ATTACHMENT II
EXHIBIT II-C - UPDATE: FEBRUARY 1, 2025
COMPREHENSIVE INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
MANAGED CARE PILOT PROGRAM

Section I. Definitions and Acronyms

The provisions in **Attachment II and its Exhibits** apply to this Managed Care Plan, unless otherwise specified in this Exhibit.

A. Definitions

In addition to the definitions required in **Attachment II**, **Section I,** Definitions and Acronyms, Sub-Section A. Definitions, the Managed Care Plan shall use the following terms:

Developmental Disability (DD) - As defined in s. 393.063(11), F.S.

iConnect - As defined in Rule 65G-13.001, F.A.C.

Intellectual Disability (ID) - As defined in s. 393.063(23), F.S.

HCBS Settings Providers - Assisted Living Facilities, Adult Family Care Homes, Adult Day Health Centers, and settings that provide the following Comprehensive Pilot Services: Residential Habilitation, Adult Day Training, and Prevocational Services.

B. Acronyms

In addition to the acronyms in **Attachment II**, **Section I.**, Definitions and Acronyms, the Managed Care Plan shall use the following additional acronyms:

IDD - Intellectual and Developmental Disabilities

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Section II. General Overview

A. Purpose

1. As a result of changes in the law passed during the 2023 Florida Legislative session, the State was directed to seek federal approval to pay through a managed care model for comprehensive Medicaid services, including home and community-based services described in s. 393.066(3), Florida Statutes (F.S.) and approved through the State's home and community-based services Medicaid waiver program for individuals with intellectual and developmental disabilities (IDD). The Agency in consultation with the Agency for Persons with Disabilities (APD) obtained authority from the Centers for Medicare & Medicaid Services (CMS) to implement the Comprehensive IDD Pilot Program in Statewide Medicaid Managed Care (SMMC) Regions D and I for coverage of comprehensive services pursuant to s. 393.066(3), F.S.

2. The Agency awarded the Comprehensive IDD Managed Care Pilot Program (Comprehensive IDD Pilot Program) to an existing Long-Term Care (LTC) Plan providing services pursuant to s. 409.981, F.S.

3. The Agency will administer the program in consultation with APD and will share with APD any and all program data provided to the Agency by the Managed Care Plan, as needed, in the course of that administration. The Agency will consult with APD on audits relating to person centered care, development of measures of access, quality, and quality assurance monitoring, and will conduct these and other activities in consultation with APD.

4. The Managed Care Plan shall ensure services meet the home and community-based settings requirements specified in 42 CFR 441.301.

5. The Participant Directed Option included in **Attachment II, Exhibit II-B** is not included in the Comprehensive IDD Pilot Program.

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

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Section III. Eligibility and Enrollment

A. General Provisions

Enrollee participation in the Comprehensive IDD Pilot Program is voluntary and limited to the maximum number of enrollees specified in the General Appropriations Act. Enrollment in the Comprehensive IDD Pilot Program does not automatically entitle enrollees to any other services under Chapter 393, F.S.

B. Eligibility

1. The population eligible to receive Comprehensive IDD Pilot Program services shall consist of only those voluntary recipients specified in **Attachment II and its Exhibits** of this Contract, who also meet the following criteria:

a. Must be eligible for Medicaid.

b. Must be eighteen (18) years of age or older.

c. Must be in a pre-enrollment category for Developmental Disabilities Individual Budgeting Waiver (iBudget) services under chapter 393, F.S. and assigned to one (1) pre-enrollment categories 1 through 6, as specified in s. 393.065(5), F.S.

d. Must reside in a region (Region D or Region I) in which the Managed Care Plan is authorized to provide Comprehensive IDD Pilot Program services.

2. The Agency in consultation with APD reserves the right to make adjustments to the eligibility requirements and criteria used to identify recipients eligible to enroll in a Managed Care Plan and receive Comprehensive IDD Pilot Program services.

C. Enrollment

1. General Provisions

a. The APD will offer the opportunity of enrollment to all individuals within each specified pre-enrollment category and will prioritize enrollment on a first-come, first-served basis to funded geographical areas.

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

c. The Managed Care Plan shall provide Comprehensive IDD Pilot Program services to Medicaid recipients who meet eligibility requirements for the Comprehensive IDD Pilot Program, as authorized by the Agency and APD.

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

2. Verification of Enrollment

There are no additional verification of enrollment provisions unique to the Comprehensive IDD Pilot Program.

3. Temporarily Stopping or Limiting Enrollment

There are no additional temporary stopping or limiting enrollment provisions unique to the Comprehensive IDD Pilot Program.

D. Disenrollment

1. General Provisions

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

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

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

d. In addition to the reasons cited in Rule 59G-8.600, F.A.C., the following reason constitutes cause for disenrollment from the Managed Care Plan: The enrollee is an American Indian or Alaskan Native as defined in 42 CFR 438.14(a).

2. Involuntary Disenrollment

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

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Section III. Eligibility and Enrollment

3. Voluntary Disenrollment

a. Enrollees receiving Comprehensive IDD Pilot Program services may request disenrollment from the program at any time. Enrollees who wish to disenroll and who have participated in the Comprehensive IDD Pilot Program for at least one (1) year will be offered immediate enrollment into either the LTC or iBudget waiver programs upon disenrollment from the Comprehensive IDD Pilot Program. Enrollees wishing to enroll in one of the other waiver programs must still meet the eligibility criteria for those waivers to enroll.

b. The Managed Care Plan shall submit a monthly disenrollment report to the Agency when the Managed Care Plan is notified by the enrollee of their request to disenroll for any reason from the Comprehensive IDD Pilot Program.

4. Medicaid Redetermination Assistance

There are no additional Medicaid Redetermination Assistance provisions unique to the Comprehensive IDD Pilot Program.

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Section IV. Marketing

Any marketing of the Comprehensive IDD Pilot Program that includes a program description shall utilize Agency-approved language.

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Section V. Enrollee Services

A. General Provisions

There are no additional general provisions unique to the Comprehensive IDD Pilot Program.

B. Enrollee Materials

1. New Enrollee Procedures and Materials

a. The Managed Care Plan shall provide new enrollee materials no later than five (5) business days after the effective date of enrollment for all enrollees.

C. Enrollee Services

1. Toll-Free Enrollee Helpline

a. There are no additional general provisions to the Comprehensive IDD Pilot Program.

2. Level of Care Redetermination

The Managed Care Plan shall:

a. Conduct Level of Care (LOC) redeterminations as required by this Contract.

b. Track LOC redeterminations to ensure enrollees are reassessed face-to-face using the APD-form **iBudget HCBS Waiver Eligibility Work Sheet** to ensure the LOC determination is authorized annually.

c. Ensure the appropriate Managed Care Plan staff have received the APD-specified training for completion of the APD-form **iBudget HCBS Waiver Eligibility Work Sheet** using the APD iConnect system.

d. The Managed Care Plan shall conduct the annual LOC redetermination and submit the completed APD-form **iBudget HCBS Waiver Eligibility Work Sheet**, **APD-iConnect Person-Centered Support Plan (PCSP),** and any required medical documentation to APD between sixty (60) and thirty (30) days prior to the one (1) year anniversary date of the previous LOC determination.

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Section VI. Service Administration

A. Required Comprehensive IDD Pilot Program Benefits

1. General Provisions

a. The Managed Care Plan shall provide all services as specified in **Exhibit II-A** Managed Medical Assistance (MMA) Program and **Exhibit II-B**, Long-Term Care (LTC) Managed Care Program as specified in 409.973 F.S. and in this **Exhibit**.

b. In the provision of covered services for Comprehensive IDD Pilot Program enrollees, the references in the Florida Medicaid Polices and Rule References for covered services in the Comprehensive IDD Pilot Program are in the Florida Medicaid Policies and Rule References for Pilot Program Services Table, **Table 1**, shall supersede any references to covered services in **Exhibit II-B**, Long-Term Care (LTC) Managed Care Program.

c. In the provision of covered services, the Managed Care Plan shall ensure services meet the medical necessity criteria, as defined in 59G-1.010, F.A.C.

2. Specific Comprehensive IDD Pilot Program Services to be Provided

The Managed Care Plan shall provide covered services specified in s. 409.98, F.S. and s. 393.066(3), F.S., the approved federal waivers for the Comprehensive IDD Pilot program, and the following Medicaid rules and services listed on the associated fee schedules. When providing services under **Section VI.A.1.a.,** above, which exceed limits outlined in the Florida Medicaid Coverage and Limitations Handbooks, Florida Medicaid Coverage Policies, and the associated Florida Medicaid Fee Schedules, the Managed Care Plan shall comply with the approved federal waivers for the Comprehensive IDD Pilot program and applicable Medicaid rules. Florida Medicaid Polices and Rule References for covered services in the Comprehensive IDD Pilot Program are in the Florida Medicaid Policies and Rule References for Comprehensive IDD Pilot Program Services Table, **Table 1**, below:

TABLE 1
FLORIDA MEDICAID POLICIES AND RULE REFERENCES FOR COMPREHENSIVE IDD PILOT PROGRAM SERVICES

Rule No.	Policy Name	Applicable Comprehensive IDD Pilot Program Services
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Companion
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Supported Employment

59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Adult Day Training
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Prevocational Services
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Consumable Medical Supplies
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Durable Medical Equipment
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Environmental Accessibility Adaptions
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Personal Emergency Response System
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Personal Supports
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Residential Habilitation (Standard)
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Residential Habilitation (Behavior Focused)
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Residential Habilitation (Intense Behavior)
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Residential Habilitation (Enhanced Intensive Behavior)
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Special Medical Home Care
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Supported Living Coaching
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Behavior Analysis Services
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Behavior Assistant Services

59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Dietitian Services
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Private Duty Nursing
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Residential Nursing Services
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Skilled Nursing
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Occupational Therapy
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Physical Therapy
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Respiratory Therapy
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Speech Therapy
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Specialized Mental Health Counseling
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Transportation Services
59G-13.070	Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook	Dental Services*
59G-4.192	Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy	Adult Day Health Care
59G-4.192	Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy	Assisted Living
59G-4.192	Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy	Home Delivered Meals
59G-4.192	Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy	Caregiver Training

59G-4.192	Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy	Medication Administration
59G-4.192	Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy	Medication Management
59G-4.192	Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy	Assistive Care
59G-4.192	Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy	Hospice

*Coverage of dental services through the Comprehensive IDD Pilot Program is secondary to the dental services provided by the Statewide Medicaid Managed Care Dental Program and associated expanded benefits.

B. Expanded Benefits

The Managed Care Plan shall provide all expanded benefits as described in **Attachment I** to Comprehensive IDD Pilot Program enrollees. Additional expanded benefits may be provided to enrollees as agreed upon by the Managed Care Plan and as approved by the Agency.

C. Excluded Services

There are no additional provisions unique to the Comprehensive IDD Pilot Program.

D. Coverage Provisions

1. Comprehensive IDD Pilot Program Services provided in an APD Licensed Group Home

The Managed Care plan must consult with APD before placing a Comprehensive IDD Pilot Program enrollee in a group home licensed by APD.

