

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
STANDARD CONTRACT**

THIS CONTRACT is entered into between the State of Florida, **AGENCY FOR HEALTH CARE ADMINISTRATION**, hereinafter referred to as the "**Agency**", whose address is 2727 Mahan Drive, Tallahassee, Florida 32308, and **[HEALTH PLAN NAME]** hereinafter referred to as the "**Vendor**" or "**Health Plan**", whose address is [Vendor Address], a Florida Corporation, to provide Medicaid Long Term Care Services to eligible Medicaid beneficiaries.

I. THE VENDOR HEREBY AGREES:

A. General Provisions

1. To provide services according to the terms and conditions set forth in this Contract, **Attachment I**, Scope of Services, **Attachment II**, Core Contract Provisions and all other attachments named herein which are attached hereto and incorporated by reference (collectively referred to herein as the "Contract").
2. To perform as an independent vendor and not as an agent, representative or employee of the Agency.
3. To recognize that the State of Florida, by virtue of its sovereignty, is not required to pay any taxes on the services or goods purchased under the terms of this Contract.

B. Federal Laws and Regulations

1. This Contract contains federal funds, therefore, the Vendor shall comply with the provisions of 45 CFR, Part 74, and/or 45 CFR, Part 92, and other applicable regulations.
2. This Contract contains federal funding in excess of **\$100,000.00**, therefore, the Vendor must, upon Contract execution, complete the Certification Regarding Lobbying form, **Attachment IV**. If a Disclosure of Lobbying Activities form, Standard Form LLL, is required, it may be obtained from the Agency's Contract Manager. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the Agency's Procurement Office.
3. Pursuant to 2 CFR, Part 376, the Vendor must, upon Contract execution, complete the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts, **Attachment V**.

C. Audits and Records

1. To maintain books, records, and documents (including electronic storage media) pertinent to performance under this Contract in accordance with generally accepted accounting procedures and practices which sufficiently and properly reflect all revenues and expenditures of funds provided by the Agency under this Contract.

2. To assure that these records shall be subject at all reasonable times to inspection, review, or audit by state personnel and other personnel duly authorized by the Agency, as well as by federal personnel.
3. To maintain and file with the Agency such progress, fiscal and inventory reports as specified in **Attachment II**, Core Contract Provisions, and other reports as the Agency may require within the period of this Contract. In addition, access to relevant computer data and applications which generated such reports should be made available upon request.
4. To ensure that all related party transactions are disclosed to the Agency Contract Manager.
5. To include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments.

D. Retention of Records

1. To retain all financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of six (6) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of six (6) years, the records shall be retained until resolution of the audit findings.
2. Persons duly authorized by the Agency and federal auditors, pursuant to 45 CFR, Part 74 and/or 45 CFR, Part 92, shall have full access to and the right to examine any of said records and documents.
3. The rights of access in this section must not be limited to the required retention period but shall last as long as the records are retained.

E. Monitoring

1. To provide reports as specified in **Attachment II**, Core Contract Provisions. These reports will be used for monitoring progress or performance of the contractual services as specified in **Attachment I**, Scope of Services and **Attachment II**, Core Contract Provisions.
2. To permit persons duly authorized by the Agency to inspect any records, papers, documents, facilities, goods and services of the Vendor which are relevant to this Contract.

F. Indemnification

The Vendor shall save and hold harmless and indemnify the State of Florida and the Agency against any and all liability, claims, suits, judgments, damages or costs of whatsoever kind and nature resulting from the use, service, operation or performance of work under the terms of this Contract, resulting from any act, or failure to act, by the Vendor, its subcontractor, or any of the employees, agents or representatives of the Vendor or subcontractor.

G. Insurance

1. To the extent required by law, the Vendor shall be self-insured against, or will secure and maintain during the life of this Contract, Workers' Compensation Insurance for all its employees connected with the work of this project and, in case any work is subcontracted, the Vendor shall require the subcontractor similarly to provide Workers' Compensation Insurance for all of the latter's employees unless such employees engaged in work under this Contract are covered by the Vendor's self insurance program. Such self insurance or insurance coverage shall comply with the Florida Workers' Compensation law. In the event hazardous work is being performed by the Vendor under this Contract and any class of employees performing the hazardous work is not protected under Workers' Compensation statutes, the Vendor shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of its employees not otherwise protected.
2. The Vendor shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal & advertising injury and products and completed operations. This insurance will provide coverage for all claims that may arise from the services and/or operations completed under this Contract, whether such services and/or operations are by the Vendor or anyone directly employed by it. Such insurance shall include the State of Florida as an Additional Named Insured for the entire length of the Contract and hold the State of Florida harmless from subrogation. The Vendor shall set the limits of liability necessary to provide reasonable financial protections to the Vendor and the State of Florida under this Contract.
3. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Vendor's current insurance policy(ies) shall contain a provision that the insurance will not be canceled for any reason except after thirty (30) calendar days written notice. The Vendor shall provide thirty (30) calendar days written notice of cancellation to the Agency's Contract Manager.

H. Assignments and Subcontracts

To neither assign the responsibility of this Contract to another party nor subcontract for any of the work contemplated under this Contract without prior written approval of the Agency. No such approval by the Agency of any assignment or subcontract shall be deemed in any event or in any manner to provide for the incurrence of any obligation of the Agency in addition to the total dollar amount agreed upon in this Contract. All such assignments or subcontracts shall be subject to the conditions of this Contract and to any conditions of approval that the Agency shall deem necessary.

I. Return of Funds

To return to the Agency any overpayments due to unearned funds or funds disallowed pursuant to the terms of this Contract that were disbursed to the Vendor by the Agency. The Vendor shall return any overpayment to the Agency within forty (40) calendar days after either discovery by the Vendor, its independent auditor, or notification by the Agency, of the overpayment.

J. Purchasing

1. P.R.I.D.E.

It is expressly understood and agreed that any articles which are the subject of, or required to carry out this Contract shall be purchased from the corporation identified under Chapter 946, Florida Statutes, if available, in the same manner and under the same procedures set forth in Section 946.515(2), and (4), Florida Statutes; and, for purposes of this Contract, the person, firm or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for this Agency insofar as dealings with such corporation are concerned.

The "Corporation identified" is PRISON REHABILITATIVE INDUSTRIES AND DIVERSIFIED ENTERPRISES, INC. (P.R.I.D.E.) which may be contacted at:

P.R.I.D.E.
12425 28th Street North, Suite 300
St. Petersburg, FL 33716
E-Mail: info@pride-enterprises.org
(727) 556-3300
Toll Free: 1-800-643-8459
Fax: (727) 570-3366

2. RESPECT of Florida

It is expressly understood and agreed that any articles that are the subject of, or required to carry out, this Contract shall be purchased from a nonprofit agency for the blind or for the severely handicapped that is qualified pursuant to Chapter 413, Florida Statutes, in the same manner and under the same procedures set forth in Section 413.036(1) and (2), Florida Statutes; and, for purposes of this Contract, the person, firm, or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for this Agency insofar as dealings with such qualified nonprofit agency are concerned.

The "nonprofit agency" identified is RESPECT of Florida which may be contacted at:

RESPECT of Florida
2475 Apalachee Parkway, Suite 205
Tallahassee, Florida 32301-4946
(850) 487-1471
Website: www.respectofflorida.org

3. Procurement of Products or Materials with Recycled Content

It is expressly understood and agreed that any products which are required to carry out this Contract shall be procured in accordance with the provisions of Section 403.7065, Florida Statutes.

K. Civil Rights Requirements/Vendor Assurance

The Vendor assures that it will comply with:

1. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin.
2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.
3. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.
4. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.
5. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.
6. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.
7. All regulations, guidelines, and standards as are now or may be lawfully adopted under the above statutes.

The Vendor agrees that compliance with this assurance constitutes a condition of continued receipt of or benefit from funds provided through this Contract, and that it is binding upon the Vendor, its successors, transferees, and assignees for the period during which services are provided. The Vendor further assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to participants or employees in connection with any of its programs and activities are not discriminating against those participants or employees in violation of the above statutes, regulations, guidelines, and standards.

L. Discrimination

An entity or affiliate who has been placed on the discriminatory vendor list may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity. The Florida Department of Management Services is responsible for maintaining the discriminatory vendor list and intends to post the list on its website. Questions regarding the discriminatory vendor list may be directed to the Florida Department of Management Services, Office of Supplier Diversity at (850) 487-0915.

M. Requirements of Section 287.058, Florida Statutes

1. To submit bills for fees or other compensation for services or expenses in detail sufficient for a proper pre-audit and post-audit thereof.

2. Where applicable, to submit bills for any travel expenses in accordance with Section 112.061, Florida Statutes. The Agency may establish rates lower than the maximum provided in Section 112.061, Florida Statutes.
3. To provide units of deliverables, including reports, findings, and drafts, in writing and/or in an electronic format agreeable to both Parties, as specified in **Attachment I**, Scope of Services, and **Attachment II**, Core Contract Provisions to be received and accepted by the Contract Manager prior to payment.
4. To comply with the criteria and final date, as specified herein, by which such criteria must be met for completion of this Contract.

This Contract shall begin upon execution by both Parties or **August 1, 2013**, (whichever is later) and end on **August 31, 2018**, inclusive.

5. The Vendor agrees that the Agency may unilaterally cancel this Contract for refusal by the Vendor to allow public access to all documents, papers, letters, or other material made or received by the Vendor in conjunction with this Contract, unless the records are exempt from Section 24(a) of Art. I of the State Constitution and Section 119.07(1), Florida Statutes.
6. To comply with Patents, Royalties, Copyrights, Right to Data, and Works for Hire/Software requirements as follows:

The Vendor, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Vendor. The Vendor has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Vendor or is based solely and exclusively upon the Agency's alteration of the article.

The Agency will provide prompt written notification of a claim of copyright or patent infringement and shall afford the Vendor full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Vendor may, at its option and expense procure for the Agency the right to continue the use of, replace or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Vendor and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).

If the Vendor brings to the performance of this Contract a pre-existing patent, patent-pending and/or copyright at the time of Contract execution, the Vendor shall retain all rights and entitlements to that pre-existing patent, patent-pending and/or copyright, unless this Contract provides otherwise.

If the Vendor uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under this Contract, the Vendor shall disclose, in writing, all intellectual properties relevant to the

performance of this Contract which the Vendor knows, or should know, could give rise to a patent or copyright. The Vendor shall retain all rights and entitlements to any pre-existing intellectual property which is so disclosed. Failure to disclose will indicate that no such property exists. The Agency will then have the right to all patents and copyrights which arise as a result of performance under this Contract as provided in this section.

If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Contract, or in any way connected herewith, the Vendor shall refer the discovery or invention to the Agency for a determination whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the Vendor in such a manner as to preserve and protect the legal rights of the Agency.

Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation and works of any similar nature, the Agency has the right to use, duplicate and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the state. Pursuant to Section 286.021, Florida Statutes, no person, firm, corporation, including Parties to this Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.

The Agency will have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Vendor under this Contract.

All rights and title to works for hire under this Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this Contract.

The computer programs, materials and other information furnished by the Agency to the Vendor hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Vendor. The services and products listed in this Contract shall become the property of the Agency upon the Vendor's performance and delivery thereof. The Vendor hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Vendor hereunder, together with the products delivered and services performed by the Vendor hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, Florida Statutes, and that the Vendor shall not disclose, publish or use same for any purpose other than the purposes provided in this Contract; however, upon the Vendor first demonstrating to the Agency's satisfaction that such information, in part or in whole, (1) was already known to the Vendor prior to its receipt from the Agency; (2) became known to the Vendor from a source other than the Agency; or (3) has been

disclosed by the Agency to third parties without restriction, the Vendor shall be free to use and disclose same without restriction. Upon completion of the Vendor's performance or otherwise cancellation or termination of this Contract, the Vendor shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the Vendor's possession.

The Vendor warrants that all materials produced hereunder will be of original development by the Vendor and will be specifically developed for the fulfillment of this Contract and will not knowingly infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the Vendor shall indemnify and hold the Agency harmless from and against any loss, cost, liability or expense arising out of any breach or claimed breach of this warranty.

The terms and conditions specified in this section shall also apply to any subcontract made under this Contract. The Vendor shall be responsible for informing the subcontractor of the provisions of this section and obtaining disclosures.

7. The financial consequences that the Agency must apply if the Vendor fails to perform in accordance with this Contract are outlined in **Attachment II, Core Contract Provisions**.

N. Sponsorship

Pursuant to Section 286.25, Florida Statutes, any nongovernmental organization which sponsors a program financed partially by state funds or funds obtained from a state agency shall, in publicizing, advertising, or describing the sponsorship of the program, state:

“Sponsored by [HEALTH PLAN NAME] and the State of Florida, **AGENCY FOR HEALTH CARE ADMINISTRATION**.”

If the sponsorship reference is in written material, the words "State of Florida, AGENCY FOR HEALTH CARE ADMINISTRATION" shall appear in the same size letters or type as the name of the organization.

O. Use Of Funds For Lobbying Prohibited

To comply with the provisions of Section 216.347, Florida Statutes, which prohibits the expenditure of Contract funds for the purpose of lobbying the Legislature, the judicial branch or a state agency.

P. Public Entity Crime

A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, Florida Statutes, for category two, for a period of thirty-six (36) months from the date of being placed on the convicted vendor list.

Q. Health Insurance Portability and Accountability Act

To comply with the Department of Health and Human Services Privacy Regulations in the Code of Federal Regulations, Title 45, Sections 160 and 164, regarding disclosure of protected health information as specified in **Attachment III**, Business Associate Agreement.

R. Confidentiality of Information

Not to use or disclose any confidential information, including social security numbers that may be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Medicaid recipient or services under this Contract for any purpose not in conformity with state and federal laws, except upon written consent of the recipient, or his/her guardian.

S. Employment

To comply with Section 274A (e) of the Immigration and Nationality Act. The Agency will consider the employment by any contractor of unauthorized aliens a violation of this Act. If the Vendor knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. The Vendor shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Contract.

T. Work Authorization Program

The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. The Vendor shall only employ individuals who may legally work in the United States (U.S.) – either U.S. citizens or foreign citizens who are authorized to work in the U.S. The Vendor shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, <https://e-verify.uscis.gov/emp>, to verify the employment eligibility of all new employees hired by the Vendor during the term of this Contract and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to this Contract.

U. Scrutinized Companies Lists

The Vendor shall complete **Attachment VI**, Vendor Certification Regarding Scrutinized Companies List, certifying that it is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes. Pursuant to Section 287.135(5), Florida Statutes, the Vendor agrees the Agency may immediately terminate this Contract for cause if the Vendor is found to have submitted a false certification or if the Vendor is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the Contract.

II. THE AGENCY HEREBY AGREES:

A. Contract Amount

To pay for contracted services according to the conditions of **Attachment I**, Scope of Services and **Attachment II**, Core Contract Provisions, in an amount not to exceed (XXXX), subject to the availability of funds. Funding for this Contract is appropriated in the 2013-2014 Legislative Budget, under the Prepaid Health Plan line. The State of Florida's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature.

III. THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE:

A. Termination

1. Termination at Will

This Contract may be terminated by the Agency upon no less than thirty (30) calendar days written notice, without cause, unless a lesser time is mutually agreed upon by both Parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

2. Termination Due To Lack of Funds

In the event funds to finance this Contract become unavailable, the Agency may terminate the Contract upon no less than twenty-four (24) hours' written notice to the Vendor. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The Agency will be the final authority as to the availability of funds. The Vendor shall be compensated for all work performed up to the time notice of termination is received.

3. Termination for Breach

Unless the Vendor's breach is waived by the Agency in writing, the Agency may, by written notice to the Vendor, terminate this Contract upon no less than twenty-four (24) hours' written notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. If applicable, the Agency may employ the default provisions in Florida Administrative Code Rule 60A-1.006(3).

Waiver of breach of any provisions of this Contract shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms of this Contract. The provisions herein do not limit the Agency's right to remedies at law or to damages.

B. Contract Managers

1. The Agency's Contract Manager's contact information is as follows:

[Contract Manager's Name]
Agency for Health Care Administration
2727 Mahan Drive, MS# 20
Tallahassee, FL 32308
(850) 412-4262

2. The Vendor's Contract Manager's contact information is as follows:

[Vendor's Contract Manager's Name]
[Vendor's Name]
[Vendor's Address]
[Vendor's Phone Number]

3. All matters shall be directed to the Contract Managers for appropriate action or disposition. A change in Contract Manager by either Party shall be reduced to writing through an amendment or minor modification to this Contract by the Agency.

C. Renegotiation or Modification

1. Modifications of provisions of this Contract shall only be valid when they have been reduced to writing and duly signed during the term of the Contract. The Parties agree to renegotiate this Contract if federal and/or state revisions of any applicable laws, or regulations make changes in this Contract necessary.
2. The rate of payment and the total dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the Agency's operating budget.

D. Name, Mailing and Street Address of Payee

1. The name (Vendor name as shown on Page 1 of this Contract) and mailing address of the official payee to whom the payment shall be made:

[Vendor's Name]
[Vendor's Address]

2. The name of the contact person and street address where financial and administrative records are maintained:

[Financial and Administrative Records Contact Name]
[Financial and Administrative Records Address]

E. All Terms and Conditions

This Contract and its attachments as referenced herein contain all the terms and conditions agreed upon by the Parties.

IN WITNESS THEREOF, the Parties hereto have caused this three hundred fourteen (314) page Contract, which includes any referenced attachments, to be executed by their undersigned officials as duly authorized. This Contract is not valid until signed and dated by both Parties.

