliance with 42 CFR 438.230, 42 CFR 438.604(a)(6), 42 CFR 438.608(c)(d), and 42 CFR 455.104(b)(2)-(4):

   a. The name and address of any person (individual or corporation) with an ownership or control interest in the Managed Care Plan and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

   b. The date of birth and SSN of any individual with an ownership or control interest in the Managed Care Plan and its subcontractors.

   c. Other tax identification number of any corporation with an ownership or control interest in the Managed Care Plan and any subcontractors in which the Managed Care Plan has five (5) percent or more interest.

   d. Information on whether an individual or corporation with ownership or control interest in the Managed Care Plan as a spouse, parent, child, or sibling.

   e. Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the Managed Care Plan has a five (5) percent or more interest is related to another person with ownership or control interest in the Managed Care Plan as a spouse, parent, child, or sibling.

   f. The name of any other disclosing entity in which an owner of the Managed Care Plan has an ownership or control interest.

g. The name, address, date of birth, and SSN or any managing employee of the Managed Care Plan.

   (42 CFR 438.604(a)(6); 42 CFR 455.104(b)(1)(i)-(iii); 42 CFR 455.104(b)(2)-(4); 42 CFR 438.230; 42 CFR 438.608(c)(2)).

h. In addition, PSN shall also file all additional information required in Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest, which is not specifically required in a.-g. above.

i. Disclosure shall be made on forms prescribed by the Agency for business transactions (42 CFR 455.105); conviction of crimes (42 CFR 455.106); public entity crimes (s. 287.133(2)(a), F.S.); disbarment and suspension (Executive Order No. 12549, 52 Fed. Reg., pages 20360-20369, and Section 4707 of the Balanced Budget Act of 1997); and, for PSNs, an attestation disclosing any changes in the percentages of provider ownership interest and changes in the provider make-up of the board of directors or members and/or managers if structured as a limited liability company, or any change to information originally provided in response to the ITN on Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest. The forms are available through the Agency and are to be submitted to the Agency by September 1 of each Contract year. In addition, the Managed Care Plan shall submit to the Agency for review, full disclosure of ownership and control of the Managed Care Plan and any subcontractors as required in 42 CFR 438.608(c), and any changes in management within five (5) days of knowing the change shall occur and at least sixty (60) days before any change in the Managed Care Plan's ownership or control takes effect.

5. The following definitions apply to ownership disclosure:

   a. A person with an ownership interest or control interest means a person or corporation that meets any of the following:

      (1) Owns, indirectly or directly, five percent (5%) or more of the Managed Care Plan's capital or stock, or receives five percent (5%) or more of its profits.

      (2) Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Managed Care Plan or by its property or assets and that interest is equal to or exceeds five percent of the total property or assets.

      (3) Is an officer or director of the Managed Care Plan, if organized as a corporation, or is a partner in the Managed Care Plan, if organized as a partnership.

      (4) Has a controlling interest in a PSN as defined by the Affiliation Criteria to Determine Controlling Interest for Purposes of the SMMC ITN contained in Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest.

   b. The percentage of direct ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the Managed Care Plan's assets used to secure the obligation. Thus, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of the Managed Care Plan's assets, the person owns six percent (6%) of the Managed Care Plan.

c. The percent of indirect ownership or control is calculated by multiplying the percentage of ownership in each organization. Thus, if a person owns ten percent (10%) of the stock in a corporation, which owns eighty percent (80%) of the Managed Care Plan's stock, the person owns eight percent (8%) of the Managed Care Plan.

6. The following definitions apply to management disclosure:

   a. Changes in management are defined as any change in the management control of the Managed Care Plan. Examples of such changes are those listed below and in **Section IX.**, Administration and Management, or equivalent positions by another title.

   b. Changes in the board of directors or officers of the Managed Care Plan, medical director, CEO, administrator, and CFO.

   c. Changes in the management of the Managed Care Plan where the Managed Care Plan has decided to contract out the operation of the Managed Care Plan to a management corporation. The Managed Care Plan shall disclose such changes in management control and provide a copy of the contract to the Agency for approval at least sixty (60) days prior to the management contract start date.

   d. Changes in management control disclosed by a PSN in Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest.

7. The Managed Care Plan shall conduct criminal history record check on all principals of the Managed Care Plan, and all persons with five percent (5%) or more ownership interest in the Managed Care Plan, or who have executive management responsibility for the Managed Care Plan, or have the ability to exercise effective control of the Managed Care Plan (Section 435.04, F.S.).

   a. Principals of the Managed Care Plan shall be as defined in Section 409.907, F.S.

   b. The Managed Care Plan shall initiate the criminal history check on newly hired principals (officers, directors, agents, and managing employees) within thirty (30) days of the hire date, if the individual's fingerprints are not already retained in the Care Provider Background Screening Clearinghouse (Clearinghouse, see Section 435.12, F.S.).

   c. The Managed Care Plan shall conduct this verification as follows:

      (1) By requesting screening results through the Agency's background screening system. (See the Agency's background screening website.) If the person's fingerprints are not retained in the Clearinghouse and/or eligibility results are not found, the Managed Care Plan shall submit complete sets of the person's fingerprints electronically for Medicaid Level II screening following the process described on the Agency's Care Provider Background Screening Clearinghouse website.

      (2) The Managed Care Plan shall complete and email a Background Screening (BGS) Managed Care User Registration Agreement to the Agency at: BGSCREEN@ahca.myflorida.com.

(3) In accordance with Section 435.12(2)(c), F.S., the Managed Care Plan shall register with the Clearinghouse and maintain the employment status of all employees within the Clearinghouse. The Managed Care Plan shall report initial employment status and changes to the Clearinghouse within ten (10) business days after the initial employment or change.

(4) The Managed Care Plan shall comply with the employment screening regulations described in Chapter 435, F.S.

(5) By the five (5) year expiration date of retained fingerprints for a Managed Care Plan principal, the Managed Care Plan shall initiate and complete a new background screening via the Agency's Care Provider Background Screening Clearinghouse website for that individual.

8. The Managed Care Plan shall submit to the Agency, within five (5) business days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Managed Care Plan who has been found guilty of, regardless of adjudication, or who entered a plea of *nolo contendere* or guilty to, any of the offenses listed in Section 435.04, F.S. The Managed Care Plan shall submit information to the Agency for such persons who have a record of illegal conduct according to the background check. The Managed Care Plan shall keep a record of all background checks to be available for Agency review upon request.

9. The Managed Care Plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Managed Care Plan, who has committed any of the above listed offenses shall not contract with the Agency (42 CFR 455.434 and Section 435.04, F.S.). In order to avoid termination, pursuant to a timeline as determined by the Agency, the Managed Care Plan shall submit a CAP, acceptable to the Agency, which ensures that such person is divested of all interest and/or control and has no role in the operation and/or management of the Managed Care Plan.

10. The Managed Care Plan shall submit to the Agency reports regarding current administrative subcontractors and affiliates as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

D. Conflict of Interest

This Contract is subject to the provisions of Chapter 112, F.S. Within ten (10) business days of discovery, the Managed Care Plan shall disclose to the Agency the name of any officer, director or agent who is an employee of the State of Florida, or any of its agencies. Further, within this same timeframe, the Managed Care Plan shall disclose the name of any State Employee who owns, directly or indirectly, an interest of five percent (5%) or more in the Managed Care Plan or any of its affiliates. The Managed Care Plan shall disclose the name of any Agency or DOEA employee who owns, directly or indirectly, an interest of one percent (1%) or more in the Managed Care Plan or any of its affiliates. The Managed Care Plan covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of the services hereunder. The Managed Care Plan further covenants that in the performance of this Contract, no person having any such known interest shall be employed. No official or employee of the Agency and

no other public official of the State of Florida or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking of carrying out this Contract shall, prior to completion of this Contract, voluntarily acquire any personal interest, direct or indirect, in this Contract or proposed Contract.

E. Readiness

1. Prior to enrolling recipients in the Managed Care Plan in each authorized region, the Agency shall conduct a plan-specific readiness review to assess the Managed Care Plan's readiness and ability to provide services to recipients. The plan readiness review may include, but is not limited to, desk and onsite review of plan procedures and corresponding documents, the Managed Care Plan's provider network and corresponding Contracts, a walk-through of the Managed Care Plan's processes, system demonstrations, and interviews with Plan staff. The scope of the plan readiness review may include any and all Contract requirements, as determined by the Agency.

2. If a Managed Care Plan does not meet the plan readiness deadlines established by the Agency, the Agency may grant an extension for the Managed Care Plan to correct deficiencies. The Agency has no obligation to modify the proposed regional implementation schedule to accommodate the time needed for a Managed Care Plan to address deficiencies.

3. The Agency will not enroll recipients into a Managed Care Plan until the Agency has determined that the Managed Care Plan meets all plan readiness review requirements.

4. The Agency reserves the right, at its sole discretion, to terminate the Contract with the Managed Care Plan in a region if the plan fails to meet the plan readiness deadlines.

F. Withdrawing Services from a Region

1. If the Managed Care Plan intends to withdraw services from a region, the Managed Care Plan shall provide the Agency with one hundred eighty (180) days' notice. Once the Agency receives the request for withdrawal, the Managed Care Plan shall not receive new voluntary enrollments, mandatory assignments, and reinstatements.

2. The Managed Care Plan shall work with the Agency to develop a transition plan for enrollees, particularly those in the hospital, those under care coordination/case management and those with complex medical needs. The Managed Care Plan withdrawing from a region shall perform as follows:

   a. Notice its enrollees, providers and subcontractors of the change at least sixty (60) days before the last day of service.

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

3. The notice to enrollees shall contain the same information as required for a notice of termination according to **Section XIV.**, Special Terms and Conditions, **Sub-Section G.**, Termination Procedures.

4. If the Managed Care Plan withdraws from a region before the end of the term of this Contract, the Managed Care Plan shall pay the costs and penalties specified in Section 409.967(2)(i)1, F.S., and **Section XII.**, Sanctions and Corrective Action Plans, and this Contract through which the Managed Care Plan operates in any other region shall be terminated in accordance with the termination procedures in Section 409.967(2)(i)3, F.S., this Section and **Section XII.**, Sanctions and Corrective Action Plans.

5. As specified in Section 409.967(2)(i)1. F.S., if the Managed Care Plan intends to withdraw services from a region, the Managed Care Plan shall provide the Agency with one hundred eighty (180) days' notice and work with the Agency to develop a transition plan for enrollees, particularly those under case management and those with complex medical needs, and provide data needed to maintain existing case relationships.

6. As specified in Section 409.967 (2)(i)1., F.S., the Managed Care Plan that limits enrollment levels or leave a region before the end of this Contract term must continue to provide services to the enrollee for ninety (90) days or until the enrollee is enrolled in another Managed Care Plan, whichever occurs first.

G. Termination Procedures

1. In conjunction with the **Standard Contract, Section III.**, THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE, **Sub-Section A.**, Termination, all provider agreements and subcontracts shall contain termination procedures. The Managed Care Plan agrees to extend the thirty (30)-day termination notice found in the **Standard Contract, Section III.**, THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE, **Sub-Section A.**, Termination, **Item 1.**, Termination at Will, to one hundred eighty (180) days' notice. Depending on the volume of Managed Care Plan enrollees affected, the Agency may require an extension of the termination date. Once the Agency receives the request for termination, the Managed Care Plan shall not receive new voluntary enrollments, mandatory assignments, and reinstatements going forward.

2. The Managed Care Plan shall work with the Agency to create a transition plan that shall ensure the orderly and reasonable transfer of enrollee care and progress whether or not the enrollees are hospitalized, under care coordination/case management, and/or have complex medical needs. The Managed Care Plan shall perform as follows:

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

   b. Provide to the Agency the data needed by the Agency to maintain existing case/care relationships.

3. The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination shall specify the nature of termination, the extent to which performance of work

   under this Contract is terminated, and the date on which such termination shall become effective. In accordance with s. 1932(e)(4), Social Security Act, the Managed Care Plan shall be provided with an opportunity for a hearing prior to termination for cause. This does not preclude the Agency from terminating without cause.