2. Service Gap Identification and Contingency Plan

There are no additional provisions unique to the Comprehensive IDD Pilot Program.

3. Reactive Strategies

a. The Managed Care Plan shall ensure all care coordinators and network providers are in compliance with s. 393.13, F.S., “Treatment of persons with developmental disabilities”, during service planning and delivery. Section 393.13, F.S., outlines the rights of individuals with developmental disabilities. The intent is the treatment and services provided to the Comprehensive IDD Pilot Program enrollees should be designed to meet the needs of the enrollee, protect the integrity of their legal and

human rights, and be directed by the principles of self-determination.

b. The Managed Care Plan shall ensure services are to be provided in the least restrictive environment and promote opportunities for community inclusion. Additionally, s. 393.13, F.S. specifies the following with regards to treatment and behavior management:

(1) Enrollees shall receive prompt medical treatment that is consistent with accepted standards of medical practice in the community;

(2) Medication shall not be used as punishment, for the convenience of staff, as a substitute for behavior analysis services, or in unnecessary or excessive quantities;

(3) Enrollees shall not be subjected to a treatment program to eliminate problematic or unusual behaviors without first being examined by a physician who determines that such behaviors are not organically caused;

(4) Treatment programs involving the use of noxious or painful stimuli are prohibited; and

(5) Enrollees have the right to be free from unnecessary use of restraint or seclusion. Use of these shall be employed only in emergencies to protect the enrollee or others from imminent injury. Use of restraints are not to be employed as punishment, for the convenience of staff, or as a substitute for a support plan. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends, further, they shall not cause physical injury to the enrollee and shall be designed to allow the greatest possible comfort.

c. The Managed Care Plan shall ensure all care coordinators have received training on the requirements of 65G-8 F.A.C., “Reactive Strategies”. This shall include at minimum:

(1) Identification of increased service need due to problematic or unusual behaviors and documentation of need in the Person-Centered Support Plan;

(2) Requesting and authorizing Behavior Support Assessment services, and subsequent approval of Behavior Support services;

(3) The different types of reactive strategies that may be implemented and prohibited procedures;

(4) The requirements for approval of use of reactive strategies; and

(5) The documentation and reporting requirements for when reactive strategies are used.

d. All Comprehensive IDD Pilot Program network providers serving enrollees with problematic or unusual behaviors that may require use of reactive strategies are required to train their staff in an APD approved curriculum for emergency procedures as described in 65G-8, F.A.C., "Reactive Strategies". Such training programs must be approved by APD prior to implementation by the provider and prior to implementation of reactive strategies with the enrollee. The network provider must maintain records of certification of all staff for review by the Managed Care Plan, APD, and the Agency.

e. The Managed Care Plan Care coordinators are responsible for ensuring all behavior support plans are submitted to the appropriate APD Region Local Review Committee (LRC) in accordance with the requirements set forth in Chapter 65G-4, F.A.C. The use of reactive strategies shall follow the requirements set forth in Chapter 65G-8, F.A.C. Behavior Analysts work with the APD Region LRC on submission and discussion of plans; however, the care coordinator must track and document the process and committee decisions.

f. The Managed Care Plan shall ensure all network providers document and report the use of approved reactive strategies to APD and the Managed Care Plan Care Coordinator in accordance with Rule 65G-8, F.A.C.

4. Medication Administration

a. Pursuant to Rule 65G-7, F.A.C., "Medication Administration," any enrollee's need for assistance with medication administration or ability to self-administer medication without supervision must be documented by the enrollee's physician, PA, or APRN on an "Authorization for Medication Administration," APD Form 65G-7.002A. The Managed Care Plan care coordinator shall ensure completion of these forms for all enrollees who are prescribed medication or take over-the-counter medication.

b. Pursuant to Rule 65G-7, F.A.C., "Medication Administration," in addition to an executed Authorization for Medication Administration Form and prior to providing an enrollee with medication assistance, a signed "Informed Consent for Medication Administration" APD Form 65G-7.002 B must be obtained from the client or the client's legal and/or authorized representative.

c. Prior to providing medication management to enrollees, all Comprehensive IDD Pilot Program network providers who are not licensed, authorized, certified, or otherwise permitted by Florida Law to administer medication or to supervise self-administration of medication must complete an approved "Basic Medication Administration Training" or "Prescribed Enteral Formula Administration Training" with an APD approved trainer.

d. The Managed Care Plan shall ensure sufficient numbers of RNs and LPNs in the service area are approved APD Medication Administration and Validation Trainers to train the network providers.

e. Network providers are required to comply with 65G-7 F.A.C., including all training, storage, and documentation requirements.

f. The Managed Care Plan care coordinator shall monitor for compliance with 65G-7 F.A.C. during face-to-face visits with enrollees. This monitoring shall include, at minimum:

(1) Review of staff Medication Assistance Provider (MAP) certification;

(2) Review of Medication Administration Record (MAR) for the last 90 days;

(3) Maintain a copy of any Medication Error Reports in the enrollee's central record;

(4) A review of all current prescriptions and doctors' orders and complete updates to the person-centered support plan as necessary; and

(5) Discuss with provider any potential medication errors, as defined by 67G-7.006 F.A.C., and ensure appropriate reporting measures were taken using APD form 65G-7.006 A., "Medication Error Report".

g. For enrollees who live in an APD licensed group home, the enrollee's care coordinator shall complete monitoring as described in **Section VI.**, Services Administration, **Sub-section D.**, Coverage Provisions, **Item 5**., Medication Administration, **Sub-Item d**. Additionally, APD staff monitor APD group homes on a monthly basis. The care coordinator shall work collaboratively with the APD team to ensure compliance with all aspects of medication management.

h. The Managed Care Plan shall issue alerts or reports to both the provider and APD when non-compliance with 65G-7 F.A.C. is identified during care coordination visits or other monitoring activities completed by the Managed Care Plan.

i. The Managed Care Plan shall submit the information included on the MAR to the Agency in accordance with **Attachment II**, **Section XVI.**, Reporting Requirements, and the Managed Care Plan Report Guide.

E. Care Coordination/ Case Management

1. General Provisions

a. The Managed Care Plan shall ensure that the enrollee and the enrollee's support system, including the legal representative and/or the authorized representative, as applicable, is involved in all face-to-face visits with the enrollee.

b. The Managed Care Plan shall complete and submit to DCF the CF-ES 2515 Form (Certification of Enrollment Status Home and Community Based Services (HCBS)) within ten (10) business days after receipt of the applicable enrollment file from the Agency or its agent. The Managed Care Plan shall retain proof of submission of the completed CF-ES 2515 Form (Certification of Enrollment Status HCBS) to DCF. The CF-ES 2515 Form (Certification of Enrollment Status HCBS) and the CF-ES 2515 Form Instructions are located at https://myflfamilies.com/forms

2. Care Coordination Program Description

Care Coordinators for Comprehensive IDD Pilot Program enrollees shall be dedicated one hundred percent (100%) to providing care coordination services to Comprehensive IDD Pilot Program enrollees as required in **Attachment II and its Exhibits**, and located in the State of Florida. Additionally, Care Coordinators will deploy a systematic approach to partner with and guide program enrollees and their support systems on an individualized path to maximize health and safety as well as well-being and potential.

3. Initial Visit

a. The Managed Care Plan shall conduct initial visits with enrollees in a face-to-face visit with the enrollee within five (5) business days of the enrollee's effective date of enrollment, or sooner, if the Managed Care Plan has information indicating that the enrollee has immediate needs for services.

b. At the initial face-to-face visit, the Managed Care Plan shall:

(1) Conduct the care coordination assessment, develop and finalize the person-centered support plan, including all goals and services to remove barriers and achieve client driven goals to achieve a state of thriving. Plan should also include the frequency, duration, and amount of supports and services that the Managed Care Plan, the enrollee and the enrollee's support system, including the legal representative and/or the authorized representative, as applicable, agree upon during the initial face-to-face visit.

(2) Confirm in writing the enrollee's receipt of the following items:

(i) Enrollee Handbook

(ii) Provider Directory

(iii) Managed Care Plan ID Card

(3) Explain the enrollee's rights and responsibilities, including procedures for filing a grievance, appeals, and or Medicaid Fair Hearing including continuation of benefits during the fair hearing process.

(4) Assist enrollees living in their own home or family home with developing a disaster/emergency plan for their household that considers the special needs of the enrollee and assist enrollees to register with the State's Emergency Preparedness Special Needs Shelter Registry, if applicable.

(5) Notify an enrollee residing in an Assisted Living Facility (ALF), Adult Family Care Home (AFCH), Group home, or is an enrollee receiving residential habilitation Adult Day Health Care (ADHC), adult day training, or prevocational services, of their right to receive Comprehensive IDD Pilot Program services in a residential or non-residential setting and to participate in his or her community, regardless of his or her living arrangement.

(6) Review the enrollee handbook to ensure enrollees and their legal and/or authorized representatives are familiar with the contents, especially related to covered services, enrollee rights and responsibilities, the grievance and appeals process, and reporting abuse, neglect, and exploitation; and

c. If the Managed Care Plan is unable to provide care coordination services to an enrollee, a letter requesting that the enrollee contact the Managed Care Plan should be left at, or sent to, the enrollee's residence. If the Managed Care Plan is unable to locate/contact the enrollee within a continuous sixty (60)-day period, the Managed Care Plan shall report the enrollee to the Agency in accordance with **Attachment II**, **Section XVI**., Reporting Requirements, and the Managed Care Plan Report Guide.

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

4. Comprehensive Assessment/Reassessment

The Managed Care Plan shall conduct a comprehensive assessment(s) and reassessment(s) of the enrollee utilizing APD-required forms including the **iBudget HCBS Waiver Eligibility Work Sheet** and the **APD Person-Centered Support Plan**. APD shall coordinate access and training for the Managed Care Pan care coordinator staff.

a. The Managed Care Plan shall conduct a comprehensive assessment of the enrollee that identifies enrollee needs across multiple domains, including current health conditions; functional, physical, or adaptive needs; current providers; caregiver or other supports available; natural supports; transportation barriers; medications; behavioral health conditions; preferences for treatment, time, and managing money; reactive strategies; personal goals; community living support needs; and the availability of caregiver support to inform the creation of the APD Person-Centered Support Plan, including the program enrollee's goals to achieve a state of thriving.

b. The Managed Care Plan shall conduct an annual reassessment (no later than three hundred sixty-four (364) days or more frequently, if needed) of the enrollee to facilitate the person-centered support plan update. The Managed Care Plan shall use the APD required **iBudget HCBS Waiver Eligibility Work Sheet**.

(1) The Managed Care Plan shall submit a monthly reassessment report to the Agency.

5. Initial Person-Centered Support Plan/Reviews

a. Person-Centered Support Plan Approach

(1) The Managed Care Plan shall identify the Comprehensive IDD Pilot Program service needs of enrollees in an APD-required support plan template in iConnect. The Managed Care Plan shall use a person-centered approach regarding the enrollee assessment and needs, documenting prior approval with APD of reactive strategies, taking into account not only covered services, but also other needed services and community resources, regardless of payor source, as applicable.

