Section I. General Overview

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

This Exhibit includes additional provisions applicable to the Managed Care Plan offering a Specialty Product, as appropriate.

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Section II. Eligibility and Enrollment

A. General Provisions

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

B. Eligibility

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

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

3. Serious Mental Illness Specialty Population Eligibility Criteria

a. The Managed Care Plan offering a Specialty Product for enrollees with Serious Mental Illness (SMI) agrees that the population eligible to enroll in the Specialty product shall consist of only those mandatory and voluntary recipients specified in **Attachment II and its Exhibits** of this Contract, who meet all of the following criteria:

(1) Must be at least six (6) years or older.

(2) Diagnosed with a serious mental illness, as defined by the Agency, which typically includes one of the following diagnostic categories: psychotic disorders, bipolar disorder, major depression, schizophrenia, delusional disorder, or obsessive-compulsive disorder.

b. The Agency reserves the right to adjust the eligibility requirements and criteria used to identify recipients eligible to enroll in the SMI Specialty product.

4. HIV/AIDS Specialty Population Eligibility Criteria

a. The Managed Care Plan offering a Specialty Product for enrollees with HIV/AIDS agrees that the population eligible to enroll in Specialty product shall consist of only those mandatory and voluntary recipients specified in **Attachment II and its Exhibits** of this Contract, who meet the following criteria:

(1) Must be diagnosed with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS).

b. The Agency reserves the right to adjust the eligibility requirements and criteria used to identify recipients eligible to enroll in the HIV/AIDS Specialty product.

5. Child Welfare Specialty Population Eligibility Criteria

a. The Managed Care Plan offering a Specialty Product for enrollees served by the Child Welfare system agrees that the population eligible to enroll in the Specialty product shall consist of only those mandatory and voluntary recipients specified in **Attachment II and its Exhibits**, and who meet all of the following criteria:

(1) Is under the age of twenty-one (21) years.

(2) Has a child welfare case or post adoption case open for services as identified in the FSFN database.

(3) Has an FSFN eligibility indicator in FMMIS.

b. The Agency reserves the right to adjust the eligibility requirements and criteria used to identify recipients eligible to enroll in the Child Welfare Specialty product. The Agency may, at its sole discretion, expand the eligibility criteria to include young adults who choose to remain in extended foster care up to the age of twenty-six (26) years.

C. Enrollment

1. Notification of Enrollee Pregnancy

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

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

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

3. Specialty Population-Specific Verification of Eligibility

a. HIV/AIDS and SMI Eligibility Verification

(1) The Agency shall identify the Specialty population eligible for enrollment in the MMA Plus Plan or Comprehensive LTC Plus Plan's Specialty product through an Agency-approved algorithm.

The Agency may revise the algorithm as needed to update the process of identifying recipients with HIV/AIDS or SMI. The Managed Care Plan offering a Specialty Product agrees to collaborate with the Agency in such reviews and provide consultation to the Agency regarding revisions to data elements upon request.

b. Child Welfare Eligibility Verification

The Agency shall identify the Specialty population eligible for enrollment in the Managed Care Plan's Specialty Product based on daily eligibility criteria from FSFN.

4. Specialty Population-Specific Verification of Enrollment

a. The Managed Care Plan shall have policies and procedures for its Specialty Product, subject to Agency approval, to verify the Specialty population eligibility criteria of each enrolled recipient. The Managed Care Plan offering a Specialty Product shall submit policies and procedures for its Specialty product regarding screening for Specialty population eligibility prior to implementation of such policies and procedures.

b. Policies and procedures regarding screening for Specialty population eligibility must include:

(1) Timeframes for verification of Specialty population eligibility criteria.

(2) Mechanisms for reporting the results of Specialty population eligibility screening to the Agency.

(3) Mechanisms for submitting disenrollment requests for enrollees that do not meet Specialty population eligibility criteria.

(4) Such other verifications, protocols, or mechanisms as may be required by the Agency to ensure enrolled recipients meet defined Specialty population eligibility criteria.

c. The Managed Care Plan may develop and implement for its Specialty Product, subject to Agency approval, policies and procedures to identify recipients meeting the Specialty product eligibility criteria and who have not been identified by Agency. The Agency may enroll such recipients upon receipt of verification pursuant to the screening requirements specified above.

D. Disenrollment

The Managed Care Plan shall submit involuntary disenrollment requests for enrollees of its Specialty Product to the Agency or its designee, in a format and timeframe prescribed by the Agency, for each enrollee that does not meet the Specialty product eligibility criteria, pursuant to the Specialty population screening requirements specified above in **Section C.**, Enrollment.

E. Medicaid Redetermination Assistance

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

2. The Managed Care Plan shall identify enrollees under the age of eighteen (18) years who do not have a disability determination and receive private duty nursing, Prescribed Pediatric Extended Care (PPEC) services, or medical foster care services. For an enrollee identified as not having a disability determination, the Managed Care Plan shall instruct each enrollee's parent or legal guardian to apply for a disability determination for the enrollee from the Social Security Administration (SSA) or DCF prior to the enrollee's nineteenth (19th) birthday.

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Section III. Marketing

The Managed Care Plan offering a Specialty Product shall develop and implement, subject to Agency approval, policies and procedures that ensure the confidentiality of recipients diagnosed with a Specialty condition in the conduct of any marketing activities pursuant to **Attachment II and its Exhibits**.

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Section IV. Enrollee Services

A. General Provisions

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

B. Enrollee Material

1. Provider Directory

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

2. Online Enrollee Materials

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

b. The Managed Care Plan shall make the Wholesale Prescription Drug Importation List publicly available on the Managed Care Plan's website without requiring enrollee or provider login.

c. The Managed Care Plan shall display on its website for covered outpatient drugs information explaining that imported prescribed drug products included on the Canadian Prescription Drug Importation Program's Wholesale Prescription Drug Importation List shall be prioritized over products on the Agency's Medicaid PDL for enrollees for which Medicaid is the primary payor.

3. Provisions Specific to the Plus Plan

The Managed Care Plan offering a Specialty Product for enrollees with a Child Welfare special condition identified on the Agency's enrollment file shall develop and implement, subject to Agency approval, policies and procedures that ensure the confidentiality of enrollees eligible for Specialty product enrollment in the distribution of all enrollee materials pursuant to **Attachment II and its Exhibits**.

C. Enrollee Services

1. Reinstatement Notice

a. In addition to requirements in **Attachment II**, **Section IV.**, Enrollee Services, **Sub-Section B.**, Enrollee Material, **Item 6.**, Reinstatement Notice, the Managed Care Plan shall include in its reinstatement notice:

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

2. Enrollee ID Card Requirements

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

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

3. Toll-Free Enrollee Help Line

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

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Section V. Services Administration

A. Required MMA Benefits

1. Specific MMA Services to be Provided

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

TABLE 1
FLORIDA MEDICAID POLICIES AND RULE REFERENCES FOR MMA SERVICES

Rule No.	Policy Name
59G-4.013	Allergy Services Coverage Policy
59G-4.015	Ambulance Transportation Services Coverage Policy
59G-4.020	Ambulatory Surgical Center Services Coverage Policy
59G-4.022	Anesthesia Services Coverage Policy
59G-4.025	Assistive Care Services Coverage Policy
59G-4.125	Behavior Analysis Services Coverage Policy
59G-4.028	Behavioral Health Assessment Services Coverage Policy
59G-4.031	Behavioral Health Community Support Services Coverage Policy
59G-4.370	Behavioral Health Intervention Services Coverage Policy
59G-4.029	Behavioral Health Medicaid Management Services Coverage Policy
59G-4.027	Behavioral Health Overlay Services Coverage and Limitations Handbook
59G-4.052	Behavioral Health Therapy Services Coverage Policy
59G-4.033	Cardiovascular Services Coverage Policy
59G-8.700	Child Health Services Targeted Case Management
59G-4.040	Chiropractic Services Coverage Policy
59G-4.055	County Health Department Services
59G-4.252	Diabetic Supply Services
59G-4.105	Dialysis Services Coverage Policy
59G-4.070	Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook
59G-4.072	Durable Medical Equipment and Medical Supply Services: Specialized
59G-4.073	Durable Medical Equipment and Medical Supply Services: Orthotic and Prosthetic
59G-4.074	Durable Medical Equipment and Medical Supply Services: Respiratory
59G-4.075	Durable Medical Equipment and Medical Supply Services: Wheelchairs, Hospital Beds, and Ambulatory Aids
59G-4.076	Durable Medical Equipment and Medical Supply Services: Continence, Ostomy, and Wound Care
59G-4.077	Durable Medical Equipment and Medical Supply Services: Enteral and Parenteral Nutrition

59G-4.085	Early Intervention Services Coverage Policy
59G-4.015	Emergency Transportation Services Coverage Policy
59G-4.087	Evaluation and Management Services Coverage Policy
59G-4.100	Federally Qualified Health Center Services
59G-4.026	Gastrointestinal Services Coverage Policy
59G-4.108	Genitourinary Services Coverage Policy
59G-4.110	Hearing Services Coverage Policy
59G-4.130	Home Health Services Coverage Policy
59G-4.140	Hospice Services Coverage Policy
59G-4.150	Inpatient Hospital Services Coverage Policy
59G-4.032	Integumentary Services Coverage Policy
59G-4.190	Laboratory Services Coverage Policy
59G-1.045	Medicaid Forms
59G-4.197	Medical Foster Care Services
59G-4.199	Mental Health Targeted Case Management Handbook
59G-4.201	Neurology Services Coverage Policy
59G-4.330	Non-Emergency Transportation Services Coverage Policy
59G-4.200	Nursing Facility Services Coverage Policy
59G-4.318	Occupational Therapy Services Coverage Policy
59G-4.207	Oral and Maxillofacial Surgery Services Coverage Policy
59G-4.211	Orthopedic Services Coverage Policy
59G-4.160	Outpatient Hospital Services Coverage Policy
59G-4.222	Pain Management Services Coverage Policy
59G-4.215	Personal Care Services Coverage Policy
59G-4.320	Physical Therapy Services Coverage Policy
59G-4.220	Podiatry Services Coverage Policy
59G-4.250	Prescribed Drug Services Coverage Policy
59G-4.261	Private Duty Nursing Services Coverage Policy
59G-4.002	Provider Reimbursement Schedules and Billing Codes
59G-4.240	Radiology and Nuclear Medicine Services Coverage Policy
59G-4.264	Regional Perinatal Intensive Care Center Services
59G-4.030	Reproductive Services Coverage Policy
59G-4.235	Respiratory System Services Coverage Policy
59G-4.322	Respiratory Therapy Services Coverage Policy
59G-4.280	Rural Health Clinic Services
59G-4.295	Specialized Therapeutic Services Coverage and Limitations Handbook
59G-4.324	Speech-Language Pathology Services Coverage Policy
59G-4.120	Statewide Inpatient Psychiatric Program Coverage Policy
59G-4.295	Therapeutic Group Care Services Coverage Policy
59G-4.360	Transplant Services Coverage Policy
59G-4.340	Visual Aid Services Coverage Policy
59G-4.210	Visual Care Services Coverage Policy

(1) Ambulatory Surgical Center Services

The Managed Care Plan shall not be responsible for dental services provided in an Ambulatory Surgical Center unless otherwise specified in this Contract.

(2) Behavior Analysis Services

The Managed Care Plan shall be responsible for the coverage of behavior analysis services to its enrollees.

(3) Child Health Services Targeted Case Management Services

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

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

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

(4) Clinic Services

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

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

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

- Optometric services.
- Podiatric services.

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

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

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

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

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

- Diagnostic and treatment radiology services.

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

- Emergency services.
- Services rendered away from the FQHC clinic or satellite clinic.
- Immunization services.
- Home health services.
- Prescription drug services.
- WIC certifications and recertifications.

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

(i) Adult health screening services.

(ii) Well-child visits.

(iii) Family planning services.

(iv) Immunization services.

(v) Medical primary care services.

(vi) Registered nurse services.

(5) Community Behavioral Health Services

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

(b) In addition to the above provisions, see **Attachment II**, **Section I.**, General Overview, **Sub-Section G.**, Prioritizing Mental Wellness for Florida's Youth, **Item 3.**, regarding evidence-based practices for children with intense behaviors.

(c) The Managed Care Plan shall ensure the provision of behavioral health services to enrollees on the iBudget Waiver or Waitlist who are dually diagnosed with a developmental disability and a mental health diagnosis.

(6) Early Intervention Services

(a) The Managed Care Plan shall promote increased use of prevention and early intervention services (EIS) for at-risk enrollees, birth through thirty-six (36) months of age. The Managed Care Plan shall provide covered EIS services specified in accordance with the following Medicaid rules and contractual requirements, utilizing only the procedure codes and modifiers listed in the associated fee schedules in the Early Intervention Services Table, **Table 2**, below:

TABLE 2 **EARLY INTERVENTION SERVICES TABLE**		
Service	Coverage Policy	Procedure Code and Modifier
Evaluation and screenings	59G-4.085 Early Intervention Services Coverage Policy	Per Early Intervention Services Fee Schedule
Assistive technology services and devices	59G-4.070 Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook	Per the Durable Medical Equipment and Medical Supply Services Provider Fee Schedule for All Medicaid Recipients. Procedure codes must include the TL modifier.
Audiology services	59G-4.110 Hearing Services	Per the Hearing Services Fee Schedule. Procedure codes must include the TL modifier.
Nursing services	59G-4.130 Home Health Services Coverage Policy	Per the Home Health Visit Services Fee Schedule. Procedure codes must include the TL modifier.
Medical services (e.g., physician services)	59G-4.087 Evaluation and Management Services Coverage Policy	Per the Practitioner Fee Schedule. Procedure codes must include the TL modifier.
Occupational therapy services	59G-4.318 Occupational Therapy Services Coverage Policy	Per the Occupational Therapy Services Fee Schedule.

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

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

(c) The Managed Care Plan shall reimburse each qualified provider, as identified in **Section VII.**, Provider Network and Services, **Sub-Section A.**, Network Adequacy Standards, **Item 5.**, Specialists and Other Providers, **Sub-Item b.**, of this Exhibit, conducting the early intervention services evaluation.

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

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

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

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

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

(7) Emergency Services

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

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

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

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

(e) The Managed Care Plan shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as the Managed Care Plan can safely transport the enrollee to a participating facility. The Managed Care Plan may transfer the enrollee, in accordance with State and federal law, to a participating hospital that has the service capability to treat the enrollee's emergency medical condition. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) and 42 CFR 457.1228 as responsible for coverage and payment.

(f) In accordance with 42 CFR 438.114, 42 CFR 457.1228 and s. 1932(b)(2)(A)(ii) of the Social Security Act, the Managed Care Plan shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service through a participating or non-participating provider. Those post- stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non- emergency services. The Managed Care Plan can choose not to cover non-emergency services if they are provided by a non-participating provider, except in any circumstances detailed below.

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

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

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

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

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

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

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

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

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

(8) Family Planning Services and Supplies

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

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

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

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

(e) The Managed Care Plan shall implement an outreach program and other strategies for identifying every pregnant enrollee. This includes but is not limited to care coordination/case management, claims analysis, and use of health risk assessment. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant.

(9) Hearing Services

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

(10) Hospital Services

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

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

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

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

(ii) Penalizing or otherwise reducing or limiting the reimbursement of an

attending physician because the physician provided care in a manner consistent with NMHPA.