4. Upon receipt of final notice of termination, on the date and to the extent specified in the notice of termination, the Managed Care Plan shall:

   a. Continue work under this Contract until the termination date unless otherwise required by the Agency

   b. Cease enrollment of new enrollees under this Contract

   c. Terminate all marketing activities and subcontracts relating to marketing

   d. Assign to the State those subcontracts as directed by the Agency's contracting officer including all the rights, title and interest of the Managed Care Plan for performance of those subcontracts

   e. In the event the Agency has terminated the Managed Care Plan's Medicaid participation in one region, complete the performance of this Contract in all other regions in which the Managed Care Plan's participation was not terminated

   f. Take such action as may be necessary, or as the Agency's contracting officer may direct, for the protection of property related to this Contract that is in the possession of the Managed Care Plan and in which the Agency has been granted or may acquire an interest

   g. Not accept any payment after this Contract ends, unless the payment is for the time period covered under this Contract. Any payments due under the terms of this Contract may be withheld until the Agency receives from the Managed Care Plan all written and properly executed documents as required by the written instructions of the Agency.

   h. At least sixty (60) days before the termination effective date, provide written notification to all enrollees of the following information: the date on which the Managed Care Plan shall no longer participate in the State's Medicaid program and instructions on contacting the Agency's enrollment broker help line to obtain information on enrollment options and to request a change in Managed Care Plan.

5. If the Managed Care Plan fails to disclose any business relationship, as defined in Section 409.966(3)(b), F.S., with another Managed Care Plan in the same region during the procurement process, the Managed Care Plan's Contract and all other SMMC contracts with the Managed Care Plan shall be terminated.

6. In the event the Agency terminates the Managed Care Plan's participation in more than one region due to non-compliance with Contract requirements, the Managed Care Plan's entire Contract shall be terminated in accordance with Section 409.967(2)(i)3., F.S.

7. If the Managed Care Plan Contract is terminated by either the Managed Care Plan or the Agency (with cause) prior to the end of this Contract period, the Managed Care Plan shall be assessed the performance bond required under this Contract to cover the costs of issuing a solicitation and selecting a new Managed Care Plan. The Agency's damages in the event of termination shall be considered to be the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

H. Agency Contract Management

1. The Agency shall be responsible for management of this Contract. Contract management shall be conducted in good faith, with the best interest of the State and the Medicaid recipients it serves being the prime consideration. The Agency shall make all statewide policy decisions via issuance of a Policy Transmittal or Contract Interpretation, which shall be included in the next amendment.

2. The Managed Care Plan shall submit all procedures to the Agency as required by this Contract. Unless specified elsewhere in this Contract, procedures required by this Contract shall be submitted to the Agency at least seventy-five (75) days before the proposed effective date of the policy and procedure or change. Other procedures related to this Contract shall be submitted to the Agency upon request. If the Agency has requested procedures, the Managed Care Plan shall notify the Agency of any subsequent changes in such materials. The Managed Care Plan providing MMA and LTC services shall submit one (1) set of procedures that include all MMA and LTC contractually required provisions.

3. The Managed Care Plan may seek an interpretation from the Agency of any Contract requirement or Medicaid policy. When an interpretation of this Contract is sought, the Managed Care Plan shall submit a written request to the Agency's Secretary, or designee, in a format prescribed by the Agency.

4. The terms of this Contract do not limit or waive the ability, authority or obligation of the OIG, MPI, its contractors, DOEA, or other duly constituted government units (State or federal) to audit or investigate matters related to or arising out of this Contract.

5. This Contract shall be amended only as follows (unless specified elsewhere in this Contract):

   a. The parties cannot amend or alter the terms of this Contract without a written amendment and/or change order to this Contract.

   b. The Agency and the Managed Care Plan understand that any such written amendment to amend or alter the terms of this Contract shall be executed by an officer of each party, who is duly authorized to bind the Agency and the Managed Care Plan.

   c. The Agency reserves the right to amend this Contract within the scope set forth in the procurement (to include original Contract and all Attachments) in order to clarify requirements or if it is determined by the Agency that modifications are necessary to better serve or provide covered services to the eligible population.

I. Disputes

1. To dispute an interpretation of this Contract, the Managed Care Plan must request that the Agency's Secretary, or designee, hear and decide the dispute. The Managed Care Plan must submit a written dispute of this Contract interpretation directly to the Deputy Secretary; by U.S. mail and/or commercial courier service (hand delivery shall not be accepted); this submission must be received by the Agency within twenty-one (21) days after the interpretation of this Contract and shall include all arguments, materials, data,

and information necessary to resolve the dispute (to include all evidence, documentation and exhibits). A Managed Care Plan submitting such written requests for appeal or dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such appeal or dispute to the following mailing address:

Agency for Health Care Administration
Attn: Managed Care Appeals/Disputes, MS 70
2727 Mahan Drive
Tallahassee, FL 32308

Regardless of whether delivered by U.S. mail or commercial courier service, appeals or disputes not delivered to the above address will be denied.

The Managed Care Plan waives any dispute not raised within twenty-one (21) days of receiving a notice of this Contract interpretation. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving a Contract interpretation, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission submitted within the twenty-one (21) days following its receipt of the notice of this Contract interpretation in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

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

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

J. Indemnification

1. The Managed Care Plan, agrees to indemnify, defend, and hold harmless the Agency, as provided in this Clause.

2. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the "Duty to Indemnify and Defend"), extend to any completed, actual, pending, or threatened action, suit, claim, or proceeding, whether civil, criminal, administrative, or investigative (including any action by or in the right of the Managed Care Plan), and whether formal or informal, in which the Agency is, was, or becomes involved and which in any way arises from, relates to, or concerns the Managed Care Plan's acts or omissions related to this Contract (inclusive of all Attachments and Exhibits) (collectively "Proceeding").

a. Duty to Indemnify. The Managed Care Plan agrees to hold harmless and indemnify the Agency to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages, and costs of whatsoever name and description, including attorneys' fees, arising from or relating to any Proceeding.

b. Duty to Defend. With respect to any Proceeding, the Managed Care Plan agrees to fully defend the Agency and shall timely reimburse all of the Agency's legal fees and costs; provided, however, that the amount of such payment for attorneys' fees and costs is reasonable pursuant to Rule 4-1.5, Rules Regulating the Florida Bar. The Agency retains the exclusive right to select, retain, and direct its defense through defense counsel funded by the Managed Care Plan pursuant to the Duty to Indemnify and Defend the Agency.

3. Expense Advance. The presumptive right to indemnification of damages shall include the right to have the Managed Care Plan pay the Agency's expenses in any Proceeding as such expenses are incurred and in advance of the final disposition of such Proceeding.

4. Enforcement Action. In the event that any claim for indemnity, whether an Expense Advance or otherwise, is made hereunder and is not paid in full within sixty (60) days after written notice of such claim is delivered to the Managed Care Plan, the Agency may, but need not, at any time thereafter, bring suit against the Managed Care Plan to recover the unpaid amount of the claim (hereinafter "Enforcement Action"). In the event the Agency brings an Enforcement Action, the Managed Care Plan shall pay all of the Agency's attorneys' fees and expenses incurred in bringing and pursuing the Enforcement Action.

5. Contribution. In any Proceeding in which the Managed Care Plan is held to be jointly liable with the Agency for payment of any claim of any kind (whether for damages, attorneys' fees, costs, or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Managed Care Plan shall contribute toward satisfaction of the claim whatever portion is or would be payable by the Agency in addition to that portion which is or would be payable by the Managed Care Plan, including payment of damages, attorneys' fees, and costs, without recourse against the Agency. No provision of this part, or of any other section of this Contract (inclusive of all Attachments and Exhibits), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the State or the Agency's immunity to suit or limitations on liability; (ii) obligate the State or the Agency to indemnify the Managed Care Plan for the Managed Care Plan's own negligence, or otherwise assume any liability for the Managed Care Plan's own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

K. Public Records Requests

1. In accordance with s.119.0701, F.S., and notwithstanding **Standard Contract, Section I.**, THE VENDOR HEREBY AGREES, **Sub-Section I.**, Public Records Requests**.**, Requirements of Section 287.058, F.S., in addition to other Contract requirements provided by law, the Managed Care Plan shall comply with public records laws, as follows:

a. The Managed Care Plan shall keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Contract.

b. The Managed Care Plan shall provide the public with access to public records on the

same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in s. 119.0701, F.S., or as otherwise provided by law.

c. The Managed Care Plan agrees that it is the custodian of any and all recordings for purposes of the Public Records Act, Chapter 119, F.S., and is solely responsible for responding to any public records requests for recordings. This responsibility includes gathering, redacting, duplication, and provision of the recordings, as well as defense of any actions for enforcement brought pursuant to Section 119.11, F.S.

d. The Managed Care Plan shall ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law.

e. The Managed Care Plan shall meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Managed Care Plan upon termination of this Contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the IT systems of the Agency.

f. If the Managed Care Plan does not comply with a public records request, the Managed Care Plan shall be subject to enforcement of this Contract provisions in accordance with this Contract.

L. Communications

Notwithstanding any term or condition of this Contract to the contrary, the Managed Care Plan bears sole responsibility for ensuring that its performance of this Contract (and that of its subcontractors related to this Contract) fully complies with all State and federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including, but not limited to, the Florida Security of Communications Act, Sections 934.01, et seq., F.S., and the Electronic Communications Privacy Act, 18 U.S.C. 2510 et seq. (hereafter, collectively, “Communication Privacy Laws”).

1. Prior to intercepting, recording, or monitoring any communications which are subject to Communication Privacy Laws, the Managed Care Plan must:

   a. Submit a plan which specifies in detail the manner in which the Managed Care Plan (and its subcontractors related to this Contract) shall ensure that such actions are in full compliance with Communication Privacy Laws (the “Privacy Compliance Plan”).

   b. Obtain written approval, signed and stamped by the Agency Contract Manager, of the Privacy Compliance Plan.

2. No modifications to an approved Privacy Compliance Plan may be implemented by the Managed Care Plan unless an amended Privacy Compliance Plan is submitted to the Agency, and written approval of the amended Plan is signed and stamped by the Agency Contract Manager. Agency approval of the Managed Care Plan’s Privacy Compliance

Plan in no way constitutes a representation by the Agency that the Privacy Compliance Plan is in full compliance with applicable Communication Privacy Laws, or otherwise shifts or diminishes the Managed Care Plan's sole burden to ensure full compliance with applicable Communication Privacy Laws in all aspects of the Managed Care Plan's performance of this Contract. Violation of this term may result in sanctions to include termination of this Contract and/or liquidated damages.

M. Audits and Monitoring

1. The Agency may conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency may conduct a review of a sample of analyses performed by the Managed Care Plan to verify the quality of the Managed Care Plan's analyses. Reasonable notice shall be provided for reviews conducted at the Managed Care Plan's place of business.

2. Reviews may include, but shall not be limited to, reviews of procedures, computer systems, recipient records, accounting records, and internal quality control reviews. The Managed Care Plan shall work with any reviewing entity selected by the Agency.

3. During this Contract period, these records shall be available at the Managed Care Plan's office at all reasonable times. After this Contract period and for ten (10) years following, the records shall be available at the Managed Care Plan's chosen location subject to the approval of the Agency. If the records need to be sent to the Agency, the Managed Care Plan shall bear the expense of delivery. Prior approval of the disposition of the Managed Care Plan and subcontractor records must be requested and approved by the Agency. This obligation survives termination of this Contract.

4. The Managed Care Plan shall comply with all applicable federal requirements pertaining to procurement, including, but not limited to, Chapter 2 of the CFR and any other final or interim rules with respect to audit requirements of federal contracts administered through State and local public agencies.

N. Inspection of Records and Work Performed

1. The Agency and its authorized representatives shall, at all reasonable times, have the right to enter the Managed Care Plan's premises, or other places where duties under this Contract are performed. All inspections and evaluations shall be performed in such a manner as not to unduly delay work.

2. The Managed Care Plan shall retain all financial records, enrollee records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of ten (10) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of ten (10) years, the records shall be retained until resolution of the audit findings.

3. Refusal by the Managed Care Plan to allow access to all records, documents, papers, letters, other materials or on-site activities related to this Contract performance shall constitute a breach of this Contract.

4. The right of the Agency and its authorized representatives to perform inspections shall continue for as long as the Managed Care Plan is required to maintain records.