(2) The Managed Care Plan shall ensure that the process:

(a) Provides necessary information and support to ensure that the enrollee directs the process and is enabled to make informed choices and decisions. This includes allowing the enrollee to help make decisions about service options and the identification of personal goals.

(b) Allows the enrollee, regardless of setting, to achieve a state of thriving or maintain their highest level of self-sufficiency as identified through the enrollee's short, medium, and long-term goals.

(c) Allows the enrollee or legal and/or authorized representative to invite anyone of his or her choosing to participate.

(d) Is timely in accordance with **Section VI**., Service Administration, **Sub-Section E**., Care Coordination/Case Management, of this Attachment and occurs at times and locations of convenience to the enrollee.

(e) Offers the enrollee a choice regarding the services and supports the enrollee receives and from whom.

(f) Includes care coordinator contact information and a method for the enrollee to request updates to the person-centered support plan, as needed.

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

b. Person-Centered Support Plan Standard

(1) The Managed Care Plan shall develop a person-centered support plan in accordance with Rule 59G-13.070, F.A.C. and 42 CFR 441.301, within the timeframes specified within this Exhibit, that is based upon, at a minimum, the results of the APD-required HCBS waiver eligibility worksheet of the enrollee and that is specific to the enrollee's needs.

(2) The Managed Care Plan shall ensure that the written person-centered support plan:

(a) Reflects that the setting in which the enrollee resides is chosen by the enrollee.

(b) Reflects the enrollee's strengths, preferences, and self-care capabilities.

(c) Reflects clinical and support needs as identified through the comprehensive assessment process.

(d) Establishes person-centered goals and objectives, including employment/volunteer (as applicable) and community integration and community living goals, and desired wellness, health, functional, and quality of life outcomes for the member, and how HCBS services are intended to help the member achieve these goals.

(e) Reflects the services and supports (paid and unpaid) that will assist the enrollee to achieve identified goals, and the providers of those services and supports, including natural supports.

(f) Encourages the integration of natural supports including the development of an informal volunteer network of caregivers, family, neighbors, not for profit, faith based entities, and others to assist the enrollee or primary caregiver with supports, resources, and services. These supports will be integrated into an enrollee's person-centered support plan and correlated with the enrollee's goals to promote community integration, skills for independence, and maximization and achievement of their full potential as agreed to and approved by the enrollee or the enrollee's legal and/or authorized representative.

(g) Reflects risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

(h) Identifies the enrollee and/or entity (as appropriate) responsible for monitoring the person-centered support plan.

(i) Prevents the provision of unnecessary or inappropriate services and supports.

(j) Documents any modification and exception to the HCBS setting requirements are supported by a specific assessed need and documented in the person-centered support plan.

(k) Identifies any existing plans of care and service providers and assesses the adequacy of existing services.

(l) Determines whether the enrollee has advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian.

(3) The Managed Care Plan shall utilize the APD person-centered support plan template, in the iConnect system that addresses the criteria specified above and includes the minimum components specified in Rule 59G-4.192, F.A.C. and 42 CFR 441.301. The Managed Care Plan is permitted to keep another copy of the person-centered support plan in their system as long as it has all the same elements and information as the copy in the iConnect system.

(4) The enrollee or enrollee's legal and/or authorized representative shall indicate whether they agree or disagree with each service authorization, and review, sign, and date the person-centered support plan at initial development, annual review, and any time the person-centered support plan is updated. The enrollee may request additional time to review a draft person-centered support plan prior to signing. Signatures may be hard copy or electronic.

(5) The Managed Care Plan shall provide a copy of the person-centered support plan to the enrollee or enrollee's legal and/or authorized representative.

(6) The Managed Care Plan shall ensure that a copy of the enrollee's person-centered support plan is forwarded within ten (10) business days of initial development or any subsequent updates, to the enrollee's primary care provider (PCP) and, if applicable, to the HCBS Settings Provider(s). The PCP and HCBS Settings Provider(s) shall be advised, in writing, of whom to contact with questions regarding the adequacy of the person-centered support.

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

c. Service Planning Standard

(1) The Managed Care Plan shall ensure that, during face-to-face care planning, the care coordinator has an electronic tablet or device that captures all of the elements of assessments and the entire person-centered support plan. The tablet or device shall be interoperable with the Managed Care Plan's care management service authorization platform(s) and the iConnect system.

(2) The Managed Care Plan shall ensure the care coordinator:

(a) Documents the entire care planning process in the enrollee record.

(b) Provides the enrollee with information about the available providers when service needs are identified so that the enrollee can make an informed choice of providers.

(c) Coordinates the services with appropriate providers upon the enrollee's or enrollee legal and/or authorized representative's agreement to the person-centered support plan.

(d) Identifies the enrollee's PCP, specialists, and Comprehensive IDD Pilot Program providers involved in the enrollee's treatment and obtains the required authorizations for release of information in order to coordinate and communicate with the PCP and Comprehensive IDD Pilot Program providers.

(e) Informs the enrollee's PCP and Comprehensive IDD Pilot Program providers that the enrollee should be encouraged to adopt healthy habits and maintain his or her personal independence.

(f) Informs the enrollee or the enrollee's legal and/or authorized representative when a PCP must prescribe an HCBS service.

(g) Assists the enrollee in acquiring documentation needed for requested services, including a physician's order for those services requiring a physician's order.

(h) Coordinates the effort to obtain a PCP or to change the PCP if the enrollee does not have a PCP or wishes to change PCP.

(i) Verifies that medically necessary services are available in the enrollee's community. If a service is not currently available, the care coordinator shall substitute a combination of other services in order to meet the enrollee's needs until such time as the desired service becomes available. The enrollee may need a temporary alternative placement if services cannot be provided to safely meet the enrollee's needs.

(j) Monitors the services and placement of each enrollee assigned to their caseload in order to assess the continued suitability of the services and placement in meeting the enrollee's needs as well as the quality of the care delivered by the enrollee's service providers.

(3) The Managed Care Plan shall not require an enrollee to enter a living /setting because it is more cost-effective than other settings.

(4) The Managed Care Plan shall submit a summary report of the physical location/residence of all enrollees as specified in **Section XVI.,** Reporting

Requirements, and the Managed Care Plan Report Guide as well as ensure the information is updated within the iConnect system.

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

6. Monthly Contact Requirement

a. The Managed Care Plan shall maintain, at a minimum, monthly contact (virtual, telephonic, or face-to-face) with each Comprehensive IDD Pilot Program services enrollee, or the enrollee's legal and/or authorized representative, to verify satisfaction with and receipt of services, supports, and resources that contribute to the outlined goals within the person-centered plan, including, but not limited to, health safety, and well-being, any health status and concerns, and if there are any additional needs. If desired by the enrollee, or the enrollee's legal and/or authorized representative, the monthly contact shall be conducted face-to-face.

(1) For an enrollee residing in an APD-licensed residential facility, receiving supported living coaching, or receiving personal supports, the Managed Care Plan shall visit enrollees at least monthly to fulfill contact requirements as specified in the Developmental Disabilities Individual Budgeting Handbook.

(2) For an enrollee who has requested a voluntary suspension of authorized services, the Managed Care Plan shall obtain verbal or written consent prior to enacting a suspension of an HCBS service (except for private duty nursing services), using the Agency-required form. The Managed Care Plan may obtain verbal consent from the enrollee prior to enacting the suspension of service, but the Managed Care Plan shall follow up to obtain the enrollee or legal and/or authorized representative's signature on the form at the next face-to-face visit.

7. Ongoing Contact Requirements

a. The care coordinator shall meet face-to-face at least every ninety (90) days with the enrollee and/or the enrollee's legal and/or authorized representative, in order to:

(1) Review the enrollee's entire person-centered support plan and, if necessary, update the enrollee's person-centered support plan as warranted by changes in the enrollee's circumstances. The Managed Care Plan shall review the person-centered support plan in a face-to-face visit more frequently than once every ninety (90) days if the enrollee experiences a significant change.

(2) Discuss the frequency, duration, and amount of authorized services, confirm receipt of services, health status concerns, if there are any additional needs, and the authorized providers for each service. If the enrollee or the legal and/or

authorized representative reports any issues, or the care coordinator discovers any issues during the face-to-face visit, the care coordinator shall document the actions taken to resolve the issues as quickly as possible.

(3) Discuss and jointly assess measurable advancements and overall enrollee satisfaction in regard to progress made towards sequenced goals, removal of any identified barriers to the achievement of established goals, and any adjustments desired or necessary.

(4) Assess needs and identify any changes or enhancements necessary to the enrollee's support system, including informal unpaid community supports, and incorporate necessary steps and responsible party for the activation of identified resources.

(5) Discuss the enrollee's perception of his/her progress toward established goals.

(6) Identify any barriers to the achievement of the enrollee's goals.

(7) Develop new goals as needed.

(8) Document the enrollee's current functional, medical, behavioral, and social strengths.

b. The Managed Care Plan shall have an annual face-to-face visit with the enrollee to:

(1) Complete the annual reassessment with the enrollee and the enrollee's legal and/or authorized representative.

(2) Determine the enrollee's health status, functional status, satisfaction with services, and change in service needs to update the current person-centered support plan.

(3) Develop a new person-centered support plan.

c. The Managed Care Plan shall conduct a face-to-face visit with the enrollee within three (3) business days following an enrollee's change of placement type or following a significant change in an enrollee's condition. This review shall be conducted to ensure that appropriate services and supports are in place and that the enrollee agrees with the person-centered support plan as authorized.

d. For enrollees ages eighteen (18) through twenty (20) years and receiving private duty nursing services, the Managed Care Plan shall conduct the Multi-Disciplinary Team (MDT) review requirement as described in the applicable Coverage Policies. The Managed Care Plan shall:

(1) Conduct the MDT meeting concurrent with the initial plan of care development;

(2) Conduct the MDT meeting every six (6) months concurrent with the plan of care review; and

(3) Document the MDT meetings and recommendations in the enrollee record.

e. If the Managed Care Plan is unable to contact an enrollee to schedule an ongoing visit, a letter shall be sent to the enrollee or enrollee's legal and/or authorized representative requesting contact within ten (10) business days from the date of the letter. If no response is received by the designated date, the Managed Care Plan shall report such inability to locate enrollees to the Agency, as specified in **Section XVI.**, Reporting Requirements, and the Managed Care Plan Report Guide indicating loss of contact so that appropriate action may be taken.

8. Freedom of Choice

There are no additional provisions unique to Freedom of Choice for the Comprehensive IDD Pilot Program.

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

There are no additional provisions related to PASRR unique to the Comprehensive IDD Pilot Program.

10. Transition of Care

There are no additional provisions related to Transition of Care unique to the Comprehensive IDD Pilot Program.

11. Disease Management Program

There are no additional provisions related to the Disease Management Program unique to the Comprehensive IDD Pilot Program.

12. Quality Enhancements

There are no additional provisions related to Quality Enhancements unique to the Comprehensive IDD Pilot Program.