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

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

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

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

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

(h) The Managed Care Plan shall be responsible for the reimbursement of care for enrollees who have been diagnosed with Tuberculosis disease, or show symptoms of having Tuberculosis and have been designated a threat to the public health by the Florida DOH Tuberculosis Program and shall observe all of the following:

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

(ii) For enrollees determined to be a threat to public health and receiving Tuberculosis treatment at a DOH contracted hospital, the Managed Care Plan shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and DOH, and

shall also pay any wrap-around costs not included in the per-diem rate.

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

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

(j) The Managed Care Plan shall not:

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

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

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

(l) The Managed Care Plan shall not be responsible for dental services provided in an outpatient hospital setting unless otherwise specified in this Contract.

(11) Immunizations

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

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

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

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

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

(12) Laboratory and Imaging Services

Newborn screening services in accordance with s. 383.14, F.S., which outlines

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

(13) Medical Foster Care Services

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

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

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

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

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

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

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

(15) Nursing Facility Services

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

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

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

i. The enrollee needs long-term nursing facility services and is not

receiving nursing facility services in lieu of inpatient hospital services nor admitted for rehabilitation services.

ii. The enrollee has completed all PASRR requirements.

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

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

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

(16) Oral and Maxillofacial Surgery Services

The Managed Care Plan shall be responsible for the coverage of services to its enrollees for treatment of cleft lip, cleft palate, or other craniofacial deformities.

(17) Physician Services

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

(18) Prescribed Drug Services

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

(b) The Managed Care Plan shall comply with all applicable provisions of the "*Prescription Drug Reform Act*", enacted by the Legislature of the State of Florida, and codified into law in Chapter No. 2023-20 and Chapter 2023-30, Laws of Florida.

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

(d) The Managed Care Plan shall provide coverage of imported prescribed drug products authorized through the Canadian Prescription Drug Importation Program.

(e) The Managed Care Plan shall provide those products and services associated with the dispensing of medicinal drugs pursuant to a valid

prescription, as defined in Chapter 465, F.S., Prescribed drug services shall include all prescription drugs listed in the Agency's Medicaid PDL.

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

(g) The Managed Care Plan may only make available drugs which are not listed on the Agency's Medicaid PDL after trial and failure of the Agency's Medicaid PDL products within the same therapeutic category. Managed Care Plans may not cover generics of brand products listed on the Agency's Medicaid PDL.

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

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

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

(i) The Managed Care Plan may have a pharmacy lock-in program that complies with the Agency-established Pharmacy Lock-in Policy and Guidelines. The lock-in period shall not exceed twelve (12) consecutive months. The Managed Care Plan shall submit its lock-in program procedures in writing for approval by the Agency in advance of implementation.

(j) The Managed Care Plan shall notify providers who may prescribe or are currently prescribing a drug that is being deleted from the Agency's Medicaid

PDL within thirty (30) days of the Managed Care Plan being notified of the change by the Agency. Implementation of PDL changes must be completed within forty-five (45) days of being notified of the change by the Agency.

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

(l) The Managed Care Plan shall implement formulary management tool (FMT) changes from the weekly comprehensive drug list update within fourteen (14) days of a file being provided to the Managed Care Plan by the Agency. Pharmacy prior authorization automation system changes must be implemented within forty-five (45) days of being notified by the Agency. Managed Care Plans must coordinate implementation with all network pharmacies to comply with the weekly comprehensive drug list updates.

(19) Therapeutic Group Care Services

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

(20) Therapy Services

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

(21) Transplant Services

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

TABLE 3
TRANSPLANT SUMMARY OF RESPONSIBILITY

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

(22) Transportation Services

(a) The Managed Care Plan shall provide NET and emergency transportation services to eligible enrollees twenty-four (24) hours per day, seven (7) days

per week for its enrollees who have no other means of transportation available to any covered service and transportation to services not covered by the Managed Care Plan specified in **Section V.**, Services Administration, **Sub-Section C.**, Excluded Services, including prepaid dental services, prescribed drugs, and expanded benefits.

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

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

(ii) Establishing a minimum twenty-four (24) hour advance notification policy to obtain transportation services, and communicating that policy to its enrollees and transportation providers. However, advance notification policies shall comport with the timely access to medical care requirements as specified in **Section VII.**, Provider Network and Services, **Sub-Section A.**, Network Adequacy Standards, of this Exhibit.

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

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

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

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

Such services shall not be counted as inpatient hospital days.

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

(3) Detoxification or addictions receiving facilities licensed under s. 397, F.S., in lieu of inpatient detoxification hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If detoxification or addictions receiving facility beds are at

capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Managed Care Plan shall demonstrate adequate capacity for inpatient detoxification hospital care in anticipation of such transfers. Such services shall be subject to the requirements of 42 CFR 438.6(e).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) Psychotropic injection services provided by licensed nurses to adults in lieu of physician administration.

(15) Prescription digital therapeutic when paired with outpatient visit in lieu of inpatient

hospitalization.

(16) Housing Assistance and Targeted Case Management for people with homelessness or at risk for homelessness and diagnosis of SMI and/or SUD in lieu of emergency department visit or inpatient hospitalization for SMI and/or SUD.

(17) Functional family therapy in home or community for children or adolescents with a history of justice involvement or at high risk for justice involvement in lieu of emergency department visits, or inpatient hospitalization.

3. Behavioral Health and Supportive Housing Assistance Pilot

a. The Agency shall implement a voluntary pilot program to provide additional behavioral health services and supportive housing assistance services appropriate for Medicaid enrollees ages twenty-one (21) years and older with serious mental illness (SMI), substance use disorder (SUD), or SMI with co-occurring SUD, who are homeless or at risk of homelessness.

b. The Agency shall be responsible for selecting eligible Managed Care Plans to provide behavioral health and supportive housing assistance services in the federally approved regions.

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

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

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

4. Customized Benefits

a. As permitted by Section 409.973(2), F.S., the Managed Care Plan may customize expanded benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services.

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

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

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

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

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

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

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

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

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

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

f. The Managed Care Plan shall submit the Customized Benefit Notifications Report to the Agency in accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

B. Expanded Benefits

The Managed Care Plan offering a Specialty Product shall offer any Specialty-specific expanded benefits to eligible enrollees in the applicable managed care program, subject to any Agency-approved service limitations set forth in **Attachment I** of this Contract.

C. Excluded Services

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

1. CHD Certified Match Program services.

2. Developmental Disabilities Individual Budgeting (iBudget) HCBS Waiver services.

3. Familial Dysautonomia HCBS Waiver services.

4. Hemophilia Factor-related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program services.

5. ICF/IID services.

6. School-based services provided through the Medicaid Certified School Match Program.

7. Model HCBS Waiver services.

8. Newborn Hearing services.

9. Prescribed Pediatric Extended Care services.

10. Program for All-Inclusive Care for Children services.

11. Substance Abuse County Match Program services.

12. PACE services.

13. Florida Assertive Community Treatment (FACT) services.

D. Coverage Provisions

1. Primary Care Provider Initiatives

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

b. The Managed Care Plan shall provide information to each enrollee on the importance of selecting a PCP and the procedure for selecting a PCP (Section 409.973(4), F.S.) and shall allow each enrollee to choose his or her network provider to the extent possible and appropriate (42 CFR 438.3(l)).

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

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

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

f. The Managed Care Plan shall assign a PCP to those enrollees who did not choose a PCP at the time of Managed Care Plan selection. The Managed Care Plan shall take into consideration the enrollee's last PCP (if the PCP is known and available in the

Managed Care Plan's network), closest PCP to the enrollee's ZIP code location, keeping children/adolescents within the same family together, enrollee's age (adults versus children/adolescents), and PCP performance measures.

(1) If the language and/or cultural needs of the enrollee are known to the Managed Care Plan, the Managed Care Plan shall assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee.

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

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

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

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

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

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

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

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

2. New Enrollee Procedures

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

In addition to completing the initial health risk assessment, the Managed Care Plan

shall complete a supplemental caregiver assessment, as described in Section 6.2.1 of Rule 59G-4.192, F.A.C., for enrollees enrolled in or on the waitlist for the Developmental Disabilities Individual Budgeting (iBudget) Waiver.

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

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

(1) The Managed Care Plan shall ensure that health risk assessments are completed on at least eighty percent (80%) of:

(a) Pregnant enrollees.

(b) Enrollees on the waitlist for or enrolled in the iBudget Waiver.

(c) Enrollees diagnosed with a serious mental illness.

(d) Enrollees diagnosed with HIV/AIDS.

(2) The Managed Care Plan offering a Specialty Product shall ensure health risk assessments are completed on at least ninety percent (90%) of:

(a) Enrollees diagnosed with an SMI.

(b) Enrollees diagnosed with HIV/AIDS.

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

The Managed Care Plan shall ensure that health risk assessments are completed on at least eighty percent (80%) of:

(1) Enrollees diagnosed with cancer.

(2) Enrollees diagnosed with depression.

(3) Enrollees diagnosed with diabetes.

(4) Enrollees diagnosed with asthma.

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

the Agency.

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

3. Enrollee Screening and Education

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

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

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

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

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

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

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

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

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

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

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

g. In addition to the above provisions, see **Attachment II**, **Section I.**, General Overview, **Sub-Section G.**, Prioritizing Mental Wellness for Florida's Youth, **Item 1.**, **Sub-Item d.**, regarding enrollee outreach and education on mental health services for children and adolescents.

4. Protective Custody Coverage Provisions

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

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

E. Care Coordination/Case Management

1. General Provisions

a. The Managed Care Plan shall implement case management processes for enrollees over the age of twenty-one (21) years who are receiving services in a nursing facility until the enrollee is discharged from the nursing facility or is enrolled into the SMMC LTC Program.

b. The Managed Care Plan shall implement case management processes for enrollees under the age of twenty-one (21) years who are receiving services in a skilled nursing facility, receiving private duty nursing services in their family home or other community-based setting, receiving Prescribed Pediatric Extended Care (PPEC) services, and receiving medical foster care services.

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

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

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

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

2. Case Management Program Description

a. General Provisions

(1) In addition to the provisions of **Attachment II**, **Section V.**, **Service Administration**, **Sub-Section E.**, Care Coordination/Case Management, **Sub-Item 2.**, Case Management Program Description, the Managed Care Plan shall maintain written procedures for the case management of enrollees over the age of twenty one (21) years receiving nursing services in a nursing facility and enrollees under the age of twenty-one (21) years receiving private duty nursing services, PPEC services, medical foster care services, or nursing facility services, which shall include:

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

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

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

(2) The Managed Care Plan shall maintain written procedures for the care coordination/case management of enrollees under the age of twenty-one (21) years who are enrolled in the iBudget Waiver or on the waitlist for the Waiver.

b. Care Coordination/Case Management Program Description Requirements Specific to the Managed Care Plan Offering a Specialty Product

(1) In addition to the provisions set forth in **Attachment II**, the Managed Care Plan offering a Specialty Product shall provide care coordination/case management to enrollees appropriate to the needs of persons meeting the Specialty product eligibility criteria. The Managed Care Plan offering a Specialty Product shall develop, implement, and maintain an Agency-approved care coordination/case management program specific to the Specialty population.

(2) The Managed Care Plan offering a Specialty Product for enrollees with a Specialty condition shall submit a care coordination/case management program description annually to the Agency, at a date specified by the Agency. The care coordination/case management program description shall, at a minimum, address:

(a) The organization of care coordination/case management staff, including the role of qualified and trained nursing, social work, pharmacy, and specialty health personnel in case management processes;

(b) Maximum caseload for case managers with an adequate number of qualified and trained case managers to meet the needs of enrollees;

(c) Case manager selection and assignment, including protocols to ensure new enrollees are assigned to a case manager immediately;

(d) Protocols for initial contact with enrollees to develop a person-centered care plan, as well as requirements for the frequency and type of ongoing minimum contacts with enrollees, including a time of discharge from an inpatient facility;

(e) Surrogate decision-making, including protocols if the enrollee is not capable of making his/her own decisions, but does not have a legal representative or authorized representative available;

(f) Outreach programs that make a reasonable effort to locate and/or re-engage enrollees who have not received follow-up care for ninety (90) days or more;

(g) Enrollee access to case managers, including provisions for access to back-up case managers as needed;

(h) Assessment and reassessment of the acuity level and service needs of each enrollee;

(i) Care planning for treatment of a Specialty condition that is tailored to the individual enrollee and is in agreement with evidenced-based guidelines for treatment of the Specialty population;

(j) Coordination of care through all levels of practitioner care (primary care to specialist);

(k) Monitoring compliance with scheduled appointments, laboratory results, and medication adherence;

(l) Interventions to avoid unnecessary use of emergency departments, inpatient care, and other acute care services;

(m) Patient education to assist enrollees in better management of their health issues including the principles of recovery and resiliency.

(n) Linking enrollees to community or other support services.

For enrollees in a Managed Care Plan offering a Specialty Product for enrollees with a SMI, coordination with and referrals to providers of other related services for enrollees with SMI.

(o) For enrollees in a Managed Care Plan offering a Specialty Product for enrollees with a Child Welfare specialty condition indicated on the Agency's enrollment file, protocols and other mechanisms for coordinating services with DCF, Florida Assertive Community Teams, and any other public or private organizations that provide services to the Specialty product population to ensure effective program coordination and non-duplication of services.

(p) For enrollees in a Managed Care Plan offering a Specialty Product for enrollees with HIV/AIDS, protocols and other mechanisms for accomplishing coordination of services with public or private organizations that provide services to individuals with HIV/AIDS, including but not limited to local HIV/AIDS Service Organizations and Ryan White programs, to ensure effective program coordination and non- duplication of services.

3. Initial Plan of Care/ Reviews

a. The Managed Care Plan shall convene an MDT every six (6) months for enrollees under the age of twenty-one (21) years receiving private duty nursing, PPEC services, nursing facility services, and medical foster care services to provide a comprehensive review of the services and supports that the enrollee needs, and to authorize any Medicaid reimbursable services that are prescribed for the enrollee. The Managed Care Plan shall develop a person-centered individualized service plan documenting all service needs for enrollees under the age of twenty-one (21) years receiving private duty nursing or nursing facility services. The Managed Care Plan shall convene an MDT meeting more frequently, if needed, based on any changes in the enrollee's medical condition or a significant life change.

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

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

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

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

4. Contact Requirements

a. Monthly Contact Requirements for Enrollees Under the Age of Twenty-One Years Private Duty Nursing Services, Nursing Facility Services, Prescribed Pediatric Extended Care Services, or Medical Foster Care Services

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

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

b. Monthly Contact Requirements for Enrollees of a Managed Care Plan's Specialty Product

(1) Regardless of the enrollee's Specialty condition type, the Managed Care Plan shall maintain, at a minimum, monthly telephone contact with enrollees of the Managed Care Plan's Specialty product receiving care coordination/case management, or the enrollee's authorized representative, to verify satisfaction with and receipt of services.

(2) The case manager shall discuss on the phone or in-person, at least every ninety (90) days with the enrollee and/or the enrollee's authorized representative, in order to:

(a) Review the enrollee's plan of care and, if necessary, update the enrollee's plan of care. The Managed Care Plan shall review the plan of care in a face-to-face visit more frequently than once every ninety (90) days if the enrollee experiences a significant change.

(b) Discuss the frequency, duration, and amount of authorized services, and the authorized providers for each service. If the enrollee or the authorized representative reports any issues or the case manager discovers any issues during the once every ninety (90) days meeting, the case manager shall document the actions taken to resolve the issues as quickly as possible.

5. Freedom of Choice

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

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

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

6. Pre-Admission Screening and Resident Review

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

7. Chronic Disease Management Program

See specific provisions in **Attachment II**, **Section I.**, General Overview, Sub-Section **E.**, Prioritizing Florida's Vulnerable Citizens.