5. The Managed Care Plan shall be responsible for all storage fees associated with all records maintained under this Contract. The Managed Care Plan is also responsible for the destruction of all records that meet the retention schedule noted above.

6. Failure to retain all records as required may result in cancellation of this Contract. The Agency shall give the Managed Care Plan advance notice of cancellation pursuant to this provision and shall pay the Managed Care Plan only those amounts that are earned prior to the date of cancellation in accordance with the terms and conditions of this Contract. Performance by the Agency of any of its obligations under this Contract shall be subject to the Managed Care Plan's compliance with this provision.

7. In accordance with Section 20.055, F.S., the Managed Care Plan and its subcontractors shall cooperate with the OIG in any investigation, audit, inspection, review or hearing; and shall grant access to any records, data or other information the OIG deems necessary to carry out its official duties.

O. Employment

The Managed Care Plan shall comply with Section 274A of the Immigration and Nationality Act. The Agency shall consider the employment by any Managed Care Plan of unauthorized aliens a violation of this Act. If the Managed Care Plan knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. The Managed Care Plan shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Contract.

P. Work Authorization Program

The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. The Managed Care Plan shall only employ individuals who may legally work in the U.S. – either U.S. citizens or foreign citizens who are authorized to work in the U.S. The Managed Care Plan shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired by the Managed Care Plan during the term of this Contract and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to this Contract.

Q. Equal Employment Opportunity (EEO) Compliance

The Managed Care Plan awarded a Contract shall not discriminate in its employment practices with respect to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap.

R. Discrimination

Pursuant to s. 287.134(2)(a), F.S., an entity or affiliate who has been placed on the discriminatory vendor list may not submit a Bid, Proposal, or Reply on a contract to provide any goods or services to a public entity; may not submit a Bid, Proposal, or Reply on a contract

with a public entity for the construction or repair of a public building or public work; may not submit Bids, Proposals, or Replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity. The Florida Department of Management Services is responsible for maintaining the discriminatory vendor list. Questions regarding the discriminatory vendor list may be directed to the Florida Department of Management Services, Office of Supplier Diversity at (850) 487-0915.

S. Patents, Royalties, Copyrights, Right to Data, and Sponsorship Statement

1. The Managed Care Plan, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Managed Care Plan. The Managed Care Plan has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Managed Care Plan or is based solely and exclusively upon the Agency's alteration of the article.

2. The Agency shall provide prompt written notification of a claim of copyright or patent infringement and shall afford the Managed Care Plan full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Managed Care Plan may, at its option and expense procure for the Agency the right to continue the use of, replace, or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Managed Care Plan and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).

3. If the Managed Care Plan brings to the performance of this Contract a pre-existing patent, patent-pending, and/or copyright, the Managed Care Plan shall retain all rights and entitlements to that pre-existing patent, patent pending and/or copyright, unless this Contract provides otherwise.

4. If the Managed Care Plan uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under this Contract, the Managed Care Plan shall disclose, in writing, all intellectual properties relevant to the performance of this Contract which the Managed Care Plan knows, or should know, could give rise to a patent or copyright. The Managed Care Plan shall retain all rights and entitlements to any pre-existing intellectual property which is so disclosed. Failure to disclose shall indicate that no such property exists. The Agency will then have the right to all patents and copyrights which arise as a result of performance under this Contract as provided in this Sub-Section.

5. If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Contract, or in any way connected herewith, the Managed Care Plan shall refer the discovery or invention to the Agency for a determination whether patent protection shall be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent

rights or copyrights shall be marked and dated by the Managed Care Plan in such a manner as to preserve and protect the legal rights of the Agency.

6. Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings, or other graphic representation, and works of any similar nature, the Agency has the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to s. 286.021, F.S., no person, firm, corporation, including parties to this Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.

7. The Agency shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Managed Care Plan under any Contract.

8. Pursuant to s. 286.25, F.S., all non-governmental vendors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the Managed Care Plan shall include the statement: “Sponsored by (name of Managed Care Plan) and the State of Florida, Agency for Health Care Administration.” If the sponsorship reference is in written material, the words, “State of Florida, Agency for Health Care Administration” shall appear in the same size letters or type as the name of the organization.

9. All rights and title to works for hire under this Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this Contract.

10. The computer programs, data, materials and other information furnished by the Agency to the Managed Care Plan hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Managed Care Plan. The services and products listed in this Contract shall become the property of the Agency upon the Managed Care Plan’s performance and delivery thereof. The Managed Care Plan hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Managed Care Plan hereunder, together with the products delivered and services performed by the Managed Care Plan hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, F.S., and that the Managed Care Plan shall not disclose, publish, or use same for any purpose other than the purposes provided in this Contract; however, upon the Managed Care Plan first demonstrating to the Agency’s satisfaction that such information, in part or in whole, (1) was already known to the Managed Care Plan prior to its receipt from the Agency; (2) became known to the Managed Care Plan from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the Managed Care Plan shall be free to use and disclose same without restriction. Upon completion of the Managed Care Plan’s performance or otherwise

cancellation or termination of this Contract, the Managed Care Plan shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the Managed Care Plan's possession.

11. The Managed Care Plan warrants that all materials produced hereunder shall be of original development by the Managed Care Plan and shall be specifically developed for the fulfillment of this Contract and shall not knowingly infringe upon or violate any patent, copyright, trade secret, or other property right of any third party, and the Managed Care Plan shall indemnify and hold the Agency harmless from and against any loss, cost, liability, or expense arising out of any breach or claimed breach of this warranty.

12. The terms and conditions specified in this Sub-Section shall also apply to any subcontract made under this Contract. The Managed Care Plan shall be responsible for informing the subcontractor of the provisions of this Sub-Section and obtaining disclosures.

T. Confidentiality of Information

1. The Managed Care Plan shall not use or disclose any information, that is confidential by State or federal law, including, but not limited to, Social Security numbers that may be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Medicaid recipient or services under this Contract for any purpose not in conformity with State and federal laws, except upon written consent of the recipient, or his/her guardian.

2. Confidential information, including Medicaid information, shall be used only as authorized for purposes directly related to the administration of this Contract. The Managed Care Plan must have a process that specifies that patient-specific information remains confidential, is used solely for the purposes of data analysis or other Managed Care Plan responsibilities under this Contract, and is exchanged in a manner compliant with HIPAA/HITECH and only for the purpose of conducting a review or other duties outlined in this Contract.

3. Any patient-specific information and/or data constituting protected health care information received by the Managed Care Plan can be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Managed Care Plan is retained by the Agency. The Managed Care Plan must have in place written confidentiality procedures to ensure confidentiality and to comply with all federal and State laws (including the HIPAA and HITECH Acts) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).

4. The Managed Care Plan’s subcontracts must explicitly State expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the Managed Care Plan. If provider-specific data are released to the public, the Managed Care Plan shall have procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, F.S., are met.

5. Any releases of information to the media, the public, or other entities require prior approval from the Agency.

6. The Managed Care Plan must submit to the Agency Contract Manager:

   a. Notice, in a manner and format prescribed by the Agency, of the discovery of any new use or disclosure of PHI that is not in compliance with the Contract or State or federal law (See **Standard Contract**, **Attachment III**, Business Associate Agreement, item 11a.).

   b. Copies of all United States Department of Health and Human Services (HHS) breach notifications per 45 CFR 164.408(c), including breaches involving five hundred (500) or more individuals, no later than sixty (60) days after the end of each calendar year, concurrently with an attestation in accordance with 42 CFR 438.606(c) (See **Standard Contract**, **Attachment III**, Business Associate Agreement, item 11d.).

U. Legal Action Notification

The Managed Care Plan shall give the Agency, by certified mail, immediate written notification (no later than thirty (30) calendar days after service of process) of any action or suit filed or of any claim made against the Managed Care Plan by any subcontractor, vendor, or other party that results in litigation related to this Contract for disputes or damages exceeding the amount of fifty thousand dollars **($50,000)**.

V. Venue

1. In the event of any legal challenges to this Contract, the Managed Care Plan shall agree and shall consent that hearings and depositions for any administrative or other litigation related to this procurement shall be held in Leon County, Florida. The Agency, in its sole discretion, may waive this venue for depositions.

2. The Managed Care Plan (and their successors, including, but not limited to, their parent(s), affiliates, subsidiaries, subcontractors, assigns, heirs, administrators, representatives, and trustees) acknowledges that this Contract and its Exhibits, Attachments, or amendments are not rules nor subject to rulemaking under Chapter 120 (or its successor) of the Florida Statutes and are not subject to challenge as a rule or non-rule policy under any provision of Chapter 120, F.S.

3. This Contract shall be delivered in the State of Florida and shall be construed in accordance with the laws of Florida. Wherever possible, each provision of this Contract shall be interpreted in such a manner as to be effective and valid under applicable law, but if any provision shall be found ineffective, then to the extent of such prohibition or invalidity, that provision shall be severed without invalidating the remainder of such provision or the remaining provisions of this Contract.

4. The exclusive venue and jurisdiction for any action in law or in equity to adjudicate rights or obligations arising pursuant to or out of this Contract for which there is no administrative remedy shall be the Second Judicial Circuit Court in and for Leon County, Florida, or, on appeal, the First District Court of Appeal (and, if applicable, the Florida Supreme Court). Any administrative hearings hereon or in connection herewith shall be held in Leon County, Florida.

W. Performance Bond

1. The Managed Care Plan shall furnish to the Agency a performance bond in the amount specified in the Plan-specific **Attachment I**, **Section IV.**, Special Provisions, **Sub-Section C**., Special Terms and Conditions, of this Contract for all regions in which the Managed Care Plan is awarded a Contract. If the Managed Care Plan is awarded a Contract in more than one (1) region, the Managed Care Plan shall furnish a single bond for the total amount.

2. The bond must be furnished to the Agency within thirty (30) calendar days after execution of the Contract and prior to commencement of any work under this Contract. Thereafter, the bond shall be furnished on an annual basis, thirty (30) calendar days prior to the new Contract year for the same amount as required for the initial performance bond. A copy of all performance bonds shall be submitted to the Agency's Contract Manager. The performance bond must not contain any provisions that shorten the time for bringing an action to a time less than that provided by the applicable Florida Statute of Limitations. See Section 95.03, F.S. No payments shall be made to the Managed Care Plan until an acceptable performance bond is furnished to the Agency.

3. The Managed Care Plan shall maintain an effective performance bond for the full term of this Contract. The performance bond shall remain in effect for the full term of the Contract, including any renewal period. The Agency shall be named as the beneficiary of the Managed Care Plan's bond. The bond shall provide that the insurer or bonding company(s) pay losses suffered by the Agency directly to the Agency.

4. The Managed Care Plan shall bear cost of the performance bond.

5. Should the Managed Care Plan terminate this Contract prior to the end of the Contract period, an assessment against the bond shall be made by the Agency to cover the costs of issuing a new solicitation and selecting a new Managed Care Plan. The Managed Care Plan agrees that the Agency's damages in the event of termination by the Managed Care Plan shall be considered to be for the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

X. Fidelity Bond

The Managed Care Plan shall secure and maintain during the life of this Contract and any Contract extension(s), a blanket fidelity bond from a company doing business in the State of Florida on all personnel in its employment. The bond shall be issued in the amount of at least two hundred fifty thousand dollars **($250,000)** per occurrence. Said bond shall protect the Agency from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of the Managed Care Plan and subcontractors, if any. Proof of coverage shall be submitted to the Agency within sixty (60) calendar days after execution of this Contract and prior to the delivery of health care. To be acceptable to the Agency for fidelity bonds, a surety company shall comply with the provisions of Chapter 624, F.S.

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Y. Insurance

1. To the extent required by law, the Managed Care Plan shall be self-insured against, or shall secure and maintain during the life of this Contract, Worker's Compensation Insurance for all its employees connected with the work of the Contract and, in case any work is subcontracted, the Managed Care Plan shall require the subcontractor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under the Contract are covered by the Managed Care Plan's self-insurance program. Such self-insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the Managed Care Plan under the Contract and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the Managed Care Plan shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of its employees not otherwise protected.