F. Authorization of Service

1. General Provisions

a. The Managed Care Plan 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 of individuals with IDD.

b. The Managed Care Plan shall develop and implement, subject to Agency approval, policies and procedures to notify the Agency of utilization of new clinical practice guidelines for treatment of individuals with IDD.

2. Service Authorization

a. The Managed Care Plan shall ensure service authorizations are consistent with the services documented on enrollee's person-centered support plan, including the amount, frequency, and duration necessary to support the enrollee adequately and safely in the setting of his or her choice.

b. The Managed Care Plan shall send authorizations to all applicable providers for the agreed upon services, including amount, frequency, and duration, within twenty-four (24) hours of the initial face-to-face visit. If the Managed Care Plan fails to comply with the requirements of this provision, the Managed Care Plan may be subject to liquidated damages pursuant to **Section XIV.,** Liquidated Damages, as determined by the Agency.

c. The Managed Care Plan shall start services for all HCBS, for eighty-five percent (85%) of the applicable population within seven (7) days of the initial face-to-face visit. The timeframe for starting services is measured by the number of days between the day of the initial face-to-face visit and the day on which all approved services are rendered or the first of the initial enrollment month, whichever is later.

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

d. The Managed Care Plan shall not deny covered services based on an incomplete person-centered support plan.

e. The Managed Care Plan shall authorize ongoing services within the timeframes specified in the enrollee's person-centered support plan.

f. The Managed Care Plan shall process service authorization requests for respite services requested on an emergent basis within the expedited timeframes specified in **Section VI.**, Service Administration, **Sub-Section F.**, Authorization of Services.

g. The Managed Care Plan may determine the duration for which services shall be authorized in accordance with the definition of medical necessary criteria, and shall be consistent with the end date of the services as specified in the person-centered support plan.

h. The Managed Care Plan shall not deny authorization for a service solely because a caregiver is at work or is unable to participate in the enrollee's care because of their own medical, physical, or cognitive impairments.

i. The Managed Care Plan shall not deny medically necessary services required for the enrollee to remain safely in the community because of cost.

j. If the care coordinator and PCP or attending physician do not agree regarding the need for a change in LOC, placement, or physician's orders for medical services, the care coordinator shall refer the case to the Managed Care Plan's Clinical Director for review. The Clinical Director shall work with the Medical Director responsible for reviewing the case, discussing it with the PCP and/or attending physician, if necessary, and making a determination in order to resolve the issue.

k. In addition to the requirements specified in **Attachment II**, the Managed Care Plan shall ensure a notice of adverse benefit determination is provided to enrollees receiving Comprehensive IDD Pilot Program 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.

3. Utilization Management Program Description

There are no additional Utilization Management Program Description provisions unique to the Comprehensive IDD Pilot Program.

4. Service Authorization System

There are no additional Service Authorization System provisions unique to the Comprehensive IDD Pilot Program.

G. Community Partnerships

The Managed Care Plan shall make referrals to local and regional community-based organizations and state-funded programs when there are identified needs that are not covered by the Comprehensive IDD Pilot Program. Referrals to community-based organizations and state-funded programs shall be made on behalf of the enrollee, caregiver, and others in the household to delay and prevent institutionalization and maximize community integration of the enrollee, caregiver, and others in the household.

1. Hope Florida - A Pathway to Prosperity and Additional Pathways

The Managed Care Plan will be required to provide care coordination to guide enrollees in need of an individualized path to prosperity. As additional pathways are identified, the Managed Care Plan shall provide care coordination/case management to guide enrollees in need of an individualized path to prosperity, future Hope Florida initiatives including a Pathway to Possibilities, by focusing on community collaboration between the private sector, faith-based community, nonprofits, and government entities; break down traditional community silos; maximize resources; and uncover opportunities for enrollees to achieve greater independence.

Section VII. Grievance and Appeal System

The Managed Care Plan shall submit a monthly summary report of all enrollees whose HCBS services have been denied, reduced, or terminated for any reason as specified in **Section XVI.,** Reporting Requirements, and the Managed Care Plan Report Guide.

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Section VIII. Provider Services

A. Network Adequacy Standards

1. Network Capacity and Geographic Access Standards

a. Pursuant to s. 409.982(4), F.S., 409.98(1)-(19), F.S., and 409.9855 (3), F.S., 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, Managed Medical Assistance Provider Network Standards Table 4, in **Exhibit II-A** and **Table 2,** Comprehensive IDD Pilot Program Network Adequacy Requirements Table, 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.

b. The Managed Care Plan shall ensure that physicians with training and demonstrated experience in treating individuals with intellectual and developmental disabilities are members of the provider network.

c. The Managed Care Plan shall ensure that providers are qualified to provide services listed in **Section VIII**. Provider Services, **Sub-Section A**. Network Adequacy Standards of **Attachment II and its Exhibits**, are members of the provider network.

d. The Managed Care Plan shall ensure that its providers are compliant with Chapter 393, F.S., as applicable.

e. All providers of the services listed in **Table 1**, Florida Medicaid Polices and Rule References for Comprehensive IDD Pilot Program Services, of this **Exhibit** that reference Rule 59G-13.070, F.A.C., must meet the provider qualifications outlined in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook as adopted by reference in rule 59G-13.070, F.A.C.

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TABLE 2 COMPREHENSIVE IDD PILOT PROGRAM NETWORK ADEQUACY REQUIREMENTS TABLE*		
Comprehensive IDD Managed Care Program Benefit	**Minimum Network Adequacy Requirements Urban Counties**	**Minimum Network Adequacy Requirements Rural Counties**
Adult Day Health Care	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Adult Dental Services*	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Assisted Living	≥ 2 providers with adequate staffing capacity and beds to serve the population.	≥ 2 providers with adequate staffing capacity and beds to serve the population.
Behavior Analysis Services	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Behavior Assistant Services	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Care Coordination	Each care coordinator's caseload may not exceed caseload ratios as described in **Section IX.B.6.b.** of this Exhibit.	The plan shall have adequate staffing capacity where the caseload does not exceed 18 enrollees per care coordinator.
Caregiver Training	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Dietitian Services	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Environmental Accessibility Adaptations	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Home Delivered Meals	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.

Hospice	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Life Skills Development Level 1 – Companion	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Life Skills Development Level 2 – Supported Employment	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Life Skills Development Level 3 – Adult Day Training	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Life Skills Development Level 4 – Prevocational Services	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Medication Administration	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Medication Management	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Occupational Therapy	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Personal Emergency Response System (PERS)	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Personal Supports	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Physical Therapy	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Private Duty Nursing	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Residential Habilitation	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.

Residential Nursing	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Respiratory Therapy	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Respite	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Skilled Nursing	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Specialized Medical Equipment and Supplies	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Specialized Medical Home Care	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Specialized Mental Health Counseling	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Speech Therapy	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.	≥ 2 providers with adequate staffing capacity within a 30-minute driving distance or 15 miles for 95% of enrollees.
Supported Living Coaching	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.
Transportation	≥ 2 providers with adequate staffing capacity to serve the population.	≥ 2 providers with adequate staffing capacity to serve the population.

*Coverage of dental services through the Comprehensive IDD Pilot Program is secondary to the dental services provided by the Statewide Medicaid Managed Care Dental Program and associated expanded benefits.

B. Network Management

1. General Provisions

The Managed Care Plan shall ensure Comprehensive IDD Pilot Program services are available to Comprehensive IDD Pilot Program enrollees on a seven (7) day a week basis, and for extended hours, as dictated by enrollee needs.

2. Annual Network Development Plan

The Managed Care Plan shall address the availability, including number of compliant HCBS Settings Providers and accessibility, of Comprehensive IDD Pilot Program services providers relevant to the Comprehensive IDD Pilot Program services population in its annual network plan submitted to the Agency in accordance with **Attachment II and its Exhibits**.

3. Regional Network Changes

In addition to the requirements of **Section VII**., Grievance and Appeal System, **Sub-Section B**., Expanded Benefits, the Managed Care Plan shall notify the Agency within seven (7) business days of the loss of a nursing facility, adult day health care center, AFCH, ALF, adult day training, prevocational services, or residential habilitation provider in a region where another participating nursing facility, adult day health care center, AFCH, ALF, prevocational services, or residential habilitation provider of equal service ability is not available to ensure compliance with the geographic access standards specified in this Exhibit.

4. Facility-based Services Provider Network Changes

There are no additional provisions related to Facility-based Services Provider Network Changes unique to the Comprehensive IDD Pilot Program.

C. Provider Credentialing and Contracting

1. General Provisions

There are no additional provisions related to General Provisions unique to the Comprehensive IDD Pilot Program.

2. Credentialing and Recredentialing

The Managed Care Plan shall verify provider credentialing and recredentialing criteria as directed by the Agency to ensure that ALFs, AFCHs, Residential Habilitation, Adult Day Training, Prevocational Services, and ADHC providers meet HCBS Provider Requirements.

a. The Managed Care Plan shall verify facility compliance through an on-site review, using the Agency-prescribed HCBS Settings Assessment and Remediation Tools, prior to offering the provider as an enrollee choice.

b. For active HCBS Providers, the Managed Care Plan shall notify the Agency of any HCBS Settings providers that are not in compliance with the credentialing and recredentialing requirements. The Managed Care Plan, the Agency, and APD will coordinate remediation activities with the HCBS Settings providers.

c. The Managed Care Plan’s credentialing and recredentialing process shall include ensuring that all Comprehensive IDD Pilot Program providers are appropriately

qualified, as specified in Rule 59G-1.070, F.A.C., 59G-4.192, F.A.C., and 65G-2, F.A.C. Network adequacy requirements for Comprehensive IDD Pilot Program are listed in **Table 2,** Comprehensive IDD Pilot Program Minimum Network Adequacy Requirements, above.

d. The Managed Care Plan shall provide reports demonstrating provider network qualifications as specified in **Attachment II, Section XVI.**, Reporting Requirements, and the Managed Care Plan Report Guide.

3. Minority Recruitment and Retention Plan

There are no additional provisions related to Minority Recruitment and Retention Plan unique to the Comprehensive IDD Pilot Program.

4. Prohibition Against Discriminatory Practices

There are no additional provisions related to Prohibition Against Discriminatory Practices unique to the Comprehensive IDD Pilot Program.

5. Provider Agreement Requirements

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

(1) (Insert provider name) shall develop and maintain policies and procedures for back-up plans in the event of absent employees, and that each provider maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees;

(2) (Insert residential habilitation, assisted living, adult day health care, adult day training and prevocational provider name) shall conform to the HCBS Settings Requirements. The Managed Care Plan shall include the following statement verbatim in its provider agreements with ALF, AFCH, and residential habilitation providers:

(Insert assisted living, adult day health care, adult day training /residential habilitation identifier) will support the enrollee's community inclusion and integration by working with the care coordinator and enrollee to facilitate the enrollee's personal goals and community activities.

Enrollees residing in (insert residential habilitation, assisted living provider identifier) shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options and documented in the enrollee's person-centered support plan.