8. Transition of Care

a. Transition of Care Provisions for Hospital/Institutional Discharge

(1) It is the Agency's intention that the Managed Care Plan take any and all necessary action to ensure the provision of safe and coordinated discharge planning is provided to each enrollee transitioning from a hospital or institutional setting to another level of care.

(2) In addition to the provisions of **Attachment II**, **Section V.**, Service Administration, **Sub-Section E.**, Care Coordination/Case Management, **Item 2.**, Case Management Program Description, the Managed Care Plan's transition of care procedures shall include the following minimum functions:

(a) Coordination of hospital/institutional discharge planning and post discharge care, to include:

i. Contacting hospital/institutional providers, enrollees, and guardians within forty-eight (48) hours of admission to begin coordination and discharge planning. The discharge planning shall identify enrollee needs, barriers to discharge, and solutions to barriers.

ii. Ensuring post-discharge appointments are scheduled prior to discharge and following up with enrollees within forty-eight (48) hours after the appointment time to confirm appointments were kept and assisting in rescheduling if needed; and

iii. Documenting coordination and communication efforts in enrollee records.

(b) Assisting with scheduling any follow-up appointments;

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

(d) Facilitating communication with community service providers; and

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

(3) The Managed Care Plan will provide families of children in a nursing facility preparing to transition their child home at minimum, up to fifty thousand dollars ($50,000) per lifetime for home readiness projects, such as physical adaptions to their home or vehicle in accordance with **Attachment II**, **Section V**. Service Administration, **Sub-Section B.**, Expanded Benefits.

b. Transition of Care Provisions for Behavior Analysis Services

The Managed Care Plan's transition of care procedures shall include coordination and transition of behavior analysis services from the fee-for-service delivery system to the managed care delivery system, provision of continuity of care in accordance with **Attachment II**, **Section VIII.**, Quality, **Sub-Section H.**, Continuity of Care in Enrollment, conducting regularly scheduled stakeholder meetings for families and providers of enrollees receiving behavior analysis services, and providing additional enrollee outreach and provider education consistent with **Attachment II**, **Section VII.**, Provider Network and Services, **Sub-Section D.**, Provider Services, **Item 4.**, Provider Education and Training.

c. Transition of Care Requirements Unique to the Managed Care Plan Offering a Child Welfare Specialty Product

(1) The Managed Care Plan offering a Child Welfare Specialty Product shall develop and maintain transition of care policies and procedures for enrollees who are transitioning out of the child welfare system which shall include provisions for convening a comprehensive treatment team meeting to discuss the services and supports the enrollee will need post- separation. If the services are not covered by Medicaid, the Managed Care Plan shall inform the enrollee of its Specialty product, or their authorized representative, of any community programs that may be able to meet their needs and make the necessary referrals, as needed.

(2) The Managed Care Plan offering a Child Welfare Specialty Product shall begin transition planning one (1) year prior to the expected date upon which an enrollee will age-out of the child welfare system.

(3) The Managed Care Plan offering a Child Welfare Specialty Product shall begin transition planning immediately upon notification that an enrollee has achieved permanency status.

9. Long-Term Care Program Referrals

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

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

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

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

b. The following information must be included with the referral to CARES:

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

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

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

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

10. Additional Care Coordination/Case Management Provisions Applicable to the Managed Care Plan Offering a Specialty Product

a. The Managed Care Plan offering a Specialty Product for enrollees with a Specialty condition shall maintain, at a minimum, quarterly contact (telephonic or face-to-face) with each Specialty Product enrollee, or the enrollee's authorized representative, to verify satisfaction with and receipt of services.

b. The Managed Care Plan offering a Specialty Product for enrollees with a Specialty condition shall establish a supervisor-to-case-manager ratio that is conducive to a sound support structure for case managers. Supervisors must have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers. A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of enrollee assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including the

development and implementation of continuous improvement strategies to address identified deficiencies, must be documented and made available to the Agency upon request.

c. The Managed Care Plan offering a Specialty Product shall provide all care coordination/case managers with adequate orientation and ongoing training on subjects relevant to enrollees diagnosed with a Specialty condition. The Managed Care Plan offering a Specialty Product shall develop a training plan to provide uniform training to all care coordination/case management. This training plan should include formal training classes as well as practicum observation and instruction for newly hired staff.

d. The Managed Care Plan offering a Specialty Product for enrollees with a Specialty Condition shall provide all newly hired care coordination/case management staff orientation and pre-service training covering areas applicable to responsibilities and duties performed.

e. In addition to review of areas covered in orientation, the Managed Care Plan offering a Specialty product shall also provide all care coordination/case management staff with regular ongoing in-service training on topics relevant to the Specialty condition.

f. The Managed Care Plan offering a Specialty Product enrollees with a Specialty Condition shall maintain documentation of training dates and staff attendance as well as copies of materials used for orientation, pre-service and in-service training for care coordination/case management staff.

11. Additional Care Coordination/Case Management Requirements

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

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

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

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

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

c. See **Attachment II**, **Section I.**, General Overview, **Sub-Section G.**, Prioritizing Mental Wellness for Florida's Youth, **Item 1.**, for provisions on care coordination services to enrollees under the age of eighteen (18) years who are high utilizers of CSU and inpatient psychiatric hospital services.

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

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

e. Prenatal Care

The Managed Care Plan shall:

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

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

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

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

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

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

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

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

(d) Identifying enrollees with involvement in the Child Welfare system.

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

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

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

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

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

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

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

(b) Incorporate the treatment preferences of the enrollee;

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

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

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

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

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

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

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

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

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

i. See **Attachment II**, **Section I.**, General Overview, **Sub-Section G.**, Prioritizing Mental Wellness for Florida's Youth, **Item 1.**, for provisions on coordination of care with DCF regional Children's Care Coordinators and the managing entities for enrollees under the age of eighteen (18) years who have high utilization of CSU or inpatient mental health services.

j. See **Attachment II**, **Section I.**, General Overview, **Sub-Section G.**, Prioritizing Mental Wellness for Florida's Youth, **Item 1.**, **Sub-Item a.**, for assignment of care coordinators to enrollees under the age of eighteen (18) who have high utilization of CSU or inpatient mental health services.

k. See **Attachment II**, **Section I.**, General Overview, **Sub-Section G.**, Prioritizing Mental Wellness for Florida's Youth, **Item 1.**, **Sub-Item f.**, for reporting requirements for case management activities on enrollees under the age of eighteen (18) years who have high utilization of CSU or inpatient mental health services, in accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

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

(1) Ensure development of a comprehensive discharge plan begins at the time of admission to a crisis or inpatient behavioral health program inpatient setting to ensure the enrollee's smooth transition to the next level of service or to the community and shall require that behavioral health care providers:

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

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

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

(2) Ensure that the discharge plan incorporates the enrollee's needs for continuity in existing behavioral health therapeutic relationships.

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

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

(5) Monitor and follow-up to ensure that clinically indicated behavioral health services are offered and available to enrollees within seven (7) days of discharge from an inpatient setting.

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

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

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

12. Healthy Behaviors Program

a. General Provisions

(1) Pursuant to Section 409.973(3), F.S., the Managed Care Plan shall establish and maintain programs to encourage and reward healthy behaviors.

(2) The Managed Care Plan shall receive written approval of its healthy behavior programs from the Agency before implementing the programs. The Managed Care Plan's program shall include a detailed description of the program, including the goals of the program, how targeted enrollees will be identified, the interventions the Managed Care Plan intends to use, rewards for or incentives to participate, research to support the effectiveness of the program, and evidence that the program is medically approved or directed, as applicable. Programs administered by the Managed Care Plan must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States DHHS OIG. The Managed Care Plan is encouraged to seek an advisory opinion from OIG once the specifics of its Healthy Behaviors programs are determined.

(3) The Managed Care Plan may, through its healthy behavior programs, deploy a number of interventions as part of the overall therapeutic process. Examples of interventions:

(a) Series of counseling sessions;

(b) Series of health educational classes;

(c) Gym membership;

(d) Nicotine replacement therapy patches;

(e) Meal planning services (e.g. NutriSystem®);

(f) The provision of medication therapy management support services provided by a community health worker; and

(g) Diabetes prevention programs with a status of recognized, pending recognition, or preliminary recognition on the CDC registry.

(4) The Managed Care Plan shall make all programs, including incentives and rewards available to all enrollees and shall not use incentives or rewards to direct individuals to select a particular provider.

(5) The Managed Care Plan shall inform new enrollees about the healthy behaviors program and actively engage in outreach and communication about the health benefits of its healthy behavior programs, including incentives and rewards.

(6) The Managed Care Plan shall consider partnering with other agencies such as State and local public health entities, provider organizations, local community groups, or other entities to educate enrollees about the program or to help administer it.

(7) The Managed Care Plan shall annually inform primary care providers of the availability of healthy behavior programs and incentives to support enrollee engagement.

(8) The Managed Care Plan shall not include the provision of gambling, alcohol, tobacco, or drugs (except for over-the-counter drugs) in any of its incentives or rewards and shall state on the incentive or reward that it may not be used for such purposes.

(9) The Managed Care Plan’s healthy behavior program shall include a detailed description of the rewards and incentives offered to enrollees. Incentives by themselves do not constitute an effective program. Incentives or rewards may have some health- or child development-related function (e.g., clothing, food, books, safety devices, infant care items, subscriptions to publications that include health-related subjects, or membership in clubs advocating educational advancement and healthy lifestyles.). Incentive or reward dollar values shall be in proportion to the importance of the healthy behavior being encouraged or rewarded (e.g., a tee-shirt for attending one (1) health education class, but a gift card for completion of a series of classes).

(10) Both incentives and rewards offered to enrollees shall be reasonable, simple, and provided on a timely basis. Incentives or rewards may include any of the following:

(a) Gift cards;

(b) Flexible spending accounts that may be used for health and wellness items;

(c) Vouchers for health and wellness related items; and

(d) Points or credits which are redeemable for goods or services.

(11) Incentives and rewards shall be limited to a value of twenty dollars (**$20**). The exceptions to this monetary limit are as follows:

(a) Programs that require the enrollee to complete a series of activities (e.g.; completion of a series of health education classes). In these instances, the incentive or reward shall be limited to a value of fifty dollars (**$50**).

(b) Infant car seats, strollers, and cloth baby carriers/slings that are offered as incentives to engage in a healthy behavior program or rewards for completion of an action or a series of activities may have a special exception to the dollar value, with Agency approval.

(c) Participation in multiple healthy behavior programs. In these instances, the incentive or reward shall be limited to a value of fifty dollars (**$50**) for each healthy behavior program.

(12) The Managed Care Plan shall not include in the dollar limits on incentives or rewards any money spent on the transportation of enrollees to services or childcare provided during the delivery of services; or the healthy behavior program or associated interventions.

(13) Healthy Behavior incentives/rewards are non-transferable from one Managed Care Plan to another.

b. Healthy Behaviors Program Specific Provisions

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

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

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

(c) A medically approved alcohol recovery program or substance abuse recovery program, including but not limited to opioid abuse recovery, shall be evidenced-based and recognized by medical professionals as an effective treatment method/approach. The program may include interventions such as medically assisted detoxification, medication, and behavioral therapy, followed by treatment and relapse prevention as a part of the overall therapeutic process.

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

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

(a) Initial contact with a new enrollee;

(b) Routine physical examinations;

(c) Initial prenatal contact;

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

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

c. Healthy Behaviors Outcomes

(1) The Managed Care Plan shall report on its healthy behavior programs in accordance with **Section XV.**, Accountability, and the Managed Care Plan Report Guide. This shall include submitting data related to each healthy behavior program, caseloads (new and ongoing) for each healthy behavior program, and the amount and type of rewards/incentives provided for each healthy behavior program.

(2) The Managed Care Plan shall evaluate each healthy behavior program annually in order to assess enrollee engagement (i.e., the number of enrollees participating), program completion rates, and health benefit outcomes/effectiveness and to submit the results of its annual evaluation to the Agency, in a format prescribed by the Agency, by October 1 of each Contract year.

(3) The Managed Care Plan shall publish the results of the annual evaluation on its website by October 1 of each Contract year.

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.

F. Community Partnerships to Improve Outcomes (CPIO)

See **Attachment II**, **Sections I.**, General Overview, **Sub-Section D.**, Prioritizing Florida's Families and Family Choice, for MMA provisions on Community Partnerships to Improve Outcomes.

G. Authorization of Services

1. General Provisions

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

2. Utilization Management Program Description

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

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

   If the Managed Care Plan fails to comply with the requirements of this Section, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

b. For enrollees with special health care needs identified in accordance with **Section V.**, Services Administration, **Sub-Section E.**, Care Coordination/Case Management, **Item 4.**, Contact Requirements, **Sub-Item c.**, of this Exhibit, a mechanism to allow enrollees with special health care needs to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

c. For emergency behavioral health inpatient services and care when provided according to this provision and resulting from a Baker Act admission, procedures to provide expedited authorization for continued stays.

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

e. Streamlined or waived authorization processes for prior authorization of services to promote ease of access to medically necessary services to enrollees involved in the child welfare system, as identified by the Agency. This provision is applicable to all

Managed Care Plan types for enrollees with a Child Welfare specialty condition indicated on the Agency's enrollment file.

f. A description of a prior authorization program for covered outpatient drugs (i.e., physician-administered and prescribed drug services) that complies with the following:

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

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

(3) The requirements of Section 409.912(5)(a)1., F.S., regarding responding within a twenty-four (24) hour review period to requests for drug prior authorization, and providing the enrollee with a seventy-two (72)-hour drug supply in an emergency or when the Managed Care Plan does not provide a response within twenty-four (24) hours;

g. A procedure for the authorization, in accordance with this Exhibit, **Section VII.**, Provider Network and Services, **Sub-Item A.**, Network Adequacy Standards, **Item 9.**, Timely Access Standards, for facility services and associated ancillary medical services secondary to dental care authorized by the PDHP and provided in a facility under the direction of a dentist when considered medically necessary due to the enrollee's special healthcare needs.

h. Issuing service authorizations to enrollees requesting transportation services.

3. Service Authorization System

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

4. Practice Guidelines/Evidence-based Criteria

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

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

c. The Managed Care Plan offering a Specialty Product for enrollees with a Specialty condition shall ensure its Utilization Management Program Description, service authorization systems, practice guidelines and clinical decision- making required pursuant to **Attachment II and its Exhibits** are consistent with prevailing standards of professional medical practice and with standards regarding the most recent clinical practice guidelines in treatment for the Specialty population. The Managed Care Plan offering a Specialty Product for enrollees with a Specialty condition shall develop and

implement, subject to Agency approval, policies and procedures to notify the Agency of clinical practice guidelines for treatment of the Specialty population.

5. Clinical Decision-Making

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

6. Service Authorization Standards for Decisions

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

7. Changes to Utilization Management Components

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

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Section VI. Enrollee Grievance and Appeal System

A. General Provisions

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

B. Use of Independent Review Organization

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

C. Process for Complaints

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

D. Process for Grievances

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

E. Notice of Adverse Benefit Determination

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

2. Hernandez Settlement Agreement Requirements

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

(7) An unreasonable delay in filling the prescription;

(8) A denial of the prescription;

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

(10) The expiration of a prescription.

b. The Managed Care Plan shall maintain a log of all correspondence and communications from enrollees relating to the HSA ombudsman process. The

Managed Care Plan shall submit the ombudsman log report quarterly to the Agency, as required **in Section XV.**, Accountability, and the Managed Care Plan Report Guide.