   The Managed Care Plan shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal and advertising injury, and products and completed operations. This insurance shall provide coverage for all claims that may arise from the services and/or activities completed under this Contract, whether such services and/or activities are by the Managed Care Plan or anyone directly, or indirectly employed by it. Such insurance shall include a Hold Harmless Agreement in favor of the State of Florida and also include the State of Florida as an Additional Named Insured for the entire length of this Contract and hold the State of Florida harmless from subrogation. The Managed Care Plan shall set the limits of liability necessary to provide reasonable financial protections to the Managed Care Plan and the State of Florida under the Contract.

2. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Managed Care Plan's current insurance policy(ies) shall contain a provision that the insurance shall not be canceled for any reason except after thirty (30) calendar days written notice. The Managed Care Plan shall provide thirty (30) calendar days written notice of cancellation to the Agency's Contract Manager.

3. The Managed Care Plan shall submit insurance certificates evidencing such insurance coverage prior to execution of a Contract with the Agency.

Z. MyFloridaMarketPlace Vendor Registration and Transaction Fee

1. MyFloridaMarketPlace Vendor Registration. Each vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in Section 287.012, F.S., shall register in MyFloridaMarketPlace, in compliance with Rule 60A-1.033, F.A.C., unless exempt under Rule 60A-1.033(3), F.A.C.

2. MyFloridaMarketPlace Transaction Fee. This Contract has been exempted by the Florida Department of Management Services from paying the transaction fee per Rule 60A-1.031(4)(a and b), F.A.C.

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AA. Agency Goals

The Managed Care Plan shall submit a written report on progress towards the commitments contained within **Attachment I** of this Contract on a quarterly basis, as described in **Section XV**., Accountability, **Sub-Section B.**, Managed Care Plan Reporting Requirements, **Item 1.**, General Reporting Requirements. If the Managed Care Plan wishes to discontinue or modify any of the commitments contained within **Attachment I** of this Contract, the Managed Care Plan must submit a request to the Agency for review and approval. This request must include the Managed Care Plan's reason for wanting to discontinue or modify the commitment as well as a proposed substitution of equal or similar value. Discontinuation of or non-performance of a commitment by the Managed Care Plan without prior approval of the Agency may result in monetary or non-monetary contract actions, as determined by the Agency.

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Section XV. Accountability

A. General Provisions

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

2. The Managed Care Plan shall be required to provide to the Agency or its agents any other information, documentation, or data relative to this Contract in accordance with 42 CFR 438.604(b). In such instances, and at the direction of the Agency, the Managed Care Plan shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested. The Managed Care Plan shall have at least thirty (30) days to fulfill such ad hoc requests, unless the Agency directs the Managed Care Plan to provide data or information in less than thirty (30) days. The Managed Care Plan shall certify that data and information it submits to the Agency is accurate, truthful, and complete in accordance with 42 CFR 438.606.

3. Deadlines for reports and submissions referred to in this Contract specify the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.

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

5. All reports filed on a quarterly basis shall be filed on a calendar year quarter (i.e., January – March, April – June, July – September, October – December), unless otherwise specified in this Contract.

6. Unless otherwise specified, all reports and submissions shall be submitted electronically, as prescribed in the reporting guidelines or submissions summary. Materials including PHI shall be submitted to the Agency SFTP sites.

7. The Agency reserves the right to modify the reporting or submission requirements and to provide technical assistance to the Managed Care Plan for up to ninety (90) days , to allow the Managed Care Plan to complete implementation, unless otherwise required by law.

8. The Managed Care Plan shall be provided with written notification of any modifications to reporting or submission requirements.

9. If the Managed Care Plan fails to submit the required reports or submissions accurately or within the timeframes specified, the Managed Care Plan shall be subject to fines or otherwise sanctioned in accordance with **Section XII.**, Sanctions and Corrective Action Plans.

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B. Managed Care Plan Reporting Requirements

1. General Reporting Requirements

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

2. Required Reports

a. The Managed Care Plan shall comply with reports required by the Agency as specified in the Managed Care Plan Report Guide. All reports shall be submitted to the Agency Contract Manager unless otherwise indicated in the Managed Care Report Guide. A summary of the reporting requirements is provided in **Table 10**, Summary of Reporting Requirements Table, below:

TABLE 10
SUMMARY OF REPORTING REQUIREMENTS

Report Name	Plan Type	Frequency
Additional Network Adequacy Standards Report	All Plans	Weekly
Administrative Subcontractors and Affiliates Report	All Plans	Quarterly
Adverse and Critical Incident Summary Report	All Plans	Monthly
Annual Fraud and Abuse Activity Report	All Plans	Annually
ASR Financial Reports	All Plans	Annually Quarterly
Audited Financial Statements	All Plans	Annually
Claims Aging Report	All Plans	Monthly
Denied/Suspended/Terminated Provider Report	All Plans	Quarterly
Electronic Visit Verification Report	All Plans	Monthly
Enhanced Care Coordination for Enrollees Under Age 21 Receiving Skilled Nursing Facility, Prescribed Pediatric Care, or Private Duty Nursing Services	All Plans	Monthly
Enrollee Complaints, Grievance and Plan Appeals Report	All Plans	Monthly

TABLE 10 SUMMARY OF REPORTING REQUIREMENTS		
Report Name	**Plan Type**	**Frequency**
Enrollee Help Line Statistics Report	All Plans	Monthly
Inter-Rater Reliability Audit Report	All Plans	Quarterly
Managed Care Plan Internal Training Report	All Plans	Monthly
Marketing Agent Status Report	All Plans	Quarterly
Marketing/Public/Educational Events Report	All Plans	Monthly
Member Satisfaction Improvement Report	All Plans	Quarterly
Non-Emergency Transportation Timeliness Report	All Plans	Monthly
Non-Special Needs Plan Financial Report	All Plans	Annually
Performance Measure Action Plan	All Plans	Quarterly
Performance Measure Report	All Plans	Annually
Plan-Specific Commitments Progress Report	All Plans	Quarterly
Provider Complaint Report	All Plans	Monthly
Provider Network File	All Plans	Weekly
Quarterly Fraud and Abuse Activity Report	All Plans	Quarterly
Suspected/ Confirmed Fraud & Abuse Reporting	All Plans	Within fifteen (15) days of detection
Suspected/Confirmed Waste Reporting	All Plans	Quarterly
Hope Florida Reporting	All Plans	Annually

3. **Certification of Timely, Complete and Accurate Submission**

   a. The Managed Care Plan shall assure the timely, complete, and accurate submission of each report.

   b. The Managed Care Plan's CEO, CFO or an individual who reports to the CEO or CFO and who has delegated authority to certify the Managed Care Plan's reports, shall attest, under penalty of perjury, based on his/her best knowledge, information, and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful and complete (42 CFR 438.606(a) and (b); 457.1201(o); and 425.1201(n)(2)).

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

C. Managed Care Plan Submission Requirements

1. General Submission Requirements

The Managed Care Plan shall comply with the Managed Care Plan Submissions Summary in submitting required reports, including the report formats, templates, instructions, data specifications, submission timetables and locations, and other materials contained in the guide. The Managed Care Plan Submissions Summary shall be posted on the Agency's website. The Managed Care Plan shall be furnished with appropriate technical assistance in using the Managed Care Plan Submissions Summary.

2. Required Submissions

The Managed Care Plan shall comply with reports required by the Agency as specified in the Managed Care Plan Submissions Summary. All reports shall be submitted to the Agency Contract Manager unless otherwise indicated in the Managed Care Plan Submissions Summary on the Agency's website. A summary of the submission requirements is provided in the Summary of Submission Requirements Table, **Table 11**, below:

TABLE 11
SUMMARY OF SUBMISSION REQUIREMENTS

Submission Name	Plan Type	Due
Annual Audited Financial Statements	All Plans	March 31
Annual Healthy Behavior Program Evaluation	All Plans	October 1
Business Continuity-Disaster Recovery (BC-DR) Plan/Certification	All Plans	May 1
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Vendor's Final Report and Action Plan to Address Results of CAHPS Survey	All Plans	October 1
Case Management Program Description	All Plans	June 1
Chronic Disease Management Update Report	All Plans	June 1
Complex Chronic Disease Management Summary Report	All Plans	June 1
Complex Chronic Disease Management Update Report	MMA	Quarterly
Compliance and Anti-fraud and Abuse Prevention Plan	All Plans	September 1
Emergency Management Plan	All Plans	May 1
Enrollee Record Review Strategy	All Plans	June 1
Enrollee Satisfaction Survey, Proposal for Survey Administration and Reporting	All Plans	December 1
Experience Implementing Anti-Fraud Plan & Investigating Possible Fraud or Abuse Report	All Plans	September 1

TABLE 11 SUMMARY OF SUBMISSION REQUIREMENTS		
Submission Name	**Plan Type**	**Due**
Multiple Signature Verification Agreement Form	All Plans	Within thirty (30) days of change
Multiple Signature Verification Agreement Attestation	All Plans	April 1
Multiple Signature Verification Agreement for Custody Arrangements Form	All Plans	Within thirty (30) days of change
Multiple Signature Verification Agreement for Custody Arrangements Attestation	All Plans	April 1
National Association of Insurance Commissioners Health Statements	All Plans	March 31
Network Development Plan	All Plans	September 1
Ownership and Management Disclosure and Any Subcontractors	All Plans	September 1
Performance Improvement Projects (PIP) – Ongoing	All Plans	October 1
Provider Satisfaction Survey and Managed Care Plan’s Action Plan to Address Results of Provider Satisfaction Survey	All Plans	September 1
Provider Satisfaction Survey Plan	All Plans	January 1
Quality Improvement (QI) Plan Update and Annual QI Program Evaluation Findings	All Plans	November 1
Subcontractor Monitoring Schedule	All Plans	December 1

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Section XVI. Definitions and Acronyms

A. Definitions

The Florida Medicaid Definitions Policy contains definitions of commonly used terms that are applicable to all sections of Rule Chapter 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy, rule, or this Contract. (Rule 59G-1.010, F.A.C.) The following terms as used in this Contract shall be used unless this Contract otherwise expressly requires a different construction and/or interpretation. Some defined terms do not appear in all Contracts.

Abuse, Neglect and Exploitation — As defined in Chapter 415, F.S., and Chapter 39, F.S.

Accountable Care Organization (ACO) — An entity qualified as an accountable care organization in accordance with federal regulations (42 CFR Part 425), and which meets the requirements of a provider service network (PSN) as described in Section 409.912(1) and (2)(b) and 409.962(1) or 409.962(9), F.S.

Activities of Daily Living (ADL) — As defined in Rule 59G-4.192, F.A.C.

Acute Care Services — Short-term medical treatment that may include, but is not limited to, community behavioral health, hearing, home health, independent laboratory and x-ray, inpatient hospital, outpatient hospital/emergency medical, practitioner, prescribed drug, vision, or hospice services.

Adjudicated Claim — A claim for which a determination has been made to pay, accept, deny, or reject the claim.

Adjudicated Date — The date the Managed Care Plan processed for determination of payment, acceptance, denial, or rejection.

Advance Directive — A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination — As defined in 42 CFR Part 438.400(b).

Adverse Incident — An injury of an enrollee occurring during delivery of Managed Care Plan covered service that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred.
2. Is not consistent with or expected to be a consequence of service provision.
3. Occurs as a result of service provision to which the patient has not given his informed consent.
4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

Section XVI. Definitions and Acronyms

After Hours — The hours between 5:00 p.m. and 8:00 a.m. local time, Monday through Friday inclusive, and all-day Saturday and Sunday. State holidays are included.

Agency — State of Florida, Agency for Health Care Administration (AHCA), its employees acting in their official capacity, or its designee.

Agent — A term that refers to certain independent contractors with the State that perform administrative functions, including, but not limited to, fiscal agent activities; outreach, eligibility, and enrollment activities; and systems and technical support. The term as used herein does not create a principal-agent relationship.

Aging and Disability Resource Center (ADRC) — An agency designated by the Department of Elder Affairs (DOEA) to develop and administer a plan for a comprehensive and coordinated system of services for older and disabled persons.

Aging Network Service Provider — A system of essential community providers including all providers that have previously participated in home and community-based (HCB) waivers serving elders or community service programs administered by DOEA pursuant to Section 409.982(1)(c), F.S., or Section 430.205, F.S.

Appeal – See Plan Appeal.

Ancillary Services — Diagnostic tests, laboratory tests, therapy services, radiology services, and pharmaceuticals ordered by primary care physicians or specialists.