Choice of:
- *Private or semi-private rooms, as available;*
- *Roommate for semi-private rooms;*
- *Locking doors to living unit/bedroom;*
- *Access to telephone and unlimited length of use;*
- *Eating schedule;*
- *Activities schedule; and*
- *Participation in facility and community activities.*

Ability to have:
- *Unrestricted visitation; and*
- *Snacks as desired.*

Ability to:
- *Prepare snacks as desired; and*
- *Maintain personal sleeping schedule.*

(3) Include the following statement verbatim in its provider agreement with ALF and residential habilitation providers:

(Insert ALF/residential habilitation identifier) hereby agrees to accept monthly payments from (insert plan identifier) for enrollee services as full and final payment for all HCBS services detailed in the enrollee's person-centered support plan which are to be provided by (insert ALF/residential habilitation identifier). Enrollees remain responsible for the separate ALF/residential habilitation room and board costs as detailed in their resident contract. As enrollees age in place and require more intense or additional HCBS services, (insert ALF/residential habilitation identifier) may not request payment for new or additional services from an enrollee, their family members or personal representative. (Insert ALF/residential habilitation identifier) may only negotiate payment terms for services pursuant to this provider agreement with (insert plan identifier).

(4) For ADHC, Adult Day Training (ADT), and Prevocational Services providers, that they shall conform to the HCBS Settings Requirements. The Managed Care Plan shall include the following statement verbatim in its provider agreements with ADHC, ADT, and Prevocational Services providers:

(Insert ADHC/ADT/Prevocational Services provider identifier) will support the enrollee's community inclusion and integration by working with the care coordinator and enrollee to facilitate the enrollee's personal goals and community activities.

Enrollees accessing adult day health services, adult day training, and prevocational services in (insert provider identifier) shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- *Daily activities;*
- *Physical environment;*
- *With whom to interact;*
- *Access to telephone and unlimited length of use;*
- *Eating schedule;*
- *Activities schedule; and*
- *Participation in facility and community activities.*

Ability to have:

- *Right to privacy;*
- *Right to dignity and respect;*
- *Freedom from coercion and restraint; and*
- *Opportunities to express self through individual initiative, autonomy, and independence.*

(5) That HCBS providers shall report critical incidents to the Managed Care Plan in a manner and format specified by the Managed Care Plan, so as to ensure reporting of such critical and reportable incidents to the Agency within twenty-four (24) hours of the incident. The Managed Care Plan shall not require nursing facilities or ALFs to report critical incidents or provide incident reports to the Managed Care Plan. Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law, including but not limited to ss. 400.147 and 429.23, F.S., and Chapters 39 and 415, F.S.

(6) Medication administration incidents in an APD-licensed group home are reported by the provider to the APD and the Managed Care Plan.

6. Network Performance Management

There are no additional provisions related to Network Performance Management unique to the Comprehensive IDD Pilot Program.

7. Provider Termination and Continuity of Care

The Managed Care Plan shall provide a full one hundred eighty (180) - day continuity of care period for enrollees in the Comprehensive IDD Pilot Program.

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D. Provider Services

1. Provisions for Providers Subject to HCBS Settings Requirement

a. As directed by the Agency in consultation with APD, the Managed Care Plan shall monitor provider compliance with provider agreement requirements and take corrective action as necessary if the Managed Care Plan, the Agency or APD concludes a residential habilitation, assisted living, adult day health care, adult day training, or prevocational services provider does not meet the HCBS Settings Requirements.

(1) Upon discovery of non-compliance with the HCBS Settings Requirements by a residential habilitation, assisted living, adult day health care, adult day training, or prevocational services provider, the Managed Care Plan shall require the provider to remediate all areas of non-compliance within ten (10) business days of discovery. The Managed Care Plan must submit documentation of the remediation to the Agency in a format and timeframe specified by the Agency.

(2) As directed by the Agency in consultation with APD, the Managed Care Plan shall not place, continue to place, and/or provide reimbursement for enrollees residing in an ALF, AFCH, or residential habilitation or receiving residential habilitation, assisted living, adult day health care, adult day training, or prevocational services from a provider that does not meet the HCBS Settings Requirements and/or does not have a provider agreement as specified in **Section VIII.**, Provider Network and Services, **Sub-Section C**., Provider Credentialling and Contracting, **Item 5**, Provider Agreement Requirements, **Sub-Item a.(2)**, of this **Exhibit**.

(3) As directed by the Agency in consultation with APD, the Managed Care Plan must terminate providers that are non-compliant with HCBS Settings Requirements.

(4) If the Managed Care Plan identifies a residential habilitation, adult day training or prevocational service provider that is not also an iBudget provider, the Managed Care Plan shall assess the provider for compliance with HCBS final setting rules. The Managed Care Plan shall educate providers on the HCBS Settings Requirement and provide the tools to HCBS Setting providers before conducting assessments. The Managed Care Plan shall continue to monitor the provider for compliance and notify the Agency in the event the provider meets heightened scrutiny requirements.

2. Provider Handbook and Bulletin Requirements

There are no additional provisions related to Provider Handbook and Bulletin Requirements unique to the Comprehensive IDD Pilot Program.

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3. Provider Education and Training

The Managed Care Plan 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 eligible individuals with unmet needs. The Managed Care Plan shall hold their contracted providers for services listed in **Table 1** to the training requirements of the Developmental Disabilities Individual Budgeting Waiver Handbook, Rule 59G-13.070, F.A.C.

4. Toll-Free Provider Help Line

There are no additional provisions related to Toll-Free Provider Help Line unique to the Comprehensive IDD Pilot Program.

5. Provider Complaint System

There are no additional provisions related to the Provider Complaint System unique to the Comprehensive IDD Pilot Program.

E. Claims and Provider Payment

There are no additional claims and provider payment provisions unique to the Comprehensive IDD Pilot Program.

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Section IX. Quality

A. Quality Improvement

1. General Provisions

The Managed Care Plan shall appoint a staff member with five (5) or more years of experience and/or training in working individuals with intellectual and developmental disabilities (IDD) to the QI program committee.

2. Accreditation

There are no additional accreditation provisions unique to the Comprehensive IDD Pilot Program.

3. Quality Improvement Program

There are no additional Quality Improvement Program provisions unique to the Comprehensive IDD Pilot Program.

4. Quality Improvement Program Committee

There are no additional Quality Improvement Program Committee provisions unique to the Comprehensive IDD Pilot Program.

5. Comprehensive IDD Pilot Program Services-Specific Quality Improvement Plan Requirements

In addition to the requirements set forth in **Attachment II and its Exhibits**, the Managed Care Plan's 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 individuals with intellectual and developmental disabilities.

6. EQRO Coordination Requirements

There are no additional EQRO Coordination Requirements provisions unique to the Comprehensive IDD Pilot Program.

B. Performance Measures (PMs)

1. General Provisions

There are no additional General Provisions unique to the Comprehensive IDD Pilot Program.

2. Required Performance Measures

a. Agency-Prescribed

The Managed Care Plan shall collect and report the following performance measures in **Tables 4 and 5**, below, certified via qualified auditor, as specified in **Section XVI**., Reporting Requirements, and the Managed Care Plan Report Guide.

b. Comprehensive IDD Pilot Program Waiver Performance Measure Requirements

The Managed Care Plan shall collect and report on the following performance measures in **Table 3,** Comprehensive IDD Pilot Program Waiver Performance Measures, below for enrollees receiving Comprehensive IDD Pilot Program services.

TABLE 3 COMPREHENSIVE IDD MANAGED CARE PILOT PROGRAM WAIVER PERFORMANCE MEASURES	
a.	Number and percent of new applicants receiving a level of care (LOC) evaluation prior to enrollment
b.	Number and percent of annual level of care (LOC) redeterminations conducted between sixty (60) and thirty (30) days prior to the one (1)-year anniversary of the previous LOC determination that are completed correctly via the contractual process.
c.	Number and percent of enrollees having a current level of care based on the state approved assessment tool.
d.	Number and percent of new licensed service providers, by type, within the Comprehensive IDD Pilot Program Plan provider network that meets provider qualifications prior to delivering services.
e.	Number and percent of current, licensed providers, by type, within the Comprehensive IDD Pilot Program Plan provider network that meets provider qualifications continuously.
f.	Number and percent of non-licensed/non-certified providers by type in Comprehensive IDD Pilot Program Plan network meeting waiver service provider qualifications prior to service delivery.
g.	Number and percent of non-licensed/non-certified providers by type in Comprehensive IDD Pilot Program Plan network meeting waiver services provider qualifications continuously.
h.	Number and percent of providers with staff mandated to report abuse, neglect, and exploitation, verified by Comprehensive IDD Pilot Program Plan that staff have received appropriate training.
i.	Number and percent of providers whose staff received training in an APD approved curriculum for behavioral emergency procedures consistent with requirements of the Reactive Strategies.
j.	Number and percent of new settings providers that meet the HCBS settings requirements.

k.	Number and percent of enrollees whose care plan include supports and services consistent with assessed needs and risks.
l.	Number and percent of enrollees with care plan documenting personal goal setting and community integration goal setting.
m.	Number and percent of enrollee plans of care distributed within ten days of development to primary care physician and home and community-based services setting.
n.	Number and percent of enrollee plans of care where enrollee participation is verified by signatures
o.	Number and percent of enrollees whose care plans are updated at least annually.
p.	Number and percent of enrollees whose care plan are updated when needs have changed.
q.	Number and percent of enrollees' plans of care reviewed on a face-to-face basis at least every three months.
r.	Number and percent all new enrollees with signatures on the care plan indicating a choice of services and service providers.
s.	Number and percent of new enrollee with freedom of choice forms indicating choice between waiver services and institutional care in their case records.
t.	Number and percent of critical incidents reported to AHCA within required time frames.
u.	Number and percent of health, safety and welfare issues reported in critical incidents reports within twenty-four (24) hours.
v.	Number and percent of Adult Protective Services (APS) cases of enrollees with substantiated reports of abuse, neglect, or exploitation (ANE) reported by the Plan as critical incidents.
w.	Number and percent of enrollees with reports of use of prohibited restraints, reported by the Plan to Adult Protective Services (APD) within 24 hours of the incident.
x.	Number and percent of recipients who received a telephone contact from their care coordinator at least monthly to assess health status, satisfaction with services and any other needs.
y.	Number and percent of AHCA-reviewed case files that are 100% compliant with contract requirements.
z.	Number and percent of ongoing settings providers that meet the HCBS settings requirements at their recredentialing determination.