F. Standard Resolution of Plan Appeals

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

G. Extension of Plan Appeal

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

H. Expedited Resolution of Plan Appeals

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

I. Notice of Plan Appeal Resolution

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

J. Process for Medicaid Fair Hearings

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

K. Appellate Responsibilities

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

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Section VII. Provider Network and Services

A. Network Adequacy Standards

1. General Provisions

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

b. The Agency reserves the right to establish provider network standards for mental health therapists co-located with Primary Care Providers in network, Pediatricians in network, and FQHCs under agreement with the Managed Care Plan.

2. Network Capacity and Geographic Access Standards

a. Pursuant to Section 409.967(2)(c)(1) and 42 CFR 438.68(b)(1)(i)-(viii), and 42 CFR 457.1218, the Managed Care Plan must maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all plan enrollees. At a minimum, the Managed Care Plan shall contract with the providers specified in the Managed Medical Assistance Provider Network Standards Table, **Table 4**, below. The Managed Care Plan shall ensure regional provider ratios and provider-specific geographic access standards for enrollees in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the table. The regional provider ratios shall be based upon one hundred percent (100%) of the Managed Care Plan's actual monthly enrollment measured at the first of each month, by region, for all regions.

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TABLE 4
MANAGED MEDICAL ASSISTANCE
PROVIDER NETWORK STANDARDS TABLE

	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Enrollee*
Primary Care Providers	30	20	30	20	1:750 enrollees
Specialists					
Allergy	80	60	90	75	1:20,000 enrollees
Cardiology	50	35	75	60	1:3,700 enrollees
Cardiology (PEDS)	100	75	110	90	1:16,667 enrollees
Cardiovascular Surgery	100	75	110	90	1:10,000 enrollees
Chiropractic	80	60	90	75	1:10,000 enrollees
Dermatology	60	45	75	60	1:7,900 enrollees
Endocrinology	100	75	110	90	1:25,000 enrollees
Endocrinology (PEDS)	100	75	110	90	1:20,000 enrollees
Gastroenterology	60	45	75	60	1:8,333 enrollees
General Surgery	50	35	75	60	1:3,500 enrollees
Infectious Diseases	100	75	110	90	1:6,250 enrollees
Internal Medicine Specialist	30	20	30	20	1:3,000 enrollees
Midwife	80	60	90	75	1:20,000 enrollees
Nephrology	80	60	90	75	1:11,100 enrollees
Nephrology (PEDS)	100	75	110	90	1:39,600 enrollees
Neurology	60	45	75	60	1:8,300 enrollees
Neurology (PEDS)	100	75	110	90	1:22,800 enrollees
Neurosurgery	100	75	110	90	1:10,000 enrollees
Obstetrics/ Gynecology	50	35	75	60	1:1,500 enrollees
Oncology	80	60	90	75	1:5,200 enrollees
Ophthalmology	50	35	75	60	1:4,100 enrollees
Optometry	50	35	75	60	1:1,700 enrollees
Orthopedic Surgery	50	35	75	60	1:5,000 enrollees
Otolaryngology	80	60	90	75	1:3,500 enrollees

TABLE 4 MANAGED MEDICAL ASSISTANCE PROVIDER NETWORK STANDARDS TABLE					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Enrollee*
Pediatrics (including Adolescent Medicine)	50	35	75	60	1:1,500 enrollees
Pharmacy	15	10	15	10	1:2,500 enrollees
24-hour Pharmacy	60	45	60	45	n/a
Podiatry	60	45	75	60	1:5,200
Pulmonology	60	45	75	60	1:7,600 enrollees
Rheumatology	100	75	110	90	1:14,400 enrollees
Therapist (Occupational)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Occupational)	30	20	60	45	1:1,500 enrollees
Therapist (Speech)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Speech)	30	20	60	45	1:1,500 enrollees
Therapist (Physical)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Physical)	30	20	60	45	1:1,500 enrollees
Therapist (Respiratory)	100	75	110	90	1:8,600 enrollees
Therapist, Pediatric (Respiratory)	60	45	75	60	1:1,500 enrollees
Urology	60	45	75	60	1:10,000 enrollees
Facility/ Group/ Organization					
Hospitals (acute care)	30	20	30	20	1 bed: 275 enrollees
Hospital or Facility with Birth/Delivery Services (including Birthing Center)	30	20	30	20	1 bed: 275 enrollees
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	n/a	n/a	n/a	n/a	2: County

TABLE 4 MANAGED MEDICAL ASSISTANCE PROVIDER NETWORK STANDARDS TABLE					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Enrollee*
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed:3,000 enrollees
Statewide Inpatient Psychiatric Program Providers (Inpatient Psychiatric Under 21 State Plan Benefit)	n/a	n/a	n/a	n/a	1 bed: 3,000 enrollees
Medication and Methadone Treatment Programs	30	20	60	45	n/a

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TABLE 4
MANAGED MEDICAL ASSISTANCE PROVIDER NETWORK STANDARDS TABLE

	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Behavioral Health					
Licensed Practitioners of the Healing Arts (LPHA)	30	20	30	20	1:1,000
Board Certified or Board Eligible Child Psychiatrists	30	20	60	45	1:3,500
Board Certified or Board Eligible Adult Psychiatrists	30	20	60	45	1:375
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units	n/a	n/a	n/a	n/a	1 bed: 500 enrollees
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed: 2,000 enrollees
Inpatient Substance Abuse Detoxification Units	n/a	n/a	n/a	n/a	1 bed: 1,000 enrollees

3. **Specialty Product-Specific Network Capacity Enhancements**

   a. The Managed Care Plan offering an SMI Specialty Product shall select and approve its Primary Care Providers (PCPs) that practice in one of the following areas: general practice, family practice, pediatrics, obstetricians, and internal medicine. The Managed Care Plan offering an SMI Specialty Product shall ensure that physicians with training

and demonstrated experience in treating persons diagnosed with SMI are members of the provider network and can be designated as PCPs. The Managed Care Plan offering an SMI Specialty Product may designate psychiatrists with training and demonstrated experience in primary care as PCPs.

b. Notwithstanding the Provider Network Standards established in **Attachment II**, **Section VII.**, Provider Network and Services, the Managed Care Plan shall, at a minimum, maintain enhanced provider ratios as indicated in the below Table applicable to the Managed Care Plan's Specialty product population.

- **Table 5-A**, Managed Medical Assistance Provider Network Standards SMI Specialty Product Enhancements Table
- **Table 5-B**, Managed Medical Assistance Provider Network Standards HIV/AIDS Specialty Product Enhancements Table
- **Table 5-C**, Managed Medical Assistance Provider Network Standards CW Specialty Product Enhancements Table

The Agency shall determine regional provider ratios for the Specialty product based upon one hundred percent (100%) of the Managed Care Plan's actual monthly enrollment measured at the first of each month, by region.

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TABLE 5-A MANAGED MEDICAL ASSISTANCE PROVIDER NETWORK STANDARDS SMI SPECIALTY PRODUCT ENHANCEMENTS TABLE					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Behavioral Health					
Licensed Practitioners of the Healing Arts (LPHA)	30	20	30	20	1:1,000
Board Certified or Board Eligible Child Psychiatrists	30	20	60	45	1:3,500
Board Certified or Board Eligible Adult Psychiatrists	30	20	60	45	1:375
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units/Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed: 500 enrollees
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed: 2,000 enrollees
Inpatient Substance Abuse Detoxification Units	n/a	n/a	n/a	n/a	1 bed: 1,000 enrollees
Pharmacy					
24-hour Pharmacy	60	45	60	45	2:county

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TABLE 5-B MANAGED MEDICAL ASSISTANCE PROVIDER NETWORK STANDARDS HIV/AIDS SPECIALTY PRODUCT ENHANCEMENTS TABLE					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Specialists					
Infectious Disease	100	75	110	90	1:1000
Pharmacy					
24-hour Pharmacy	60	45	60	45	2: county

TABLE 5-C MANAGED MEDICAL ASSISTANCE PROVIDER NETWORK STANDARDS CHILD WELFARE SPECIALTY PRODUCT ENHANCEMENTS TABLE					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Primary Care Providers					
Pediatrics (Including Adolescent Medicine)	30	20	30	20	1:500
Behavioral Health					
Licensed Practitioners of the Healing Arts	30	20	30	20	1:750
Board Certified or Board Eligible Child Psychiatrists	30	20	30	20	1:2,500

4. Primary Care Providers

a. The Managed Care Plan shall enter into provider agreements with at least one (1) FTE PCP per seven hundred fifty (750) enrollees. The Managed Care Plan may increase the physician's ratio by seven hundred fifty (750) enrollees for each FTE ARNP or PA affiliated with the participating physician's office. The Managed Care plan shall ensure a sufficient selection of FTE PCPs in each of the following four (4) specialty areas within the geographic access standards indicated above:

(1) Family Practice;

(2) General Practice;

(3) Pediatrics; and

(4) Internal Medicine.

b. The Managed Care Plan shall ensure the following:

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

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

5. Specialists and Other Providers

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

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

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

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

b. For pediatric specialists not listed on **Table 4**, Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at an agreed upon location or at a PCP's office within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code. Alternatively, for pediatric specialists not listed in **Table 4**, Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.

c. The Managed Care Plan may increase the Psychiatrist's ratio by seven hundred fifty (750) enrollees for each FTE ARNP with a certificate of psychiatric nursing through the American Nurses Credentialing Center or physician's assistant (PA) with a Certificate of Added Qualifications in psychiatry through the National Commission on Certification of Physician Assistants, and affiliated with the participating Psychiatrist's office.

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

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

f. The Managed Care Plan shall enter into provider agreements with a sufficient number of behavioral health providers to ensure adequate accessibility for enrollees to evidence-based practices for children with intense behaviors as provided in see **Attachment II**, **Section I.**, General Overview, **Sub-Section G.**, Prioritizing Mental Wellness for Florida's Youth, **Item 3.**

g. The Managed Care Plan shall ensure the availability of massage therapists licensed in accordance with Chapter 480, F.S. and physical therapists licensed in accordance with Chapter 486, F.S. for the provision of services under **Section V.**, Service Administration, **Sub-Section A.**, Required MMA Benefits, **Item 1.**, Specific MMA Services to be Provided, **Sub-Item a.**, **Part (20)** of this Exhibit.

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

(1) Early intervention services providers must be:

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

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

c. Enrolled in Florida Medicaid;

d. Qualified as specified in Rule 59G-4.085, F.A.C., Early Intervention Services Coverage Policy.

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

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

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

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

l. The Managed Care Plan shall implement a detailed plan for supporting health homes for children with medical complex conditions (MCC) and execute formal contracts (that comply with the Provider Agreement requirements in Section VII.C.5.) with the Florida children's hospitals that must include the following minimum elements:

(1) Specific name of the health home clinic for children with MCC;

(2) Specific name and Medicaid provider ID of the physician director;

(3) Specific name of the lead care coordinator; and

(4) List of reimbursement codes for special services provided by health homes for children with MCC.

6. Public Health Providers

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

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

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

(3) FQHCs qualified pursuant to rule 59G-4.100, F.A.C. (including those with co-located behavioral health services).

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

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

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

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

   (3) The provision of immunizations;

   (4) Family planning services and related pharmaceuticals;

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

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

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

c. The Managed Care Plan shall reimburse the CHD when the CHD notifies the Managed Care Plan and provides the Managed Care Plan with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.

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

e. The Managed Care Plan shall not deny claims for services delivered by CHD providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

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

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

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

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

j. The Managed Care Plan shall make a good faith effort to execute memorandums of agreement with private schools, charter schools, and school districts participating in the certified match program regarding the coordinated provision of school-based services pursuant to ss. 1011.70, 409.9071, F.S., 409.908(22), F.S., and 409.9072, F.S.

(1) The Agency will provide fee-for-service claims data to the Managed Care Plan for school-based services provided to Medicaid recipients enrolled in the Managed Care Plan.

(2) The Managed Care Plan shall use such data and information to ensure effective program coordination and non-duplication of services, as well as to enhance communication with the enrollees' families to bolster their awareness about the Managed Care Plan's EPSDT benefits and the availability of services.

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

l. The Managed Care Plan shall report quarterly to the Agency in a format specified by the Agency, the payment rates and the payment amounts made to IHCPs for contractual services provided by these entities. When the amount the IHCP would have received under the fee-for-service reimbursement system, the Agency shall comply with 42 CFR 438.14(c)(3).

7. Facilities and Ancillary Providers

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

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

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

(3) Hospital providers in the Managed Care Plan's provider network participate in the ENS; the Managed Care Plan shall achieve and maintain Florida HIE ENS

participation of at least eighty percent (80%) of total hospital beds in each region of the Managed Care Plan's provider network; and

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

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

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

d. In accordance with Section 409.975(1)(e), F.S., the Managed Care Plan may offer a provider agreement to each licensed home medical equipment and supplies provider and to each Medicaid enrolled DME provider in the region, as specified by the Agency, that meets quality and fraud prevention and detection standards established by the Managed Care Plan and that agrees to accept the lowest price previously negotiated between the Managed Care Plan and another such provider, by service and provider type, as specified by the Agency.

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

8. Essential Providers

a. Pursuant to Section 409.975(1)(b), F.S., certain providers are statewide resources and essential providers for all Managed Care Plans in all regions. The Managed Care Plan shall include these essential providers in its network, pursuant to Section 409.908(26), F.S., even if the provider is located outside of the region served by the Managed Care Plan.

b. Statewide essential providers include:

(1) Faculty plans of Florida medical school faculty physician groups;

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

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

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

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

c. The Managed Care Plan shall submit all essential provider contracts for Agency review to determine compliance with Contract requirements as specified in **Section VII.**, Provider Network and Services, **Sub-Section C.**, Provider Credentialing and Contracting, **Item 5.**, Provider Agreement Requirements, of this Exhibit.

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

(1) The Managed Care Plan shall make monthly payments to faculty plans of Florida medical school faculty physician groups as specified in **Section VII.**, Provider Network and Services, **Sub-Section E.**, Claims and Prover Payment, **Item 22.**, Directed Payment Programs, **Sub-Item a.**, of this Exhibit.

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

(3) Except for payments for emergency services, the Managed Care Plan shall make payments to a non-participating specialty children's hospital, and non-participating Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v), equal to the highest rate established by contract between that provider and any other Medicaid Managed Care Plan.

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

f. Pursuant to Section 409.975(1)(a), F.S., the Managed Care Plan shall include all providers in the region that are determined by the Agency as essential Medicaid providers, unless the Agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Essential providers include SIPP providers.

9. Timely Access Standards

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

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

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

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

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

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

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

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

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

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

b. Quarterly, the Managed Care Plan shall review a statistically valid sample of PCP, specialist, and behavioral health offices' average appointment wait times to ensure services are in compliance with this **Sub-Section (a)** above, and report the results to the Agency as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide (42 CFR 438.206(c)(1)(iv),(v), and (vi)), and 42 CFR 457.1230.

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

10. Network Adequacy Measures

a. General Network Adequacy Measures

(1) The Managed Care Plan shall collect regional data on the measures as specified in the General Provider Network Adequacy Standards Table, **Table 6**, below, in order to evaluate its provider network and to ensure that covered services are reasonably accessible.

(2) The Managed Care Plan shall comply with the regional standards for each measure as specified in the General Provider Network Adequacy Standards Table, **Table 6**, below.

(3) The Managed Care Plan shall submit the results of the network adequacy standards specified in the General Provider Network Adequacy Standards Table, **Table 6**, below, to the Agency quarterly as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

(4) The Agency reserves the right to require the Managed Care Plan to collect data and report results on additional network adequacy standards.