[HEALTH PLAN NAME]

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION

SIGNED BY: _____

SIGNED BY: _____

NAME: _____

NAME: _____

TITLE: _____

TITLE: _____

DATE: _____

DATE: _____

FEDERAL ID NUMBER (or SS Number for an individual): XX-XXXXXX

VENDOR FISCAL YEAR ENDING DATE: December 31st

List of Attachments included as part of this Contract:

Specify Type	Letter/ Number	Description
Attachment	I	Scope of Services (10 Pages)
Attachment	II	Core Contract Provisions (285 Pages)
Attachment	III	Business Associate Agreement (4 Pages)
Attachment	IV	Certification Regarding Lobbying (1 Page)
Attachment	V	Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts (1 Page)
Attachment	VI	Vendor Certification Regarding Scrutinized Companies List (1 Page)

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2013 – 2018 Long-Term Care Health Plan Model Contract

**ATTACHMENT I
SCOPE OF SERVICES
LONG-TERM CARE (LTC) MANAGED CARE PLANS**

A. Plan Type

1. The Managed Care Plan is approved to provide contracted services as denoted by “X” in Table 1, LTC Plan Type, below.

TABLE 1 - LTC Plan Type				
Effective Date: 08/01/13 – 08/31/18				
Capitated Managed Care Plan				Fee-for-Service (FFS) Managed Care Plan*
Health Maintenance Organization (HMO)	LTC Provider Service Network (LTC PSN)	Exclusive Provider Organization (EPO)	Medicare Advantage Special Needs Plan (MA SNP)	LTC Provider Service Network (LTC PSN)

* FFS Managed Care Plans are capitated by the Agency for transportation only.

2. Contract Structure: The Managed Care Plan Contract is made up of three distinct parts: **Attachment I**, Scope of Services and its Exhibits; **Attachment II**, Core Contract Provisions, and Exhibits applicable to **Attachment II**. In general these parts include the following:
 - a. **Attachment I**, Scope of Services, includes contract provisions that are unique to the particular managed care plan and denote such plan-specific specifications as plan type, population served, services covered, method of payment. Its exhibits specify the plan-specific regions covered and enrollment levels, regional start-up schedule (not plan-specific) and payment rates.
 - b. **Attachment II**, Core Contract Provisions, includes contract provisions that apply to all managed care plans unless specifically noted otherwise.
 - c. Exhibits to **Attachment II**, Core Contract Provisions, include contract provisions that are unique to the specific component of the SMMC (either long-term care (LTC) or managed medical assistance (MMA), and specify further requirements distinct to either capitated or FFS managed care plans, as appropriate. For purpose of the long-term care contract, the exhibits will be long-term care specific.

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B. Population(s) to be Served

1. Population Groups

The Managed Care Plan shall deliver covered services to the population(s) identified in **Attachment II**, Core Contract Provisions, Section III, Eligibility and Enrollment.

2. Minimum Enrollment Levels

The Managed Care Plan shall contract with and maintain a provider network in accordance with **Attachment II, Exhibit 7**, sufficient to meet its recipient enrollment levels by region, and at a minimum, the enrollment levels, by region, specified in **Attachment I, Exhibit 2**, Table 2 below.

3. Maximum Enrollment Levels (see also Attachment I, Exhibit 2)

The Agency assigns the Managed Care Plan an authorized maximum enrollment level for the region(s) indicated in **Attachment I**, Scope of Services, **Exhibit 1**, Maximum Enrollment Levels. The assignment shall be based on the maximum regional enrollment levels specified in **Attachment I**, Scope of Services, **Exhibit 2**, Table 2, Managed Care Plan, Region Required Enrollment Levels, and any increases requested by the Managed Care plan and approved by the Agency. The authorized maximum enrollment level listed is effective upon Contract execution unless otherwise specified in **Attachment I**, Scope of Services, **Exhibit 1**, Maximum Enrollment Levels.

- a. The Agency must approve in writing any increase or decrease in the Managed Care Plan's maximum enrollment level for the region(s) to be served as specified in **Attachment II**, Core Contract Provisions, **Exhibit 2**, General Overview, sub-items C.22. and D.26.
- b. Such approval shall be based upon the Managed Care Plan's satisfactory performance of terms of the Contract and upon the Agency's approval of the Managed Care Plan's administrative and service resources, as specified in this Contract, in support of each enrollment level.
- c. The regional roll-out schedule and Agency-specified maximum enrollment levels for each region in the long-term care component of the Statewide Medicaid Managed Care program are specified in **Attachment I**, Scope of Services, **Exhibit 2**, Table 2, Managed Care Plan, Region Required Enrollment Levels.

- (1) **Attachment I**, Scope of Services, **Exhibit 2**, Table 2, Managed Care Plan, Region Required Enrollment Levels, indicates the Agency's regional enrollment level(s) a Managed Care Plan is required to accommodate using the calculation in the following formula:

Regional Enrollment Level = (100% of total eligible population divided by the minimum number of required plans) multiplied by 2

Example: 17,466 (total eligible) divided by 5 (minimum required plans for region) = 3,493 times 2 = 6,986 enrollees per plan (numbers are rounded)

- i. In regions where only two (2) plans are required, each plan must be able to serve one hundred (100%) percent of the eligible population.
 - ii. The Agency will determine the total eligible population.
 - iii. The Agency may revise this calculation annually or more frequently as needed based on changes in enrollment levels and/or to ensure the regional populations are appropriately served.
- (2) The Managed Care Plan may request a higher enrollment capacity. These can be increased only as specified in sub-item 2.a. and b. above, and will be documented, by amendment, in **Attachment I**, Scope of Services, **Exhibit 1**, Maximum Enrollment Levels.

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C. Covered Service(s) to be Provided

1. Covered Medicaid Services

The Managed Care Plan shall ensure the provision of the Medicaid services specified in **Attachment II**, Core Contract Provisions, Section V, Covered Services, Section VI, Behavioral Health Services, and as specified in applicable exhibits to **Attachment II**. At a minimum, they shall include:

TABLE 2 - Minimum Long-Term Care Managed Care Benefits Effective Date: 08/01/13 – 08/31/18 (see Attachment II, Exhibit 5 and s. 409.98, F.S.)
Adult companion care
Adult day health care
Assisted living
Assistive care services
Attendant care
Behavioral management
Care coordination/Case management
Caregiver training
Home accessibility adaptation
Home-delivered meals
Homemaker
Hospice
Intermittent and skilled nursing
Medical equipment and supplies
Medication administration
Medication management
Nursing facility
Nutritional assessment/Risk reduction
Personal care
Personal emergency response system (PERS)
Respite care
Therapies, occupational, physical, respiratory, and speech
Transportation, non-emergency

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2. **Approved Expanded Benefits**

The Managed Care Plan shall provide the following expanded benefits to enrollees as specified in Table 3, Expanded Benefits, below in accordance with **Attachment II**, Core Contract Provisions, and Exhibit 17.

TABLE 3 – Expanded Benefits Effective Date: 08/01/13 – 08/31/18
OVER-THE-COUNTER MEDICATION/SUPPLIES
ASSISTED LIVING FACILITY/ADULT FAMILY CARE HOME BED HOLD

3. **Other Service Requirements**

The Managed Care Plan shall meet the minimum service requirements as outlined and defined in **Attachment II**, Core Contract Provisions.

D. **Method of Payment**

1. **General**

This is a fixed price (unit cost) Contract awarded through competitive procurement unless specifically exempted from procurement under s. 409.981(4) and (5), F.S. The Agency will manage this Contract for the delivery of services to enrollees (service units). The Managed Care Plan will be paid through the Agency’s Medicaid fiscal agent, in accordance with the terms of this Contract, a total dollar amount not to exceed **(XXXX)**, subject to the availability of funds in accordance with **Attachment II**, Core Contract Provisions, Section XIII, Method of Payment, and **Attachment II**, Core Contract Provisions, **Exhibit 13**, Method of Payment – LTC Plans.

- a. The Managed Care Plan shall be paid for the region(s) as indicated in **Attachment I, Exhibit 1**, Regional Awards and Maximum Enrollment Levels.
- b. All payments made to the Managed Care Plan shall be in accordance with this section and **Attachment II**, Core Contract Provisions, Section XIII, Method of Payment, and **Exhibit 13**, Method of Payment – LTC Plans.

2. **Capitation Rates**

Attachment I, Scope of Services, **Exhibit 3**, of this Contract provides the capitation rates for each region. The capitation rate payment shall be in accordance with **Attachment II**, Core Contract Provisions, Section XIII, Method of Payment, and **Exhibit 13**, Method of Payment – LTC Plans. These rates are titled “**ESTIMATED MANAGED CARE PLAN RATES; NOT FOR USE UNLESS APPROVED BY CMS.**”

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3. **Benchmark and Fee-for-Service Rates (LTC FFS Managed Care Plans Only)**

- a. **Attachment I**, Scope of Services, **Exhibit 3**, FFS Managed Care Plans, provides the benchmark rates for each region. The benchmark rate payment shall be in accordance with **Attachment II**, Core Contract Provisions, Section XIII, Method of Payment, and **Exhibit 13**, Method of Payment – LTC Plans. These rates are titled “**ESTIMATED MANAGED CARE PLAN LTC RATES; NOT FOR USE UNLESS APPROVED BY CMS.**”
- b. Each month the Agency shall pay the Managed Care Plan the applicable capitation rate in **Exhibit 13**, Method of Payment – LTC Plans, for transportation services for each enrollee who appears on the Health Plan’s HIPAA-compliant X12 820 file, in accordance with **Attachment II**, Core Contract Provisions, **Exhibit 13**, Method of Payment – LTC Plans. These rates are titled “**ESTIMATED MANAGED CARE PLAN LTC RATES; NOT FOR USE UNLESS APPROVED BY CMS.**”
- c. All Medicaid fee-for-service claims will be paid to the Managed Care Plan’s providers according to the Medicaid Provider Fee Schedules and in accordance with **Attachment II**, Core Contract Provisions.

E. Assumptions

1. An even enrollment distribution by region was assumed for each plan in a region. As the program rolls out and matures, the actual enrollment distribution by plan will be known.
2. Any material changes to the program requirements or eligibility may result in these values needing updating. In particular, if the Health Insurer Fee effective January 1, 2014 is determined to apply to Medicaid MLTC programs, these values may require updating.

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2013 – 2018 Long-Term Care Health Plan Model Contract

ATTACHMENT I

EXHIBIT 1
REGIONAL AWARDS AND MAXIMUM ENROLLMENT LEVELS
Effective Date: 08/01/13 – 08/31/18

Exhibit 1, Maximum Enrollment Levels, provides Managed Care Plan specific enrollment levels.

TABLE 1 (Region 1)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
2,973	0084620-01

TABLE 2 (Region 2)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
4,058	0084620-02

TABLE 3 (Region 3)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
4,607	0084620-03

TABLE 4 (Region 4)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
6,058	0084620-04

TABLE 5 (Region 5)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
9,963	0084620-05

TABLE 6 (Region 6)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
4,788	0084620-06

TABLE 7 (Region 7)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
6,225	0084620-07

TABLE 8 (Region 8)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
5,596	0084620-08

TABLE 9 (Region 9)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
7,854	0084620-09

TABLE 10 (Region 10)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
7,822	0084620-10

TABLE 11 (Region 11)

Effective Date: 08/01/2013	
Maximum Enrollment Level	Provider Number
6,903	0084620-11

2013 – 2018 Long-Term Care Health Plan Model Contract

ATTACHMENT I

EXHIBIT 2

LTC Regional Start-Up Schedule and Region Required Enrollment Levels

Effective Date: 08/01/13 – 08/31/18

Table 1 - Regional Start-Up Schedule		
Effective Date: 08/01/13 – 08/31/18		
Region	Plan Readiness Deadline	Enrollment Effective Date
7	May 1, 2013	August 1, 2013
8 & 9	June 1, 2013	September 1, 2013
2 & 10	August 1, 2013	November 1, 2013
11	September 1, 2013	December 1, 2013
5 & 6	November 1, 2013	February 1, 2014
1, 3 & 4	December 1, 2013	March 1, 2014

Table 2 - Managed Care Plan - Network Adequacy – Minimum Enrollment Levels	
Effective Date: 08/01/13 – 08/31/18	
Region	Minimum Enrollment Level
1	2,973
2	4,058
3	4,607
4	6,058
5	9,963
6	4,788
7	6,225
8	5,596
9	7,854
10	7,822
11	6,903

Table 3 - Medicaid Regions – County Breakdown	
Effective Date: 08/01/13 – 08/31/18	
Region	Counties
1	Escambia, Okaloosa, Santa Rosa and Walton
2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington
3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union
4	Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia
5	Pasco and Pinellas
6	Hardee, Highlands, Hillsborough, Manatee and Polk
7	Brevard, Orange, Osceola and Seminole
8	Charlotte, Collier, Desoto, Glades, Hendry, Lee and Sarasota
9	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
10	Broward
11	Miami-Dade and Monroe

**ATTACHMENT I - 2013 – 2018 Long-Term Care Health Plan Model Contract
EXHIBIT 3**

**FFS MANAGED CARE PLANS
Effective Date: [mm/dd/yy - mm/dd/yy]**

MANAGED CARE PLAN LTC RATES BY REGION

"ESTIMATED MANAGED CARE PLAN RATES; NOT FOR USE UNLESS APPROVED BY CMS"

Region	Enrollment Period	Pre-Enrollment Benchmark Mix Percentage ¹		Base Capitation Rate ² (PMPM) <i>without transportation</i>		Agency-Required Transition			Final ³ Blended Rate ⁴
		HCBS	Non-HCBS	HCBS	Non-HCBS	Percent	Adjusted Mix Percentage		
							HCBS	Non-HCBS	
01	Mar 1, 2014 to Aug 31, 2014	22.7%	77.3%	\$ 1,098.62	\$ 4,658.77	1.00%	23.7%	76.3%	\$ 3,815.47
02	Nov 1, 2013 to Aug 31, 2014	27.9%	72.1%	\$ 760.15	\$ 4,661.31	1.67%	29.6%	70.4%	\$ 3,506.33
03	Mar 1, 2014 to Aug 31, 2014	30.9%	69.1%	\$ 1,098.62	\$ 4,660.60	1.00%	31.9%	68.1%	\$ 3,523.13
04	Mar 1, 2014 to Aug 31, 2014	28.7%	71.3%	\$ 1,098.62	\$ 4,662.89	1.00%	29.7%	70.3%	\$ 3,604.87
05	Feb 1, 2014 to Aug 31, 2014	32.1%	67.9%	\$ 1,234.60	\$ 4,756.57	1.17%	33.3%	66.7%	\$ 3,584.04
06	Feb 1, 2014 to Aug 31, 2014	37.7%	62.3%	\$ 1,234.60	\$ 4,661.83	1.17%	38.9%	61.1%	\$ 3,330.17
07	Aug 1, 2013 to Aug 31, 2014	35.6%	64.4%	\$ 1,228.83	\$ 4,756.17	2.00%	37.6%	62.4%	\$ 3,430.73
08	Sep 1, 2013 to Aug 31, 2014	27.3%	72.7%	\$ 1,358.05	\$ 4,988.14	2.00%	29.3%	70.7%	\$ 3,923.12
09	Sep 1, 2013 to Aug 31, 2014	34.9%	65.1%	\$ 1,454.45	\$ 4,992.89	2.00%	36.9%	63.1%	\$ 3,686.83
10	Nov 1, 2013 to Aug 31, 2014	56.8%	43.2%	\$ 1,360.12	\$ 5,211.93	1.67%	58.5%	41.5%	\$ 2,958.45
11	Dec 1, 2013 to Aug 31, 2014	63.6%	36.4%	\$ 1,361.16	\$ 5,210.39	1.50%	65.1%	34.9%	\$ 2,705.76

Region	Administrative Allowance ⁵	Transportation Capitation Rate (PMPM)
All	4.9%	\$0.12

1. The actual pre-enrollment case mix will be updated for each region based on the region's beginning enrollment date. The most recent 12 months of historical claims data that precede a three-month run-off period immediately prior to the enrollment date will be used to calculate the pre-enrollment case mix. For example, Region 7 begins enrollment on August 1, 2013. The three-month run-off period extends from May through July 2013, with the preceding 12 months (May 2012 through April 2013) providing the historical data for Region 7's pre-enrollment case mix. Similarly, the enrollment date for Region 6 is February 1, 2014. The historical data used for Region 6's pre-enrollment mix represents the 12 months from November 2012 through October 2013.

2. The Base Capitation Rates will be updated to reflect changes in the nursing home payment rates or other program changes.

3. The actual final rate paid to plans will be based on each plan's enrollment mix, adjusted by the Agency-Required Transition Percent.

4. Rates recalibrated based on actual enrollment must be budget neutral to the state, using the rates calculated from the Adjusted Mix Percentage as the benchmark. The rates displayed do not include transportation.

5. This statewide percentage is applied to the region-specific PCCB developed for the FFS PSN.

2013 – 2018 Long-Term Care Health Plan Model Contract

ATTACHMENT II
CORE CONTRACT PROVISIONS

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Section I Definitions and Acronyms

A. Definitions

The following terms as used in this Contract shall be construed and/or interpreted as follows, unless the Contract otherwise expressly requires a different construction and/or interpretation. Some defined terms do not appear in all contracts.

Abandoned Call — A call in which the caller elects an option and is either not permitted access to that option or disconnects from the system.

Abuse (for program integrity functions) — Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid program.

Abuse, Neglect and Exploitation — In accordance with Chapter 415, F.S., and Chapter 39, F.S., for the purposes of this Contract these definitions are relative to long-term care:

“Abuse” means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee’s physical, mental, or emotional health. Abuse includes acts and omissions.