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TABLE 4 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.	Ambulatory Care: Emergency Department Visits (AMB)
5.	Antidepressant Medication Management (AMM)
6.	Asthma Medication Ratio (AMR)
7.	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
8.	Blood Pressure Control for Patients with Diabetes (BPD)
9.	Breast Cancer Screening (BCS)
10.	Cervical Cancer Screening (CCS)
11.	Chlamydia Screening in Women (CHL)
12.	Colorectal Cancer Screening (COL)
13.	Controlling High Blood Pressure (CBP)
14.	Depression Screening and Follow-up for Adolescents and Adults (DSF-E)
15.	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication (SSD)
16.	Eye Exam for Patients with Diabetes (EED)
17.	Follow-up after Emergency Department Visit for Substance Use (FUA)
18.	Follow-up after Emergency Department Visit for Mental Illness (FUM)
19.	Follow-up after Hospitalization for Mental Illness (FUH)
20.	Hemoglobin A1c Control for Patients with Diabetes (HBD)
21.	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
22.	Kidney Health Evaluation for Patients with Diabetes (KED)
23.	Plan All-Cause Readmissions (PCR)
24.	Postpartum Depression Screening and Follow-up (PDS-E)
25.	Prenatal and Postpartum Care (PPC)
26.	Prenatal Depression Screening and Follow-up (PND-E)
27.	Prenatal Immunization Status (PRS-E)
28.	Social Need Screening and Intervention (SNS-E)
29.	Statin Therapy for Patients with Cardiovascular Disease and Diabetes (SPC/SPD)
30.	Unhealthy Alcohol Use Screening and Follow-up (ASF-E)

Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)	
31.	Concurrent Use of Opioids and Benzodiazepines (COB-AD)
32.	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)
33.	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)
34.	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)
35.	HIV Viral Load Suppression (HVL-AD)
36.	Screening for Depression and Follow-up Plan (CDF-AD)
37.	Use of Opioids at High Dosage in Persons without Cancer (OHD-AD)
38.	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

TABLE 5 REQUIRED PERFORMANCE MEASURES	
Healthcare Effectiveness Data and Information Set (HEDIS)	
1.	Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update (LTSS-CAU)
2.	LTSS Comprehensive Care Plan and Update (LTSS-CPU)
3.	LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)
4.	LTSS Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)
Centers for Medicare and Medicaid Services Medicaid Managed Long-Term Services and Supports (MLTSS) Measures*	
5.	MLTSS Screening, Risk Assessment, and Plan of Care to Prevent Future Falls
6.	MLTSS Admission to a Facility from the Community
7.	MLTSS Minimizing Facility Length of Stay

3. Quality Assessment and Performance Improvement Program

In addition to the requirements specified in **Attachment II, Section VII.B.2.**, the Managed Care Plan shall report information as specified in 42 CFR 438.330(b)(5)(i) and (ii) in its annual quality assessment and performance improvement program report.

4. Publication of Performance Measures

There are no additional Publication of Performance Measures provisions unique to the Comprehensive IDD Pilot Program.

Section IX. Quality

C. Performance Improvement Projects (PIPs)

1. General Provisions

There are no additional General Provisions unique to the Comprehensive IDD Pilot Program.

2. PIP Proposals

a. The Managed Care Plan shall perform two (2) Agency-approved performance improvement projects (PIPs) as specified below:

(1) One (1) of the PIPs shall focus on improving behavior analysis services for enrollees in the Comprehensive IDD Pilot Program; and

(2) One (1) of the PIPs shall focus on improving residential habilitation services for enrollees in the Comprehensive IDD Pilot Program.

3. Annual PIP Submission

There are no additional Annual PIP Submission provisions unique to the Comprehensive IDD Pilot Program.

4. EQRO Validation

There are no additional EQRO Validation provisions unique to the Comprehensive IDD Pilot Program.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

a. The Managed Care Plan shall conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for this Comprehensive IDD Pilot Program population for a time period specified by the Agency, using the HCBS CAHPS Survey 1.0 available at https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey/index.html.

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

c. The Managed Care Plan shall adhere to the following Survey Administration Guidelines:

(1) The Managed Care Plan shall contract with an Agency-approved survey vendor certified by the NCQA to administer the HCBS CAHPS Survey.

(2) The survey must be administered telephonically or in-person.

(3) The Managed Care Plan shall include in the survey sample only those enrollees who have been enrolled in the Comprehensive IDD Pilot Program for at least three (3) consecutive months.

(4) The Managed Care Plan shall have its sample validated by an NCQA-certified HEDIS Auditor.

(5) All enrollees must be included in the survey each year. To increase response rates in order to meet the target number of completed surveys, the Managed Care Plan may send a pre-notification letter and/or postcard to enrollees to let them know they may be called to participate in the survey, and/or increase the number of call attempts made to enrollees on different days and at different times.

(6) The Managed Care Plan shall submit to the Agency:

a. An Excel file of the survey results (including the responses to each survey item for each respondent).

b. An Excel file of the tabulated response rates for the plan for each survey item.

c. An attestation completed by the Managed Care Plan's survey vendor in accordance with the requirements in Chapter 2 of the SMMC Managed Care Plan Report Guide.

d. The Managed Care Plan shall report the HCBS CAHPS survey results to the Agency by September 1 of each year.

e. The Managed Care Plan shall use the results of the annual HCBS CAHPS survey to develop and implement plan-wide activities designed to improve member satisfaction. The Managed Care Plan shall submit the Member Satisfaction Improvement Report on a quarterly basis on activities pertaining to improving member satisfaction resulting from the annual enrollee satisfaction survey, as specified in **Section VIII.** and the Managed Care Plan Report Guide.

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2. Provider Satisfaction Survey

There are no additional provider satisfaction survey provisions unique to the Comprehensive IDD Pilot Program.

E. Enrollee Record Requirements

1. General Provisions

In addition to the enrollee record requirement provisions in **Attachment II and its Exhibits**, the enrollee record for the Managed Care Plan's enrollees receiving Comprehensive IDD Pilot Program services shall include documentation of the enrollee's consent to participate. The Managed Care Plan must obtain the enrollee's consent to participate prior to the provision of Comprehensive IDD Pilot Program services. Written consent is preferable; however, verbal consent and documentation of the verbal consent is acceptable.

2. Enrollee Record Review Strategy

There are no additional enrollee record review strategy provisions unique to the Comprehensive IDD Pilot Program.

3. Standards for Enrollee Records

a. The Managed Care Plan shall ensure the enrollee record documents all activities and interactions with the enrollee and any provider(s) involved in the support and care of the enrollee. In addition to the requirements specified in **Attachment II**, the record shall include, at a minimum, the following information:

(1) Enrollee demographic data including emergency contact information, guardian contact data, if applicable, permission forms and copies of assessments, evaluations, reactive strategies, and medical and medication information;

(2) Legal data such as guardianship papers, court orders and release forms;

(3) Copies of eligibility documentations, including LOC determinations by APD;

(4) Identification of the enrollee's PCP and HCBS provider(s);

(5) Information from quarterly face-to-face visit that addresses at least the following:

- The enrollee's current medical/functional/behavioral health status, including strengths, preferences, needs, and reactive strategy approval;

- Identification of family/informal support system or community resources and their availability to assist the enrollee, including barriers to assistance;

- The enrollee's ability to participate in the review and/or with whom the care coordinator discusses services needs and goals in the event the enrollee is unable to participate;

- An assessment of the enrollee's environment, including risk screening, and/or other special needs;

- Environmental and/or other special needs (e.g., safety risks, sanitation, need for physical adaptations, general condition of the home, amount of space, adequacy of sleeping area, access to the bathroom, temperature, availability of food, etc.);

(6) Needs assessments;

(7) Person-centered support plan;

(8) Documentation of enrollee's responses to HCBS Settings Requirements queries;

(9) Documentation of interaction and contacts (including monthly telephone contacts and enrollee-specific correspondence) with enrollee, family of enrollees, PCP, service providers, or other individuals related to provision of services;

(10) Documentation of issues relevant to the enrollee remaining in the community with supports and services consistent with his or her capacities and abilities. This includes monitoring achievement of goals and objectives as set forth in the person-centered support plan;

(11) Documentation of the managed care plan's consultation with APD before placing a Comprehensive IDD Pilot Program enrollee in a group home licensed by APD;

(12) Residential agreements between the facility(ies) and the enrollee;

(13) Problems with service providers, with a planned course of action noted;

(14) Record of service authorizations;

(15) Documentation that the enrollee has received and signed, if applicable, all required plan and program information (including copies of the enrollee handbook, provider directory, person-centered support plan, etc.);

(16) Documentation of the discussion with the enrollee on the procedures for filing complaints and grievances;

(17) Notices of Adverse Benefit Determination sent to the enrollee regarding denial, termination, reduction or suspension of services;

(18) Proof of submission to DCF of the completed CF-ES 2506A Form (Client Referral/Change) and CF-ES 2515 Form (Certification of Enrollment Status HCBS);

(19) Other documentation as required by the Managed Care Plan;

(20) Copy of the contingency plan and other documentation that indicates the enrollee/legal and/or authorized representative has been advised regarding how to report unplanned gaps in authorized service delivery;

(21) Copy of the disaster/emergency plan for the enrollee's household that considers the special needs of the enrollee; and

(22) Documentation of choice between institutional and HCBS services and choice of providers.

c. The Managed Care Plan's enrollee record information shall be maintained by the Managed Care Plan in compliance with State regulations for record retention. Written and electronically retrievable documentation of all evaluations and re-evaluations shall be maintained as required in 42 CFR 441.303(c)(3). The Managed Care Plan shall specify in policy where records of evaluation and re-evaluations of LOC are completed in the APD-iConnect system and reported using the monthly Eligibility Worksheet Report.

F. Provider-Specific Performance Monitoring

1. General provisions

There are no additional general provisions unique to the Comprehensive IDD Pilot Program.

2. Peer Review

There are no additional peer review provisions unique to the Comprehensive IDD Pilot Program.

3. Monitoring Activities

a. The Managed Care Plan shall develop an organized quality assurance and quality improvement program to enhance delivery of services, including, but not be limited to conducting quarterly enrollee record audits and quarterly reviews of the consistency of enrollee assessments/service authorizations (inter-rater reliability). The Managed Care Plan shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Managed

Care Plan has taken to resolve identified issues. The Managed Care Plan shall submit this information to the Agency on a quarterly basis, thirty (30) days after the close of each quarter.

b. The Managed Care Plan shall implement a system of internal monitoring of the case management program, using, at a minimum, the Case File Audit Report and the results of its monitoring, including case file audits, reviews of the consistency of enrollee assessments and service authorizations, and the development and implementation of continuous improvement strategies to address identified deficiencies.

   (1) The Managed Care Plan shall submit its Case File Audit Report template to the Agency for review and approval prior to implementation and revision.

   (2) In addition to monitoring the care coordinator's compliance with the requirements of this Exhibit, the Managed Care Plan shall target the monitoring of person-centered support plans and practices with its Case File Audit Report.

   (3) The Managed Care Plan shall conduct the Case File Audit Report on a quarterly basis, at a minimum, with a statistically significant sample of the Comprehensive IDD Pilot Program.