TABLE 6 GENERAL PROVIDER NETWORK ADEQUACY MEASURES TABLE										
Measure		Region								
		A	B	C	D	E	F	G	H	I
The Managed Care Plan agrees that at least ______ percent of required participating PCPs (as required by the Managed Medical Assistance Provider Network Table in Exhibit B-1), by region, are accepting new Medicaid enrollees.	Standard	90	90	85	90	85	90	85	85	85
The Managed Care Plan agrees that at least ______percent of the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1), by region, are accepting new Medicaid enrollees.	Standard	90	90	90	90	90	90	90	90	90
The Managed Care Plan agrees that at least _ percent of required participating PCPs (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1), by region, offer after hours appointment availability to Medicaid enrollees.	Standard	50	50	45	45	50	40	50	50	50
The Managed Care Plan agrees that no more than ________ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in **Section VIII.**, Quality, **Sub- Section H.**, Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.	Standard	5	8	3	5	5	5	5	10	8
The Managed Care Plan agrees that no more than _________ percent of enrollee specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in **Section VIII.**, Quality, **Sub-Section H.**, Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.	Standard	10	10	8	8	8	8	10	10	8

b. Network Adequacy Measures Applicable to the Specialty Product

(1) Notwithstanding the Provider Network Standards established in **Attachment II**, **Section VII.**, Provider Network and Services, the Managed Care Plan offering a Product shall comply with the regional standards for each measure as specified below in:

- **Table 7-A**, Provider Network Adequacy Measures SMI Specialty Product Table.
- **Table 7-B**, Provider Network Adequacy Measures HIV/AIDS Specialty Product Table.
- **Table 7-C**, Provider Network Adequacy Measures Child Welfare Specialty Product Table.

TABLE 7-A
PROVIDER NETWORK ADEQUACY MEASURES
SMI SPECIALTY PRODUCT TABLE

Measure		Region								
		A	B	C	D	E	F	G	H	I
The Managed Care Plan agrees that no more than _ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in **Section VIII.**, Quality **Sub- Section H.**, Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.	Standard	5	8	6	10	10	10	5	10	10
The Managed Care Plan agrees that no more than _ percent of enrollee specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in **Section VIII.**, Quality, **Sub- Section H.**, Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.	Standard	15	15	15	10	15	15	8	10	15

TABLE 7-B
PROVIDER NETWORK ADEQUACY MEASURES
HIV/AIDS SPECIALTY PRODUCT TABLE

Measure		Region								
		A	B	C	D	E	F	G	H	I
The Managed Care Plan agrees that no more than _____ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in **Section VIII.**, Quality, **Sub-Section H.**, Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.	Standard	10	10	6	10	10	5	10	10	10
The Managed Care Plan agrees that no more than ____ percent of enrollee specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in **Section VIII.**, Quality, **Sub-Section H.**, Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.	Standard	15	15	15	10	15	8	15	10	15

TABLE 7-C
PROVIDER NETWORK ADEQUACY MEASURES
CHILD WELFARE SPECIALTY PRODUCT TABLE

Measure		Region								
		A	B	C	D	E	F	G	H	I
The Managed Care Plan agrees that no more than _____ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in **Section VIII.**, Quality, **Sub-Section H.**, Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.	Standard	10	10	6	10	10		10	10	10
The Managed Care Plan agrees that no more than ____ percent of enrollee specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in **Section VIII.**, Quality, **Sub-Section H.**, Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.	Standard	15	15	15	10	15		15	10	15

(2) The Managed Care Plan offering a Specialty Product agrees that at least fifty percent (50%) of required participating primary care providers, (as required by **Table 4**, Managed Medical Assistance Provider Network Standards Table), in this region, offer after hour appointment availability.

(3) The Managed Care Plan offering a Child Welfare Specialty Product shall maintain network contracts with ninety percent (90%) of the providers available in each region for the following services:

(a) Specialized Therapeutic Foster Care

(b) Specialized Therapeutic Group Care

(c) Behavioral Health Overlay Services

(d) Comprehensive Behavioral Health Assessments

(e) Statewide Inpatient Psychiatric Program

B. Network Management

1. Annual Network Development Plan

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

(1) The assistance and communication tools provided to PCPs when they refer enrollees to specialists and the methods used to communicate the availability of this assistance to the providers; and

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

b. The Managed Care Plan offering a Specialty Product shall address the availability and accessibility of specialty providers relevant to the Specialty population in its annual network plan submitted to the Agency in accordance with **Attachment II and its Exhibits**.

2. Regional Network Changes

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

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C. Provider Credentialing and Contracting

1. General Provisions

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

2. Credentialing and Recredentialing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Provider Training Verification

a. The Managed Care Plan offering a Specialty Product for enrollees with HIV/AIDS or SMI shall require formal training or verification of completed training for network providers in the use of assessment tools, assessment instruments and in techniques for identifying individuals with unmet health needs and evidence based.

b. The Managed Care Plan offering a Child Welfare Specialty Product for enrollees in the Child Welfare system shall require formal training or verification of completed training for network providers in the use of behavioral health assessment tools, assessment instruments and in techniques for identifying individuals with unmet behavioral health needs, and evidence-based practice, the dependency system, and trauma-informed care.

4. Hernandez Settlement Agreement Surveys

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

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

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

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

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

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

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

5. Provider Agreement Requirements

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

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

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

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

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

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

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

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

      (a) Authentication and authorization of users;

      (b) Authentication of the origin of the information;

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

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

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

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

(9) For providers participating as PCPs, require such providers to assess each enrollee's health-related social needs, document identified needs in the enrollee record utilizing the ICD-10-CM Z-codes identified in the, Z-Codes for Health-Related Social Needs Table, **Table 8**, below, and provide such codes via claims submissions to the Managed Care Plan. The following Z-codes are used to identify socioeconomic and psychosocial circumstances:

TABLE 8 Z-CODES FOR HEALTH-RELATED SOCIAL NEEDS	
ICD-10-CM Code	**Code Description**
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk-factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z61	Problems related to negative life events in childhood
Z62	Other problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

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6. Provider Termination and Continuity of Care

a. The Managed Care Plan shall notify enrollees in accordance with the provisions of this Contract and State and federal law regarding provider termination (42 CFR 438.10(f)(1) and 42 CFR 457.1207).

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

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

D. Provider Services

1. Provider Handbook and Bulletin Requirements

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

a. Well-child visit program services and standards;

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

c. PCP responsibilities; and

d. Telemedicine requirements for providers.

2. Additional Provider Handbook Requirements for the Specialty Product

In addition to the provisions set forth in **Attachment II**, **Section VII.**, Provider Network and Services, the Managed Care Plan offering a Specialty Product shall include Specialty product-specific information regarding policies, procedures, and protocols, to include information on:

a. Specialized provider education requirements;

b. Requirements for care in accordance with the most recent clinical practice guidelines for treatment of the specialty condition;

c. Treatment adherence services available from the Specialty product;

d. PCP criteria including procedures for required use of approved assessment instruments for treatment of the specialty condition;

e. Specialty Case Management policies and procedures including role of the provider in the Specialty product's medical case management/care coordination services;

f. Referral to services including services outside of the Specialty product's covered services and services provided through interagency agreements;

g. Quality measurement standards for providers and requirements for exchange of data;

h. Enrollee access to clinical trials, including coverage of costs for an enrollee's participation in clinical trials. Such policies and procedures shall be updated at least annually and submitted to the Agency annually by June 1;

i. For the Child Welfare Specialty product, collaboration with DCF and CBCs to facilitate obtaining medical and case plan information and records; and

j. For the SMI Specialty product, coordination protocols for Community Mental Health Centers to ensure appropriate and comprehensive treatment planning that addresses the enrollee's medical and behavioral health needs.

3. Provider Education and Training

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

b. The Managed Care Plan offering a Specialty Product shall develop and implement, subject to Agency approval, a continuing education program that provides ongoing education with continuing education (medical and non-medical) to network providers, at no cost to such providers, on topics including, but not limited to, evidence-based practice.

E. Claims and Provider Payment

1. MMA Physician Incentive Program

a. Pursuant to Section 409.967(2)(a), F.S., and as specified by the Agency, the Managed Care shall implement an incentive program compliant with 42 CFR 422.208, 42 CFR 422.210 and 42 CFR 457.1201(h) wherein payment rates for the following eligible physicians, who meet certain qualifying criteria, as established by the Agency, shall equal or exceed Medicare rates for services provided. This incentive program shall be referred to as the MMA Physician Incentive Program (MPIP):

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

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

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

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

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

1. Anesthesiology;
2. Critical Care Medicine;
3. Emergency Medicine;
4. Hospitalist;
5. Neonatology;
6. Pathology; or
7. Radiology.

b. The following providers are excluded from the MPIP:

(1) Providers that do not have a contractual arrangement with the Managed Care Plan (except as noted above).

(2) Services provided in an FQHC.

(3) Services provided in an RHC.

(4) Services provided in a CHD.

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

(6) Services provided by Public Hospital Physicians participating in the Public Hospital Physician State Directed Payment Program.

c. The Managed Care Plan shall implement the Agency's MPIP model and qualifying criteria (performance and quality measures) that each physician type must meet in order to earn the enhanced payment. The Agency may update the MPIP model on an annual basis and will notify the Managed Care Plan of changes to the MPIP by June 1 of each year.

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

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

f. During the first and second Contract Years, the Managed Care Plan that is new to a region shall consider a provider new to its network to be qualified for MPIP if the provider was previously qualified for MPIP under another plan in the same region during the last Contract Year of the 2018-2024 Contract term.

g. If the Managed Care Plan fails to comply with the requirements of this Section, including failure to make appropriate payment to an eligible physician that meets the qualifying criteria 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.

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

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

Step 1: The Managed Care Plan shall calculate the physician's total compensation for included services provided to eligible enrollees for the time period (e.g., October 1, 2024 – September 30, 2025), including all of the following: fee-for-service payments, capitation payments, case management fees, incentive payments, shared savings payments (upside), and shared risk payments (upside or downside).

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

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

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

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

2. The Managed Care Plan shall not deny claims submitted by a non-participating provider rendering services pursuant to **Section V.**, Services Administration, **Sub-Section D.**, Coverage Provisions, **Item 1.**, Primary Care Provider Initiatives, of this Exhibit, solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

3. The Managed Care Plan shall not deny claims for the provision of emergency services and care submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

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

5. Regardless of how an inpatient facility is reimbursed (Diagnosis Related Group or per diem), the enrollee's MMA Managed Care Plan at the time of admission shall be responsible for payment of the entire inpatient stay for that admission, even if the enrollee changes Managed Care Plans during the hospital stay. For professional and ancillary services provided during an inpatient admission, the Managed Care Plan to whom an enrollee is assigned to on the date of service shall be responsible for payment of such services.

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

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

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

8. The Agency will set hospice LOC and room and board rates based upon the rate development methodology detailed in 42 CFR part 418 for per diem rates and Chapter 409.906 (14), F,S,, and 59G-4.140, F.A.C., for room and board rates. The Managed Care Plan shall pay hospices an amount no less than the published Agency Hospice Room and Board rates and the Hospice ICF-DD Room and Board Rates, as applicable, set by the Agency and published on the Agency website.

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

10. Pursuant to Section 409.967(2)(b), F.S., the Managed Care Plan shall pay for services required by ss. 395.1041 and 401.45, F.S., provided to an enrollee for the provision of emergency services and care by a non-participating provider. The Managed Care Plan must comply with s. 641.3155, F.S., Reimbursement for services under this paragraph is the lesser of:

a. The non-participating provider's charges;

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

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

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

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

11. Notwithstanding the requirements set forth for coverage of emergency services and care, the Managed Care Plan shall approve all claims for emergency services and care by participating and non-participating providers pursuant to the requirements set forth in s. 641.3155, F.S., and 42 CFR 438.114 and 42 CFR 457.1228.

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

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

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

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

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

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

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

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

16. Provider Preventable Conditions

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

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

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

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

(4) Relative to all above requirements, not:

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

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

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

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

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

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

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

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

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

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

19. The Managed Care Plan shall reimburse pharmacies for products and services associated with the dispensing of imported prescribed drug products on the Wholesale Prescription Drug Importation List. See **Attachment I**, Scope of Services, **Exhibit I-< >,** Plan-Specific Commitments.

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

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

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

b. Obstetrical care (at first visit);

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

d. Transplants.

22. Directed Payment Programs

a. Physician Supplemental Payment (PSP) Program: The Managed Care Plan shall make monthly payments as specified in the Plan-specific **Attachment I** of this Contract to faculty plans of Florida medical school faculty physician groups in an amount specified by the Agency. The payment amount shall be the per member, per month amount multiplied by the Managed Care Plan's monthly enrollment, Florida Cancer Hospital Payment (FCHP) Program: The Managed Care Plan shall make monthly payments as specified in the Plan-specific **Attachment I** of this Contract, **Section III.**, Method of Payment, to qualified Florida cancer hospitals (FCHP Program). The payment amount shall be the per-member, per-month amount multiplied by the Managed Care Plan's monthly enrollment in the applicable region. Florida cancer hospitals that are qualified for monthly payments that meet the criteria under 42 USC s. 1395www(d)(1)(B)(v).

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

c. Public Hospital Program (PHP): The Managed Care Plan shall make the MMA Public Hospital Physician Uniform Payment Increase to qualified physicians as specified in the Plan-specific **Attachment I** of this Contract, **Section III.**, Method of Payment. 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. Quality Improvement Plan

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

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

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

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

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

e. Have been identified as exceeding the Managed Care Plan’s prescription limits as permitted under **Section V.**, Services Administration;

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

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

2. Quality Improvement Plan Requirements for the Specialty Product

In addition to the requirements set forth in **Attachment II and its Exhibits**, for the Specialty product the Quality Improvement (QI) Plan shall include measurement of adherence to clinical and preventive health guidelines consistent with prevailing standards of professional medical practice and with standards regarding the most recent clinical and evidence-based practice guidelines for treatment of the specialty condition.

a. For the Child Welfare Specialty Product, such standards shall be consistent with guidelines for pediatric and psychiatric treatment.

b. For the SMI Specialty Product, such standards shall be consistent with guidelines for SMI treatment.

c. For the HIV/AIDS Specialty Product, such standards shall be consistent with guidelines for HIV/AIDS treatment.

B. Performance Measures (PMs)

1. Required Performance Measures

a. The Managed Care Plan shall collect and report the performance measures in the Required Performance Measures Table, **Table 9**, below, certified via a qualified auditor.