Area Agency on Aging — An agency designated by the DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older persons.

Automated Phone Tree System — A telephone information system consisting of a fixed-menu of options which registers information or routes calls based on a programmed response. A phone tree prompts the caller to respond to a menu of options by pressing phone keys on a touch-tone telephone. A phone tree also includes interactive voice response (IVR) technology that allows the telephone information system to interact with a caller speaking words or short phrases and responds with prerecorded or dynamically generated audio to further direct the caller on how to proceed to available options.

Automatic Call Distribution (ACD) — A device or system that manages incoming calls, handles incoming calls based on the number called and associated automated handling instructions, and distributes incoming calls to a specific group of terminals that agents use, based on caller need, call type, or agent skill set.

Average Hold Time — The average length of time calls were placed on hold by an agent.

Average Speed of Answer (ASA) — The average amount of time i.e., (delay) it takes for calls to be answered during a specific time period. The total delay divided by total number of calls.

Section XVI. Definitions and Acronyms

Biometric Technology — The use of computer technology to identify people based on physical or behavioral characteristics such as fingerprints, retinal or voice scans.

Blog (Web Blog) — A type of website, usually maintained by an individual with regular entries of commentary, description of events, or other materials such as graphics or video. Entries are commonly displayed in reverse-chronological order.

Branding — Marketing through branding advertisements are typically used in television ads, and flash information quickly across a screen for the sole purpose of enticing an enrollee or potential enrollee to contact the Managed Care Plan to enroll or obtain more information. Branding also includes “banner-like” advertisements which are usually in some media other than television (e.g., outdoor advertising and internet banner ads). Branding advertisements are intended to be brief and to entice someone to call the Managed Care Plan or to alert someone that information is forthcoming.

Broadcast — Video, audio, text, or email messages transmitted through an internet, cellular, or wireless network for display on any device.

Business Days — A day scheduled for regular State of Florida employees to work: Monday through Friday, except holidays observed by regular State of Florida employees. Timeframes requiring completion within a number of business days shall mean by 5:00 p.m. Eastern Time on the last workday.

Calendar Day — A period of 24 hours from midnight to midnight.

Calendar Year — A twelve (12) month period of time beginning on January 1 and ending on December 31.

Call Abandonment — The number of customers who hang up or who are disconnected before they can be connected to a call center agent.

Call Blockage (System Reported) — The percentage of calls offered that make it into the system that are forced disconnects, as reported by the automated call distribution reporting software.

Call Blockage (Telecom Provider) — The percentage of calls offered that are not allowed into the system as reported from the telecom provider.

Call Center — A physical place equipped for receiving a large volume of requests by telephone and where telephone calls are handled, usually with some amount of computer automation, to respond to incoming inquiries from callers. Call centers may function as a component of a broader contact center, or as a customer interaction center from which all customer contacts are managed via telephone, email, fax, online chat, or other means of communication.

Capitation Rate — The per-member, per-month amount, including any adjustments, that is paid by the Agency to a Managed Care Plan for each Medicaid recipient enrolled under a Contract for the provision of Medicaid services during the payment period.

Section XVI. Definitions and Acronyms

Care Coordination — Organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

Case Management — As defined in 42 CFR 441.18 and Rule 59G-1.010, F.A.C.

Cause — As defined in Rule 59G-8.600, F.A.C.

Children/Adolescents — Enrollees under the age of twenty-one (21) years.

Children's Medical Services Health Plan (CMS Plan) — A Managed Medical Assistance Plan solely operating a Specialty line of business for children with chronic conditions operated by the Florida Department of Health's Children's Medical Services Network as specified in Section 409.974(4), F.S., through a single, statewide Contract with the Agency that is not subject to the SMMC procurement requirements, or regional plan limits, but must meet all other plan requirements for the MMA program.

Children's Multidisciplinary Assessment Team --- An interagency coordinated team of reviewers that assist in coordinating services for children under 21 years of age with complex medical conditions. CMAT's primary purpose is to review the medical and psychosocial assessment and make a medically necessary determination of eligibility for Medicaid funded long-term care services.

Chronic Disease Management (CDM) — A system of coordinated health care intervention and communication for populations with conditions in which patient self-care efforts are significant. Chronic disease management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Claim — (1) A bill for services, (2) a line item of service, or (3) all services for one (1) recipient within a bill, pursuant to 42 CFR 447.45, in a format prescribed by the Agency through its Medicaid provider handbooks.

Clean Claim — A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

Closed-loop Referral System — An integrated data and tracking system that uses technology to track cross-sector referrals and services a patient receives.

Cold-Call Marketing — Any unsolicited personal contact with a Medicaid recipient by the Managed Care Plan, its staff, its volunteers, or its vendors with the purpose of influencing the Medicaid recipient to enroll in the Managed Care Plan or either to not enroll in, or disenroll from, another Managed Care Plan.

Child Welfare Community-based Care Lead Agency (CBC) — A non-profit agency that works across a Department of Children and Families (DCF) region under contract with DCF to facilitate the coordinated delivery of child welfare services.

Section XVI. Definitions and Acronyms

Community Care for the Elderly Lead Agency — An entity designated by an Area Agency on Aging and given the authority and responsibility to coordinate services for functionally impaired elderly persons.

Community Living Support Plan — As defined in Section 429.02, F.S.

Community Partner Network — A coalition of community-based organizations that provide services and supports for individuals' health-related social needs, including referral(s), planning, program development, information sharing and management, community awareness, and individual education.

Community Partnerships to Improve Outcomes (CPIO) — Certain health-related, community-based services that the Managed Care Plan must offer and coordinate access to its enrollees. The Managed Care Plan is not reimbursed by the Agency/Medicaid for these types of services.

Complaint — Any oral or written expression of dissatisfaction by an enrollee submitted to the Managed Care Plan or to a State agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Managed Care Plan employee, failure to respect the enrollee's rights, Managed Care Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Managed Care Plan's Contract. A complaint is a subcomponent of the enrollee grievance and appeal system.

Comprehensive Assessment — As defined in Rule 59G-4.192, F.A.C.

Comprehensive Assessment and Review for Long-Term Care Services (CARES) — A program operated by the DOEA that is Florida's federally mandated LTC preadmission screening program for Medicaid Institutional Care Program (ICP) nursing facility and Medicaid waiver program applicants. An assessment is performed to identify LTC needs; establish level of care (medical eligibility for nursing facility care); and recommend the least restrictive, most appropriate placement. Emphasis is on enabling people to remain in their homes through provision of home-based services or with alternative placements such as assisted living facilities.

Continuous Quality Improvement — A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

Contract Manager — The Agency individual responsible for providing overall Contract direction, acting as liaison between the Managed Care Plan and other Agency staff and monitoring the Managed Care Plan's performance.

Contract Year — Each October 1 through September 30.

Contracting Officer — The Secretary of the Agency or designee.

Copayment — As described in Rule 59G-1.010, F.A.C.

Covered Services — Those services provided by the Managed Care Plan in accordance with this Contract, and as outlined in **Section V.**, Service Administration, and the **Exhibit B-1**, MMA Exhibit or **Exhibit B-2**, LTC Exhibit, respectively.

Critical Incident — Critical events that negatively impact the health, safety, or welfare of a LTC Plan enrollee, including death by suicide, homicide, abuse/neglect, or that is otherwise unexpected; adverse incident or major illness; sexual battery; medication errors; suicide attempts; altercations requiring medical intervention; or elopement.

Customized Benefit Package (CBP) — Covered services, which may vary in amount, scope, and/or duration from those listed in **Section V.**, Service Administration, and the **Exhibit B-1**, MMA Exhibit. The CBP must meet State standards for actuarial equivalency and sufficiency as specified in this Contract. CBP is also referred to as "benefit grid."

Date of Claim Receipt — The date the Managed Care Plan receives the claim at its designated claims receipt location, as indicated by its date stamp on the claim (42 CFR 447.45(d)(5)-(6)).

Date of Claim Payment — The date of the check or other form of payment (42 CFR 447.46).

Day (or Days) — All seven (7) days of the week. Unless otherwise specified, the term "days" in this Contract refers to calendar days.

Department of Children and Families (DCF) — The State agency responsible for overseeing programs involving behavioral health, childcare, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness, and programs that identify and protect abused and neglected children and adults.

Department of Elder Affairs (DOEA) — The primary State agency responsible for administering human services programs to benefit Florida's elders and developing policy recommendations for LTC in addition to overseeing the implementation of federally funded and State-funded programs and services for the State's elderly population.

Department of Health (DOH) — The State agency responsible for public health, public primary care and personal health, disease control, and licensing of health professionals.

Direct Ownership Interest — The possession of equity in the capital, the stock, or the profits of the disclosing entity (42 CFR 455.101).

Direct Secure Messaging (DSM) — Enables Managed Care Organizations and providers to securely send patient health information to many types of organizations.

Direct Service Provider, Long-term Care — A person eighteen (18) years of age or older who, pursuant to a program to provide services to the elderly or disabled, has direct, face-to-face contact with a client while providing services to the client and has access to the client's living areas, funds, personal property, or personal identification information as defined in s. 817.568, F.S. The term includes coordinators, managers, and supervisors of residential facilities and volunteers (Section 430.0402(1)(b), F.S.).

Disclosing Entity — A Medicaid provider, other than an individual practitioner or group of practitioners, or a fiscal agent that furnishes services or arranges for funding of services under Medicaid, or health-related services under the social services program.

Disaster — As defined by Section 252.34, F.S.

Disaster Recovery Plan — A plan to ensure continued business processing through adequate alternative facilities, equipment, backup files, documentation, and procedures in the event that the primary processing site is lost to the Managed Care Plan.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) — As defined by 42 U.S.C. § 1396d(r)(5) and 42 CFR 440.40(b) or its successive regulation.

Educational Event — An event designed to inform Managed Care Plan enrollees about Medicaid programs and does not include marketing.

Eligible Plan — In accordance with Section 409.962(7), F.S., means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under Section 409.912(1) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

Emergency Department Care — Emergency services and care received in an emergency department or outpatient hospital.

Emergency Medical Transportation — See Emergency Transportation.

Emergency Room Care — Emergency Care, Emergency Medical Services, or Emergency Services as defined in Rule 59G-1.010, F.A.C.

Emergency Services — Emergency Care, Emergency Medical Services, or Emergency Services as defined in Rule 59G-1.010, F.A.C.

Emergency Transportation — The provision of emergency transportation services in accordance with Rule 59G-4.015, F.A.C.

Encounter Data — A record of diagnostic or treatment procedures or other medical, allied, or LTC provided to the Managed Care Plan's Medicaid enrollees, excluding services paid by the Agency on a fee-for-service basis.

Endorsement — A celebrity or influencer who gives a declaration of support in writing or speaking as to the quality or merit of a product or service.

Enrollee Record — As used in reference to provider, a medical record, as defined in Rule 59G-1.010, F.A.C. As used in reference to the Managed Care Plan, a comprehensive file containing information regarding the management of services for an enrollee including the plan of care and documentation of care coordination/case management activities.

Enrollment — The process by which an eligible Medicaid recipient signs up to participate in a Managed Care Plan.

Enrollment Broker — The State's contracted or designated entity that performs functions related to outreach, education, enrollment, and disenrollment of potential enrollees into a Managed Care Plan.

Enrollment Files — X-12 834 files sent by the Agency's Medicaid designee to the Managed Care Plan to provide the Managed Care Plan with its official Medicaid recipient enrollment.

Enrollment Specialists — Individuals, authorized through an Agency-approved process, who provide one-on-one information to Medicaid recipients to help them choose the Managed Care Plan that best meets their health care needs.

Event Notification Service (ENS) — An automated alerting service that provides timely alert messages to subscribing the Managed Care Plan and accountable care organizations when patients are discharged from a hospital or emergency department.

Excluded Parties List System (EPLS) — The EPLS, or its equivalent is a federal database containing information regarding entities debarred, suspended, proposed for debarment, excluded, or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits.

Excluded Services — As described in **Section V.**, Service Administration**, Sub-Section C.**, Excluded Services, of this Contract.

Exclusive Provider Organization (EPO) — Pursuant to Chapter 627, F.S., a group of health care providers that have entered into a written agreement with an insurer to provide benefits under a health insurance policy.