   (4) The Managed Care Plan shall document its monitoring findings and make such findings available to the Agency upon request.

c. The Managed Care Plan shall have data collection and analysis capabilities that enable the tracking of enrollee service utilization, cost, and demographic information and maintain documentation of the need for all services provided to enrollees.

d. The Managed Care Plan shall provide reports demonstrating case management monitoring and evaluation as specified in **Section XVI.,** Reporting Requirements, and the Managed Care Plan Report Guide. These reports shall include results for the following performance measures including but not limited to:

   (1) Number and percentage of LOC-related redeterminations within three hundred thirty-five (335) days of previous LOC determination;

   (2) Number and percentage of complete and accurate LOC forms for annual reevaluations sent to the Agency for Persons with Disabilities (APD) within thirty (30) days of LOC due date;

   (3) Number and percentage of staff meeting mandated abuse, neglect and exploitation training requirements;

   (4) Number and percentage of enrollee plans of care being distributed within ten (10) business days of development, or as updated, to the enrollee's PCP and HCBS provider;

(5) Number and percentage of plans of care/summaries where enrollee participation is verified by signatures (hard copy and electronic are accepted);

(6) Number and percentage of enrollee person-centered support plans reviewed for changing needs on a face-to-face basis at least every three (3) months and updated as appropriate;

(7) Number and percentage of person-centered support plan services delivered according to the person-centered support plan as to service type, scope, amount and frequency;

(8) Number and percentage of enrollees with person-centered support plans addressing all identified care needs;

(9) Number and percentage of critical incidents reported within twenty-four (24) hours to the appropriate Agency;

(10) Number and percentage of enrollee records that include evidence that advance directives were discussed with the enrollee;

(11) Number and percentage of enrollees requesting a Fair Hearing and outcomes;

(12) Number and percentage of enrollees whose record contains a person-centered support plan that includes the availability of family/informal support systems, and the amount of assistance the existing support systems are able to provide to the enrollee; and

(13) Number and percentage of enrollees whose record contains a person-centered support plan that includes Comprehensive IDD Pilot Program service authorizations for time periods that are shorter than the end date of the person-centered support plan.

G. Additional Quality Management Requirements

1. Abuse/Neglect and Critical Incident Reporting Standard

The Managed Care Plan shall ensure the adherence to the following provisions:

a. The Managed Care Plan shall ensure suspected cases of abuse, neglect and/or exploitation are reported to the Florida Abuse Hotline (1-800-96A-BUSE) (s. 415.1034, F.S.). If the investigation requires the enrollee to move from his/her current location(s), the Managed Care Plan shall assist the investigator in finding a safe living environment or another participating provider of the enrollee’s choice.

b. The Managed Care Plan shall serve the enrollees designated as "high" risk within seventy-two (72) hours of referral to the Managed Care Plan from the Florida Adult Protective Services Unit or designee. The Managed Care Plan shall provide Adult Protective Services, a primary and back-up contact person, including a telephone number, for "high" risk referrals. The Managed Care Plan's contacts shall return calls from Adult Protective Services within twenty-four (24) hours of initial contact.

c. Documentation related to the suspected abuse, neglect, or exploitation, including the reporting of such, must be kept in a confidential file, separate from the enrollee record. This documentation will consist of only the necessary elements for the treatment of and service delivery to a vulnerable adult. The Managed Care Plan shall make the file available to the Agency upon request.

d. The Managed Care Plan shall report critical and reportable incidents to the Agency within twenty-four (24) hours of the incident. The Managed Care Plan shall ensure providers adhere to the timelines specified in Rule 65G-2.010(5), F.A.C. The Managed Care Plan shall not require nursing facilities or ALFs to report critical incidents or provide incident reports to the Managed Care Plan. Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law, including but not limited to ss. 400.147 and 429.23, F.S., and Chapters 39 and 415, F.S.

e. The Managed Care Plan shall report uses of reactive strategies to the Agency within twenty-four hours of the incident.

f. The Managed Care Plan shall report incidents involving medication administration to the Agency within 24 hours of discovering the error.

g. The Managed Care Plan shall report critical incidents to the Agency as specified in **Section XVI**., Reporting Requirements, and the Managed Care Plan Report Guide.

H. Continuity of Care in Enrollment

The Managed Care Plan shall be responsible for continuity of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, including those services previously authorized under the fee-for-service delivery system or by the enrollee's immediate former Managed Care Plan, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers for up to one hundred eighty (180) days after the effective date of enrollment. The Managed Care Plan shall reimburse nonparticipating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless said provider agrees to an alternative rate. The health plans shall ensure the new enrollees have a seamless transition of services in the first ninety (90) days of enrollment.

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Section X. Administration and Management

A. General Provisions

There are no additional general provisions for administration and management unique to the Comprehensive IDD Pilot Program.

B. Organizational Governance and Staffing

1. General Provisions

There are no additional general provisions unique to the Comprehensive IDD Pilot Program.

2. Minimum Staffing Requirements

The positions described below represent the minimum management staff required for the Managed Care Plan in addition to their MMA and LTC positions. The Managed Care Plan shall notify the Agency of changes in the staff positions indicated below, within five (5) business days of the changes in staffing. The Managed Care Plan shall not delegate minimum staffing positions.

a. The Managed Care Plan shall designate a full-time Contract Manager to work directly with the IDD population served under this Contract. The Contract Manager shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to this Contract. The Contract Manager shall have the authority to administer the day-to-day business activities of this Contract, including revising processes or procedures and assigning additional resources as needed to maximize the efficiency and effectiveness of services required under this Contract. The Managed Care Plan shall meet in person, or by telephone, at the request of the Agency. The Contract Manager shall be located in the State of Florida.

b. The Managed Care Plan shall designate a dedicated Clinical Director who is a physician licensed in the State of Florida with experience providing services to the IDD populations served under this Contract. shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to the IDD population served by this Contract.

c. The Managed Care Plan shall designate a full-time Lead Care Coordinator, qualified by knowledge, training, and experience in care coordination for the IDD population to provide guidance for HCBS, health care, and other services covered in this Contract. The Lead Care Coordinator shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to this Contract.

d. The Managed Care Plan shall designate a Provider Relations Lead qualified by training and experience in Provider Network Development, Contracting and Credentialing/Recredentialing and other provider services as outlined in this Contract. The Provider Relations Lead shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan devoted to this Contract.

3. Case Management/ Care Coordination Staff Qualifications and Experience

There are no additional general provisions for case management/ care coordination qualifications and experience unique to the Comprehensive IDD Pilot Program.

4. Case Management/Care Coordination Supervision

a. Supervision of care coordinators:

(1) A supervisor-to-care-coordinator ratio shall be established that is conducive to a sound support structure for care coordinators. Supervisors shall have adequate time to train and review the work of newly hired care coordinators as well as provide support and guidance to established care coordinators.

b. Care Coordinator supervisor qualifications:

(1) Successful completion of a Level II criminal history and/or background investigation; and

(2) Master's degree in a human service, social science or health field and has a minimum of two (2) years' experience in case management, at least one (1) year of which shall be related to IDD populations; or

(3) Bachelor's degree in a human service, social science, or health field with a minimum of five (5) years' experience in case management, at least one (1) year of which shall be related to the IDD populations; or

(4) Professional human service, social science or health related experience may be substituted on a year-for-year basis for the educational requirement, (i.e., a high school diploma or equivalent and nine (9) years of experience in a human service, social science or health field, five (5) years of which shall be related to case management, at least one (1) year of which shall be related to the IDD populations).

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5. Minimum Training Requirements

a. The Managed Care Plan shall provide care coordinators with adequate orientation and ongoing training on subjects relevant to the Comprehensive IDD Pilot Program population being served. The Managed Care Plan shall maintain documentation of training dates and staff attendance, as well as copies of materials used. The Managed Care Plan shall ensure that there is a training plan in place to provide uniform training to all care coordinators. This plan shall include formal training classes as well as practicum observation and instruction for newly hired care coordinators.

b. The Managed Care Plan shall submit the training plan and any resources, PowerPoints, handouts, or notes to the Agency's SFTP site in: SUBMISSIONS Folder> Quality Submissions, no later than January 15th of each year.

c. The Managed Care Plan shall provide orientation and training to newly hired case managers, in a minimum of the following areas:

(1) The role of the care coordinator in utilizing person-centered planning and practices in the delivery Comprehensive IDD Pilot Program case management services per 42 CFR 441.301, including allowing the enrollee to direct the care planning to the maximum extent possible;

(2) The role of the care coordinator in advocating on behalf of the enrollee;

(3) Enrollee rights and responsibilities;

(4) Enrollee safety, including fall prevention, and infection control;

(5) Case management responsibilities as outlined in this **Exhibit**;

(6) Case Management procedures specific to the Managed Care Plan;

(7) The Comprehensive IDD Pilot Program component of SMMC and the continuum of MMA, LTC, and Comprehensive IDD Pilot Program services, including available service settings and service restrictions/limitations and coordination with dental services;

(8) The Managed Care Plan's provider network by location, service type, and capacity;

(9) Information on local resources for housing, education, and employment services/program that could help enrollees gain greater self-sufficiency in these areas;

(10) 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.);

(11) Information on intense behaviors and reactive strategies, alternative methods to avoid the use of restraint and seclusion, and APD rules and procedures;

(12) General medical information, such as symptoms, medications, and treatments for diagnostic categories common to the IDD population serviced by the Managed Care Plan;

(13) Behavioral health information, including identification of the enrollee's behavioral health needs and how to refer the enrollee to behavioral health services; and

(14) Reassessment processes.

(a) The Managed Care Plan shall provide all care coordinators with an annual review of orientation topics listed above, as well as regular ongoing training on topics relevant to the population(s) served. The following are examples of topics that could be covered:

(i) In-service training on issues affecting the aged, intellectual and developmentally disabled populations;

1. Abuse, neglect, and exploitation training;

2. Policy updates and new procedures;

3. Refresher training for areas found deficient through the Managed Care Plan;

4. Interviewing skills;

(ii) Assessment/observation skills;

1. Cultural competency;

2. Enrollee rights per 393, F.S.;

3. Critical and reportable incident reporting;

4. Medical/behavioral health issues;

5. Medication awareness (including identifying barriers to compliance and side effects);

6. Reactive Strategies; and

7. Medication Administration.

d. The Managed Care Plan shall ensure all case management staff hold current CPR certification.

e. The Managed Care Plan shall train all affected staff, prior to implementation, on the use of redetermination date information and submit documentation of such training to the Agency for review within five (5) business days after the Agency's direction for training.

f. The Managed Care Plan shall submit reports to the Agency on care coordinator training as specified in **Section XVI**., Reporting Requirements and the Managed Care Plan Report Guide.

6. Case Load Requirements

a. The Managed Care Plan shall have an adequate number of qualified and trained case managers to meet the needs of enrollees.

b. Caseload Ratio Requirements:

The Managed Care Plan shall ensure that care coordinator caseloads do not exceed a ratio of eighteen (18) enrollees to one (1) care coordinator for enrollees.

c. The Managed Care Plan shall have written protocols to ensure assignment of a case manager immediately upon enrollment of newly enrolled enrollees.

d. The Managed Care Plan shall ensure that case management/care coordinators 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.

e. The Managed Care Plan shall report to the Agency monthly on its care coordinator caseloads as specified in **Section XVI.**, Reporting Requirements, and the Managed Care Plan Report Guide.

C. Subcontracts

1. The Managed Care Plan may enter into subcontracts with APD qualified organizations for the provision of care coordination services to individuals enrolled in the Comprehensive IDD Pilot Program.