“Exploitation” of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult’s funds, assets, or property for the benefit of someone other than the vulnerable adult.
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

“Neglect” of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term “neglect” also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. “Neglect” is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

“Neglect” of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an

environment when such deprivation or environment causes the child's physical, behavioral, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

Accountable Care Organization (ACO) — An entity qualified as an accountable care organization in accordance with federal regulations (see 42 CFR Part 425), and which meets the requirements of a provider service network (PSN) as described in s. 409.912(4)(d), F.S.

Action — The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the state. The failure of the Managed Care Plan to act within ninety (90) days from the date the Managed Care Plan receives a grievance, or forty-five (45) days from the date the Managed Care Plan receives an appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.

Activities of Daily Living (ADL) — Basic tasks of everyday life which include, dressing, grooming, bathing, eating, transferring in and out of bed or a chair, walking, climbing stairs, toileting, bladder/bowel control, and the wearing and changing of incontinence briefs.

Acute Care Services — Short-term medical treatment that may include, but is not limited to, community behavioral health, dental, hearing, home health, independent laboratory and x-ray, inpatient hospital, outpatient hospital/emergency medical, physician, prescribed drug, vision, or hospice services.

Advance Directive — A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Advanced Registered Nurse Practitioner (ARNP) — A licensed advanced registered nurse practitioner who works in collaboration with a physician according to protocol, to provide diagnostic and clinical interventions. An ARNP must be authorized to provide these services by Chapter 464, F.S., and protocols filed with the Board of Medicine.

Adverse Incident — Critical events that negatively impact the health, safety, or welfare of enrollees. Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents.

Agency — State of Florida, Agency for Health Care Administration (AHCA) or its designee.

Agent — A term that refers to certain independent contractors with the state that perform administrative functions, including but not limited to: fiscal agent activities; outreach, eligibility and enrollment activities; and systems and technical support. The term as used herein does not create a principal-agent relationship.

Aging and Disability Resource Center — An agency designated by the DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older and disabled persons.

Aging Network Service Provider — A system of essential community providers including all providers that have previously participated in home and community-based waivers serving elders or community service programs administered by the Department of Elder Affairs (DOEA) pursuant to s. 409.982(1)(c), F.S., or s. 430.205, F.S., and to whom the Agency or DOEA has made payments in the six (6) months prior to the release of the long-term managed care ITN.

Ancillary Provider — A provider of ancillary medical services who has contracted with a managed care plan to serve the managed care plan's enrollees.

Appeal — A formal request from an enrollee to seek a review of an action taken by the Managed Care Plan pursuant to 42 CFR 438.400(b).

Area Agency on Aging — An agency designated by the DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older persons.

Authoritative Host — A system that contains the master or "authoritative" data for a particular data type, e.g., enrollee, provider, managed care plan, etc. The authoritative host may feed data from its master data files to other systems in real time or in batch mode. Data in an authoritative host is expected to be up to date and reliable.

Baker Act — The Florida Mental Health Act, pursuant to ss. 394.451 through 394.4789, F.S.

Bed Hold Day(s) — The reservation of a bed in a nursing facility (including beds for individuals receiving hospice services), when a resident is admitted into the hospital or is on therapeutic leave during a Medicaid covered stay.

Behavioral Health Care Provider — A licensed behavioral health professional, such as a clinical psychologist, or registered nurse qualified due to training or competency in behavioral health care, who is responsible for the provision of behavioral health care to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide behavioral health services to enrollees.

Behavioral Health Services — Services listed in the Community Behavioral Health Services Coverage & Limitations Handbook and the Targeted Case Management Coverage & Limitations Handbook as specified in Attachment II, Core Contract Provisions, Section VI, Behavioral Health Care, Item A., General Provisions.

Beneficiary Assistance Program — A state external conflict resolution program authorized under s. 409.91211(3)(q), F.S., available to Medicaid participants, that provides an additional level of appeal if the Managed Care Plan's process does not resolve the conflict.

Benefits — A schedule of health care services to be delivered to enrollees covered by the Managed Care Plan as set forth in Attachment II, Core Contract Provisions, Section V, Covered Services, and Section VI, Behavioral Health Care, and Attachment I, Scope of Services of this Contract.

Biometric Technology — The use of computer technology to identify people based on physical or behavioral characteristics such as fingerprints, retinal or voice scans.

Blocked Call — A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up behind a defined threshold.

Business Days — Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday, and Friday. State holidays are excluded.

Calendar Days — All seven (7) days of the week. Unless otherwise specified, the term “days” in this attachment refers to calendar days.

Capitated Managed Care Plan — A managed care plan that is licensed or certified as a fully risk-bearing entity, or qualified pursuant to s. 409.912(4)(d), F.S., in the state, and is paid a prospective per-member, per-month payment by the Agency.

Capitation Rate — The per-member, per-month amount, including any adjustments, that is paid by the Agency to a capitated managed care plan for each Medicaid recipient enrolled under a Contract for the provision of Medicaid services during the payment period.

Care Coordination/Case Management — A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an enrollee's health needs using communication and all available resources to promote quality outcomes. Proper care coordination/case management occurs across a continuum of care, addressing the ongoing individual needs of an enrollee rather than being restricted to a single practice setting.

Case Record — A record that includes information regarding the management of services for an enrollee including the plan of care and documentation of care coordination/case management activities.

Cause — Special reasons that allow mandatory enrollees to change their managed care plan choice outside their open enrollment period. May also be referred to as “good cause.” (See 59G-8.600, F.A.C.)

Centers for Independent Living (CIL) – Non-profit agencies serving all Florida counties with an array of services to enable people of all ages with disabilities to live at home, work, maintain their health, care for their families, and take part in community activities.

Centers for Medicare & Medicaid Services (CMS) — The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children’s Health Insurance Program under Title XXI of the Social Security Act.

Certification — The process of determining that a facility, equipment or an individual meets the requirements of federal or state law, or whether Medicaid payments are appropriate or shall be made in certain situations.

Check Run Summary File — Required Managed Care Plan file listing all amounts paid to providers for each provider payment adjudication cycle. For each provider payment in each adjudication cycle, the file must detail the total encounter payments to each respective provider. This file must be submitted along with the encounter data submissions. The file must be submitted in a format and in timeframes specified by the Agency.

Child Health Check-Up-Program (CHCUP) — A set of comprehensive and preventive health examinations provided on a periodic basis to identify and correct medical conditions in children/adolescents. Policies and procedures are described in the Child Health Check-Up Services Coverage and Limitations Handbook. (See definition of **Early and Periodic Screening, Diagnosis and Treatment Program.**)

Children/Adolescents — Enrollees under the age of 21. For purposes of the provision of Behavioral Health Services, excluding inpatient psychiatric services, adults are persons age 18 and older, and children/adolescents are persons under age 18, as defined by the Department of Children and Families.

Children's Medical Services Network — A primary care case management program for children from birth through age 18 with special health care needs, administered by the Department of Health for physical health services and the Department of Children and Families for behavioral health.

Claim — (1) A bill for services, (2) a line item of service, or (3) all services for one (1) recipient within a bill, pursuant to 42 CFR 447.45, in a format prescribed by the Agency through its Medicaid provider handbooks.

Clean Claim — A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

Cold Call Marketing — Any unsolicited personal contact with a Medicaid recipient by the Managed Care Plan, its staff, its volunteers, or its vendors with the purpose of influencing the Medicaid recipient to enroll in the Managed Care Plan or either to not enroll in, or disenroll from, another managed care plan.

Commission for the Transportation Disadvantaged (CTD) — An independent commission housed administratively within the Florida Department of Transportation. The CTD's mission is to ensure the availability of efficient, cost-effective, and quality transportation services for transportation-disadvantaged persons.

Community Care for the Elderly Lead Agency — An entity designated by an Area Agency on Aging and given the authority and responsibility to coordinate services for functionally impaired elderly persons.

Community Living Support Plan — A written document prepared by or on behalf of a mental health resident of an assisted living facility with a limited mental health license and the resident's behavioral health case manager in consultation with the administrator of the facility or the administrator's designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs that enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident that indicate the need for professional services.

Community Outreach — The provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. Community outreach also includes the

provision of information about health care services, preventive techniques, and other health care projects and the provision of information related to health, welfare, and social services or social assistance programs offered by the State of Florida or local communities.

Community Outreach Materials — Materials regarding health or nutritional information or information for the benefit and education of, or assistance to, a community on health-related matters or public awareness that promotes healthy lifestyles. Such materials are meant specifically for the community at large and may also include information about health care services, preventive techniques, and other health care projects and the provision of information related to health, welfare, and social services or social assistance programs offered by the State of Florida or local communities. Community outreach materials are limited to brochures, fact sheets, billboards, posters, and ad copy for radio, television, print, or the Internet.

Community Outreach Representative — A person who provides health information, information that promotes healthy lifestyles, information that provides guidance about social assistance programs, and information that provides culturally and linguistically appropriate health or nutritional education. Such representatives must be appropriately trained, certified, and/or licensed, including but not limited to, social workers, nutritionists, physical therapists, and other health care professionals.

Complaint — Any oral or written expression of dissatisfaction by an enrollee submitted to the Managed Care Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Managed Care Plan employee, failure to respect the enrollee's rights, Managed Care Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Managed Care Plan's Contract. A complaint is a subcomponent of the grievance system.

Comprehensive Assessment and Review for Long-Term Care Services (CARES) — A program operated by the DOEA that is Florida's federally mandated long-term care preadmission screening program for Medicaid Institutional Care Program nursing facility and Medicaid waiver program applicants. An assessment is performed to identify long-term care needs; establish level of care (medical eligibility for nursing facility care); and recommend the least restrictive, most appropriate placement. Emphasis is on enabling people to remain in their homes through provision of home-based services or with alternative placements such as assisted living facilities.

Comprehensive Long-Term Care Plan — A managed care plan that provides services described in s. 409.973, F.S., and also provides the services described in s. 409.98, F.S.

Contested Claim (FFS PSNs Only) — A claim that has not been authorized and forwarded to the Medicaid fiscal agent by the Managed Care Plan because it has a material defect or impropriety.

Continuous Quality Improvement — A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

Contract, Long-Term Care — As a result of receiving a regional award from the Agency pursuant to s. 409.966(2), F.S., and/or s. 409.981, F.S., and successfully meeting all plan

readiness requirements, the agreement between the Managed Care Plan and the Agency where the Managed Care Plan will provide Medicaid-covered services to enrollees, comprising the Contract and any addenda, appendices, attachments, or amendments thereto, and be paid by the Agency as described in the terms of this Contract.

Contract Period, Long-Term Care –The term of the Contract beginning no earlier than August 1, 2013, and ending August 31, 2018.

Contract Year, Long-Term Care — Each September 1st through August 31st within the Contract period; however, for Contracts beginning August 1, 2013, the first Contract year shall be defined as August 1, 2013, through August 31, 2014.

Contracting Officer — The Secretary of the Agency or designee.

County Health Department (CHD) — Organizations administered by the Department of Health to provide health services as defined in Chapter 154, Part I., F.S., including promoting public health, controlling and eradicating preventable diseases, and providing primary health care for special populations.

Coverage & Limitations Handbook and/or Provider General Handbook (Handbook) — A Florida Medicaid document that provides information to a Medicaid provider about enrollee eligibility; claims submission and processing; provider participation; covered care, goods and services; limitations; procedure codes and fees; and other matters related to participation in the Medicaid program.

Covered Services — Those services provided by the Managed Care Plan in accordance with this Contract, and as outlined in Section V, Covered Services, and Section VI, Behavioral Health Care, and Attachment I, Scope of Services.

Crisis Support — Services for persons initially perceived to need emergency behavioral health services, but upon assessment, do not meet the criteria for such emergency care. These are acute care services available twenty-four hours a day, seven days a week (24/7) for intervention. Examples include: mobile crisis, crisis/emergency screening, crisis hot line, and emergency walk-in.

Customized Benefit Package (CBP) (MMA Plans Only) — Covered services, which may vary in amount, scope, and/or duration from those listed in Section V, Covered Services, and Section VI, Behavioral Health Care. The CBP must meet state standards for actuarial equivalency and sufficiency. CBP is also referred to as “benefit grid.”

Department of Children and Families (DCF) — The state agency responsible for overseeing programs involving behavioral health, childcare, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness, and programs that identify and protect abused and neglected children and adults.

Department of Elder Affairs (DOEA) — The primary state agency responsible for administering human services programs to benefit Florida’s elders and developing policy recommendations for long-term care in addition to overseeing the implementation of federally funded and state-funded programs and services for the state’s elderly population.

Department of Health — The state agency responsible for public health, public primary care and personal health, disease control, and licensing of health professionals.

Direct Ownership Interest — The ownership of stock, equity in capital or any interest in the profits of a disclosing entity.

Direct Secure Messaging (DSM) – Enables Managed Care Organizations and providers to securely send patient health information to many types of organizations.

Direct Service Behavioral Health Care Provider — An individual qualified by training or experience to provide direct behavioral health services under the direction of the Managed Care Plan's medical director.

Direct Service Provider, Long-Term Care — A person eighteen (18) years of age or older who, pursuant to a program to provide services to the elderly or disabled, has direct, face-to-face contact with a client while providing services to the client and has access to the client's living areas, funds, personal property, or personal identification information as defined in s. 817.568, F.S. The term includes coordinators, managers, and supervisors of residential facilities and volunteers. (See s. 430.0402(1)(b), F.S.)

Direct Service Worker – An employee who is directly-hired by a participant to provide participant directed services as authorized on the participant's care plan. The direct service worker may be any qualified individual chosen by the participant including a neighbor, family member, or friend.

Direct Submitter (FFS MMA and LTC PSNs Only) — A Medicaid FFS provider that has been authorized by the FFS Managed Care Plan to submit electronic claims directly to the Agency's Medicaid fiscal agent for payment without requiring such claims to be submitted by the provider to the Managed Care Plan for individual authorization and subsequent submission by that FFS Managed Care Plan to the Medicaid fiscal agent. The FFS Managed Care Plan must submit direct submitter authorization requests, in writing, to its Contract manager in order for such providers to be processed by the Medicaid fiscal agent for direct submitter inclusion. The payment reconciliation process specified in Attachment II, Core Contract Provisions, Section XIII, Method of Payment, includes claims submitted by direct submitters.

Disclosing Entity — A Medicaid provider, other than an individual practitioner or group of practitioners, or a fiscal agent that furnishes services or arranges for funding of services under Medicaid, or health-related services under the social services program.

Disease Management — A system of coordinated health care intervention and communication for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Disenrollment — The Agency-approved discontinuance of an enrollee's participation in a managed care plan.

Downward Substitution of Care — The use of less restrictive, lower cost services than otherwise might have been provided, that are considered clinically acceptable and necessary to meet specified objectives outlined in an enrollee's plan of treatment, provided as an alternative to higher cost services.

Dual Eligible — An enrollee who is eligible for both Medicaid (Title XIX) and Medicare (Title XVIII) programs.

Durable Medical Equipment (DME) — Medical equipment that can withstand repeated use, is customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the enrollee's home.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) — As defined by 42 CFR 440.40(b)(2012) or its successive regulation, means: (1) Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and (2) Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. Pursuant to s. 42 CFR 441.56 (2012) or its successive regulation, this is a program about which all eligible individuals and their families must be informed. EPSDT includes screening (periodic comprehensive child health assessments): consisting of regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. As a minimum, these screenings must include, but are not limited to: (a) comprehensive health and developmental history, (b) comprehensive unclothed physical examination, (c) appropriate vision testing, (d) appropriate hearing testing, (e) appropriate laboratory tests, (vi) dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. Screening services must be provided in accordance with reasonable standards of medical and dental practice determined by the Agency after consultation with recognized medical and dental organizations involved in child health care. Requirements for screenings are contained in the Medicaid Child Health Check-Up Coverage and Limitations handbook. Diagnosis and treatment include: (a) diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids; (b) dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and (c) appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) **(See definition of Child Health Check-up program.)**

Eligible Plan — In accordance with s. 409.962(6), F.S., a health insurer authorized under Chapter 624, an exclusive provider organization (EPO) authorized under Chapter 627, a health maintenance organization (HMO) authorized under Chapter 641, F.S., or an accountable care organization (ACO) authorized under federal law. For purposes of the medical assistance (MMA) component of the SMMC program, the term also includes a provider service network (PSN) authorized under s. 409.912(4)(d), and the Children's Medical Services Network authorized under Chapter 391. For purposes of the long-term care component of the SMMC program, the term also includes entities qualified under 42 CFR Part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plan, Program of All-Inclusive Care for the Elderly, and long-term care PSNs, in accordance with s. 409.981(1), F.S.

Emergency Mental Health Services — Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of

severity that would meet the requirements for an involuntary examination (see s. 394.463, F.S.), and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Emergency Medical Condition — (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes (see s. 395.002, F.S.).

Emergency Services and Care — Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Emergency Transportation — The provision of emergency transportation services in accordance with s. 409.908 (13)(c)4., F.S.

Employer Authority — Authority bestowed to PDO participants enabling them to hire, train, schedule, dismiss, and supervise their direct service workers.

Encounter Data — A record of diagnostic or treatment procedures or other medical, allied, or long-term care provided to the Managed Care Plan's Medicaid enrollees, excluding services paid by the Agency on a fee-for-service basis.

Enrollee — A Medicaid recipient enrolled in a managed care plan.

Enrollment — The process by which an eligible Medicaid recipient signs up to participate in a managed care plan.

Enrollment Broker — The state's contracted or designated entity that performs functions related to outreach, education, enrollment, and disenrollment of potential enrollees into a managed care plan.

Enrollment Specialists — Individuals, authorized through an Agency-approved process, who provide one-on-one information to Medicaid recipients to help them choose the managed care plan that best meets the health care needs of them and their families.

Excluded Parties List System (EPLS) — The EPLS is a federal database containing information regarding entities debarred, suspended, proposed for debarment, excluded, or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits.