Expanded Benefit — A benefit covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency.

Expedited Appeal Process — The process by which the appeal of a Managed Care Plan's adverse benefit determination is accelerated because the standard timeframe for resolution of the plan appeal could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function.

External Quality Review (EQR) — The analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a Managed Care Plan.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other related activities as set forth in federal regulations, or both.

Facility-Based — As the term relates to services, services the enrollee receives from a residential facility in which the enrollee lives. Under this Contract, assisted living facility services, assistive care services, adult family care homes and nursing facility care are facility-based services.

Federal Fiscal Year — The United States government's fiscal year, which starts October 1 and ends on September 30.

Federally Qualified Health Center (FQHC) — An entity that is receiving a grant under Section 330 of the Public Health Service Act, as amended (Also see s. 1905(l)(2)(B) of the Social Security Act.)

Fee Schedule — A list of health services or products covered by the Florida Medicaid program in the fee-for-service delivery system, which provide the associated reimbursement rates for each covered service or product and are promulgated into rule.

First-Call Resolution — Calls resolved upon initial contact via the toll-free help line. Call does not require a transfer to any other department.

Fiscal Year — The State of Florida fiscal year is the twelve (12) month period beginning July 1 and ending June 30.

Florida Assertive Community Treatment Services — As described in Rule 59G-4.127. F.A.C.

Florida Medical School Quality Network (FMSQN) — The network as specified in Section 409.975(2), F.S.

For Cause --- See Cause.

Formulary Management Tool --- A software tool that operationalizes the coding and status of drugs.

Full-Benefit Dual Eligible — An enrollee who is eligible for full Medicaid benefits under Medicaid (Title XIX) and Medicare (Title XVIII) programs.

Full-Time Equivalent (FTE) Position/Employee — The equivalent of one (1) full-time employee who works forty (40) hours per week.

Fully Enrolled Provider — An enrollment type that is furnished to a provider that meets the full eligibility credentialing for participation in Florida Medicaid. Enrolled providers are eligible to provide services to recipients enrolled in either fee-for-service or managed care.

Functional Status — The ability of an individual to perform self-care, self-maintenance, and physical activities in order to carry on typical daily activities.

Grievance and Appeal System — As defined by 42 CFR 438.400(b).

Habilitation Services and Devices — As defined in 45 CFR 156.115.

Health Assessment — A complete health evaluation combining health history, physical assessment, and the monitoring of physical and psychological growth and development.

Healthcare Effectiveness Data and Information Set (HEDIS) — The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

Health Care-Acquired Condition (HCAC) — A condition, occurring in any inpatient hospital or inpatient psychiatric hospital setting, including CSUs, identified as a hospital-acquired condition by the Secretary of Health and Human Services under Section 1886(d)(4)(D)(iv) and (p)(3) of the Social Security Act for purposes of the Medicare program as specified in the Florida Medicaid State Plan.

Health Care Professional — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist, certified respiratory therapy technician, and licensed pharmacist.

Health Care Service Pools — As defined in Section 400.980, F.S.

Health Information Exchange (HIE) — The secure, electronic exchange of health information among authorized stakeholders in the health care community – such as care providers, patients, and public health agencies – to drive timely, efficient, high-quality, preventive, and patient-centered care.

Health Information Technology for Economic and Clinical Health (HITECH) Act — The Health Information Technology Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

Health Insurance — As defined in s. 624.603, F.S.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) — A federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

Health Insurance Premium Payment (HIPP) Program — A program that reimburses part or all of a Medicaid recipient's share of employer-sponsored health care coverage, if available and cost-effective.

Health Maintenance Organization (HMO) — An organization or entity licensed in accordance with Chapter 641, F.S.

Healthy Behaviors — A program offered by the Managed Care Plan in accordance with Section 409.973(3), F.S., that encourages and rewards behaviors designed to improve the enrollee's overall health.

Hernandez Settlement Agreement — An agreement as a result of the Hernandez vs. Medows lawsuit, effective May 14, 2004, relating to the type of notification a pharmacy must give a Medicaid recipient when the pharmacy refuses to fill a prescription.

High Utilizer — Children and adolescents under 18 years of age with three or more admissions into a Crisis Stabiization Unit (CSU) or an inpatient psychiatric hospital within 180 days.

Home and Community-Based Services (HCBS) — Services as defined in 42 CFR 440.180.

Home and Community-Based (HCB) Settings Requirements — As defined in 42 CFR 441.301(c)(4).

Home Health Care — As defined in Rule 59G-4.130, F.A.C.

Hospice Services — As described in Rule 59G-4.140, F.A.C.

Hospital Outpatient Care — As described in Rule 59G-4.160, F.A.C.

Hospital Services Agreement — The agreement between the Managed Care Plan and a hospital to provide medical services to the Managed Care Plan's enrollees.

Hospitalization — As described in Rule 59G-4.150 F.A.C.

In Lieu of Service — As defined in 42 CFR 438.3(e)(2).

Incentive — Related to an MMA Healthy Behaviors Program, something offered to an enrollee that encourages or motivates him or her to act. For example, an incentive may be offered for enrolling in a series of educational classes focused on the target behavior. Incentives should be linked to effective engagement strategies. For example, providing a financial incentive to address a substance abuse problem must be supported by an effective, evidence-based approach/program.

Indirect Ownership — An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity (42 CFR 455.101). See also as calculated in 42 CFR 455.102.

Individual Marketing Appointments — Marketing appointments are individual appointments designed to steer or attempt to steer, enrollees or potential enrollees toward a Managed Care Plan. All individual appointments between an agent and an enrollee or potential enrollee are considered marketing appointments regardless of the content discussed.

Information — As the term relates to Information Management and Systems, (a) Structured Data: Data that adhere to specific properties and validation criteria that are stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; (b) Document: Information that does not meet the definition of structured data includes text files, spreadsheets, electronic messages and images of forms and pictures.

Information System(s) — A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents as well as non-digitalized audio and video;

and/or (b) the processing and/or calculating of information and non-digitalized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

Injury — Any of the following outcomes when caused by an adverse incident:

1. Death
2. Brain damage
3. Spinal damage
4. Permanent disfigurement
5. Fracture or dislocation of bones or joints
6. Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
7. Any condition requiring surgical intervention to correct or control
8. Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care

Insolvency — A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

Institutions for Mental Disease (IMD) — As defined in 42 CFR 435.1010.

Insurer — Pursuant to s. 624.03, F.S., every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

Interactions — Conversational exchange of messages.

Inter-Rater Reliability — The degree of agreement among raters.

Intervention —Any measure or action that is intended to improve or restore health or alter the course of a disease.

Kick Payment — The method of reimbursing the Managed Care Plan in the form of a separate one (1) time fixed payment for specific services.

Leg A — Transportation from the originating pick-up site to the provider/appointment location.

Leg B — Return transportation from the provider/appointment location to the originating site.

Licensed — A facility, equipment, or an individual that has formally met State, county, and local requirements, and has been granted a license by a local, State, or federal government entity.

Licensed Practitioner of the Healing Arts — A psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

Limited Enrolled Provider — An enrollment type that is furnished to a provider that meets the basic eligibility credentialing for participation in Florida Medicaid. Limited Enrollment providers are only eligible to provide services to recipients enrolled in managed care.

List of Excluded Individuals and Entities (LEIE) — A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, health care providers, patients and others relating to parties excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Long-Term Care Level of Care (LOC) — The type of LTC required by an enrollee based on medical needs. The criteria for Intermediate LOC (Level I and II) are described in Rule 59G-4.180, F.A.C., and the criteria for Skilled LOC are described in Rule 59G-4.290, F.A.C.

Managed Behavioral Health Organization (MBHO) — A behavioral health care delivery system managing quality, utilization, and cost of services. Additionally, an MBHO measures performance in the area of mental disorders.

Managed Care Plan Report Guide — A companion guide to the SMMC Managed Care Plan Contracts that provides detailed information about standard reports required by this Contract to be submitted by the Managed Care Plan to the Agency. Such detailed information includes report-specific format and submission requirements, instructions for completion, and report templates and supplemental tables.

Mandatory Assignment — The process the Agency uses to assign enrollees to a Managed Care Plan. The Agency automatically assigns those enrollees required to be in a Managed Care Plan who did not voluntarily choose one.

Mandatory Enrollee — The categories of eligible Medicaid recipients who must be enrolled in a Managed Care Plan.

Mandatory Potential Enrollee — A Medicaid recipient who is required to enroll in a Managed Care Plan but has not yet made a choice.

Marketing — Marketing includes activities and use of materials by the Managed Care Plan with the intent to draw an enrollee or potential enrollee's attention to a plan or to influence a potential enrollee or enrollee's decision-making process when selecting a plan for enrollment or deciding to remain enrolled in a plan (That is, retention-based marketing).

Marketing Agent — In accordance with s. 626.015, F.S., a Florida licensed health insurance agent who acts on behalf of the Managed Care Plan to provide marketing activities to enrollees and potential enrollees.

Marketing Events — Marketing events are events designed to steer, or attempt to steer, enrollees or potential enrollees toward a plan. Appointed and licensed marketing agent(s), in accordance with s. 626.829, F.S., from the Managed Care Plan is present distributing marketing materials, nominal gifts and/or engaging in verbal discussion regarding Plan-

specific, enrollment, and/or benefit information.

Marketing Materials — Materials used with the intent to draw a potential enrollee's attention to a plan or to influence a potential enrollee or enrollee's decision-making process when selecting a plan for enrollment or deciding to remain enrolled in a plan (That is, retention-based marketing).

Medicaid Fair Hearing — An administrative hearing conducted by the Agency to review an action taken by a Managed Care Plan that limits, denies, or stops a requested service.

Medicaid Program Integrity (MPI) — The unit of the Agency responsible for preventing and identifying fraud and abuse in the Medicaid program.

Medicaid Recipient — Any individual whom DCF, or the Social Security Administration on behalf of DCF, determines is eligible, pursuant to federal and State law, to receive medical or allied care, goods, or services for which the Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Medicaid State Plan — A written plan between a State and the federal government that outlines the State's Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each State and approved by the Centers for Medicare & Medicaid Services (CMS).

Medically Necessary or Medical Necessity — As defined in Rule 59G-1.010, F.A.C.

Medicare Advantage Plan — As defined in 42 CFR 422.2.

Missed Trip — A scheduled trip for which the transportation provider failed to pick up the enrollee.

Month — Also called calendar month, any of the twelve parts, such as January or February, into which the calendar year is divided. Unless otherwise specified, the term "month" in this Contract refers to calendar month.

Multidisciplinary Team (MDT) — For enrollees under the age of 21 years, a team that includes, at a minimum: the enrollee's care coordinator or case manager, the enrollee (if able), the enrollee's authorized representative, and other health care professionals involved in the enrollee's care.

National Correct Coding Initiative (NCCI) — A Centers for Medicare & Medicaid Services edit system that promotes national correct coding methodologies pursuant to applicable provisions of the Social Security Act, ss. 1903(r)(1)(B)(iv).

National Drug Code (NDC) — A unique 10-digit or 11-digit 3 segment number and universal product identifier for human drugs in the United States.

Network — As described in **Section V.**, Service Administration, of this Contract and its Exhibits.

Never Event (NE) — As defined by the National Quality Forum (NQF), an error in medical care that is of concern to both the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a

nature such that the risk of occurrence is significantly influenced by the procedures of the health care organization. Currently, in Florida Medicaid, never event health care settings are limited to inpatient hospitals and inpatient psychiatric hospitals, including CSUs.

Nominal Gift — An individual item or service worth fifteen dollars ($15) or less (based on the retail value of the item), with a maximum aggregate of seventy-five dollars ($75) per person, per year.

Non-Covered Service — A service that is not a benefit under either the Medicaid State Plan or the Managed Care Plan.

Non-Participating Provider — A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the Managed Care Plan to provide services.

Non-Quantitative Limits — As defined in 42 CFR 438.900, limitations that are expressed non-numerically. Also as described in 42 CFR 438.910(d)(2).

Normal Business Hours — The hours between 8:00 a.m. and 5:00 p.m. local time, Monday through Friday inclusive. State holidays are excluded.

Office of Fair Hearing (Office) — The hearing authority within the Agency for Health Care Administration designated to conduct Medicaid fair hearings per Section 409.285(2), F.S.