2. The subcontractor's employees serving in these positions shall be dedicated one hundred percent (100%) to providing care coordination services to Comprehensive IDD Pilot

Program enrollees as required in **Attachment II and its Exhibits**, and cannot provide support coordination or case management to other populations or other organizations.

D. Information Management and Systems

The Managed Care Plan shall enter into a Business Associate Agreement with the APD to facilitate use of the iConnect system.

E. Claims Data and Provider Payment

There are no additional provisions for Claims and Provider Payment unique to the Comprehensive IDD Pilot Program.

F. Encounter Data Requirements

The Managed Care Plan shall submit encounter data for the Comprehensive IDD Pilot Program population for all services: MMA, LTC, Comprehensive IDD Pilot Program, including expanded benefits. For HCBS services listed in **Table 1**, Florida Medicaid Policies and Rule References for Comprehensive IDD Pilot Program Services, the Managed Care Plan shall use the procedure codes listed on the Developmental Disabilities Individual Budgeting Waiver Services Provider Rate Table, Developmental Disabilities Individual Budgeting Waiver Disposable Incontinence Medical Supplies Fee Schedule, Codes for Consumable Medical Supplies Code for iBudget, and the Statewide Medicaid Managed Care Long-Term Care Program Handbook. The Managed Care Plan shall only use codes for the HCBS services as listed in these rules.

G. Fraud and Abuse Prevention

There are no additional fraud and abuse prevention provisions unique to the Comprehensive IDD Pilot Program.

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Section XI. Method of Payment

A. General Provisions

There are no additional general provisions unique to the Comprehensive IDD Pilot Program.

B. Fixed Price Unit Contract

There are no additional fixed price unit provisions unique to the Comprehensive IDD Pilot Program.

C. Payment Provisions

There are no additional payment provisions unique to the Comprehensive IDD Pilot Program.

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Section XII. Financial Requirements

There are no additional financial requirements unique to the Comprehensive IDD Pilot Program.

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Section XIII. Sanctions and Corrective Action Plan

There are no additional Sanction and Corrective Action Plans unique to the Comprehensive IDD Pilot Program.

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Section XIV. Liquidated Damages

A. Damages

Additional damages issues and amounts unique to the Comprehensive IDD Pilot Program are specified below.

B. Issues and Amounts

If the Managed Care Plan fails to perform any of the services set forth in the Contract, the Agency may assess liquidated damages for each occurrence listed in the Comprehensive IDD Pilot Program Liquidated Damages Issues and Amounts Table, **Table 6**, below.

TABLE 6
COMPREHENSIVE IDD PILOT PROGRAM LIQUIDATED DAMAGES ISSUES AND AMOUNTS

#	Comprehensive IDD Pilot Program Issue	Damages
1.	Failure to comply with the enrollee records documentation requirements pursuant to the Contract	One thousand dollars (**$1,000.00**) per occurrence
2.	Failure to comply with the timeframes for developing and approving a person-centered support plan for transitioning or initiating HCBS services as described in the Contract	Five hundred dollars (**$500.00**) per day, per occurrence
3.	Failure to have a face-to-face contact between the Managed Care Plan case manager and each enrollee monthly as desired by the enrollee/legal and/or authorized representative, or at least every ninety (90) days or following a significant change as described in the Contract	Five thousand dollars (**$5,000.00**) for each occurrence
4.	Failure to submit HCBS waiver eligibility worksheet in iConnect	One hundred dollars (**$100.00**) assessed for each enrollee who temporarily loses eligibility (for less than sixty (60) days) pursuant to a redetermination
5.	Failure to submit annual support plan documentation in iConnect	One hundred dollars (**$100.00**) assessed for each enrollee
6.	Failure to meet the performance standards established by the Agency regarding missed visits for personal care, attendant nursing care, homemaker, or home- delivered meals for enrollees (referred to herein as “specified HCBS”) pursuant to the Contract	Five hundred dollars (**$500.00**) per occurrence
7.	Failure to develop a person-centered support plan as described in the Contract for an enrollee that	Five hundred dollars (**$500.00**) per deficient person-centered

	includes all of the required elements, and which has been reviewed with and signed and dated by the enrollee or enrollee's legal and/or authorized representative, unless the enrollee or enrollee's legal and/or authorized representative refuses to sign, which shall be documented in writing.	support plan. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the caseload and staffing requirements specified in the Contract
8.	Failure to implement and maintain a formal Caregiver Training Program as described in this Contract	Five hundred dollars (**$500.00**) per day
9.	Failure to meet any timeframe regarding care coordination for enrollees as described in the Contract	Two hundred and fifty dollars (**$250.00**) per day, per occurrence
10.	Failure to follow-up within seven (7) days of initial person-centered support plan development to ensure that in-home HCBS services are in place as described in the Contract	Five hundred dollars (**$500.00**) for each enrollee falling below the eighty-five percent (85%) threshold for whom the Managed Care Plan failed to follow-up within seven (7) days
11.	Failure to provide a copy of the person-centered support plan to each enrollee's PCP and HCBS provider in the timeframes as described in the Contract	Five hundred dollars (**$500.00**) per day
12.	Failure to report enrollees that do not receive all Comprehensive IDD Pilot Program services listed in the approved person-centered support plan for a continuous ninety (90)-day period, as described in the Contract	For each enrollee, an amount equal to the capitation rate for the month in which the enrollee did not receive Comprehensive IDD Pilot Program Services
13.	Failure to send authorizations to all applicable providers for the agreed upon services within twenty-four (24) hours of the initial face-to-face visit as described in the Contract	One hundred dollars **($100.00**) for each occurrence
14.	Failure to comply with obligations and time frames in the delivery of annual face-to-face LOC redeterminations as described in the Contract	One thousand dollars (**$1,000.00**) per occurrence
15.	Failure to ensure that for each enrollee all necessary paperwork is submitted to DCF within the timeframes included in the Contract	One hundred dollars (**$100.00**) assessed for each enrollee who temporarily loses eligibility (for less than sixty (60) days) pursuant to a redetermination
16.	Failure to follow-up within twenty-four (24) hours of initial contact by the Florida Adult Protective Services Unit for "high risk" referrals pursuant to **Section VII.F.1.b.** of this Exhibit.	Five thousand dollars (**$5,000.00**) per occurrence

17.	Failure to serve enrollees who have been designated as "high risk" within seventy-two (72) hours after being referred to the Managed Care Plan from the Florida Adult Protective Services Unit or designee, as mandated by Florida Statutes	Five thousand dollars (**$5,000.00**) per occurrence
18.	Failure to report suspected cases of abuse, neglect, and/or exploitation of elders and individuals with intellectual and developmental disabilities to the Florida Abuse Hotline (1-800-96ABUSE) (s. 415.1034, F.S.)	Five thousand dollars (**$5,000.00**) per occurrence
19.	Failure to achieve a rate of eighty-five percent (85%) or higher for the Comprehensive HCBS Assessment and Update (LTSS-CAU)-Core Element performance measure.	One hundred dollars (**$100.00**) per each case in the denominator not present in the numerator for the measure up to the eighty-five percent (85%) rate. For measures calculated using a sample, liquidated damages will be calculated based on the extrapolated number of eligible members who are not in the numerator, not just those in the sample, up to the eighty-five percent (85%) rate.
20.	Failure to achieve a rate of eighty-five percent (85%) or higher for the Comprehensive HCBS Care Plan and Update (LTSS-CPU)-Core Elements performance measure.	One hundred dollars (**$100.00**) per each case in the denominator not present in the numerator for the measure up to the eighty-five percent (85%) rate. For measures calculated using a sample, liquidated damages will be calculated based on the extrapolated number of eligible members who are not in the numerator, not just those in the sample, up to the eighty-five percent (85%) rate.
21.	Failure to achieve a rate of eighty-five (85%) or higher for the Shared Care Plan with Primary Care Practitioner (LTSS-SCP) – Core Elements performance measure.	One hundred dollars (**$100.00**) per each case in the denominator not present in the numerator for the measure up to the eighty-five percent (85%) rate. For measures calculated using a sample, liquidated damages will be calculated based on the extrapolated number of eligible members who are not in the numerator, not just

		those in the sample, up to the eighty-five percent (85%) rate.
22.	Failure to achieve a rate of forty-five percent (45%) or higher for the Reassessment/ Care Plan Update after Inpatient Discharge (LTSS-RAC)-Core Elements performance measure.	One hundred dollars (**$100.00**) per each case in the denominator not present in the numerator for the measure up to the forty-five percent (45%) rate. For measures calculated using a sample, liquidated damages will be calculated based on the extrapolated number of eligible members who are not in the numerator, not just those in the sample, up to the forty-five percent (45%) rate.
23.	Failure to comply with the reactive strategies requirements	One thousand dollars **($1,000.00**) per occurrence
24.	Failure to comply with medication administration requirements	One thousand dollars (**$1,000.00**) per occurrence

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Section XV. Special Terms and Conditions

A. Contract Termination

1. The anticipated term of the resulting Comprehensive IDD Pilot Program Contract(s) shall be from the date of Contract execution through September 30, 2030. Performance of the Contract(s) is subject to the availability of funding; and the approval of the Centers for Medicare and Medicaid Services of the 1915(c) Home and Community-Based Services Waiver.

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Section XVI. Reporting Requirements

A. Required Reports

1. The Managed Care Plan shall comply with all reporting requirements set forth in this Contract, including reports specific to the Comprehensive IDD Pilot Program services pilot program as specified in **Table 7**, Summary of Reporting Requirements, below, and the Managed Care Plan Report Guide.

TABLE 7
SUMMARY OF REPORTING REQUIREMENTS

Report Name	Program Type	Frequency
Case Manager and Provider Training Report	Comprehensive IDD Pilot Program	Annually
Case Manager Caseload Report	Comprehensive IDD Pilot Program	Monthly
Case Management File Audit Report	Comprehensive IDD Pilot Program	Quarterly
Critical Incident and Reportable Incidents Individual	Comprehensive IDD Pilot Program	Immediately upon occurrence and no later than within twenty-four (24) hours after detection or notification Monthly
Denial, Reduction, Termination or Suspension of Services Report	Comprehensive IDD Pilot Program	Monthly
Enrollee Roster and Residence Report	Comprehensive IDD Pilot Program	Monthly
Missed Services Report	Comprehensive IDD Pilot Program	Monthly
Provider Network and Qualifications Report	Comprehensive IDD Pilot Program	Quarterly
Unable to Provide Case Management Report	Comprehensive IDD Pilot Program	Monthly
Disenrollment Report	Comprehensive IDD Pilot Program	Monthly
Eligibility Worksheet Report	Comprehensive IDD Pilot Program	Monthly
Reactive Strategies Report	Comprehensive IDD Pilot Program	Immediately upon occurrence and no later than within twenty-four (24) hours after detection or notification
Medication Administration Report	Comprehensive IDD Pilot Program	Monthly

Section XVI. Reporting Requirements

Service Authorization Performance Outcome Report	Comprehensive IDD Pilot Program	Monthly
Performance Measures Report	Comprehensive IDD Pilot Program	Annually

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