TABLE 9 REQUIRED PERFORMANCE MEASURES	
Healthcare Effectiveness Data and Information Set (HEDIS)	
1.	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
2.	Adults' Access to Preventive/Ambulatory Health Services (AAP)
3.	Adult Immunization Status (AIS-E)
4.	Antidepressant Medication Management (AMM)
5.	Asthma Medication Ratio (AMR)
6.	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
7.	Blood Pressure Control for Patients with Diabetes (BPD)
8.	Breast Cancer Screening (BCS)
9.	Cervical Cancer Screening (CCS)
10.	Child and Adolescent Well-Care Visits (WCV)
11.	Childhood Immunization Status (CIS)
12.	Chlamydia Screening in Women (CHL)
13.	Colorectal Cancer Screening (COL)
14.	Controlling High Blood Pressure (CBP)
15.	Depression Screening and Follow-up for Adolescents and Adults (DSF-E)
16.	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication (SSD)
17.	Eye Exam for Patients with Diabetes (EED)
18.	Follow-up after Emergency Department Visit for Substance Use (FUA)
19.	Follow-up after Emergency Department Visit for Mental Illness (FUM)
20.	Follow-up after Hospitalization for Mental Illness (FUH)
21.	Follow-up Care for Children Prescribed ADHD Medication (ADD)
22.	Glycemic Status Assessment for Patients with Diabetes (GSD)
23.	Immunizations for Adolescents (IMA)
24.	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
25.	Kidney Health Evaluation for Patients with Diabetes (KED)
26.	Lead Screening in Children (LSC)
27.	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)
28.	Plan All-Cause Readmissions (PCR)

29.	Postpartum Depression Screening and Follow-up (PDS-E)
30.	Prenatal and Postpartum Care (PPC)
31.	Prenatal Depression Screening and Follow-up (PND-E)
32.	Prenatal Immunization Status (PRS-E)
33.	Social Need Screening and Intervention (SNS-E)
34.	Statin Therapy for Patients with Cardiovascular Disease and Diabetes (SPC/SPD)
35.	Unhealthy Alcohol Use Screening and Follow-up (ASF-E)
36.	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
37.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)
38.	Well-Child Visits in the First 30 Months (W30)
Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)	
39.	Concurrent Use of Opioids and Benzodiazepines (COB-AD)
40.	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)
41.	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)
42.	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)(HPCMI-AD)
43.	HIV Viral Load Suppression (HVL-AD)
44.	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)
45.	Screening for Depression and Follow-up Plan (CDF-AD)
46.	Use of Opioids at High Dosage in Persons without Cancer (OHD-AD)
47.	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)	
48.	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)
49.	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)
50.	Developmental Screening in the First Three Years of Life (DEV-CH)
51.	Screening for Depression and Follow-up Plan (CDF-CH)
Other Measures	
52.	Pregnancies Conceived within 18 Months of a Previous Birth (FP-02)

b. The Managed Care Plan shall submit the first Performance Measure Report to the Agency no later than July 1, 2026, covering the measurement period of calendar year 2025. Measures should be collected based on the technical specifications for the measure, across the current Contract and the previous Managed Care Plan Contract, as applicable. All contractually required performance measures must be reported by region and statewide. The following measures are excluded from regional reporting but must still be reported at the statewide level: (1) HIV Viral Load Suppression; (2) Medical Assistance with Smoking and Tobacco Use Cessation; (3) Plan All-Cause Readmissions.

c. Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2026, covering the measurement period of calendar year 2025, all performance measure-related liquidated damages and sanctions will be in effect.

d. Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2026, covering the measurement period of calendar year 2025, the Managed Care Plan shall report on all contractually required performance measures

statewide, stratified by: age, sex, race, ethnicity, primary language, whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income, and geography. The Managed Care Plan shall continue to report all measures by region, with the exception of the measures identified in B.1.a.

e. The Agency may require that the Managed Care Plan submit performance measures stratified by other factors, with at least 60 days' notice.

f. The Agency may calculate certain measures for the Managed Care Plan. If the Agency will be calculating and reporting certain measures for the Managed Care Plan, the Agency will provide 60 days' notice and the plan will not be required to calculate and report the measures to the Agency.

g. The Managed Care Plan shall submit its HEDIS data to the NCQA by the NCQA deadline as well as to the Agency by July 1 of each year.

h. Specialty Product-Specific Performance Measure Requirements

(1) SMI Specialty Product

In addition to the performance measures in Required Performance Measures Table, **Table 9**, the Managed Care Plan shall collect data and report on the following additional nationally recognized HEDIS and CMS performance measures, in the SMI Specialty Product - Specific Performance Measure Requirements Table, Table **9-A,** below, which shall be certified by a qualified auditor:

TABLE 9-A SMI SPECIALTY PRODUCT - SPECIFIC PERFORMANCE MEASURE REQUIREMENTS	
HEDIS	
1.	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
2.	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
CMS Electronic Clinical Quality Measures	
3.	Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use (BMD)

(2) HIV/AIDS Specialty Product

(a) In addition to the provisions set forth in **Attachment II and its Exhibits,** the Managed Care Plan shall collect data and report on the following additional nationally recognized Health Resources and Services Administration (HRSA) performance measures in the HRSA – Ryan White HIV/AIDS Program Performance Measures Table, Table **9-B**, below, which shall be certified by a qualified auditor. The specifications for these measures are available online and may be accessed at:

https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio

TABLE 9-B HEALTH RESOURCES AND SERVICES ADMINISTRATION – RYAN WHITE HIV/AIDS PROGRAM PERFORMANCE MEASURES	
1	Prescription of HIV Antiretroviral Therapy
2	HIV Medical Visit Frequency

(b) The HIV/AIDS Specialty Product shall achieve improvement of at least three (3) percent for each of these performance measures in each year of the Contract, compared to the prior year's performance.

(3) Child Welfare Specialty Product

There are no additional measures specific to the Child Welfare Specialty Product.

2. Well-Child Visit Performance Measures

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

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

c. Beginning with the Well-Child Visit Report/Child Health Check-Up (CMS-416) and FL 80% Screening Report that is due to the Agency no later than July 1, 2027, covering the measurement period of FFY 2025-26, all performance measure-related liquidated damages and sanctions will be in effect.

3. Agency-Run Performance Measures

a. The Agency shall calculate the following performance measures for the Managed Care Plan in the Agency-Calculated Performance Measures Table, **Table 10**, below.

TABLE 10 AGENCY-CALCULATED PERFORMANCE MEASURES	
Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)	
1.	Live Births Weighing Less than 2,500 Grams (LBW-CH)
2.	Low-Risk Cesarean Delivery (LRCD-CH)
Solventum Potentially Preventable Events (PPEs)	
3.	Potentially Preventable Admissions (PPAs)
4.	Potentially Preventable Readmissions (PPRs)
5.	Potentially Preventable Emergency Department Visits (PPVs)

b. The Managed Care Plan shall comply with the minimum performance standards established by the Agency for the Agency-Calculated Performance Measures specified above. The Managed Care Plan shall achieve at least a two percent (2%) reduction each year of the Contract until the Managed Care Plan achieves the performance standards established by the Agency.

c. 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.

d. Due to contract year 2024-2025 being a transition year across contracts, the Agency may calculate and publicly report the measures in **Table 10**, Agency-Calculated Performance Measures, and shall label such performance measures as "transition year" measures.

e. Beginning with the calendar year 2025 and contract year 2025-2026 Agency-Calculated Performance Measures, all performance measure-related liquidated damages and sanctions will be in effect.

C. Performance Improvement Projects

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

1. One (1) of the PIPs shall focus on promoting healthy birth outcomes for mothers and infants;

2. One (1) of the PIPs shall focus on improving child and adolescent mental health;

3. One (1) of the PIPs shall be non-clinical and focus on Hope Florida; and

4. One (1) PIP shall focus on closing gaps in health care outcomes between plan sub-populations.

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

6. Specialty Product-Specific PIP Requirements

   a. The Managed Care Plan offering a Specialty Product shall include its Specialty population in the above PIPs, as appropriate.

   b. In addition to the above PIPs, the Managed Care Plan offering a Specialty Product shall perform an additional PIP focused on a clinical area in need of improvement for its Specialty population, as approved by the Agency.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

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

      (1) For adults, the CAHPS Health Plan Survey - Medicaid Survey 5.1

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

   b. The Managed Care Plan offering a Specialty Product shall conduct an annual CAHPS survey, as noted in 1.a. above, for its Specialty population.

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

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

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

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

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

2. The Managed Care Plan shall use the results of the annual CAHPS survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities

conducted by the Managed Care Plan pertaining to improving member satisfaction resulting from the annual member satisfaction survey must be reported to the Agency on a quarterly basis.

E. Enrollee Record Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Provider-Specific Performance Monitoring

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

G. Additional Quality Management Requirements

1. Incident Reporting Requirements

a. Critical Incident Reporting

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

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

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

b. Serious Adverse Event Reporting for Specialty Product Enrollees

See **Attachment II**, **Section I.**, General Overview, **Sub-Section H.**, Prioritizing Quality and Value, **Item 3.**, Stronger Performance Expectations for Specialty Product Enrollees, **Sub-Item c.**, for provisions on Serious Adverse Event Reporting for Specialty product enrollees.

2. Drug Utilization Review Program

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

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

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

(2) A description of the Managed Care Plan's design and implementation of a DUR program to encourage coordination between an enrollee's PCP and a prescriber

of a psychotropic or similar prescription drug for behavioral health problems.

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

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

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

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

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

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

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

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

3. High Utilizer Medical Record and Case Management File Review

See **Attachment II**, **Section I.**, General Overview, **Sub-Section G.**, Prioritizing Mental Wellness for Florida’s Youth, **Item 2.**, High Utilizer Medical Record and Case Management File Review, for provisions on High Utilizer Medical Record and Case Management File Review.

H. Continuity of Care in Enrollment

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

2. The Managed Care Plan shall honor any written documentation of prior authorization of ongoing covered services for a period of up to ninety (90) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.

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

a. Prior existing orders;

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

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

d. Prior authorizations;

e. Treatment plan/plan of care.

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

5. The following services may extend beyond the ninety (90) day continuity of care period, and the Managed Care Plan shall continue the entire course of treatment with the recipient's current provider as described below:

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

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

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

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

6. During the initial continuity of care period beginning on February 1, 2025, the Managed Care Plan shall honor any prior authorizations for behavior analysis services for the entirety of the continuity of care period (a minimum of ninety (90) days). The Managed Care Plan shall extend any existing prior authorizations that may expire during the initial continuity of care period for the remainder of the continuity of care period. 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 a minimum of sixty (60) days or in accordance

with a plan specific continuity of care period as listed in Exhibit I-N, Plan Specific Commitments, of Attachment I – Scope of Services. For enrollees that change plans during the initial continuity of care period, the Managed Care Plan shall coordinate with the previous plan to ensure existing prior authorizations will be honored.

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Section IX. Administration and Management

A. General Provisions

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

B. Organizational Governance and Staffing

1. Minimum Staffing

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

b. Regardless of plan type, the Managed Care Plan shall have a designated employee(s), qualified by training and experience, in each region of operation to serve as a liaison between the Managed Care Plan and the CBC Lead Agency for enrollees with a Child Welfare special condition identified on the Agency's enrollment file.

c. The Managed Care Plan offering a Specialty Product shall employ a dedicated Medical Director to oversee case management and utilization management for Specialty product enrollees.

d. In addition to the requirements set forth in **Attachment II and its Exhibits**, the Managed Care Plan offering an SMI Specialty Product shall employ a dedicated Housing Specialist to assist enrollees contending with homelessness and to coordinate with local and state housing programs to facilitate the enrollee securing and maintaining stable housing.

e. In addition to the requirements set forth in **Attachment II and its Exhibits**, the Managed Care Plan offering a Child Welfare Specialty Product shall employ a dedicated Child Welfare Medical Director to oversee case management and utilization management for Specialty product enrollees.

f. 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.

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2. Case Management Staff Qualifications and Experience

a. General Provisions for Case Management Staff Qualifications and Experience

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

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

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

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

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

b. Care Coordination/Case Management Staff Qualifications Applicable to the Specialty Product

(1) The Managed Care Plan offering a Specialty Product shall have sufficient care coordination/case management staff, qualified by training, experience and certification/licensure applicable to the Specialty population.

(2) The Managed Care Plan offering a Specialty Product shall establish, subject to Agency approval, qualifications for all care coordination/case management staff that include clinical training, licensure, and a minimum number of years of relevant experience. The Managed Care Plan offering a Specialty Product may request a waiver for staff without the aforementioned qualifications on a case-by-case basis. All such waivers must be approved in advance, in writing by the Agency.

(3) The Managed Care Plan offering a Specialty Product shall establish a supervisor-to-case-manager ratio that is conducive to a sound support structure for case managers. Supervisors must have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers. A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of enrollee assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, must be documented and made available to the Agency upon request.

3. Care Coordination/Case Management and Staff Training

a. The Managed Care Plan offering a Specialty Product shall provide all care coordination/case managers with adequate orientation and ongoing training on subjects relevant to enrollees' diagnosis. The Managed Care Plan offering a Specialty Product shall develop a training plan to provide uniform training to all care coordination/case management. This plan should include formal training classes as well as practicum observation and instruction for newly hired staff.

b. The Managed Care Plan offering a Specialty Product shall provide all newly hired care coordination/case management staff orientation and pre-service training covering areas applicable to responsibilities and duties performed.

c. In addition to review of areas covered in orientation, the Managed Care Plan offering a Specialty Product shall also provide all care coordination/case management staff with regular ongoing in-service training on following minimum topics: relevant to enrollees' diagnosis:

(1) The role of the case manager in advocating on behalf of the enrollee;

(2) Enrollee rights and responsibilities;

(3) Case management responsibilities as outlined in this Exhibit;

(4) Case management procedures specific to the Managed Care Plan;

(5) The specialty component of SMMC and the continuum of services, including available service settings and service restrictions/limitations;

(6) The Managed Care Plan's provider network by location, service type, and capacity;

(7) Information on local resources for housing, education/General Education Diploma, and employment services/program that could help enrollees gain greater self-sufficiency in these areas;

(8) Responsibilities related to monitoring for and reporting of regulatory issues and quality of care concerns, including but not limited to suspected abuse/neglect and/or exploitation and critical incidents (Chapters 39 and 415, F.S.); and

(9) Information on the enrollees' diagnosis, and continuing education and training, including risk factors, signs and symptoms, treatment options, and new developments in the field.

d. The Managed Care Plan offering a Specialty Product shall maintain documentation of training dates and staff attendance as well as copies of materials used for orientation, pre-service and in-service training for care coordination/case management staff.

4. Caseload Requirements

a. Case Management for Enrollees Under the Age of Twenty-One (21) Years Receiving Skilled Nursing Facility Services, Prescribed Pediatric Extended Care Services, or Private Duty Nursing Services

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

(a) Ten (10) enrollees to one (1) care coordinator for enrollees who are receiving services in a skilled nursing facility.

(b) Thirty (30) enrollees to one (1) case manager for enrollees under age twenty-one (21) years receiving PPEC services or private duty nursing services in their family home or other community-based setting, or receiving medical foster care services.

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

b. Case Management Caseload Requirements for Specialty Product Enrollees

(1) The Managed Care Plan shall have an adequate number of qualified and trained case managers to meet the needs of enrollees. The Managed Care Plan shall assign one case manager to each Specialty product enrollee.

(2) The Managed Care Plan shall have written protocols to ensure assignment of a case manager immediately upon enrollment of newly enrolled enrollees. The case manager assigned to special subpopulations (e.g., individuals with HIV/AIDS, behavioral health issues/serious mental illness, or substance use disorders) shall have experience or training in case management techniques for such populations.

(3) The Managed Care Plan shall consider the enrollee's PCP when assigning case managers with the goal of having the minimum number of case managers to meet the ratio requirements assigned to an individual practice.

(4) The Managed Care Plan shall ensure that case manager caseloads do not exceed the ratios indicated below for all Specialty product enrollees:

(a) HIV/AIDS: one hundred fifty (150) enrollees to one (1) case manager.

(b) SMI: two hundred (200) enrollees to one (1) case manager.

(c) Child Welfare: one hundred (100) enrollees to one (1) case manager.

Enrollees may be stratified based on individual level of acuity and need. The Agency reserves the right to review the minimum case management ratios during the term of the Contract. The Managed Care Plan shall receive authorization from the Agency prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established by the Managed Care Plan and do not require authorization. The Managed Care Plan shall submit any caseload exception requests to the Agency. The Agency may, at any time, revoke the Managed Care Plan's authorization to exceed caseload ratios.