Onboarding — The process of integrating a new provider into the Managed Care Plan's network, beginning with receipt of a complete provider enrollment application, and ending with the day the Agency successfully receives the provider on the Managed Care Plan's Provider Network Verification file.

Ongoing Course of Treatment — Services that were previously authorized or prescheduled prior to the enrollee's enrollment in the Managed Care Plan.

Open Enrollment — The sixty (60)-day period before the end of certain enrollees' enrollment year, during which the enrollee may choose to change Managed Care Plan for the following enrollment year.

Other Benefits — Service, excluding expanded benefits, covered by the Managed Care Plan for all or some enrollees (based upon criteria established by the Managed Care Plan) that exceed coverage and limitations specified under the Medicaid State Plan, including services provided in accordance with **Section V.**, Service Administration, of this Contract.

Other Provider-Preventable Condition (OPPC) — As defined in 42 CFR 447.26(b).

Participant Direction Option (PDO) — A service delivery enrollee option that enables LTC enrollees to exercise decision-making authority and control over allowable services and how those services are delivered, including the ability to hire and fire service providers. An enrollee choosing participant direction accepts responsibility for taking a direct role in managing his/her care.

Participant Direction Option Services (PDO Services) — Adult companion care, attendant care, homemaker services, intermittent and skilled nursing, and personal care services.

Participating Provider — A health care practitioner or entity authorized to do business in Florida and contracted with the Managed Care Plan to provide services to the Managed Care Plan's enrollees.

Peer Review — An evaluation of the professional practices of a provider by his or her peers. The evaluator assesses the necessity, appropriateness and quality of care furnished by comparing the care to that customarily furnished by the provider's peers and to recognized health care standards.

Penultimate Saturday — The Saturday preceding the last Saturday of the month.

Person-Centered Planning — A nondirective approach to care planning that encourages the maximum participation of an enrollee and the enrollee's family in the decision-making process.

Pharmacy Benefits Administrator — An entity contracted with a Managed Care Plan to accept pharmacy prescription claims for enrollees in the Managed Care Plan; assure these claims conform to coverage policy; and determine the allowed payment.

Pharmacy Benefits Manager — A person or entity doing business in this State which contracts to administer or manage prescription drug benefits on behalf of a Managed Care Plan.

Physician Services — As described in Rule Chapter 59G, F.A.C.

Physicians' Current Procedural Terminology (CPT®) — A systematic listing and coding of procedures and services published annually by the American Medical Association.

Plan — See Managed Care Plan.

Plan Appeal — A formal request from an enrollee to seek a review of an adverse benefit determination made by the Managed Care Plan pursuant to 42 CFR 438.400(b).

Plan Factor — A budget-neutral calculation using a Managed Care Plan's available historical enrollee diagnosis data grouped by a health-based risk assessment model. A Managed Care Plan's plan factor is developed from the aggregated individual risk scores of the Managed Care Plan's prior month's enrollment. The plan factor modifies a Managed Care Plan's monthly capitation payment to reflect the health status of its enrollees.

Post-Stabilization Care Services — Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain, improve, or resolve the enrollee's condition pursuant to 42 CFR 422.113.

Potential Enrollee — Pursuant to 42 CFR 438.2, an eligible Medicaid recipient who is subject to mandatory assignment or who may voluntarily elect to enroll in a given Managed Care Plan but is not yet an enrollee of a specific Managed Care Plan.

Potentially Preventable Emergency Room Visit (PPV) — Emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination.

Potentially Preventable Event (PPE) — Events, including potentially preventable hospital admissions, potentially preventable readmissions, potentially preventable emergency room visits, and potentially preventable ancillary services that are unlikely to provide useful diagnostic or clinical information, that could have been prevented with better access to primary care, improved medication management, or better coordination of care.

Potentially Preventable Hospital Admissions (PPAs) — Hospital admissions that may have resulted from a lack of adequate access to care or ambulatory care coordination. PPAs are ambulatory sensitive conditions.

Potentially Preventable Readmission — A return hospitalization within thirty (30) days of the initial discharge that is clinically-related to the initial hospital admission and may have resulted from lack of follow up after discharge.

Preadmission Screening and Resident Review (PASRR) — As defined by 42 CFR Part 483 and in accordance with Rule 59G-1.040, F.A.C.

Preauthorization — See Prior Authorization.

Premium — See Capitation Rate.

Prescription Drug Coverage — As described in Rule 59G-4.250, F.A.C.

Prescription Drugs — As described in Rule 59G-4.250, F.A.C.

Primary Care Physician — A practitioner licensed to practice medicine in the state of Florida and who provides primary care services as defined in Rule 59G-1.010, F.A.C.

Primary Care Provider (PCP) — A Managed Care Plan staff or participating provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

Prior Authorization — The act of authorizing specific services before they are rendered.

Program of All-Inclusive Care for the Elderly (PACE) — A program that is operated by an approved PACE organization and that provides comprehensive services to enrollees in accordance with a PACE program agreement (ss. 1894 and 1934 of the Social Security Act and 42 CFR Part 460.)

Protected Health Information (PHI) — For purposes of this Contract, PHI shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information Created, received, maintained, or transmitted by the Managed Care Plan from, or on behalf of, the Agency.

Protocols — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

Provider — A person or entity eligible for a Medicaid provider agreement.

Provider Agreement — A contract between the Managed Care Plan and a health care provider to serve Managed Care Plan enrollees.

Provider Claim Complaint Resolution — A claim complaint that is considered resolved after a claim is reviewed and either processed, or reprocessed accurately, and thereafter, the correct payment is issued, funds are recouped, or a determination is made to uphold a previous decision.

Provider-Preventable Condition (PPC) — A condition that meets the definition of a health care-acquired condition (HCAC) or other provider-preventable condition as defined in 42 CFR 447.26(b). PPCs include HCACs and other provider-preventable conditions (OPPCs) in inpatient hospital and inpatient psychiatric hospital settings, including CSUs.

Provider Service Network — An entity that meets the requirements as described in Section 409.962(14) or 409.962(9), F.S., and meets ongoing qualifications of plan eligibility as specified in Exhibit A-2-a of the ITN.

Public Event — An event planned to benefit, educate, and/or assist the community with information concerning health-related matters or public awareness. The Managed Care Plan cannot market at Public Events.

Public Event Materials — Materials used by the Managed Care Plan to educate or assist the community by providing information concerning health-related topics or topics which require public awareness.

Publication Ready — The final edition of a marketing material ready for dissemination which includes all written content and graphics. Materials which include placeholders are not considered publication ready.

Quality Assurance Monitoring Score — The average quality monitoring score resulting from monitoring of all call center agents.

Quality Improvement (QI) — The process of monitoring that the delivery of health care services is available, accessible, timely, and medically necessary.

Quantitative Limits — As defined in 42 CFR 438.900, limitations that are expressed numerically.

Readily Accessible — As defined in 42 CFR 438.10(a) in the context of information requirements.

Region — The designated geographical area within which the Managed Care Plan is authorized by this Contract to furnish covered services to enrollees. The Managed Care Plan must serve all counties in the region(s) for which it is contracted. The 67 Florida counties are divided into 11 regions pursuant to Section 409.966(2), F.S.

Rehabilitation Services and Devices — As defined in 42 CFR 440.130(d).

Remediation — The act or process of correcting a fault or deficiency.

Remote Patient Monitoring — Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support.

Residential Commitment Facilities — As applied to the Department of Juvenile Justice, refers to the out-of-home placement of adjudicated youth who are assessed and deemed by the court to be a low or moderate risk to their own safety and to the safety of the public; for use in a level 4, 6, 8, or 10 facility as a result of a delinquency disposition order. Also referred to as a residential commitment program.

Reward — Related to an MMA Healthy Behaviors Program, if used in the program, something that may be offered to an enrollee after successful completion of a milestone (meaningful step towards meeting the goal) or goal attainment. A reward should be linked to positive behavior change. For example, a reward may be offered after successful completion of a series of educational classes focused on a target behavior.

Risk Adjustment (also Risk-Adjusted) — In a managed health care setting, risk adjustment of capitation payments is the process used to distribute capitation payments across Managed Care Plans based on the relative risk factor of the members enrolled in each Managed Care Plan.

Risk Assessment — The process of collecting information from a person about hereditary, lifestyle and environmental factors to determine specific diseases or conditions for which the person is at risk.

Rural — An area with a population density of less than one hundred (100) individuals per square mile, or an area defined by the most recent United States Census as rural, i.e., lacking a metropolitan statistical area (MSA).

Sanctions — In relation to **Section XII.**, Sanctions and Corrective Action Plans: Any monetary or non-monetary penalty imposed upon a provider, entity, or person (e.g., a provider entity, or person being suspended from the Medicaid program).

Scripts — Scripts are standardized text intended to draw a potential enrollee’s attention to a plan or to influence a potential enrollee or enrollee’s decision-making process when selecting a plan for enrollment or deciding to remain enrolled in a plan. Scripts that respond to enrollee or potential enrollees’ questions or requests and provide Plan-specific, enrollment or benefit information also must be submitted to Agency prior to use. Broadcast scripts (T.V., radio, social media), marketing scripts (presentations), and telephonic scripts will be subject to review by the Agency.

Securities — United States Treasury Securities which are backed by the full faith and credit of the United States government. For purposes of this Contract, the term shall be limited to those securities approved by the Agency as specified in **Section XI.**, Financial Requirements.

Security Incident — For purposes of this Contract, security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, and includes any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity.

Serious Adverse Event (SAE) — Critical events that negatively impact the health, safety, or welfare of an enrollee receiving MMA benefits, including death by suicide, homicide, abuse/neglect, or that is otherwise unexpected; adverse incident or major illness; sexual battery; medication errors; suicide attempts; altercations requiring medical intervention; or elopement.

Serious Mental Illness (SMI) — General descriptor for one, or a combination of the following diagnostic categories: psychotic disorders, bipolar disorder, major depression, schizophrenia, delusional disorder, or obsessive-compulsive disorder.

Service Authorization — The Managed Care Plan's approval for services to be rendered.

Service Delivery Systems — Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in Section 409.973, F.S.

Service Level Agreement — The section of the Managed Care Plan's subcontract detailing the specific delegated goods and/or services to be provided along with any specific requirements or performance metrics for rendering those goods and/or services.

Sick Care — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Significant Change — As defined in Section 409.962(17), F.S.

Significant Life Change — Any event that may lead to a change in level of care or need, including, but not limited to, hospital admission, change in caregiver status, and decline in health.

Skilled Nursing Care — As described in Rules 59G-4.130 and 59G-4.261.

Social Networking — Web-based applications and services (excluding the Managed Care Plan's State-mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation, and instant messaging services.

Span of Control — Information systems and telecommunications capabilities that the Managed Care Plan itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The span of control also includes systems and telecommunications capabilities outsourced by the Managed Care Plan.

Special Health Care Needs — Enrollees who face physical, behavioral, or environmental challenges daily that place at risk their health and ability to fully function in society. This includes individuals with intellectual disabilities or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and all enrollees receiving LTC services under this Contract.

Special Supplemental Nutrition Program for Women, Infants & Children (WIC) — Program administered by the Department of Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum

and breast-feeding women, infants and children under the age of five (5) years who are determined to be at nutritional risk and who have a low to moderate income.

Specialist — As defined by Section 458.3312, F.S. For the purposes of the MMA Physician Incentive Program, a specialist is a physician other than a primary care physician or an obstetrician/gynecologist.

Specialty Product — A Specialty line of business offered by a Comprehensive LTC Plus Plan or a Managed Medical Assistance Plus Plan and offered to Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

Sponsorship Only Events — Events where the Managed Care Plan serves as a financial sponsor, provides nominal gift items for distribution through event organizer or permits the use of Plan name and logo on event materials provided by event organizer, but there is no Plan representative present distributing Plan materials or nominal gifts. Sponsorship only events do not require Agency approval and are not reported on the Marketing, Public, Educational Events Report.

State — State of Florida.

Statutory Accounting Principles — A set of accounting regulations as defined by the 2002 National Association of Insurance Commissioners Accounting Practices and Procedures Manual and as specified in s. 641.19, F.S.

Store-and-Forward — The asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site.

Subcontract — An agreement entered into for provision of services on behalf of the Managed Care Plan as related to this Contract.