Exclusive Provider Organization — Pursuant to Chapter 627, F.S., a group of health care providers that have entered into a written agreement with an insurer to provide benefits under a health insurance policy. Must be capitated by the Agency. (See Capitated Managed Care Plan.)

Expanded Benefit — A benefit offered to all enrollees covered by the Managed Care Plan for which the plan receives no direct payment from the Agency.

Expedited Appeal Process — The process by which the appeal of an action is accelerated because the standard timeframe for resolution of the appeal could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function.

External Quality Review (EQR) — The analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a managed care plan.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other related activities as set forth in federal regulations, or both.

Facility-Based Services — Services the enrollee receives from a residential facility in which the enrollee lives. Under this Contract, assisted living facility services, assistive care services, adult family care homes and nursing facility care are facility-based services.

Federal Fiscal Year — The United States government's fiscal year, which starts October 1st and ends on September 30th.

Federally Qualified Health Center (FQHC) — An entity that is receiving a grant under section 330 of the Public Health Service Act, as amended. (Also see s. 1905(l)(2)(B) of the Social Security Act.) FQHCs provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

Fee-for-Service (FFS) — A method of making payment by which the Agency sets prices for defined medical or allied care, goods or services.

Fiscal Agent — Any corporation, or other legal entity, that enters into a contract with the Agency to receive, process and adjudicate claims under the Medicaid program.

Fiscal/Employer Agent (F/EA) — A function of plans with PDO participants. Plans are required to receive, disburse, and track public funds based on a PDO participant's approved care plan. F/EA services support all programmatic, policy, and financial aspects of the PDO, including, but not limited to, enrollment functions, processing payroll, and paying federal and state taxes.

Fiscal Year — The State of Florida's Fiscal Year, which starts July 1st and ends on June 30th.

Florida Medicaid Management Information System (FMMIS or FL MMIS) — The information system used to process Florida Medicaid claims and payments to managed care plans, and to produce management information and reports relating to the Florida Medicaid program. This system is used to maintain Medicaid eligibility data and provider enrollment data.

Florida Mental Health Act — Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others) as specified in ss. 394.451 through 394.4789, F.S.

Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Full-Time Equivalent Position (FTE) — The equivalent of one (1) full-time employee who works forty (40) hours per week.

Functional Status — The ability of an individual to perform self-care, self-maintenance and physical activities in order to carry on typical daily activities.

Good Cause — See Cause.

Grievance — An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or Managed Care Plan employee or failure to respect the enrollee's rights.

Grievance Procedure — The procedure for addressing enrollees' grievances.

Grievance System — The system for reviewing and resolving enrollee complaints, grievances and appeals. Components must include a complaint process, a grievance process, an appeal process, access to an applicable review outside the Managed Care Plan (Beneficiary Assistance Program), and access to a Medicaid Fair Hearing through the Department of Children and Families.

Health Assessment — A complete health evaluation combining health history, physical assessment and the monitoring of physical and psychological growth and development.

Healthcare Effectiveness Data and Information Set (HEDIS) — The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

Health Care Professional — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist and certified respiratory therapy technician.

Health Care Service Pools — Any person, firm, corporation, partnership, or association engaged for hire in the business of providing temporary employment in health care facilities, residential facilities, and agencies for licensed, certified, or trained health care personnel including, without limitation, nursing assistants, nurses' aides, and orderlies. (See s. 400.980, F.S.)

Health Fair — An event conducted in a setting that is open to the public or segment of the public (such as the "elderly" or "schoolchildren") during which information about health care services, facilities, research, preventive techniques or other health care subjects is disseminated. At least one (1) community organization or two (2) health-related organizations that are not affiliated under common ownership must actively participate in the health fair.

Health Information Exchange (HIE) — The secure, electronic exchange of health information among authorized stakeholders in the health care community – such as care providers, patients, and public health agencies – to drive timely, efficient, high-quality, preventive, and patient-centered care.

Health Insurance Premium Payment (HIPP) Program — A program that reimburses part or all of a Medicaid recipient's share of employer-sponsored health care coverage, if available and cost-effective.

Health Maintenance Organization (HMO) — An organization or entity licensed in accordance with Chapter 641, F.S., or in accordance with the Florida Medicaid State Plan definition of an HMO.

Healthy Behaviors (MMA Plans Only) — A program offered by managed care plans that encourages and rewards behaviors designed to improve the enrollee's overall health.

Hospital — A facility licensed in accordance with the provisions of Chapter 395, F.S., or the applicable laws of the state in which the service is furnished.

Hospital Services Agreement — The agreement between the Managed Care Plan and a hospital to provide medical services to the Managed Care Plan's enrollees.

Home and Community Based (HCB) Characteristics (LTC Plans Only) - Home-like features required to be present in an enrollee's residential dwelling.

Home and Community Based Services (HCBS) – Services offered in the community setting to prevent or delay institutionalization of elderly or disabled Medicaid recipients.

Hub Site — The telecommunication distance site in Florida at which the consulting physician, dentist or therapist is delivering telemedicine services.

Indirect Ownership Interest — Ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of five percent (5%) or more in the disclosing entity. Example: If "A" owns ten percent (10%) of the stock in a corporation that owns eighty percent (80%) of the stock of the disclosing entity, "A's" interest equates to an eight percent (8%) indirect ownership and must be reported.

Individuals with Special Health Care Needs — Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. This includes individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or

degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and all enrollees in LTC plans.

Information — (a) Structured Data: Data that adhere to specific properties and validation criteria that are stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; (b) Document: Information that does not meet the definition of structured data includes text files, spreadsheets, electronic messages and images of forms and pictures.

Information System(s) — A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitized audio and video) and documents as well as non-digitalized audio and video; and/or (b) the processing and/or calculating of information and non-digitalized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

Insolvency — A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

Insurer — Pursuant to s. 624.03, F.S., every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

Instrumental Activities of Daily Living (IADL) — Activities related to independent living which include, but are not limited to, preparing meals, taking medications, using transportation, managing money, shopping for groceries or personal items, performing light or heavy housework and using a telephone.

Kick Payment (MMA Plans only) — The method of reimbursing capitated managed care plans in the form of a separate one (1) time fixed payment for specific services.

Level of Care (LOC) — The type of long-term care required by an enrollee based on medical needs. The criteria for Intermediate LOC (Level I and II) are described in 59G-4.180, FAC, and the criteria for Skilled LOC are described in 59G-4.290, FAC. Department of Elder Affairs CARES staff establish level of care for adult Medicaid enrollees.

Licensed — A facility, equipment, or an individual that has formally met state, county, and local requirements, and has been granted a license by a local, state or federal government entity.

Licensed Practitioner of the Healing Arts — A psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

List of Excluded Individuals and Entities (LEIE) — A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, health care providers, patients and others relating to parties excluded from participation in Medicare, Medicaid and all other federal health care programs.

Long-Term Care Assessment — An individualized, comprehensive appraisal of an individual's medical, developmental, behavioral, social, financial, and environmental status conducted by a qualified individual for the purpose of determining the need for long-term care services.

Long-Term Care Plan (LTC Plan) — A managed care plan that provides the services described in s. 409.98, F.S., for the long-term care component of the statewide Medicaid managed care program.

Long-Term Care Provider Service Network (LTC PSN) — Pursuant to s. 409.962(8), F.S., and s. 409.981(1), F.S., a provider service network, a controlling interest of which is owned by one or more licensed nursing facilities, assisted living facilities with seventeen (17) or more beds, home health agencies, community care for the elderly lead agencies, or hospices. LTC PSNs may be paid by the Agency on a capitated/prepaid or FFS basis. **Also refer to Provider Service Network.**

Managed Behavioral Health Organization (MBHO) — A behavioral health care delivery system managing quality, utilization and cost of services. Additionally, an MBHO measures performance in the area of mental disorders.

Managed Care Plan — An eligible plan under Contract with the Agency to provide services under the LTC or MMA component of the Statewide Medicaid Managed Care Program. .

Mandatory Assignment — The process the Agency uses to assign enrollees to a managed care plan. The Agency automatically assigns those enrollees required to be in a managed care plan who did not voluntarily choose one.

Mandatory Enrollee — The categories of eligible Medicaid recipients who must be enrolled in a managed care plan.

Mandatory Potential Enrollee — A Medicaid recipient who is required to enroll in a managed care plan but has not yet made a choice.

Marketing — Any activity or communication conducted by or on behalf of any Managed Care Plan with a Medicaid recipient who is not enrolled with the Managed Care Plan or an individual potentially eligible for Medicaid that can reasonably be interpreted as intended to influence such individual to enroll in the particular Managed Care Plan.

Medicaid — The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency under s. 409.901 et seq., F.S.

Medicaid Fair Hearing — An administrative hearing conducted by DCF to review an action taken by a managed care plan that limits, denies, or stops a requested service.

Medicaid Pending — A process in which individuals who apply for the Statewide Medicaid Managed Long-Term Care Program for HCBS and who meet medical eligibility choose to receive services before being determined financially eligible for Medicaid by DCF.

Medicaid Program Integrity (MPI) — The unit of the Agency responsible for preventing and identifying fraud and abuse in the Medicaid program.

Medicaid Recipient — Any individual whom DCF, or the Social Security Administration on behalf of DCF, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods or services for which the Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Medicaid State Plan — A written plan between a state and the federal government that outlines the state's Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each state and approved by the Centers for Medicare and Medicaid Services (CMS).

Medical Assistance Plan (MMA Plan) — A managed care plan that provides the services described in s. 409.973, F.S., for the medical assistance (MMA) component of the Statewide Medicaid Managed Care (SMMC) program.

Medical Foster Care Services — Services provided to enable children, who are under the age of 21, have medically complex needs, and whose parents cannot care for them in their own home, to live and receive care in foster homes rather than in hospitals or other institutional settings. Medical foster care services are authorized by Title XIX of the Social Security Act and s. 409.903, F.S., and Chapter 59G, F.A.C.

Medical/Case Record — Documents corresponding to medical, allied, or long-term care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR 456.111 and 42 CFR 456.211.

Medically Complex — An individual who is medically fragile who may have multiple comorbidities or be technologically dependent on medical apparatus or procedures to sustain life.

Medically Necessary or Medical Necessity — Services that include medical, allied, or long-term care, goods or services furnished or ordered to:

1. Meet the following conditions:
 - a. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
 - b. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
 - c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
 - d. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
 - e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.
2. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

3. The fact that a provider has prescribed, recommended or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Medicare — The medical assistance program authorized by Title XVIII of the Social Security Act.

Medicare Advantage Plan — A Medicare-approved health plan offered by a private company that covers both hospital and medical services, often includes prescription drug coverage, and may offer extra coverage such as vision, hearing, dental and/or wellness programs. Each plan can charge different out-of-pocket costs and have different rules for how to get services. Such plans can be organized as health maintenance organizations, preferred provider organizations, coordinated care plans, and special needs plans

Meds AD — Individuals who have income up to eighty-eight percent (88%) of federal poverty level and assets up to \$5,000 (\$6,000 for a couple) and who do not have Medicare, or who have Medicare and are receiving institutional care or hospice care, are enrolled in PACE or an HCBS waiver program, or live in an assisted living facility or adult family care home licensed to provide assistive care services.

Mental Health Targeted Case Manager — An individual who provides behavioral health care case management services directly to or on behalf of an enrollee on an individual basis in accordance with 65E-15, F.A.C., and the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.

National Provider Identifier (NPI) — An identification number assigned through the National Plan and Provider Enumerator System of the federal Department of Health & Human Services. NPIs can be obtained online at <https://nppes.cms.hhs.gov>.

Newborn — A live child born to an enrollee who is a member of the Managed Care Plan.

Non-Covered Service — A service that is not a benefit under either the Medicaid State Plan or the Managed Care Plan.

Nursing Facility — An institutional care facility that furnishes medical or allied inpatient care and services to individuals needing such services. (See Chapters 395 and 400, F.S.)

Open Enrollment — The sixty-(60) day period before the end of certain enrollees' enrollment year, during which the enrollee may choose to change managed care plans for the following enrollment year.

Outpatient — A patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive, and who does receive, professional services for less than a twenty-four (24) hour period, regardless of the hours of admission, whether or not a bed is used and/or whether or not the patient remains in the facility past midnight.

Overpayment — Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Participant – An enrollee who has chosen to participate in the PDO, and who serves as the employer.

Participant Agreement – Outlines the roles and responsibilities of the plan and the participant.

Participant/Direct Service Worker Agreement – Outlines the responsibilities of the plan, the participant, and the direct service worker under the PDO, includes the service duties that will be provided by the direct service worker, scheduled work hours and days, and rate of pay.

Participant Direction Option (PDO) – A service delivery option that enables enrollees to exercise decision-making authority and control over allowable services and how those services are delivered, including the ability to hire, supervise, and fire service providers. Under the PDO, the enrollee accepts responsibility for taking a direct role in managing his or her care.

Participating Provider — A health care practitioner or entity authorized to do business in Florida and contracted with the Managed Care Plan to provide services to the Managed Care Plan's enrollees.

Participating Specialist — A physician, licensed to practice medicine in the State of Florida, who contracts with the Managed Care Plan to provide specialized medical services to the Managed Care Plan's enrollees.

Patient Responsibility - The amount an enrollee must pay towards Medicaid services after personal, unreimbursed medical expenses, community spouse allowances, and income placed in a qualified income trust are accounted for. The patient responsibility calculation is performed by DCF's ACCESS unit and is detailed on the enrollee's Notice of Action which details the Medicaid eligibility period and the amount of patient responsibility due monthly.

PDO Pre-Screening Tool (LTC Plans Only) – The required screening tool to be used by the case manager. in assisting prospective participants and prospective representatives to determine whether they are willing and able to participate in the PDO. .

PDO Services – The services an enrollee may choose to self-direct under the participant direction option. The five (5) services offered under the PDO include: adult companion care, attendant care, homemaker services, intermittent and skilled nursing, and personal care services. The Long-Term Care Managed Care enrollee may choose to participate in the PDO for one or more of the PDO services as authorized in the enrollee's care plan.

Peer Review — An evaluation of the professional practices of a provider by the provider's peers. The evaluator assesses the necessity, appropriateness and quality of care furnished by comparing the care to that customarily furnished by the provider's peers and to recognized health care standards.

Penultimate Saturday — The Saturday preceding the last Saturday of the month.

Person Centered Approach — A nondirective approach to care planning that encourages the maximum participation of an enrollee and the enrollee's family in the decision making process.

Person Centered Planning (PCP) – A process to produce a plan of care that includes an enrollee’s care needs and includes the enrollee’s service needs, personal goals and community activities..

Pharmacy Benefits Administrator — An entity contracted to or included in a managed care plan that accepts pharmacy prescription claims for enrollees in the managed care plan; assures these claims conform to coverage policy; and determines the allowed payment.

Physician Assistant (PA) — A person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine and is certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F.S.

Physicians' Current Procedural Terminology (CPT®) — A systematic listing and coding of procedures and services published annually by the American Medical Association.

Plan Factor (MMA Only) — A budget-neutral calculation using a Managed Care Plan's available historical enrollee diagnosis data grouped by a health-based risk assessment model. A Managed Care Plan's plan factor is developed from the aggregated individual risk scores of the Managed Care Plan's prior month's enrollment. The plan factor modifies a Managed Care Plan's monthly capitation payment to reflect the health status of its enrollees.

Plan of Care — A plan which describes the service needs of each enrollee, showing the projected duration, desired frequency, type of provider furnishing each service, and scope of the services to be provided.

Portable X-Ray Equipment — X-ray equipment transported to a setting other than a hospital, clinic or office of a physician or other licensed practitioner of the healing arts.

Post-Stabilization Care Services — Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain, improve or resolve the enrollee's condition pursuant to 42 CFR 422.113.

Potential Enrollee — Pursuant to 42 CFR 438.10(a), an eligible Medicaid recipient who is subject to mandatory assignment or one who may voluntarily elect to enroll in a given Managed Care Plan, but is not yet actually enrolled in a managed care plan.

Preadmission Screening and Resident Review (PASRR) — Pursuant to 42 CFR Part 483, the process of screening and determining if nursing facility services and specialized mental health services or mental retardation services are needed by nursing facility applicants and residents. A DCF Office of Mental Health contractor completes the Level II reviews for those residents identified as having a mental illness. Agency for Persons with Disabilities staff complete reviews for those residents identified with a diagnosis of mental retardation.

Pre-Enrollment — The provision of marketing materials to a Medicaid recipient.

Preferred Drug List — A listing of prescription products selected by a pharmaceutical and therapeutics committee as cost-effective choices for clinician consideration when prescribing for Medicaid recipients.

Prescribed Pediatric Extended Care (PPEC) — A nonresidential health care center for children who are medically complex or technologically dependent and require continuous therapeutic intervention or skilled nursing services.

Primary Care — Comprehensive, coordinated and readily accessible medical care including: health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

Primary Care Case Management — The provision or arrangement of enrollees' primary care and the referral of enrollees for other necessary medical services on a twenty-four (24) hour basis.

Primary Care Provider (PCP) — A Managed Care Plan staff or participating provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

Prior Authorization — The act of authorizing specific services before they are rendered.

Program of All-Inclusive Care for the Elderly (PACE) — A program that is operated by an approved PACE organization and that provides comprehensive services to PACE enrollees in accordance with a PACE program agreement. PACE provides a capitated benefit for individuals age 55 and older who meet nursing home level of care as determined by CARES. It features a comprehensive service delivery system and integrated Medicare and Medicaid financing. (See ss. 1894 and 1934 of the Social Security Act and 42 CFR Part 460.)

Protected Health Information (PHI) — For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the Managed Care Plan from, or on behalf of, the Agency.

Protocols — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

Provider — A person or entity eligible to provide Medicaid services. MMA and LTC PSN FFS providers must have an active Medicaid provider agreement. All other providers must be eligible for a Medicaid provider agreement.