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 **Attachment II**, Scope of Services – Core Provisions, **Section XII.**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII.**, Liquidated Damages, as determined by the Agency.

(5) The Managed Care Plan shall ensure that case managers are not assigned duties unrelated to enrollee-specific case management for more than fifteen percent (15%) of their time if they carry a full caseload.

5. The Managed Care Plan shall report to the Agency monthly on its case manager caseloads as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

C. Subcontracts

1. Pharmacy Benefit Manager Subcontracts

a. The Managed Care Plan may delegate any or all functions of administering the Medicaid prescription drug benefit to one (1) or more PBMs with prior written approval of the Agency. Before entering into a subcontract, the Managed Care Plan shall obtain the Agency's prior written approval of the delegation in accordance with **Section IX.**, Administration and Management, **Sub-Section C.**, Subcontracts.

b. Provisions Pursuant to State of Florida Office of the Governor Executive Order Number 22-164

(1) As used in this Sub-Section, the following terms are defined as:

- **Adjudication transaction fees:** Fee charged by the PBM to the pharmacy for electronic claim submissions. Fee may be charged for each claim submission that is accepted by the PBM regardless of transmission status.
- **Brand or generic effective rate :** Contractual rate set forth by a PBM for the reimbursement of covered brand or generic drugs calculated using the total payments in the aggregate, by drug type, during the performance period. The effective rates are typically calculated as a discount off of industry benchmarks such as average wholesale price (AWP) or wholesale acquisition cost (WAC).

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

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

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

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

- **Maximum allowable cost (MAC) appeal pricing adjustment:** A retrospective positive payment adjustment made to a pharmacy by the Managed Care Plan or PBM pursuant to an approved MAC appeal request submitted by the same pharmacy to dispute the amount reimbursed for a drug based on the PBM's listed MAC price.

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

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

(2) All Managed Care Plan subcontracts with a PBM must contain provisions to prohibit the use of spread pricing.

(a) Contracts between the Managed Care Plan and the PBM responsible for coverage of covered outpatient drugs dispensed to the Managed Care Plan's enrollees shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the Managed Care Plan, be based on a Pass-Through Pricing model.

(b) A Pass-Through Pricing model is the Managed Care Plan's payment to the PBM for a covered outpatient drug that is equivalent to the PBM payment to the dispensing pharmacy or provider. Such payments may include a contracted professional dispensing fee between the PBM and its network

of pharmacies that would be paid if the Managed Care Plan was making the payment directly. The pass-through payment is passed through in its entirety by the Managed Care Plan or PBM to the pharmacy or provider that dispenses the drug. Pass-through payments must be paid in a manner that is not offset by any reconciliation process. Pass-through payments must remain consistent with Section 1 of Executive Order Number 22-164.

(c) If the Managed Care Plan fails to comply with the provisions prohibiting the use of spread pricing, 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) All Managed Care Plan PBM subcontracts must prohibit the practice of financial clawbacks by PBMs.

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

(b) The following shall be excluded from being defined as Reconciliation Offsets or "Clawbacks":

- Any incentive payments provided by the Managed Care Plan or PBM to a network pharmacy for meeting and/or exceeding predefined quality measures such as Healthcare Effectiveness Data and Information Set measures (HEDIS);
- Recoupment due to erroneous claims;
- Fraud, waste, and abuse;
- Claims adjudicated in error;
- Maximum Allowable Cost (MAC) appeal pricing adjustments; or
- Any other any recoupment that is returned to the State of Florida.

(c) If the Managed Care Plan fails to comply with the provisions prohibiting the practice of financial clawbacks, 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) All Managed Care Plan PBM subcontracts must require PBMs to ensure all contracts and/or agreements with participating network pharmacies to reflect that spread pricing and the use of financial clawbacks are disallowed under the Statewide Medicaid Managed Care Program.

(a) The Managed Care Plan's PBM subcontracts must contain the following verbatim statement:

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

(b) If the Managed Care Plan fails to comply with the provisions regarding PBM contracts and/or agreements with participating network pharmacies reflecting the prohibition of spread pricing and the use of financial clawbacks, 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.

(5) The Managed Care Plan and its subcontracted PBM shall provide Annual and Quarterly Pharmacy Claims Reconciliation Reports.

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

(b) Annual and Quarterly Pharmacy Claims Reconciliation Report templates will be provided by the Agency to the Managed Care Plan.

(c) If the Managed Care Plan fails to provide the necessary data to the Agency via the Quarterly and Annual Pharmacy Claims Reconciliation Reports, the Managed Care Plan may be subject to sanctions pursuant to **Section XII.**, Sanctions and Corrective Action Plans, liquidated damages pursuant to **Section XIII.**, Liquidated Damages, or reduction of capitation payments in the amount of estimated combined federal and supplemental rebates.

(6) The Managed Care Plan shall work with the Agency's fiscal agent to ensure the transfer of timely, accurate, and complete prescription encounter data, including actual amounts paid to the provider.

(a) The Managed Care Plan acknowledges that the transfer of prescription data is required by the ACA.

(b) The Agency will invoice pharmaceutical manufacturers for federal rebates mandated under federal law, and for supplemental rebates negotiated by the Agency according to Section 409.912(5)(a)7, F.S.

(c) If the Managed Care Plan fails to provide claim and provider information that assists the Agency in dispute resolution between the Agency and a drug manufacturer regarding federal drug rebates that prevents the Agency from collecting drug rebates, the Managed Care Plan shall be subject to recoupment by the Agency of any determined uncollected rebates.

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

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

and

d. For pharmacy contracts, ensure its pharmacy benefits manager provides an Agency-approved electronic message directing the pharmacist to dispense imported prescription drug products authorized through the Canadian Prescription Drug Importation Program in place of FDA-approved products for enrollees for whom Medicaid is the primary payor.

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

to 42 CFR 422.208(a)(d)) for services that the physician or physician group does not furnish itself, the Managed Care Plan shall assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(c)(2). The Managed Care Plan shall provide assurances to the Secretary of CMS that the requirements of 42 CFR 422.208 are met in accordance with 42 CFR 422.210(a).

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

D. Information Management and Systems

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

E. Encounter Data Requirements

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

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

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

4. In compliance with Section 409.967(2)(c)4., Florida Statutes, the Managed Care Plan serving children in the care and custody of the DCF must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to DCF, the applicable contracted community-based care lead agency, and the Community Based Care Integrated Health as directed by the Agency.

F. Fraud and Abuse Prevention

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

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Section X. Method of Plan Payment

A. General Provisions

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

1. A physician in the Managed Care Plan's network who has privileges at the treating hospital assumes responsibility for the enrollee's care;
2. A physician in the Managed Care Plan's network assumes responsibility for the enrollee's care through transfer;
3. A Managed Care Plan representative and the treating physician reach an agreement concerning the enrollee's care; or
4. The enrollee is discharged.

(42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)-(iv); 42 CFR 457.1228)

B. Fixed Price Unit Contract

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

C. Payment Provisions

1. Capitation Rates

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

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

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

2. Rate Adjustments and Reconciliations

a. The Agency shall be responsible for adjusting applicable capitation rates to reflect budgetary changes in the Medicaid program.

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

3. Kick Payments

a. LTC Eligible Kick Payment

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

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

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

b. Obstetrical Delivery Kick Payment

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

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

(3) To receive a kick payment for covered services specified in this Section, the Managed Care Plan must adhere to the specific requirements listed in **Attachment II**, **Exhibit II-A**, Managed Medical Assistance (MMA) Program, **Section X.**, Method of Payment, **Sub-Section C.**, Payment provisions, **Item 3.**, Kick Payments, **Sub-Item b.**, Obstetrical Delivery Kick Payment, **Part (4)**, and adhere to the following requirements:

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

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

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

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

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

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

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

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

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

4. Enrollee Payment Liability Protection

The Managed Care Plan shall not hold an enrollee liable for payment of subsequent screening and treatment needed to diagnose or stabilize an emergency medical condition, as long as the enrollee utilizes a provider in the Managed Care Plan's network (42 CFR 438.114(d)(2) and 42 CFR 457.1228).

5. Institution for Mental Disease Payment Provisions

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

6. Value-Based Purchasing (VBP) Programs

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

7. Quality Withhold Incentive

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, for provisions on the Quality Withhold Incentives.

8. Quality Preferred Assignment Incentive

See **Attachment II**, **Section I.**, General Overview, **Sub-Section H.**, Prioritizing Quality and Value, **Item 1.**, Layered Approach to Drive Continued Improvement, **Sub-Item b.**, Quality Preferred Assignment Incentive, for provisions on the Quality Preferred Assignment Incentive.

9. Achieved Savings Rebate One Percent Quality Incentive

See **Attachment II**, **Section I.**, General Overview, **Sub-Section H.**, Prioritizing Quality and Value, **Item 1.**, Layered Approach to Drive Continued Improvement**, Sub-Item a.**, Achieved Savings Rebate One Percent Quality Incentive, for provisions on the Achieved Savings Rebate One Percent Quality Incentive.

10. Prescribed Drugs High Risk Pool (PDHRP)

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

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Section XI. Financial Requirements

A. General Provisions

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

B. Insolvency Protection

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

C. Surplus

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

D. Interest

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

E. Third Party Resources

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

F. Assignment

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

G. Financial Reporting

1. Medical Loss Ratio

a. The Managed Care Plan shall maintain an annual (January 1 – December 31) medical loss ratio (MLR) of a minimum of eighty-five percent (85%) for the first full year of MMA program operation and subsequent years, beginning January 1, 2025.

b. The Agency will calculate the MLR in a manner consistent with 42 CFR 438.8, 45 CFR Part 158, 42 CFR 438.8(k), 42 CFR 457.1203(c), and Section 409.9122(9)(a), (b), and (c), F.S., To demonstrate ongoing compliance, the Managed Care Plan shall complete and submit appropriate financial reports, as specified in **Section XV.**, Accountability, and the Managed Care Plan Report Guide.

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

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

H. Inspection and Audit of Financial Records

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

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Section XII. Sanctions and Corrective Action Plans

A. Contract Violations and Non-Compliance

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

B. Corrective Action Plans

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

C. Performance Measure Sanctions

1. 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 Performance Measure Sanctions.

2. Performance measures shall be assigned a point value by the Agency that correlates to the National Committee for Quality Assurance HEDIS National Means and Percentiles for Medicaid plans. The scores will be assigned according to the HEDIS National Means and Percentiles for Medicaid Plans Table, **Table 11**, below. Individual performance measures will be grouped, and the scores averaged within each group, rounding down.

TABLE 11 HEDIS NATIONAL MEANS AND PERCENTILES FOR MEDICAID PLANS	
PM Ranking	**Score**
>= 90th percentile	6
75th – 89th percentile	5
60th – 74th percentile	4
50th – 59th percentile	3
25th-49th percentile	2
10th – 24th percentile	1
< 10th percentile	0

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

4. The Managed Care Plan may receive a monetary sanction of up to ten thousand dollars **($10,000)** for each performance measure group where the group score is below three (3) measure groups are as follows:

   a. Mental Health and Substance Abuse

      (1) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

(2) Antidepressant Medication Management (AMM) – Effective Acute Phase Treatment

(3) Follow-up after Emergency Department (ED) Visit for Substance Use (FUA) – 7 Day

(4) Follow-up after ED Visit for Mental Illness (FUM) – 7 Day

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

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

(7) Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) – Total – Blood Glucose and Cholesterol Testing

(8) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) – Total

b. Well-Child

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

(2) Childhood Immunization Status (CIS)– Combo 3

(3) Immunizations for Adolescents (IMA)– Combo 2

(4) Lead Screening in Children (LSC)

(5) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Body Mass Index Percentile Documentation

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

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

c. Other Preventive Care

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

(2) Adult Immunization Status (AIS-E) – Influenza Vaccination

(3) Breast Cancer Screening (BCS-E)

(4) Cervical Cancer Screening (CCS)

(5) Chlamydia Screening in Women – Total (CHL)

(6) Colorectal Cancer Screening (COL-E)

d. Prenatal/Perinatal

(1) Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care

(2) Prenatal and Postpartum Care (PPC) – Postpartum Care

(3) Prenatal Depression Screening and Follow-up (PND E)– Screening

(4) Postpartum Depression Screening and Follow-up (PDS-E) – Screening

(5) Prenatal Immunization Status (PRS-E) – Combination

e. Diabetes

(1) Blood Pressure Control for Patients with Diabetes (BPD)

(2) Eye Exam for Patients with Diabetes (EED)

(3) Glycemic Status Assessment for Patients with Diabetes (GSD) – Control (<8.0%)

(4) Kidney Health Evaluation for Patients with Diabetes (KED)

(5) Statin Therapy for Patients with Diabetes (SPD)– Therapy

f. Other Chronic and Acute Care

(1) Asthma Medication Ratio (AMR) – Total

(2) Controlling High Blood Pressure (CBP)

(3) Statin Therapy for Patients with Cardiovascular Disease (SPC)- Therapy

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

5. In addition to the above provisions, the Agency will review the Specialty Product data related to the performance measures specified heretofore to determine acceptable performance levels and may establish sanctions for these measures based on those levels after the first year of the Contract. In addition to the provisions set forth in the MMA Exhibits, the Agency reserves the right to determine performance measure groups which shall be subject to the sanction provisions for the Specialty Product performance measures.

D. Other Sanctions

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

E. Notice of Sanctions

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

F. Dispute of Sanctions

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

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Section XIII. Liquidated Damages

A. Damages

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

B. Issues and Amounts

1. Liquidated Damages Applicable to All Medical Assistance Plan Types

If the Managed Care Plan fails to perform any of the services set forth in the Contract, the Agency may assess liquidated damages for each occurrence listed in the MMA Issues and Amounts Table, **Table 12**, below.