Subcontractor — Any entity contracting with the Managed Care Plan to perform services or to fulfill any of the requirements requested in this Contract or any entity that is a subsidiary of the Managed Care Plan that performs services or fulfills the requirements requested in this Contract.

Surface Mail — Mail delivery via land, sea, or air, rather than via electronic transmission.

Surplus — Net worth (i.e., total assets minus total liabilities).
System Unavailability — As measured within the Managed Care Plan's information systems' span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.

Systems — See Information Systems.

Tags/Tagging — Placing personal identification information within a picture or video.

Telemedicine — As defined in Rule 59G-1.057, F.A.C.

Temporary Assistance to Needy Families (TANF) — As described in 45 CFR 260.20.

Temporary Loss Period — Period in which an enrollee loses eligibility and regains it, allowing the recipient to be re-enrolled in the Managed Care Plan in which the recipient was enrolled prior to the eligibility loss.

Temporary Management — State-imposed oversight of the operation of the Managed Care Plan, upon a finding by the State that there is continued egregious behavior by the Managed Care Plan or a substantial risk to the health of the Managed Care Plan's enrollees, or to assure the health of the Managed Care Plan's enrollees, in accordance with Section 1932(e)(2)(B) of the Social Security Act.

Testimonial — A written or spoken statement testifying to the quality or the merit of a product or service.

Timely Files — When an enrollee files for continuation of benefits on or before the later of the following:

a. Within ten (10) days of the Managed Care Plan sending the notice of adverse benefit determination; or

b. The intended effective date of the Managed Care Plan's proposed adverse benefit determination.

Unborn Activation — The process by which an unborn child, who has been assigned a Medicaid ID number, is made Medicaid eligible upon birth.

Unscheduled Trip — As defined in Rule 59G-4.330, F.A.C.

Urban — An area with a population density of greater than one hundred (100) individuals per square mile or an area defined by the most recent United States Census as urban, i.e., as having a metropolitan statistical area (MSA).

Urgent Care — Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or substantially restrict an enrollee's activity (e.g., infectious illnesses, influenza, respiratory ailments).

Urgent Medical — Any sudden or unforeseen situation that requires immediate action to prevent hospitalization or nursing facility placement.

Username — An identifying pseudonym associated with the author to messages or content generated.

Validation — The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Value-Added — As described in 42 CFR 438.3(e)(i).

Value-Based Purchasing (VBP) — A reimbursement strategy that links provider payments to improved performance by health care providers. VBP arrangements include contractual agreements between payers and health care providers that hold the health care providers accountable for both the quality and cost of care that they provide.

Vendor — An entity submitting a proposal to become a Managed Care Plan.

Violation — A determination by the Agency that a Managed Care Plan failed to act as specified in this Contract or applicable statutes, rules or regulations governing the Managed Care Plan. For the purposes of this Contract, each day that an ongoing violation continues shall be considered to be a separate violation. In addition, each instance of failing to furnish necessary and/or required medical services or items to each enrollee shall be considered to be a separate violation. As well, each day that the Managed Care Plan fails to furnish necessary and/or required medical services or items to enrollees shall be considered to be a separate violation.

Voluntary Enrollee — A Medicaid recipient who is not mandated to enroll in a Managed Care Plan but chooses to do so.

Voluntary Potential Enrollee — A Medicaid recipient who is not mandated to enroll in a Managed Care Plan, has expressed a desire to do so, but is not yet enrolled in a Managed Care Plan.

Waste — Overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.

Weekly Comprehensive Drug List — The comprehensive Medicaid covered drug list which includes active NDCs for drugs Medicaid is required to cover, including PDL and non-PDL products.

Well Care Visit — A routine medical visit for one of the following: child health checkup visit, family planning, routine follow-up to a previously treated condition or illness, adult physical or any other routine visit for other than the treatment of an illness.

Written Marketing Materials — Printed informational material targeted to enrollees and potential enrollees, which promotes the Managed Care Plan, including, but not limited to, brochures, flyers, leaflets, or other printed information about the Managed Care Plan. Written marketing material includes materials for circulation by physicians, other providers, or third parties.

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B. Acronyms

AAA — Area Agencies on Aging

ACA — Patient Protection and Affordable Care Act

ACCESS — Automated Community Connection to Economic Self-Sufficiency, the DCFs' public assistance service delivery system

ACD — Automatic Call Distribution

ACO — Accountable Care Organization

ADA — Americans with Disabilities Act of 1990

ADHC — Adult Day Health Care

ADRC — Aging and Disability Resource Center

AFCH — Adult Family Care Home

AHCA — Agency for Health Care Administration (Agency)

ALF — Assisted Living Facility

ANSI — American National Standards Institute

APD — Agency for Persons with Disabilities

ARNP — Advanced Registered Nurse Practitioner

ASA — Average Speed of Answer

ASR — Achieved Savings Rebate

BC — Business Continuity

BAA — Business Associate Agreement

CAHPS — Consumer Assessment of Healthcare Providers and Systems

CARC — Claim Adjustment Reason Code

CAP — Corrective Action Plan

CARES — Comprehensive Assessment and Review for Long-Term Care Services

CBO — Community-Based Organization

CBP — Customized Benefit Package

Section XVI. Definitions and Acronyms

CCE — Community Care for the Elderly

CCP — Cultural Competency Plan

CDC — Centers for Disease Control and Prevention

CDM — Chronic Disease Management

CEO — Chief Executive Officer

CFO — Chief Financial Officer

CFR — Code of Federal Regulations (cites may be searched online at: http://www.ecfr.gov)

CHD — County Health Department

CHRP — Community High Risk Pool

CMAT — Children's Multidisciplinary Assessment Team

CMS — Centers for Medicare & Medicaid Services

CMS Plan — Children's Medical Services Specialty Plan

COPD — Chronic Obstructive Pulmonary Disease

CPIO — Community Partnerships to Improve Outcomes

CPR — Cardiopulmonary Resuscitation

CPT® — Physicians' Current Procedural Terminology

CSU — Crisis Stabilization Unit

CTD — Commission for the Transportation Disadvantaged

DCA — District Court of Appeal

DCF — Department of Children and Families

DD — Developmental Disability or Developmental Disabilities

DEA — Drug Enforcement Administration

DFS — Department of Financial Services

DHHS — United States Department of Health & Human Services

DJJ — Department of Juvenile Justice

Section XVI. Definitions and Acronyms

DME — Durable Medical Equipment

DOEA — Department of Elder Affairs

DOH — Department of Health

DR — Disaster Recovery

DRG — Diagnostic Related Group

DSM — Direct Secure Messaging

EDI — Electronic Data Interchange

EH — Emotionally Handicapped

EIS — Early Intervention Services

ENS — Encounter Notification Service

EPLS — Excluded Parties List System

EPO — Exclusive Provider Organization

EPSDT — Early and Periodic Screening, Diagnosis and Treatment Program

EQR — External Quality Review

EQRO — External Quality Review Organization

EDT — Eastern Daylight Time

EST — Eastern Standard Time

EVV — Electronic Visit Verification

F.A.C. — Florida Administrative Code

FACT — Florida Assertive Community Treatment

FAR — Florida Administrative Register

FFS — Fee-for-Service

FIPS — Federal Information Processing Standards Publication

FMMIS — Florida Medicaid Management Information System

FMSQN — Florida Medical School Quality Network

FMV — Fair Market Value

FQHC — Federally Qualified Health Center

F.S. — Florida Statutes

FSFN — Florida Safe Families Network (formerly HomeSafeNet), also known as SACWIS, (Statewide Automated Child Welfare Information System)

FTE — Full-Time Equivalent Position

FX — Florida Health Care Connections

GAAP — Generally Accepted Accounting Principles

HCAC — Health Care-Acquired Condition

HCB — Home and Community-Based

HCBS — Home and Community-Based Services

HCPCS — Healthcare Common Procedure Coding System

HCV — Hepatitis C Virus

HEDIS — Healthcare Effectiveness Data and Information Set

HIE — Health Information Exchange

HIPAA — Health Insurance Portability and Accountability Act

HIPP — Health Insurance Premium Payment

HIT — Health Information Technology

HITECH Act — Health Information Technology for Economic and Clinical Health Act

HIV — Human Immunodeficiency Virus

HMO — Health Maintenance Organization

HSA — Hernandez Settlement Agreement

ICD — International Classification of Diseases

ICF/IID — Intermediate Care Facility for Individuals with Intellectual Disabilities

ICP — Institutional Care Program

IBNR — Incurred but Not Reported

Section XVI. Definitions and Acronyms

IFSP — Individualized Family Service Plan

IHCP — Indian Health Care Provider

IMD — Institutions for Mental Disease

ISM — Information Security Manager

IT — Information Technology

ITN — Invitation to Negotiate

LEIE — List of Excluded Individuals & Entities

LMH-ALF — Limited Mental Health Assisted Living Facility

LOC — Level of Care

LOC — Letter of Credit

LOINC — Logical Observation Identifiers Names and Codes

LTC — Long-Term Care

LTSS — Long-term Services and Supports

MBHO — Managed Behavioral Health Organization

MDT — Multidisciplinary Team

MEDS — Medicaid Encounter Data System

MFCU — Medicaid Fraud Control Unit, Office of the Attorney General

MHPAEA — Mental Health Parity and Addictions Equity Act

MLR — Medical Loss Ratio

MMA — Managed Medical Assistance

MPI — Medicaid Program Integrity Bureau, AHCA Health Quality Assurance

MPO — Medicaid Program Oversight

NAIC — National Association of Insurance Commissioners

NCCI — National Correct Coding Initiative

NCPDP — National Council for Prescription Drug Programs

NCQA — National Committee for Quality Assurance

NDC — National Drug Code

NET — Non-emergency Transportation

NIST — National Institute of Standards and Technology

NMHPA — Newborns and Mothers Health Protection Act

NPI — National Provider Identifier

ODBC — Open Database Connectivity

OIG — Office of the Inspector General

OIR — Office of Insurance Regulation

OPPC — Other Provider Preventable Condition

P&T — Pharmacy and Therapeutics

PA — Physician Assistant

PACE — Program of All-Inclusive Care for the Elderly

PASRR — Preadmission Screening and Resident Review

PBM — Pharmacy Benefits Manager

PCCB — Per Capita Capitation Benchmark

PCMH — Patient-centered Medical Home

PCP — Primary Care Provider

PCSB — Per Capita Services Benchmark

PDL — Preferred Drug List

PDO — Participant Direction Option

PERS — Personal Emergency Response Systems

PHI — Protected Health Information

PII — Personal Identifying Information

PIP — Performance Improvement Project

PM — Performance Measure

PMPM — Per Member Per Month

PNV — Provider Network Verification

PPA — Potentially Preventable Hospital Admission

PPC — Provider Preventable Condition

PPE — Potentially Preventable Event

PPEC — Prescribed Pediatric Extended Care

PPS — Prospective Payment System

PSN — Provider Service Network

QI — Quality Improvement

RARC — Remittance Advice Reason Code

RCA — Root Cause Analysis

RFP — Request for Proposal

RHC — Rural Health Clinic

SACWIS — Statewide Automated Child Welfare Information System, also known as Florida Safe Families Network (FSFN, formerly HomeSafeNet)

SAE — Serious Adverse Event

SAM — System for Award Management

SAMH — Substance Abuse & Mental Health Office of the Florida DCF

SFTP — Secure File Transfer Protocol

SIPP — Statewide Inpatient Psychiatric Program

SIU — Special Investigations Unit

SMI — Serious Mental Illness

SMMC — Statewide Medicaid Managed Care Program

SNIP — Strategic National Implementation Process

SOBRA — Sixth Omnibus Budget Reconciliation Act

SQL — Structured Query Language

SSI — Supplemental Security Income

SSN — Social Security Number

SUPPORT Act — Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act

TANF — Temporary Assistance for Needy Families

TGCS — Therapeutic Group Care Services

TLS — Transport Layer Security

TPA — Third Party Administrator

UM — Utilization Management

U.S. — United States

U.S.C. — United States Code

USDA — United States Department of Agriculture

VBP — Value-Based Purchasing

VFC — Vaccines for Children

WEDI — Workgroup for Electronic Data Interchange

WIC — Special Supplemental Nutrition Program for Women, Infants & Children

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