Provider Contract — An agreement between the Managed Care Plan and a health care provider to serve Managed Care Plan enrollees.

Provider Service Network (MMA Only) — A network established or organized and operated by a health care provider, or group of affiliated health care providers, that provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers. The PSN may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service

network organization. PSNs may be paid by the Agency on a capitated/prepaid or FFS basis. Also refer to the definition for LTC PSN. (See ss. 409.912(4)(d), F.S.)

Public Event — An event that is organized or sponsored by an organization for the benefit and education of or assistance to a community in regard to health-related matters or public awareness. A Managed Care plan may sponsor a public event if the event includes active participation of at least one (1) community organization or two (2) health-related organizations not affiliated with the Managed Care Plan.

Quality — The degree to which a managed care plan increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Enhancements — Certain health-related, community-based services that the Managed Care Plan must offer and coordinate access to its enrollees. Managed care plans are not reimbursed by the Agency/Medicaid for these types of services.

Quality Improvement (QI) — The process of monitoring that the delivery of health care services is available, accessible, timely, and medically necessary. The Managed Care Plan must have a quality improvement program (QI program) that includes standards of excellence. It also must have a written quality improvement plan (QI plan) that draws on its quality monitoring to improve health care outcomes for enrollees.

Region — The designated geographical area within which the Managed Care Plan is authorized by the Contract to furnish covered services to enrollees. The Plan must serve all counties in the Region(s) for which it is contracted. The 67 Florida counties are divided into 11 regions pursuant to s. 409.966(2), F.S. May also be referred to as “service area.”

Registered Nurse (RN) — An individual who is licensed to practice professional nursing in accordance with Chapter 464, F.S.

Remediation — The act or process of correcting a fault or deficiency.

Representative (LTC Plans Only) – An uncompensated individual designated by a PDO participant to manage the PDO responsibilities on their behalf although the participant remains the employer of record.

Residential Commitment Facilities — As applied to the Department of Juvenile Justice, refers to the out-of-home placement of adjudicated youth who are assessed and deemed by the court to be a low or moderate risk to their own safety and to the safety of the public; for use in a level 4, 6, 8, or 10 facility as a result of a delinquency disposition order. Also referred to as a residential commitment program.

Residential Facility — Those facilities where individuals live and that are licensed under Chapter 400 or 429, F.S., including nursing facilities, assisted living facilities and adult family care homes.

Risk Adjustment (also Risk-Adjusted) — In a managed health care setting, risk adjustment of capitation payments is the process used to distribute capitation payments across health plans based on the expected health risk of the members enrolled in each health plan.

Risk Assessment — The process of collecting information from a person about hereditary, lifestyle and environmental factors to determine specific diseases or conditions for which the person is at risk.

Rural — An area with a population density of less than one hundred (100) individuals per square mile, or an area defined by the most recent United States Census as rural, i.e., lacking a metropolitan statistical area (MSA).

Rural Health Clinic (RHC) — A clinic that is located in an area that has a health care provider shortage. An RHC provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. An RHC employs, contracts or obtains volunteer services from licensed health care practitioners to provide services.

Screen or Screening — A brief process, using standardized health screening instruments, used to make judgments about an enrollee's health risks in order to determine if a referral for further assessment and evaluation is necessary.

Service Authorization — The Managed Care Plan's approval for services to be rendered. The process of authorization must at least include an enrollee's or a provider's request for the provision of a service.

Service Delivery Systems — Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in s. 409.973, F.S., which include but are not limited to the Medicaid fee-for-service program and the Medicaid Managed Medical Assistance Program.

Service Gap — A gap in in-home HCBS defined as the difference between the number of hours of home care worker critical service scheduled in the enrollee's plan of care and the hours of the scheduled type of in-home HCBS that actually delivered to the enrollee.

Service Location — Any location at which an enrollee obtains any health care service provided by the Managed Care Plan under the terms of the Contract.

Share of Cost-Savings (FFS plans only) — Potential payment to the Managed Care Plan when amount of the savings pool exceeds the administrative allocation to the Managed Care Plan as determined through a reconciliation process.

Sick Care — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Social Networking — Web-based applications and services (excluding the Managed Care Plan's state-mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation and instant messaging services.

Span of Control — Information systems and telecommunications capabilities that the Managed Care Plan itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The span of control also includes systems and telecommunications capabilities outsourced by the Managed Care Plan.

Special Supplemental Nutrition Program for Women, Infants & Children (WIC) — Program administered by the Department of Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women, infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income. An individual who is eligible for Medicaid is automatically income eligible for WIC benefits. Additionally, WIC income eligibility is automatically provided to an enrollee's family that includes a pregnant woman or infant certified eligible to receive Medicaid.

Specialty Plan — An MMA plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

Spoke Site — The provider office location in Florida where an approved service is being furnished through telemedicine.

State — State of Florida.

Statewide Medicaid Managed Care Program — A program authorized by the 2011 Florida Legislature through House Bill 7107, creating Part IV of Chapter 409, F.S., to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC) and includes two components: one for managed medical assistance (MMA) and one for long-term care (LTC).

Subcontract — An agreement entered into by the Managed Care Plan for provision of administrative services on its behalf related to this Contract.

Subcontractor — Any person or entity with which the Managed Care Plan has contracted or delegated some of its functions, services or responsibilities for providing services under this Contract.

Surface Mail — Mail delivery via land, sea, or air, rather than via electronic transmission.

Surplus — Net worth (i.e., total assets minus total liabilities).

System Unavailability — As measured within the Managed Care Plan's information systems' span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.

Systems — See Information Systems.

Telebehavioral Health — The use of telemedicine to provide behavioral health individual and family therapy.

Telecommunication Equipment — Electronic equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the enrollee and the provider for the provision of covered services through telemedicine.

Telemedicine — The practice of health care delivery using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis, or treatment.

Telepsychiatry — The use of telemedicine to provide behavioral health medication management.

Temporary Assistance to Needy Families (TANF) — Public financial assistance provided to low-income families through DCF.

Transportation — An appropriate means of conveyance furnished to an enrollee to obtain Medicaid authorized/covered services.

Unborn Activation — The process by which an unborn child, who has been assigned a Medicaid ID number, is made Medicaid eligible upon birth.

Urban — An area with a population density of greater than one-hundred (100) individuals per square mile or an area defined by the most recent United States Census as urban, i.e., as having a metropolitan statistical area (MSA).

Urgent Behavioral Health Care — Those situations that require immediate attention and assessment within twenty-three (23) hours even though the enrollee is not in immediate danger to self or others and is able to cooperate in treatment.

Urgent Care — Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or substantially restrict an enrollee's activity (e.g., infectious illnesses, influenza, respiratory ailments).

Validation — The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Vendor — An entity submitting a proposal to become a managed care plan.

Violation — A determination by the Agency that a managed care plan failed to act as specified in this Contract or applicable statutes, rules or regulations governing managed care plans. For the purposes of this Contract, each day that an ongoing violation continues shall be considered to be a separate violation. In addition, each instance of failing to furnish necessary and/or required medical services or items to each enrollee shall be considered to be a separate violation. As well, each day that the Managed Care Plan fails to furnish necessary and/or required medical services or items to enrollees shall be considered to be a separate violation.

Voluntary Enrollee — A Medicaid recipient who is not mandated to enroll in a managed care plan, but chooses to do so.

Voluntary Potential Enrollee — A Medicaid recipient who is not mandated to enroll in a managed care plan, has expressed a desire to do so, but is not yet enrolled in a managed care plan.

Well Care Visit — A routine medical visit for one of the following: CHCUP visit, family planning, routine follow-up to a previously treated condition or illness, adult physical or any other routine visit for other than the treatment of an illness.

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B. Acronyms

- AAA** - Area Agencies on Aging
- ACCESS** - Automated Community Connection to Economic Self-Sufficiency, the Department of Children and Families' public assistance service delivery system
- ADL** - Activities of Daily Living
- ADRC** - Aging and Disabilities Resource Center
- AFCH** - Adult Family Care Home
- AHCA** - Agency for Health Care Administration (Agency)
- ALF** - Assisted Living Facility
- APD** - Agency for Persons with Disabilities
- ARNP** - Advanced Registered Nurse Practitioner
- BAP** - Beneficiary Assistance Program
- BMHC** - Bureau of Managed Health Care
- CAHPS** - Consumer Assessment of Healthcare Providers and Systems
- CAP** - Corrective Action Plan
- CARES** - Comprehensive Assessment and Review for Long-Term Care Services
- CCE** - Community Care for the Elderly
- CCP** - Cultural Competency Program
- CDC** - Centers for Disease Control and Prevention
- CFARS** - Children's Functional Assessment Rating Scales
- CEO** - Chief Executive Officer
- CFO** - Chief Financial Officer
- COO** - Chief Operating Officer
- CFR** - Code of Federal Regulations (cites may be searched online at: <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>)
- CHCUP** - Child Health Check-Up Program

CHD	- County Health Department
CMS	- Centers for Medicare & Medicaid Services
COPD	- Chronic Obstructive Pulmonary Disease
CPR	- Cardiopulmonary Resuscitation
CPT®	- Physicians' Current Procedural Terminology
CTD	- Commission for the Transportation Disadvantaged
DCF	- Department of Children and Families
DD	- Developmental Disability or Developmental Disabilities
DEA	- Drug Enforcement Administration
DFS	- Department of Financial Services
DHHS	- United States Department of Health & Human Services
DJJ	- Department of Juvenile Justice
DME	- Durable Medical Equipment
DOEA	- Department of Elder Affairs
DOH	- Department of Health
DSM	- Direct Secure Messaging
EDI	- Electronic Data Interchange
EH	- Emotionally Handicapped
EOMB	- Explanation of Medicaid Benefits
EPO	- Exclusive Provider Organization
EPSDT	- Early and Periodic Screening, Diagnosis and Treatment Program
EQR	- External Quality Review
EQRO	- External Quality Review Organization
ET	- Eastern Time
F.A.C.	- Florida Administrative Code

FARS	- Functional Assessment Rating Scales
FAR	- Florida Administrative Register
F/EA	- Fiscal/Employer Agent
FFS	- Fee-for-Service
FQHC	- Federally Qualified Health Center
F.S.	- Florida Statutes
FSFN	- Florida Safe Families Network (formerly HomeSafeNet), also known as SACWIS, (Statewide Automated Child Welfare Information System)
FTE	- Full-Time Equivalent Position
HCB	- Home and Community Based
HCBS	- Home and Community-Based Services
HEDIS	- Healthcare Effectiveness Data and Information Set
HIPAA	- Health Insurance Portability and Accountability Act
HITECH	- Health Information Technology for Economic and Clinical Health Act
HMO	- Health Maintenance Organization
HSA	- Hernandez Settlement Agreement
HSD	- Bureau of Medicaid Health Systems Development
IADL	- Instrumental Activities of Daily Living
ICP	- Institutional Care Program
IBNR	- Incurred But Not Reported
ITN	- Invitation to Negotiate
LEIE	- List of Excluded Individuals & Entities
LTC	- Long-Term Care
LOC	- Level of Care
MBHO	- Managed Behavioral Health Organization
MCP	- Managed Care Plan

MEDS	- Medicaid Encounter Data System
MFCU	- Medicaid Fraud Control Unit, Office of the Attorney General
MMA	- Managed Medical Assistance
MPI	- Medicaid Program Integrity Bureau, Office of the AHCA Inspector General
NCPDP	- National Council for Prescribed Drug Programs
NCQA	- National Committee for Quality Assurance
NMHPA	- Newborns and Mothers Health Protection Act
NPI	- National Provider Identifier
ODBC	- Open Database Connectivity
OIG	- Office of the Inspector General
OIR	- Office of Insurance Regulation
PA	- Physician Assistant
PACE	- Program of All-Inclusive Care for the Elderly
PASRR	- Preadmission Screening and Resident Review
PCCB	- Per Capita Capitation Benchmark
PCP	- Primary Care Provider
PERS	- Personal Emergency Response Systems
PDL	- Preferred Drug List
PDO	- Participant Direction Option
PHI	- Protected Health Information, as defined in 42 CFR 431.305(b)
PIP	- Performance Improvement Plan
PM	- Performance Measure
PMAP	- Performance Measures Action Plan
PPEC	- Prescribed Pediatric Extended Care
PSN	- Provider Service Network

- QE** - Quality Enhancement
- QI** - Quality Improvement
- RFP** - Request for Proposal
- RHC** - Rural Health Clinic
- SACWIS** - Statewide Automated Child Welfare Information System, also known as Florida Safe Families Network (FSFN, formerly HomeSafeNet)
- SAMH** - Substance Abuse & Mental Health Office of the Florida Department of Children and Families
- SFTP** - Secure File Transfer Protocol
- SIPP** - Statewide Inpatient Psychiatric Program
- SMMC** - Statewide Medicaid Managed Care Program
- SNIP** - Strategic National Implementation Process
- SOBRA** - Sixth Omnibus Budget Reconciliation Act
- SQL** - Structured Query Language
- SSI** - Supplemental Security Income
- TANF** - Temporary Assistance for Needy Families
- TGCS** - Therapeutic Group Care Services
- UM** - Utilization Management
- USDA** - United States Department of Agriculture
- WEDI** - Workgroup for Electronic Data Interchange
- WIC** - Special Supplemental Nutrition Program for Women, Infants & Children

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Section II General Overview

A. Background

1. Florida has offered Medicaid services since 1970. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC) and includes two components: one for medical assistance (MMA) and one for long-term care (LTC).
2. Under the SMMC program, the Agency contracts with managed care plans, as defined in Section I, Definitions and Acronyms, to provide services to recipients. The Agency shall not select managed care plans that have a business relationship with another managed care plan in the same region for the same managed care component (LTC or MMA component, respectively). (See s. 409.966(3)(b), F.S.)

B. Purpose

Medicaid provides health care coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The provisions in this attachment (Attachment II, Core Contract Provisions) apply to all managed care plans unless specifically noted otherwise.

Provisions unique to a specific type of managed care plan are described in Attachment I, Scope of Services and the exhibits to Attachments I and II. Attachment II, Core Contract Provisions exhibits are specific to either the LTC managed care component or the MMA managed care component, respectively, and are numbered to correspond to section numbers.

C. Responsibilities of the State of Florida (state) (See Attachment II, Core Contract Provisions, Exhibit 2)

1. The Agency for Health Care Administration (Agency) is responsible for administering the Medicaid program. The Agency will administer contracts, monitor Managed Care Plan performance, and provide oversight in all aspects of Managed Care Plan operations.
2. The Agency will not contract with Managed Care Plans that have a business relationship with another managed care plan in the same region for the same managed care component. (See s. 409.966(3)(b), F.S.)
3. The state has sole authority for determining eligibility for Medicaid and whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Managed Care Plan or are subject to annual open enrollment.
4. The Agency will review the Florida Medicaid Management Information System (FMMIS) file daily and will send written notification and information to all potential enrollees.

5. The Agency will use an established algorithm to assign mandatory potential enrollees who do not select a Managed Care Plan during their thirty (30) day choice period. The process may differ for MMA and LTC plans as required by state law and federally approved State Plan amendments and/or waivers.
6. Enrollment in a Managed Care Plan, whether chosen or assigned, will be effective at 12:01 a.m. on the first calendar day of the month following a selection or assignment that occurs between the first calendar day of the month and the penultimate Saturday of the month. For those enrollees who choose or are assigned a Managed Care Plan between the Sunday after the penultimate Saturday and before the last calendar day of the month, enrollment in a Managed Care Plan will be effective on the first calendar day of the second month after choice or assignment.
7. The Agency will notify the Managed Care Plan of an enrollee's selection or assignment to the Managed Care Plan. The Agency or its agent will send written confirmation to enrollees of the chosen or assigned Managed Care Plan. Notice to the enrollee will be sent by surface mail. Notice to the Managed Care Plan will be by file transfer.
8. The Agency shall make payment to the Managed Care Plan as specified in Attachment II, Core Contract Provisions, Section XIII, Method of Payment.
9. The Agency shall reimburse FFS MMA and FFS LTC PSN providers for correct, authorized, clean claims according to the Florida Medicaid fee schedules for reimbursement for covered services provided to enrollees. The Agency or its fiscal agent shall also reimburse non-participating FFS MMA and FFS LTC PSN providers on a FFS basis for authorized services.
10. The FFS option shall be available to a MMA or LTC PSN only for the first two (2) years of its operation. The Agency will provide a FFS MMA or LTC PSN with guidelines for developing a conversion plan to transition from FFS to a capitated Managed Care Plan. (See Attachment II, Core Contract Provisions, Section XVI, Item P. and Exhibit 15)
11. Conditioned on continued eligibility, mandatory enrollees have a lock-in period of twelve (12) consecutive months. After an initial ninety (90) day change period, mandatory enrollees may disenroll from the Managed Care Plan only for cause. The Agency or its agent will notify enrollees at least once every twelve (12) months, and for mandatory enrollees at least sixty (60) calendar days before the lock-in period ends that an open enrollment period exists giving them an opportunity to change Managed Care Plans. Mandatory enrollees who do not make a change during open enrollment will be deemed to have chosen to remain with the current Managed Care Plan, unless that Managed Care Plan no longer participates. In that case, the enrollee will be transitioned to a new Managed Care Plan.
12. The Agency will automatically re-enroll an enrollee into the Managed Care Plan in which the person was most recently enrolled if the enrollee has a temporary loss of eligibility.
 - a. For LTC plans, "temporary loss" is defined as no more than sixty (60) calendar days. In this instance, for mandatory enrollees, the lock-in period will continue as though there had been no break in eligibility, keeping the original twelve- (12) month period.