TABLE 12 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
1.	Failure to comply with the enrollee records documentation requirements pursuant to the Contract.	One thousand dollars **($1,000)** per enrollee record that does not include all of the required elements.
2.	Failure to comply with the federal and/or State well-child visit eighty percent (80%) screening rate and/or federal eighty percent (80%) well-child visit participation rate requirements described in the Contract.	Fifty thousand dollars **($50,000)** per occurrence in addition to ten thousand dollars **($10,000)** for each percentage point less than the target.
3.	Failure to attend scheduled or ad hoc CMAT staffing(s) for their assigned enrollees receiving private duty nursing, receiving medical foster care services, or receiving services in a skilled nursing facility.	One thousand dollars **($1,000)** per occurrence
4.	Failure to convene an MDT meeting focused on transition planning, as required in the Contract, for enrollees receiving services in a skilled nursing facility.	Five hundred dollars **($500)** per occurrence

TABLE 12 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
5.	Failure to develop and maintain a person-centered individualized service plan, as required in the Contract, for enrollees receiving private duty nursing services or receiving services in a skilled nursing facility.	Five hundred dollars **($500)** per occurrence
6.	Failure to develop and maintain a person-centered plan of care, as required in the Contract, for enrollees receiving medical foster care services.	One thousand dollars **($1,000)** per occurrence
7.	Failure to provide early intervention services within thirty (30) days from the date the IFSP was completed for children enrolled in the Early Steps Program.	One thousand dollars **($1,000)** per occurrence
8.	Failure to provide coordination of aftercare services at least thirty (30) days prior to discharge from a residential treatment setting for enrollees receiving residential psychiatric treatment.	One thousand dollars **($1,000)** per occurrence
9.	Failure to pay physician payment rates equal to or in excess of Medicare rates for services provided as part of a physician incentive plan approved by the Agency in accordance with Section 409.967(2)(a), F.S.	One thousand dollars **($1,000)** per occurrence, plus one hundred dollars **($100)** per day for each day the physician has not received payment.
10.	Failure to develop and document a treatment or service plan for an enrollee with complex medical issues, high service utilization, intensive health care needs, or who consistently accesses services at the highest level of care, that shall be documented in writing as described in the Contract.	Five hundred dollars **($500)** per deficient/missing treatment or service plan.
11.	Failure to provide coordination of hospital/institutional discharge planning and post discharge care of children that are involuntarily or voluntarily admitted to an inpatient psychiatric facility, including a crisis stabilization unit.	One thousand dollars **($1,000)** per occurrence

TABLE 12 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
12.	Failure to make referrals per the requirements and timeframes indicated in the Contract to complete the clinical eligibility process for members turning eighteen years (18) if residing in a nursing facility, or twenty-one (21) years if receiving private duty nursing services, when the enrollee or their authorized representative has expressed a desire to enroll in the LTC program.	One thousand dollars **($1,000)** per occurrence, plus one hundred dollars **($100)** per day for each day after the six (6) month requirement.
13.	Failure to comply with standards for the completion of health risk assessments.	Two thousand five hundred dollars **($2,500)** per occurrence.
14.	Failure to dispense imported prescription drugs included on the Wholesale Prescription Drug Importation List to enrollees for whom Medicaid is the primary payor.	Five hundred dollars **($500)** per occurrence, plus the cost of the imported prescription drugs that would have been dispensed.
15.	Failure to bring each pharmacy provider agreement into compliance with the requirements of the Canadian Prescription Drug Importation Program or to terminate the pharmacy provider's agreement by one hundred eighty (180) days after implementation of the Canadian Prescription Drug Importation Program with the Managed Care Plan.	Five hundred dollars (**$500**) per day for each day following the one hundred eightieth (180th) day after implementation of the Canadian Prescription Drug Importation Program with the Managed Care Plan that the Plan fails to bring each pharmacy provider agreement into compliance with the requirements of the Canadian Prescription Drug Importation Program and to terminate noncompliant pharmacy provider agreements.
16.	Failure to execute each dental plan agreement that is neither reviewed, approved, nor executed by one hundred twenty (120) days after contract initiation with the Agency.	Five hundred dollars (**$500**) per day for each day following the one hundred twentieth (120th) day after contract execution that the dental plan agreement is not executed as required.
17.	Failure to execute each dental plan agreement that is neither reviewed, approved, nor executed by one hundred twenty (120) days after contract initiation with the Agency. Failure to notify eligible physicians of the Agency's MPIP qualifying criteria at least sixty (60) days prior to October 1 of each year.	Five hundred dollars (**$500**) per day for each day following the one hundred twentieth (120th) day after contract execution that the dental plan agreement is not executed as required. Five thousand dollars (**$5,000**) per occurrence.

TABLE 12 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
18.	Failure to notify eligible physicians of the Agency's MPIP qualifying criteria at least sixty (60) days prior to October 1 of each year.	Five thousand dollars (**$5,000**) per occurrence.
19.	Failure to meet minimum requirements of the VBP arrangement as described in the Contract.	Five thousand dollars (**$5,000**) per occurrence.
20.	Failure to meet VBP reporting requirements as described in the Contract.	Two thousand five hundred dollars **($2,500)** per occurrence.
21.	Failure to meet VBP benchmarks as described in the Contract.	Fifty thousand dollars **($50,000)** per occurrence
22.	Failure to achieve at least a two (2) percent reduction for an Agency-Calculated Performance Measure.	Five thousand dollars **($5,000)** per occurrence.
23.	Failure to develop and maintain a person-centered plan of care, as required in the Contract, for enrollees.	One thousand dollars **($1,000)** per occurrence.
24.	Failure to execute and implement health home contracts with Florida Children's hospitals as described in this Contract.	Ten thousand dollars **($10,000)** per occurrence.
ADDITIONAL LIQUIDATED DAMAGES ISSUES AND AMOUNTS FOR THE MANAGED CARE PLAN OFFERING A SPECIALTY PRODUCT		
25.	Failure to verify Specialty population eligibility criteria of an enrolled recipient within the timeframes in the Specialty product's policies and procedures.	One hundred fifty dollars **($150)** per day for every day beyond the enrollment date.
26.	Failure to comply with required Specialty product policies and procedures subject to Agency approval pursuant to the Contract.	One thousand dollars **($1,000)** per occurrence.
27.	For the HIV/AIDS Specialty product, failure to achieve at least a three (3) percent improvement for the HRSA-Ryan White Program Performance Measures.	Five thousand dollars **($5,000)** per occurrence.

2. In addition to the provisions set forth in **Attachment II** and its Exhibits, the Agency will review the Specialty product's performance related to the performance measures specified heretofore to determine acceptable performance levels and may set liquidated damages for these measures based on those levels after the first year of the Contract.

C. Performance Measure Liquidated Damages

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

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

2. For performance measures in Tier 1 where the Managed Care Plan's rate is below the fiftieth (50th) percentile, liquidated damages may be assessed at one hundred seventy-five dollars **($175)** per eligible member not receiving the service being measured up to the fiftieth (50th) percentile rate for the measure.

3. For performance measures in Tier 2 where the Managed Care Plan's rate is below the fiftieth (50th) percentile, liquidated damages may be assessed at one hundred twenty-five dollars **($125)** per eligible member not receiving the service being measured up to the fiftieth (50th) percentile rate for the measure.

4. For performance measures in Tier 3 where the Managed Care Plan's rate is below the fiftieth (50th) percentile, liquidated damages may be assessed at one hundred dollars (**$100**) per eligible member not receiving the service being measured up to the fiftieth (50th) percentile rate for the measure.

5. The Agency may reduce the liquidated damage amount for Tier 1 by fifty dollars (**$50**), Tier 2 by thirty-five dollars (**$35**), and Tier 3 by twenty dollars (**$20**) per eligible enrollee when:

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

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

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

   a. <u>Tier 1</u>:

      (1) Timeliness of Prenatal Care

      (2) Postpartum Care

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

(4) Well-Child Visits in the First 30 Months – Age 15 Months-30 Months

(5) Adherence to Antipsychotic Medications for Individuals with Schizophrenia

(6) Antidepressant Medication Management – Effective Acute Phase Treatment

(7) Follow-up after ED Visit for Mental Illness – 7 Day

(8) Follow-up after ED Visit for Substance Use – 7 Day

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

(10) Child and Adolescent Well-Care Visits – Total

(11) Childhood Immunization Status – Combo 3

(12) Glycemic Status Assessment for Patients with Diabetes – Control (<8.0%)

(13) Controlling High Blood Pressure

(14) Immunizations for Adolescents – Combo 2

b. Tier 2:

(1) Prenatal Immunization Status – Combination

(2) Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication

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

(4) Initiation and Engagement of Alcohol & Other Drug Abuse or Dependence Treatment – Initiation of AOD – Total

(5) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total

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

(7) Asthma Medication Ratio – Total

(8) Eye Exam for Patients with Diabetes

(9) Blood Pressure Control for Patients with Diabetes

(10) Kidney Health Evaluation for Patients with Diabetes

(11) Statin Therapy for Patients with Diabetes – Therapy

(12) Statin Therapy for Patients with Cardiovascular Disease – Therapy

c. Tier 3:

(1) Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total – Blood Glucose and Cholesterol Testing

(2) Breast Cancer Screening

(3) Cervical Cancer Screening

(4) Chlamydia Screening in Women – Total

(5) Colorectal Cancer Screening

(6) Lead Screening in Children

(7) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation

7. Additional Performance Measure Liquidated Damages Specific to the Specialty Product

In addition to the above Performance Measure Liquidated Damages, the Agency may assess liquidated damages for the following measures when plan performance measure rates are below the 60th percentile:

a. Serious Mental Illness

(1) Tier 1:

(a) Adherence to Antipsychotic Medications for Individuals with Schizophrenia

(b) Antidepressant Medication Management – Effective Acute Phase Treatment

(c) Follow-up after ED Visit for Mental Illness – 7 Day

(d) Follow-up after ED Visit for Substance Use – 7 Day

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

(2) Tier 2:

(a) Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication

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

(c) Initiation and Engagement of Alcohol & Other Drug Abuse or Dependence Treatment – Initiation of AOD – Total

(d) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total

(3) Tier 3:

(a) Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total – Blood Glucose and Cholesterol Testing

b. HIV/ AIDS

There are no additional Performance Measure Liquidated Damages applicable to the HIV/AIDS Specialty product.

c. Child Welfare

In addition to the Performance Measure Liquidated Damages in the this Exhibit, the Agency may assess liquidated damages for the following measures when plan performance measure rates are below the 60th percentile:

(1) Tier 1:

(a) Well-Child Visits in the First 30 Months – Age 15 Months-30 Months

(b) Child and Adolescent Well-Care Visits – Total

(c) Childhood Immunization Status – Combo 3

(d) Immunizations for Adolescents – Combo 2

(2) Tier 2:

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

(b) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total

(3) Tier 3:

(a) Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total – Blood Glucose and Cholesterol Testing

(b) Lead Screening in Children

(c) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation

8. The Agency may amend the performance measure listing and methodology for liquidated damages with sixty (60) days' advance notice.

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Section XIV. Special Terms and Conditions

The special terms and conditions in **Attachment II**, **Section XIV.**, Special Terms and Conditions, apply to the Managed Care Plan covering MMA services.

A. Applicable Laws and Regulations

The Mental Health Parity and Addictions Equity Act

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

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

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

B. Coordination of Medical and Dental Services

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

2. Within one hundred twenty (120) days of contract execution, the Managed Care Plan shall enter into a coordination of benefits agreement with each SMMC Dental Plan. The written agreements must include, at a minimum, sections addressing the following:

   a. Quarterly, bidirectional data sharing between the Managed Care Plan and the Dental Plan that specifies the enrollee data to be shared, HIPAA protection of the data, and how the data will be used to improve dental quality performance measures;

   b. Goals, measurable objectives, and actionable strategies to integrate dental and physical health care for enrollees;

   c. Goals, measurable objectives, and actionable strategies to provide prevention, education, screening, and treatment services in schools and other community settings;

   d. Goals, measurable objectives, and actionable strategies for reducing potentially preventable events (PPE), including but not limited to potentially preventable emergency department visits (PPV), potentially preventable hospital admissions (PPA), and potentially preventable hospital readmissions (PPR);

   e. Coordination protocols for the timely care of people with cleft lip, cleft palate, or other craniofacial deformities, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;

f. Coordination protocols for the timely dental care of people with intellectual or developmental disabilities (IDD), such as people covered by the iBudget waiver, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;

g. Coordination protocols for the timely dental care of pregnant people, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;

h. Coordination protocols for timely access and utilization of ambulatory surgical centers (ASC) for dental procedures, including but not limited to how to authorize urgent ASC care for enrollees undergoing dental procedures;

i. Training the Managed Care Plan's medical providers about dental benefits offered by the Dental Plan and how to refer enrollees for dental care; and

j. Plan to evaluate the effectiveness of the agreement on an annual basis.

3. Before dental plan agreement execution, the Managed Care Plan must provide the Agency thirty (30) days to review and approve the agreements.

4. The Managed Care Plan shall be subject to liquidated damages for each dental plan agreement that is neither reviewed, approved, nor executed by one hundred twenty (120) days after contract initiation with the Agency.

5. The Managed Care Plan shall provide an annual report to the Agency about its effectiveness in coordinating dental care with the Dental Health Plans. For each Dental Health Plan agreement, the annual report shall include, at a minimum, the following:

   a. Summary of data shared between the Managed Care Plan and the Dental Plan;

   b. Trend data on the dental-related potentially preventable events, including PPV, PPA, PPR, and the impact of the agreement on those trends;

   c. Trend data about enrollees with cleft lip and cleft palate (including age, sex, case characteristics, county of residence, and region of residence), proportion in various stages of repair, the timeliness of various stages of repair, the provider types paid to care for enrollees with cleft lip and cleft palate, and the facilities providing repair for enrollees with cleft lip and cleft palate;

   d. Trend data about the use of ambulatory surgical centers for dental procedures, including the number of centers, the geographic distribution of the centers, procedures performed in the centers, and provider types, such as anesthetist, dentist, or surgeon;

   e. Trend data on dental quality performance measures and the impact of the agreements on the trend;

   f. Descriptions of revisions to coordinated efforts to improve dental quality performance measures that are below 50th percentile; and

g. Summary data on Managed Care Plan provider trainings about dental benefits.

6. If the Managed Care Plan fails to comply with the requirements of this Sub-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.

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Section XV. Accountability

A. Required Reports

The Managed Care Plan shall comply with all reporting requirements set forth in this Contract, including reports specific to the MMA managed care program as specified in the Summary of Accountability Table, **Table 13**, below, and the Managed Care Plan Report Guide.

TABLE 13 SUMMARY OF REPORTING REQUIREMENTS		
Report Name	**Program Type**	**Frequency**
Actual Value of Enhanced Payment (AVEP) MMA Physician Incentive Payment (MPIP) Report	MMA Program	Semi-Annual
Annual and Quarterly Pharmacy Claims Reconciliation Report	MMA Program	Quarterly Annually
Appointment Wait Times Report	MMA Program	Quarterly
Child Staffing Attendance Report	MMA Program	Monthly
ER Visits for Enrollees without PCP Appointment Report	MMA Program	Annually
Estimated Value of Enhanced Reimbursement (EVER)/Qualified Provider MMA Physician Incentive Program (MPIP) Report	MMA Program	Annually
Health Risk Assessment Report	MMA Program	Quarterly
Healthy Behaviors	MMA Program	Quarterly
HSA Ombudsman Log	MMA Program	Quarterly
HSA Survey	MMA Program	Annually
Institution for Mental Diseases (IMD) Reimbursement	MMA Program	Semi-Annual
Medical Foster Care Services Report	MMA Program	Monthly
PCP/PDP Appointment Report	MMA Program	Annually
Hope Florida Reporting	MMA Program	Annually

TABLE 13 SUMMARY OF REPORTING REQUIREMENTS		
Report Name	**Program Type**	**Frequency**
MMA Physician Incentive Program (MPIP) Quality Measures Report	MMA Program	Annually
Residential Psychiatric Treatment Report	MMA Program	Monthly
Service Authorization Timeliness Performance Outcome Report	MMA Program	Monthly
Supplemental HIV/AIDS Report	MMA Program	Monthly
Value-Based Purchasing Report	MMA Program	Quarterly
Well Child Health Check-Up Visit (CMS-416) and FL 80% Screening	MMA Program	Annually

B. Required Submissions

The Managed Care Plan shall comply with all submission requirements set forth in this Contract, including submissions specific to the MMA managed care program as specified in the Summary of MMA Submission Requirements Table, **Table 14**, below, and the Managed Care Plan Submissions Summary.

TABLE 14 SUMMARY OF MMA SUBMISSION REQUIREMENTS		
Submission Name	**Program Type**	**Due**
Enrollee Handbook Requirements	Specialty Product	June 1
Mental Health Parity and Addictions Equity Act (MHPAEA) Compliance	MMA Program	November 1
Root Cause Analysis	Specialty Product	November 1

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Section XVI. Definitions and Acronyms

A. Definitions

Canadian Prescription Drug Importation Program – As described in s. 381.02035, F.S.

Wholesale Prescription Drug Importation List – As described in s. 381.02035, F.S.

B. Acronyms

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

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