- b. For MMA plans, “temporary loss” is defined as no more than one hundred eighty (180) calendar days. In this instance, for mandatory enrollees, the lock-in period will continue as though there had been no break in eligibility, keeping the original twelve- (12) month period.
13. If a temporary loss of eligibility causes the enrollee to miss the open enrollment period, the Agency will enroll the person in the Managed Care Plan in which he or she was enrolled before loss of eligibility. The enrollee will have ninety (90) calendar days to disenroll without cause.
14. DCF will issue a Medicaid identification (ID) number to a newborn upon notification from the Managed Care Plan, the hospital, or other authorized Medicaid provider, consistent with the unborn activation process described in Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment.
15. The Agency will notify enrollees of their right to request disenrollment as described in Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment, Item C., Disenrollment, sub-item 2.
16. The Agency will process all disenrollments from the Managed Care Plan. The Agency or its agent will make final determinations about granting disenrollment requests and will notify the Managed Care Plan by file transfer and the enrollee by surface mail of any disenrollment decision. Enrollees dissatisfied with an Agency determination may request a Medicaid Fair Hearing.
17. When disenrollment is necessary because an enrollee loses Medicaid eligibility, disenrollment shall be at the end of the month in which eligibility was lost.
18. The Agency will monitor Managed Care Plan operations for compliance with the provisions of the Contract and applicable federal and state laws and regulations. Such monitoring may be done as desk reviews or onsite as determined by the Agency. Reviews may be conducted by various Agency units and bureaus, using Agency personnel or contracted personnel, depending on staff expertise. The Agency will provide appropriate notice when requesting needed documents and for conducting onsite reviews. The Agency will provide the Managed Care Plan with the result of such reviews and may request corrective action or impose sanctions in accordance with Attachment II, Core Contract Provisions, Section XIV, Sanctions.
19. Prior to enrolling recipients in the Managed Care Plan, the Agency will conduct a readiness review of the Managed Care Plan to assess the Managed Care Plan’s readiness and ability to provide services to recipients. The readiness review may include, but is not limited to, desk and onsite review of documents provided by the Managed Care Plan, a walk-through of the Managed Care Plan’s operations, system demonstrations, and interviews with Managed Care Plan staff. The scope of the review may include any and all Contract requirements, as determined by the Agency. The Agency will not enroll recipients into the Managed Care Plan until the Agency has determined that the Managed Care Plan meets Contract requirements.
20. The Agency shall contract with independent certified public accountants to conduct compliance audits for the purpose of auditing Managed Care Plan financial information

in order to determine and validate the achieved savings rebate in accordance with s. 409.967(3), F.S.

D. General Responsibilities of the Managed Care Plan (See Attachment I and Attachment II, Core Contract Provisions, Exhibit 2)

1. The Managed Care Plan shall comply with all provisions of this Contract, including all attachments, applicable exhibits, applicable MMA or LTC Report Guide requirements and any amendments and shall act in good faith in the performance of the Contract provisions.
2. The Managed Care Plan shall verify that information it submits to the Agency is accurate.
3. The Managed Care Plan shall develop and maintain written policies and procedures to implement all provisions of this Contract.
4. The Managed Care Plan shall submit all policies and procedures, model provider agreements and amendments, all subcontracts, and all other materials related to this Contract to the Agency for approval before implementation. Likewise, any changes in such materials must be prior approved by the Agency before they take effect.
 - a. The Managed Care Plan shall provide written materials for Agency review as follows unless specified elsewhere in the Contract:
 - (1) Third party administrator subcontracts for FFS MMA or LTC PSNs to the Agency at least ninety (90) calendar days before the effective date of the subcontract or change;
 - (2) Other written materials to the Agency at least forty-five (45) calendar days before the effective date of the material or change.
 - b. The Managed Care Plan shall provide written notice of such changes affecting enrollees to those enrollees at least thirty (30) calendar days before the effective date of change.
5. The Managed Care Plan agrees that failure to comply with all provisions of this Contract may result in the assessment of sanctions and/or termination of the Contract, in whole or in part, in accordance with Attachment II, Core Contract Provisions, Section XIV, Sanctions.
6. The Managed Care Plan shall make enrollee materials, including the provider directory and enrollee handbook(s), available online at the Managed Care Plan's website without requiring enrollee log-in. The Managed Care Plan may provide a link to applications (smartphone applications) for enrollee use that will take enrollees directly to existing Agency-approved materials on the Managed Care Plan's website, such as the Managed Care Plan's enrollee handbook and provider directory. Smartphone applications may also be known as "apps." See Section XI, Information Management and Systems, Item L., Smartphone Applications, of this Attachment. Also see Section IV, Enrollee Services,

Community Outreach and Marketing, Item A., Enrollee Services, 7.d., Provider Directory, of this Attachment.

7. The Managed Care Plan shall comply with all pertinent Agency rules in effect throughout the duration of the Contract.
8. The Managed Care Plan shall comply with all current Florida Medicaid handbooks (Handbooks) as noticed in the Florida Administrative Register (FAR), or incorporated by reference in rules relating to the provision of services set forth in Attachment II, Core Contract Provisions, Section V, Covered Services, except where the provisions of the Contract alter the requirements set forth in the Handbooks and Medicaid fee schedules. In addition, the Managed Care Plan shall comply with the limitations and exclusions in the Handbooks and Medicaid fee schedules, unless otherwise specified by this Contract. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those specified in the Handbooks and Medicaid fee schedules. The Managed Care Plan may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness, or condition. The Managed Care Plan may exceed these limits by offering expanded benefits, as described in Attachment I, Scope of Services and its exhibits.
9. This Contract, including all attachments and exhibits, represents the entire agreement between the Managed Care Plan and the Agency and supersedes all other contracts between the parties when it is executed by duly authorized signatures of the Managed Care Plan and the Agency. Correspondence and memoranda of understanding do not constitute part of this Contract. In the event of a conflict of language between the Contract and the attachments (which includes the ITN), the provisions of the Contract shall govern, unless otherwise noted. The Agency reserves the right to clarify any contractual relationship in writing and such clarification shall govern. Pending final determination of any dispute over any Agency decision, the Managed Care Plan shall proceed diligently with the performance of its duties as specified under the Contract and in accordance with the direction of the Agency's Division of Medicaid.
10. The Managed Care Plan shall have a quality improvement program that ensures enhancement of quality of care and emphasizes improving the quality of patient outcomes. The Agency may restrict the Managed Care Plan's enrollment activities if the Managed Care Plan does not meet acceptable quality improvement and performance indicators, based on performance reports and other outcome measures to be determined by the Agency. Such restrictions may include, but shall not be limited to, the termination of mandatory assignments.
11. The Managed Care Plan shall demonstrate that it has adequate knowledge of Medicaid programs, provision of covered services, quality improvement, claims data, and the capability to design and implement cost savings methodologies. The Managed Care Plan shall demonstrate the capacity for financial analyses, as necessary to fulfill the requirements of this Contract. Additionally, the Managed Care Plan shall meet all requirements for doing business in the State of Florida.
12. The Managed Care Plan may be required to provide to the Agency or its agent information or data relative to this Contract. In such instances, and at the direction of the Agency, the Managed Care Plan shall fully cooperate with such requests and furnish all

information in a timely manner, in the format in which it is requested. The Managed Care Plan shall have at least thirty (30) calendar days to fulfill such ad hoc requests, unless the Agency is directed to provide data in less than thirty (30) calendar days.

13. The Managed Care Plan shall provide care coordination/case management services as specified in Attachment II, Core Contract Provisions, Section V, Covered Services.
14. The Managed Care Plan shall monitor utilization of services. This shall include the prior authorization of claims for covered services for its enrollees as specified in Attachment II, Core Contract Provisions, Section XIII, Quality Improvement, subsection B., Utilization Management.
15. If the Managed Care Plan is capitated by the Agency for a covered service, then the Managed Care Plan shall register all participating providers for such services who are not verified as Medicaid-enrolled providers with the Agency's fiscal agent, in the manner and format determined by the Agency.
16. The Managed Care Plan shall collect and submit encounter data for each Contract year in accordance with Attachment II, Core Contract Provisions, Section X, Administration and Management. The Managed Care Plan shall ensure that its provision of provider information to the Agency is sufficient to ensure that its providers are recognized as participating providers of the Managed Care Plan for plan selection and encounter data acceptance purposes.
17. The Managed Care Plan shall encourage its providers to connect to the Florida Health Information Exchange (HIE) and promote provider use of the HIE, including educating providers on the benefits of using the HIE and the availability of incentive funding.
18. The Managed Care Plan shall provide covered services to enrollees as required for each enrollee without regard to the frequency or cost of services relative to the amount paid pursuant to the Contract. In the event of insolvency, the Managed Care Plan shall cover continuation of services to enrollees for the duration of the period for which payment has been made.
19. The Managed Care Plan shall comply with all requirements of the MMA or LTC Report Guide (as applicable) referenced in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements.
20. The Managed Care Plan shall furnish services in an amount, duration and scope that are no more restrictive than the services provided in the Medicaid FFS program and may reasonably be expected to achieve the purpose for which the services are furnished.
21. A Managed Care Plan, as an MMA or LTC PSN, may receive payment from the Agency on a FFS or prepaid (capitated) basis. An MMA or LTC PSN reimbursed by the Agency on a capitated basis shall be exempt from parts I and III of Chapter 641, F.S., but must comply with the solvency requirements in s. 641.2261(2), F.S., and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the Agency.

22. A Managed Care Plan that is an MMA or LTC FFS PSN shall be responsible for submitting clean and accurate claims on behalf of all providers in accordance with applicable Medicaid provider handbook requirements. If the Managed Care Plan is capitated by the Agency for transportation services, then the Managed Care Plan shall be responsible for paying claims for transportation services and for collecting and submitting encounter data for transportation services in accordance with Attachment II, Core Contract Provisions, Section X, Administration and Management.
23. Prior to enrolling recipients in a Managed Care Plan in each region in which the Managed Care Plan receives a resulting Contract, the Agency will conduct a plan-specific readiness review to assess the Managed Care Plan's readiness and ability to provide services to recipients. The plan readiness review may include, but is not limited to, desk and onsite review of the Managed Care Plan's policies and procedures and corresponding documents, provider network and corresponding provider contracts and subcontracts, a walk-through of the Managed Care Plan's operations, system demonstrations, and interviews with Managed Care Plan staff. The scope of the plan readiness review may include any and all Contract requirements, as determined by the Agency. The Agency will not enroll recipients into a Managed Care Plan until the Agency has determined that the Managed Care Plan meets all Contract requirements.
24. If a Managed Care Plan does not meet the plan readiness review deadlines for their respective region, as indicated in Attachment I, Scope of Services, the Agency will grant an extension for the Managed Care Plan to correct deficiencies; however, the Managed Care Plan will lose the initial enrollment of eligible recipients into its respective region and will lose its transition population, if applicable. After an extension is granted by the Agency, the Managed Care Plan will have until the penultimate Saturday before the respective region's enrollment effective date in a respective region, as indicated in Attachment I, Scope of Services, Exhibit 2, , to be deemed ready for recipient enrollment. If a Managed Care Plan is not deemed ready for recipient enrollment by the Agency by the penultimate Saturday before the respective region's enrollment effective date, this Contract will be terminated, in accordance with Attachment II, Core Contract Provisions, Section XVI. If the Managed Care Plan is not able to meet plan readiness criteria and all contractual requirements in a region, the Agency will not delay Statewide Medicaid Managed Care enrollment for other plans in the region or in other regions.
25. The FFS Managed Care Plan shall submit to the Agency for approval a comprehensive conversion plan for converting from a FFS Managed Care Plan to a capitated Managed Care Plan. Such conversion plan shall be in accordance with Agency guidelines and shall be designed to ensure that the Health Plan is capable of meeting all solvency, reserves and working capital requirements of Chapter 641 F.S. In order to comply with s. 409.912(4)(d)1., F.S., the FFS Managed Care Plan shall submit its conversion application by the first day of its second Contract year. The Health Plan must transition to a capitated plan by the last day of its second year of operation in order to continue this Contract. See Attachment II, Core Contract Provisions, Section II, C., Responsibilities of the State of Florida (state) and Section XVI, P., Termination Procedures, and Attachment II, Core Contract Provisions, Exhibit 15, Financial Requirements.

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Section III Eligibility and Enrollment

A. Eligibility (See Attachment II, Core Contract Provisions, Exhibit 3)

Except as otherwise provided below, all Medicaid recipients shall receive Medicaid covered services through the SMMC program. The following populations represent broad categories that may contain multiple eligibility groups. Certain exceptions may apply within the broad categories and will be determined by the Agency.

B. Enrollment (See Attachment I, Scope of Services and Attachment II, Core Contract Provisions, Exhibit 3)

1. General Provisions

- a. Only Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to enroll and receive services from the Managed Care Plan. Each recipient shall have a choice of Managed Care Plans and may select any authorized Managed Care Plan unless the Managed Care Plan is restricted by this Contract to a specific population that does not include the recipient.
- b. The Agency or its agent shall be responsible for enrollment, including enrollment into the Managed Care Plan, disenrollment and outreach and education activities. The Managed Care Plan shall coordinate with the Agency and its agent as necessary for all enrollment and disenrollment functions.
- c. The Managed Care Plan shall accept Medicaid recipients without restriction and in the order in which they enroll. The Managed Care Plan shall not discriminate on the basis of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services and shall not use any policy or practice that has the effect of such discrimination.
- d. Each month the Managed Care Plan shall review its X12-834 enrollment files to ensure that all enrollees are residing in the same region in which they were enrolled.
- e. Upon notification that an enrollee is pregnant or has given birth to a newborn, the Managed Care Plan shall notify DCF.

2. Enrollment in an MMA Specialty Plan — **MMA Plans Only** (See Exhibit 3)
3. Unborn Activation and Newborn Enrollment — **MMA Plans Only** (See Exhibit 3)
4. Stopping or Limiting Enrollment

The Managed Care Plan may ask the Agency to halt or reduce enrollment temporarily for any enrollment amount above the Agency's set regional enrollment limit (see Exhibit 3) if continued full enrollment would exceed the Managed Care Plan's capacity to provide required services under the Contract. The Agency may not approve or may also limit Managed Care Plan enrollments when such action is considered to be in the Agency's best interest in accordance with the provisions of this Contract. (See Exhibit 2, General Overview,

Item C., Responsibilities of the State of Florida [state], sub-item 20, and Exhibit 2, General Overview, Item C., Responsibilities of the Managed Care Plan, sub-item 26.)

C. Disenrollment (See Attachment II, Core Contract Provisions, Exhibit 3)

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 agents shall not provide or assist in the completion of a disenrollment request or assist the Agency's contracted enrollment broker in the disenrollment process.
- c. The Managed Care Plan shall ensure that enrollees who are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal on disenrollment except for the following reasons:
 - (1) Moving out of the region;
 - (2) Loss of Medicaid eligibility;
 - (3) Determination that an enrollee is in an excluded population, as defined in Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment, Item A., Eligibility, sub-item 3., Excluded Populations; or
 - (4) Enrollee death.
- d. An enrollee subject to open enrollment may submit to the Agency or its agent a request to disenroll from the Managed Care Plan. This may be done without cause during the ninety (90) calendar day change period following the date of the enrollee's initial enrollment with the Managed Care Plan, or the date the Agency or its agent sends the enrollee notice of the enrollment, whichever is later. An enrollee may request disenrollment without cause every twelve (12) months thereafter during the annual open enrollment period. Those not subject to open enrollment may disenroll at any time.
- e. The effective date of an approved disenrollment shall be the last calendar day of the month in which disenrollment was made effective by the Agency or its agent. In no case shall disenrollment be later than the first calendar day of the second month following the month in which the enrollee or the Managed Care Plan files the disenrollment request. If the Agency or its agent fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved as of the date Agency action was required.
- f. On the first day of the month after receiving notice from FMMIS that the enrollee has moved to another region, the Agency will automatically disenroll the enrollee from the Managed Care Plan and treat the recipient as if the recipient is a new Medicaid recipient eligible to choose another managed care plan pursuant to the Agency's enrollment process (see s. 409.969(2)d., F.S.).

2. When Disenrollment Can Occur

An enrollee may request disenrollment at any time. The Agency or the enrollment broker performs disenrollment as follows:

- a. For cause, at any time (see below for list of for-cause reasons), or
- b. Without cause, for enrollees subject to open enrollment, at the following times:
 - (1) During the ninety (90) days following the enrollee's initial enrollment, or the date the Agency or its agent sends the enrollee notice of the enrollment, whichever is later;
 - (2) At least every twelve (12) months;
 - (3) If the temporary loss of Medicaid eligibility has caused the enrollee to miss the open enrollment period;
 - (4) When the Agency or its agent grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); or
 - (5) During the thirty (30) days after the enrollee is referred for hospice services in order to enroll in another managed care plan to access the enrollee's choice of hospice provider.
- c. Without cause, for enrollees not subject to open enrollment, at any time.

3. Cause for Disenrollment

- a. A mandatory enrollee may request disenrollment from the Managed Care Plan for cause at any time. Such request shall be submitted to the Agency or its agent.
- b. The following reasons constitute cause for disenrollment from the Managed Care Plan:
 - (1) The enrollee does not live in a region where the Managed Care Plan is authorized to provide services, as indicated in FMMIS.
 - (2) The provider is no longer with the Managed Care Plan.
 - (3) The enrollee is excluded from enrollment.
 - (4) A substantiated marketing or community outreach violation has occurred.
 - (5) The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
 - (6) The enrollee has an active relationship with a provider who is not on the Managed Care Plan's panel, but is on the panel of another managed care

plan. "Active relationship" is defined as having received services from the provider within the six (6) months preceding the disenrollment request.

- (7) The enrollee is in the wrong Managed Care Plan as determined by the Agency.
- (8) The Managed Care Plan no longer participates in the region.
- (9) The state has imposed intermediate sanctions upon the Managed Care Plan, as specified in 42 CFR 438.702(a)(3).
- (10) The enrollee needs related services to be performed concurrently, but not all related services are available within the Managed Care Plan network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
- (11) The Managed Care Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- (12) The enrollee missed open enrollment due to a temporary loss of eligibility, defined as sixty (60) days or less for LTC enrollees and one hundred eighty (180) days or less for MMA enrollees.
- (13) Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers experienced in dealing with the enrollee's health care needs; or fraudulent enrollment.

c. Voluntary enrollees may disenroll from the Managed Care Plan at any time.

4. Involuntary Disenrollment Requests

- a. With proper written documentation, the following are acceptable reasons for which the Managed Care Plan may submit involuntary disenrollment requests to the Agency or its agent:
 - (1) Fraudulent use of the enrollee identification (ID) card. In such cases the Managed Care Plan shall report the event to MPI.
 - (2) The enrollee's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the Managed Care Plan seriously impairs the organization's ability to furnish services to either the enrollee or other enrollees.

This section does not apply to enrollees with medical or mental health diagnoses if the enrollee's behavior is attributable to the diagnoses.

An involuntary disenrollment request related to enrollee behavior must include documentation that the Managed Care Plan:

- i. Provided the enrollee at least one (1) oral warning and at least one (1) written warning of the full implications of the enrollee's actions;
 - ii. Attempted to educate the enrollee regarding rights and responsibilities;
 - iii. Offered assistance through care coordination/case management that would enable the enrollee to comply; and
 - iv. Determined that the enrollee's behavior is not related to the enrollee's medical or mental health condition.
- (3) Falsification of prescriptions by an enrollee. In such cases the Managed Care Plan shall report the event to MPI.
- b. The Managed Care Plan shall promptly submit such disenrollment requests to the Agency. In no event shall the Managed Care Plan submit a disenrollment request at such a date as would cause the disenrollment to be effective later than forty-five (45) calendar days after the Managed Care Plan's receipt of the reason for involuntary disenrollment. The Managed Care Plan shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.
- c. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the Agency. Any request not approved is final and not subject to Managed Care Plan dispute or appeal.
- d. The Managed Care Plan shall not request disenrollment of an enrollee due to:
 - (1) Health diagnosis;
 - (2) Adverse changes in an enrollee's health status;
 - (3) Utilization of medical services;
 - (4) Diminished mental capacity;
 - (5) Pre-existing medical condition;
 - (6) Uncooperative or disruptive behavior resulting from the enrollee's special needs (with the exception of Item C., Disenrollment, sub-item 4.a.(2)(b) above);
 - (7) Attempt to exercise rights under the Managed Care Plan's grievance system;
- e. When the Managed Care Plan requests an involuntary disenrollment, it shall notify the enrollee in writing that the Managed Care Plan is requesting disenrollment, the reason for the request, and an explanation that the Managed Care Plan is requesting that the enrollee be disenrolled in the next Contract month, or earlier if

necessary. Until the enrollee is disenrolled, the Managed Care Plan shall be responsible for the provision of services to that enrollee.

5. Disenrollment Notice

Each month the Managed Care Plan shall review its X12-834 enrollment files to determine which enrollees were disenrolled due to moving outside the region. Within five (5) calendar days after receipt of the Agency's enrollment files, the Managed Care Plan shall send notice of disenrollment to all such recipients with instructions to contact the enrollment broker to make a plan choice in the new region.

D. Enrollee Reporting Requirements (See Attachment II, Core Contract Provisions, Exhibit 3)

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Section IV
Enrollee Services, Community Outreach and Marketing

A. Enrollee Services (See Attachment II, Core Contract Provisions, Exhibit 4)

1. General Provisions

- a. The Managed Care Plan shall ensure that enrollees are notified of their rights and responsibilities; how to obtain care; what to do in an emergency or urgent medical situation; how to pursue a complaint, a grievance, appeal or Medicaid Fair Hearing; how to report suspected fraud and abuse; how to report abuse, neglect and exploitation; and all other requirements and benefits of the Managed Care Plan.
- b. The Managed Care Plan shall have the capability to answer enrollee inquiries through written materials, telephone, electronic transmission and face-to-face communication.
- c. The Managed Care Plan shall mail all enrollee materials to the enrollee's payee address provided by the Agency on the Managed Care Plan's monthly enrollment file. Mailing envelopes for enrollee materials shall contain a request for address correction. When enrollee materials are returned to the Managed Care Plan as undeliverable, the Managed Care Plan shall re-mail the materials to the enrollee residence address provided by the Agency if that address is different from the payee address. The Managed Care Plan shall use and maintain in a file a record of all of the following methods to contact the enrollee:
 - (1) Routine checks of the Agency enrollment reports for changes of address and/or presence of the enrollee's residence address, maintaining a record of returned mail and attempts to re-mail to either a new payee address or residence address as provided by the Agency;
 - (2) Telephone contact at the number obtained from Agency enrollment reports, the local telephone directory, directory assistance, city directory or other directory; and
 - (3) Routine checks (at least once a month for the first three (3) months of enrollment) on services or claims authorized or denied by the Managed Care Plan to determine if the enrollee has received services, and to locate updated address and telephone number information.
- d. New enrollee materials are not required for a former enrollee who was disenrolled because of the loss of Medicaid eligibility and who regains eligibility within sixty (60) days for LTC enrollees and one hundred eighty (180) days for MMA enrollees and is automatically reinstated in the Managed Care Plan, unless there was change in enrollee materials or provider directory during the timeframe in which the recipient was disenrolled. In addition, unless requested by the enrollee, new enrollee materials are not required for a former enrollee subject to open enrollment who was disenrolled because of the loss of Medicaid eligibility, regains eligibility within the time specified in this paragraph and is reinstated as a Managed Care

Plan enrollee, unless there was change in enrollee materials or provider directory during the timeframe in which the recipient was disenrolled. A notation of the effective date of the reinstatement is to be made on the most recent application or conspicuously identified in the enrollee's administrative file. Enrollees who were previously enrolled in the Managed Care Plan, and who lose and regain eligibility after the specified number of days will be treated as new enrollees.

- e. The Managed Care Plan shall notify, in writing, each person who is to be reinstated, of the effective date of the reinstatement. The notifications shall distinguish between enrollees subject to open enrollment and those who are not and shall include information about change procedures for cause, or general managed care plan change procedures through the Agency's toll-free enrollment broker telephone number as appropriate. The notification shall also instruct the enrollee to contact the Managed Care Plan if a new enrollee card, new enrollee handbook, and/or a new provider directory are needed. The Managed Care Plan shall provide such notice to each affected enrollee by the first calendar day of the month following the Managed Care Plan's receipt of the notice of reinstatement or within five (5) calendar days from receiving the enrollment file, whichever is later.

2. Requirements for Written Material

- a. The Managed Care Plan shall make all written materials available in alternative formats and in a manner that takes into consideration the enrollee's special needs, including those who are visually impaired or have limited reading proficiency. The Managed Care Plan shall notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats.
- b. The Managed Care Plan shall make all written material available in English, Spanish and all other appropriate foreign languages. The appropriate foreign languages comprise all languages in the Managed Care Plan Contract region(s) spoken by approximately five percent (5%) or more of the total population. Upon request, the Managed Care Plan shall provide, free of charge, interpreters for potential enrollees or enrollees whose primary language is not English. (See 42 CFR 438.10(c)(3).)
- c. The Managed Care Plan shall provide enrollee information in accordance with 42 CFR 438.10, which addresses information requirements related to written and oral information provided to enrollees, including: languages; format; Managed Care Plan features, such as benefits, cost sharing, provider network and physician incentive plans; enrollment and disenrollment rights and responsibilities; grievance system; and advance directives. The Managed Care Plan shall notify enrollees, on at least an annual basis, of their right to request and obtain information in accordance with the above requirements.
- d. All written materials and websites shall be at or near the fourth (4th) grade comprehension level. Suggested reference materials to determine whether the written materials meet this requirement are:

- (1) Fry Readability Index;
- (2) PROSE The Readability Analyst (software developed by Education Activities, Inc.);
- (3) Gunning FOG Index;
- (4) McLaughlin SMOG Index;
- (5) The Flesch-Kincaid Index; and/or
- (6) Other software approved by the Agency.

3. New Enrollee Materials

- a. By the first day of the assigned enrollee's enrollment or within five (5) calendar days following receipt of the enrollment file from Medicaid or its agent, whichever is later, the Managed Care Plan shall mail or hand deliver to the new enrollee: the enrollee handbook; the provider directory; the enrollee identification card; and the following additional materials:
 - (1) The actual date of enrollment;
 - (2) The enrollees' right to change their managed care plan selections, subject to Medicaid limitations;
 - (3) A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Managed Care Plan and through DCF and/or the Social Security Administration;
 - (4) A notice that enrollees who lose eligibility and are disenrolled shall be automatically re-enrolled in the Managed Care Plan if eligibility is regained within sixty (60) days for LTC enrollees and within one hundred eighty (180) days for MMA enrollees; and
 - (5) A postage-paid, pre-addressed return envelope.
- b. Each mailing/provision of materials shall be documented in the Managed Care Plan's records.
- c. Materials may be sent in separate mailings.

4. Enrollee ID Card

- a. The enrollee ID card shall include, at a minimum:
 - (1) The enrollee's name and Medicaid ID number;
 - (2) The Managed Care Plan's name, address and enrollee help line number; and

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

5. Enrollee Handbook Requirements

- a. The Managed Care Plan shall have enrollee handbooks that include the following information:
 - (1) Table of contents;
 - (2) Terms, conditions and procedures for enrollment including the reinstatement process and enrollee rights and protections;
 - (3) Enrollee rights and procedures for enrollment and disenrollment, including the toll-free telephone number for the Agency's contracted enrollment broker. The Managed Care Plan shall include the following language verbatim in the enrollee handbook:

Enrollment:

If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in [INSERT MANAGED CARE PLAN NAME] or the state enrolls you in a plan, you will have ninety (90) days from the date of your first enrollment to try the managed care plan. During the first ninety (90) days you can change managed care plans for any reason. After the ninety (90) days, if you are still eligible for Medicaid, you will be enrolled in the plan for the next nine (9) months. This is called "lock-in."

Open Enrollment:

If you are a mandatory enrollee, the state will send you a letter sixty (60) days before the end of your enrollment year telling you that you can change plans if you want to. This is called "open enrollment." You do not have to change managed care plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next twelve (12) months. Every year you may change managed care plans during your sixty (60) day open enrollment period.

Disenrollment:

*If you are a mandatory enrollee and you want to change plans after the initial ninety (90) day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state-approved cause reasons to change managed care plans: **[INSERT CAUSE LIST LANGUAGE VERBATIM FROM SECTION III, ELIGIBILITY AND ENROLLMENT, ITEM C., DISENROLLMENT, SUB-ITEM 3.b., CAUSE FOR DISENROLLMENT].***

- (4) Description of services provided, including limitations and general restrictions on provider access, exclusions and out-of-network use, and any restrictions on enrollee freedom of choice among participating providers;
- (5) Procedures for obtaining required services, including second opinions at no expense to the enrollee, and authorization requirements, including any services available without prior authorization;
- (6) Information regarding newborn enrollment, including the mother's responsibility to notify the Managed Care Plan and DCF of the pregnancy and the newborn's birth;
- (7) The extent to which, and how, after-hours and emergency coverage is provided, and that the enrollee has a right to use any hospital or other setting for emergency care;
- (8) Enrollee rights and responsibilities, including the extent to which and how enrollees may obtain services from non-participating providers and other provisions in accordance with 42 CFR 438.100;
- (9) Information about the Beneficiary Assistance program (BAP) and the Medicaid Fair Hearing process, including an explanation that a review by the BAP must be requested within one (1) year after the date of the occurrence that initiated the appeal, how to initiate a review by the BAP and the BAP address and telephone number:

Agency for Health Care Administration
Beneficiary Assistance Program
Building 1, MS #26
2727 Mahan Drive, Tallahassee, FL 32308
(850) 412-4502
(888) 419-3456 (toll-free)

- (10) Clear specifics on the required procedural steps in the grievance process, including the address, telephone number and office hours of the grievance staff. The Managed Care Plan shall specify telephone numbers to call to present a complaint, grievance, or appeal. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the Managed Care Plan without undue delays;
- (11) Information that services will continue upon appeal of a denied authorization and that the enrollee may have to pay in case of an adverse ruling;
- (12) Procedures for filing a request for disenrollment for cause. As noted in subparagraph (14), the state-approved for-cause reasons listed in Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment, Item C., Disenrollment, sub-item 3.,b., shall be listed verbatim in the disenrollment section of the enrollee handbook. In addition, the Managed Care Plan shall

include the following language verbatim in the disenrollment section of the enrollee handbook:

Some Medicaid recipients may change managed care plans whenever they choose, for any reason. To find out if you may change plans, call the Enrollment Broker 1-877-711-3662

- (13) Information that interpretation services and alternative communication systems are available, free of charge, including for all foreign languages and vision and hearing impairment, and how to access these services;
- (14) Information regarding health care advance directives pursuant to ss. 765.302 through 765.309, F.S., 42 CFR 438.6(i)(1)-(2) and 42 CFR 422.128, as follows:
 - i. The Managed Care Plan shall provide these policies and procedures to all enrollee's age 18 and older and shall advise enrollees of:
 - Their rights under state law, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and
 - The Managed Care Plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
 - ii. The information must include a description of state law and must reflect changes in state law as soon as possible, but no later than ninety (90) calendar days after the effective change.
 - iii. The Managed Care Plan's information shall inform enrollees that complaints about non-compliance with advance directive laws and regulations may be filed with the state's complaint hotline.
 - iv. The Managed Care Plan shall educate enrollees about their ability to direct their care using this mechanism and shall specifically designate which staff and/or participating providers are responsible for providing this education.
- (15) Cost sharing for the enrollee, if any;
- (16) How and where to access any benefits that are available under the Medicaid State Plan but are not covered under this Contract, including any cost sharing;
- (17) Instructions explaining how enrollees may obtain information from the Managed Care Plan about how it rates on performance measures in specific areas of service;
- (18) How to obtain information from the Managed Care Plan about quality enhancements;

- (19) Procedures for reporting abuse, neglect, and exploitation, including the abuse hotline number: 1-800-96-ABUSE;
- (20) Procedures for reporting fraud, abuse and overpayment that includes the following language verbatim:
 - i. *To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.asp*
X;
 - ii. *If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of \$500,000 per case (, Section 409.9203, Florida Statutes). You can talk to the Attorney General's Office about keeping your identity confidential and protected.*
- (21) Information regarding HIPAA relative to the enrollee's personal health information (PHI);
- (22) Toll-free telephone number of the appropriate Medicaid Area Office and Aging and Disabilities Resource Centers;
- (23) Information to help the enrollee assess a potential behavioral health problem;
- (24) How to get information about the structure and operation of the Managed Care Plan and any physician incentive plans, as set forth in 42 CFR 438.10(g)(3);
- b. For a counseling or referral service that the Managed Care Plan does not cover because of moral or religious objections, the Managed Care Plan need not furnish information on how and where to obtain the service.

6. Provider Directory

- a. The Managed Care Plan shall mail or hand deliver a provider directory to all new enrollees, including those who reenrolled after the open enrollment period. The Managed Care Plan shall provide the most recently printed provider directory and append to it a list of the providers who have left the network and those who have been added since the directory was printed. In lieu of the appendix to the provider directory the Managed Care Plan may enclose a letter stating that the most current listing of providers is available by calling the Managed Care Plan at its toll-free telephone number and at the Managed Care Plan's website. The letter shall include the telephone number and the Internet address that will take the enrollee directly to the online provider directory.

- b. The provider directory shall include the names, locations, office hours, telephone numbers of, and non-English languages spoken by current Managed Care Plan providers. The provider directory also shall identify providers that are not accepting new patients.
- c. The Managed Care Plan shall arrange the provider directory by county as follows:
 - (1) Providers listed by name in alphabetical order, showing the provider's specialty;
 - (2) Providers listed by specialty, in alphabetical order; and
 - (3) Behavioral health providers listed in a separate section by provider type, where applicable.
- d. The Managed Care Plan shall maintain an accurate and complete online provider directory containing all the information described in this subsection as well as information about licensure or registration, specialty credentials and other certifications, and specific performance indicators. The online provider directory must be searchable by:
 - (1) Name,
 - (2) Provider type,
 - (3) Distance from the enrollee's address,
 - (4) Zip code, and
 - (5) Whether the provider is accepting new patients.

The online provider directory shall also have the capability to compare the availability of providers to network adequacy standards and accept and display feedback from each provider's patients. The Managed Care Plan shall update the online provider directory at least monthly. The Managed Care Plan shall file an attestation to this effect with the Agency each month, even if no changes have occurred. (See s. 409.967(2)(c), F.S.)

- e. In accordance with s. 1932(b)(3) of the Social Security Act, the provider directory shall include a statement that some providers may choose not to perform certain services based on religious or moral beliefs.
- f. The Managed Care Plan shall have procedures to inform potential enrollees and enrollees, upon request, of any changes to service delivery and/or the provider network including the following:
 - (1) Up-to-date information about any restrictions on access to providers, including providers who are not taking new patients;

- (2) Any restrictions on counseling and referral services based on moral or religious grounds within ninety (90) days after adopting the policy with respect to any service.

7. New Enrollee Procedures **(See Attachment II, Core Contract Provisions, Exhibit 4)**

8. Enrollee Assessments **(See Attachment II, Core Contract Provisions, Exhibit 4)**

9. Enrollee Authorized Representative

The enrollee's guardian or legally authorized responsible person, as provided in s. 765.401, F.S., is permitted to act on the enrollee's behalf in matters relating to the enrollee's enrollment, plan of care, and/or provision of services, if the enrollee:

- a. Was adjudicated incompetent in accordance with the law;
- b. Is found by the provider to be medically incapable of understanding his or her rights; or
- c. Exhibits a significant communication barrier.

10. Toll-Free Enrollee Help Line

- a. The Managed Care Plan shall operate a toll-free enrollee help line, which shall respond to all areas of enrollee inquiry.
- b. The Managed Care Plan shall have telephone call policies and procedures that shall include requirements for staffing, personnel, hours of operation, call response times, maximum hold times and maximum abandonment rates, monitoring of calls via recording or other means and compliance with performance standards.
- c. The enrollee help line shall handle calls from non-English speaking enrollees, as well as calls from enrollees who are hearing impaired.
- d. The Managed Care Plan's enrollee help line must include the option for enrollees to bypass the automated attendant/IVR and speak with an enrollee help line staff member.
- e. The enrollee help line shall be fully staffed between the hours of 8:00 a.m. and 7:00 p.m. in the enrollee's time zone (Eastern or Central), Monday through Friday, excluding state holidays. The enrollee help line staff shall be trained to respond to enrollee questions in all areas, including but not limited to, covered services, provider network and transportation.
- f. The Managed Care Plan shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by the Agency before the Managed Care Plan begins operation. At a minimum, the standards shall require that, measured on a monthly basis:

- (1) All calls are answered within four (4) rings (these calls may be placed in a queue);
 - (2) Wait time in the queue shall not exceed three (3) minutes;
 - (3) The blocked call rate does not exceed one percent (1%); and
 - (4) The rate of abandoned calls does not exceed five percent (5%).
- g. The Managed Care Plan shall have an automated system available between the hours of 7:00 p.m. and 8:00 a.m., in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays. This automated system must provide callers with clear instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The Managed Care Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A Managed Care Plan representative shall respond to messages on the next business day.

11. Translation Services

The Managed Care Plan is required to provide oral translation services to any enrollee who speaks any non-English language regardless of whether the enrollee speaks a language that meets the threshold of a prevalent non-English language. The Managed Care Plan is required to notify its enrollees of the availability of oral interpretation services and to inform them of how to access such services. Oral interpretation services are required for all Managed Care Plan information provided to enrollees, including notices of adverse action. There shall be no charge to the enrollee for translation services.

12. Notices of Action (See 42 CFR 438.210)

- a. The Managed Care Plan shall notify the provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
- b. For standard authorization decisions, the Managed Care Plan shall provide notice as expeditiously as the enrollee's health condition requires and within no more than fourteen (14) calendar days following receipt of the request for service.
- c. The timeframe can be extended up to fourteen (14) additional calendar days if the enrollee or the provider requests extension or the Managed Care Plan justifies the need for additional information and how the extension is in the enrollee's interest.
- d. Expedited authorization is required when a provider indicates, or the Managed Care Plan determines, that following the standard timeline could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. An expedited decision must be made no later than three (3) working days after receipt of the request for service.

- e. The Managed Care Plan may extend the three (3) working days for expedited cases by up to fourteen (14) calendar days if the enrollee requests an extension or if the Managed Care Plan justifies the extension as prescribed in subparagraph 12.c. above.

13. Medicaid Redetermination Notices (**See Attachment II, Core Contract Provisions, Exhibit 4**)

B. Community Outreach and Marketing

1. General Provisions

- a. The Managed Care Plan's community outreach representative(s) may provide community outreach materials at health fairs/public events as noticed by the Managed Care Plan to the Agency in accordance with sub-item 4, Community Outreach Notification Process, below. The main purpose of a health fair/public event shall be to provide community outreach and shall not be for the purpose of Medicaid Managed Care Plan marketing.
- b. For each new Contract period, the Managed Care Plan shall submit to the Agency for written approval all community outreach material no later than sixty (60) calendar days before the start of the next Contract period, and, for any changes in the community outreach material, no later than thirty (30) calendar days before implementation. All materials developed shall be governed by the requirements set forth in this section.
- c. To announce participation at a specific event (health fair/public event), the Managed Care Plan shall submit a notice to the Agency in accordance with sub-item B.3., Permitted Activities.
- d. The Managed Care Plan shall be responsible for developing and implementing a written plan designed to control the actions of its community outreach representatives.
- e. All community outreach policies set forth in this Contract shall apply to staff, subcontractors, Managed Care Plan volunteers and all persons acting for, or on behalf of, the Managed Care Plan.
- f. The Managed Care Plan is vicariously liable for any outreach and marketing violations of its employees, agents or subcontractors. In addition to any other sanctions available in Attachment II, Core Contract Provisions, Section XIV, Sanctions, any violations of this section shall subject the Managed Care Plan to administrative action by the Agency as determined by the Agency. The Managed Care Plan may dispute any such administrative action pursuant to Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item I., Disputes.
- g. Nothing in this section shall preclude the Managed Care Plan from donating to or sponsoring an event with a community organization where time, money or expertise is provided for the benefit of the community. If such events are not health fairs/public events, no community outreach materials or marketing materials

shall be distributed by the Managed Care Plan, but the Managed Care Plan may engage in brand-awareness activities, including the display of Managed Care Plan or product logos. Inquiries at such events from prospective enrollees must be referred to the Managed Care Plan's enrollee services section or the Agency's enrollment broker.

2. Prohibited Activities

The Managed Care Plan is prohibited from engaging in the following non-exclusive list of activities:

- a. Marketing for enrollment to any potential members or conducting any pre-enrollment activities not expressly allowed under this Contract;
- b. Any of the prohibited practices or activities listed in s. 409.912, F.S.;
- c. Engaging in activities not expressly allowed under this Contract for the purpose of recruitment or enrollment;
- d. Practices that are discriminatory, including, but not limited to, attempts to discourage enrollment or re-enrollment on the basis of actual or perceived health status, in accordance with ss. 409.912 and 409.91211, F.S.;
- e. Direct or indirect cold call marketing or other solicitation of Medicaid applicants and recipients, either by door-to-door, telephone or other means, in accordance with Section 4707 of the Balanced Budget Act of 1997 and s. 409.912, F.S.;
- f. Activities that could mislead or confuse Medicaid recipients or misrepresent the Managed Care Plan, its community outreach representatives or the Agency, in accordance with s. 409.912, F.S. No fraudulent, misleading or misrepresentative information shall be used in community outreach, including information about other government programs. Statements that could mislead or confuse include, but are not limited to, any assertion, statement or claim (whether written or oral) that:
 - (1) The Medicaid recipient must enroll in the Managed Care Plan to obtain Medicaid or to avoid losing Medicaid benefits;
 - (2) The Managed Care Plan is endorsed by any federal, state or county government, the Agency, CMS or any other organization that has not certified its endorsement in writing to the Managed Care Plan;
 - (3) Community outreach representatives are employees or representatives of the federal, state or county government, or of anyone other than the Managed Care Plan or the organization by whom they are reimbursed;
 - (4) The state or county recommends that a Medicaid recipient enroll with the Managed Care Plan; and/or

- (5) A Medicaid recipient will lose benefits under the Medicaid program or any other health or welfare benefits to which the person is legally entitled if the recipient does not enroll with the Managed Care Plan.
- g. Granting or offering any monetary or other valuable consideration for enrollment;
 - h. Offering insurance, such as, but not limited to, accidental death, dismemberment, disability or life insurance;
 - i. Enlisting assistance of any employee, officer, elected official or agency of the state in recruitment of Medicaid recipients except as authorized in writing by the Agency;
 - j. Offering material or financial gain to any persons soliciting, referring or otherwise facilitating Medicaid recipient enrollment. The Managed Care Plan shall ensure that its staff does not market the Managed Care Plan to Medicaid recipients at any location including state offices or DCF ACCESS center;
 - k. Giving away promotional items in excess of \$5.00 retail value. Items to be given away shall bear the Managed Care Plan's name and shall be given away only at health fairs/public events. In addition, such promotional items must be offered to the general public and shall not be limited to Medicaid recipients;
 - l. Providing any gift, commission or any form of compensation to the enrollment broker, including its full-time, part-time or temporary employees and subcontractors;
 - m. Discussing, explaining or speaking to a potential member about Managed Care Plan-specific information other than to refer all Managed Care Plan inquiries to the enrollee services section of the Managed Care Plan or the Agency's enrollment broker;
 - n. Distributing any community outreach materials without prior written notice to the Agency except as otherwise allowed under Permitted Activities and Provider Compliance subsections;
 - o. Distributing any marketing materials not expressly allowed under this Contract;
 - p. Subcontracting with any brokerage firm or independent agent as defined in Chapters 624-651, F.S., for purposes of marketing or community outreach;
 - q. Paying commission compensation to community outreach representatives for new enrollees. The payment of a bonus to a community outreach representative shall not be considered a commission if such bonus is not related to enrollment or membership growth; and
 - r. All activities included in s. 641.3903, F.S.

3. Permitted Activities

The Managed Care Plan may engage in the following activities upon prior written notice to the Agency:

- a. The Managed Care Plan may attend health fairs/public events upon request by the sponsor and after written notification to the Agency as described in sub-item 4., Community Outreach Notification Process, below.
- b. The Managed Care Plan may leave community outreach materials at health fairs/public events at which the Managed Care Plan participates.
- c. The Managed Care Plan may provide Agency-approved community outreach materials. Such materials may include Medicaid enrollment and eligibility information and information related to other health care projects and health, welfare and social services provided by the State of Florida or local communities. The Managed Care Plan staff, including community outreach representatives, shall refer all Managed Care Plan inquiries to the enrollee services section of the Managed Care Plan or the Agency's enrollment broker. Agency approval of the script used by the Managed Care Plan's enrollee services section must be obtained before usage.
- d. The Managed Care Plan may distribute community outreach materials to community agencies.

4. Community Outreach Notification Process

- a. The Managed Care Plan shall submit to the Agency a written notice of its intent to attend and provide community outreach materials at health fairs/public events. (See sub-items 4.b. and 4.c. below for further notice information.)

(1) The Agency requires the following health fair/public event information:

- i. The event announcement to be given to the public;
- ii. Date, time and location of the event;
- iii. Name and type of sponsoring organization;
- iv. Event contact person and contact information;
- v. Managed Care Plan contact person and contact information; and
- vi. Names of participating community outreach representatives, their contact information and services they will provide at the event.

(2) In addition to the disclosure information listed in (1) above, if the Managed Care Plan is the primary organizer of the event, the Managed Care Plan shall submit in its community outreach health fairs/public events notification report specified in b., below, to the Agency, complete disclosure information from

each organization participating. Information shall include the name of the organization, contact person information and confirmation of participation.

(3) In addition to the disclosure information listed in (1) above, if the Managed Care Plan has been invited by a community organization to be a sponsor or attendee of an event, the Managed Care Plan shall submit in its community outreach health fairs/public events notification report specified in b., below, to the Agency, a copy of the letter of invitation from the event sponsor(s) requesting the Managed Care Plan's participation.

- b. The Managed Care Plan shall report health fair/public event notices to the Agency by submitting a community outreach health fairs/public events notification report by the 20th calendar day of the month prior to the event month. Amendments to the report are due no later than two (2) weeks prior to the event. See Attachment II, Core Contract Provisions, Section XII, Reporting Requirements.
- c. Notwithstanding the other notice requirements in this subsection, the monthly and two-(2) week advance notice requirements are waived in cases of force majeure provided the Managed Care Plan notifies the Agency by the time of the event. Force majeure events include destruction due to hurricanes, fires, war, riots and other similar acts. When providing the Agency with notice of attendance at such events, the Managed Care Plan shall include a description of the force majeure event requiring waiver of notice.
- d. The Agency will establish a statewide log to track the community outreach notifications received and may monitor such events.

5. Provider Compliance

The Managed Care Plan shall ensure, through provider education and outreach that its health care providers are aware of and comply with the following requirements:

- a. Health care providers may display Managed Care Plan-specific materials in their own offices.
- b. Health care providers cannot orally or in writing compare benefits or provider networks among Managed Care Plans, other than to confirm whether they participate in a Managed Care Plan's network.
- c. Health care providers may announce a new affiliation with a Managed Care Plan and give their patients a list of managed care plans with which they contract.
- d. Health care providers may co-sponsor events, such as health fairs and advertise with the Managed Care Plan in indirect ways; such as television, radio, posters, fliers, and print advertisement.
- e. Health care providers shall not furnish lists of their Medicaid patients to the Managed Care Plan with which they contract, or any other entity, nor can providers furnish other managed care plans' membership lists to the Managed Care Plan, nor can providers assist with Managed Care Plan enrollment.

- f. For the Managed Care Plan, health care providers may distribute information about non-Managed Care Plan-specific health care services and the provision of health, welfare and social services by the State of Florida or local communities, as long as any inquiries from prospective enrollees are referred to the enrollee services section of the Managed Care Plan or the Agency's enrollment broker.

6. Community Outreach Representatives

- a. The Managed Care Plan shall register each community outreach representative that represents the Managed Care Plan with the Agency as specified below.
 - (1) The Managed Care Plan shall submit its registration file to the Agency in accordance with the MMA or LTC Report Guide (as applicable). The Agency-supplied template must be used as specified in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, and in the MMA or LTC Report Guide (as applicable).
 - (2) The Managed Care Plan shall submit changes to the community outreach representative's initial registration to the Agency, using the same Agency-supplied template, immediately upon occurrence.
- b. While attending health fairs/public events, community outreach representatives shall wear picture identification that shows the Managed Care Plan represented.
- c. If asked, the community outreach representative shall inform the Medicaid recipient that the representative is not a state employee and is not an enrollment specialist but is a representative of the Managed Care Plan.
- d. The Managed Care Plan shall instruct and provide initial and periodic training to its community outreach representatives about the outreach and marketing provisions of this Contract.
- e. The Managed Care Plan shall implement procedures for background and reference checks for use in hiring community outreach representatives.
- f. The Managed Care Plan shall report to the Agency any Managed Care Plan staff or community outreach representative who violates any requirements of this Contract within fifteen (15) calendar days of knowledge of such violation.

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**Section V
Covered Services**

**(Also See Attachment I, Scope of Services and
Attachment II, Core Contract Provisions, Exhibit 5)**

A. Covered Services (See Attachment II, Core Contract Provisions, Exhibit 5)

1. The Managed Care Plan shall ensure the provision of services in sufficient amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services defined and specified in this Contract. The Managed Care Plan shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the enrollee's diagnosis, type of illness or condition. The Managed Care Plan may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.
2. The Managed Care Plan is responsible for ensuring that all providers, service and product standards specified in the Agency's Medicaid Services Coverage & Limitations Handbooks and the Managed Care Plan's own provider handbooks are incorporated into the Managed Care Plan's provider contracts. This includes professional licensure and certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in this Contract.
3. The Managed Care Plan shall require non-participating providers to coordinate with respect to payment and must ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network.

B. Expanded Benefits (See Attachment I and Attachment II, Core Contract Provisions, Exhibit 5)

C. Copayments and Required Service Level (See Attachment II, Core Contract Provisions, Exhibit 5)

D. Excluded Services

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

E. Moral or Religious Objections

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

1. The Agency within one-hundred twenty (120) calendar days before implementing the policy with respect to any service; and
2. Enrollees within thirty (30) calendar days before implementing the policy with respect to any service.

F. Coverage Provisions

The Managed Care Plan shall provide the services listed in Attachment II, Core Contract Provisions, Exhibit 5 in accordance with the provisions herein, and in accordance with the Florida Medicaid Coverage and Limitations Handbooks, Medicaid fee schedules (see Attachment II, Core Contract Provisions, Section II, General Overview, Sub-Item D.8.) and the Florida Medicaid State Plan. The Managed Care Plan shall comply with all state and federal laws pertaining to the provision of such services.

G. Managing Duplicative Covered Services

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

H. Quality Enhancements (See Attachment II, Core Contract Provisions, Exhibit 5)

In addition to the covered services specified in this section, the Managed Care Plan shall offer quality enhancements (QE) to enrollees in Attachment II, Core Contract Provisions, Exhibit 5 and as specified below.

1. The Managed Care Plan shall offer QEs in community settings accessible to enrollees.
2. The Managed Care Plan shall provide information in the enrollee and provider handbooks on the QEs and how to access related services.
3. The Managed Care Plan shall develop and maintain written policies and procedures to implement QEs.
4. If the Managed Care Plan involves the enrollee in an existing community program for purposes of meeting the QE requirement, the Managed Care Plan shall ensure documentation in the enrollee's medical/case record of referrals to the community program and follow up on the enrollee's receipt of services from the community program.
5. The Managed Care Plan is encouraged to actively collaborate with community agencies and organizations.

- I. Care Coordination/Case Management – (See Attachment II, Core Contract Provisions, Exhibit 5)**
- J. Case Management of Enrollees – (See Attachment II, Core Contract Provisions, Exhibit 5)**
- K. Case File Documentation – LTC Plans Only (See Attachment II, Core Contract Provisions, Exhibit 5)**
- L. Case Closure Standard – LTC Plans Only (See Attachment II, Core Contract Provisions, Exhibit 5)**
- M. Abuse/Neglect and Adverse Incident Reporting Standard – LTC Plans Only (See Attachment II, Core Contract Provisions, Exhibit 5)**
- N. Monitoring of Care Coordination and Services – LTC Plans Only (See Attachment II, Core Contract Provisions, Exhibit 5)**

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**Section VI
Behavioral Health**

See Attachment II, Core Contract Provisions, Exhibit 6

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Section VII Provider Network

A. General Provisions

1. The Managed Care Plan shall have sufficient facilities, service locations and personnel to provide the covered services as required by this Contract.
2. The Managed Care Plan shall provide the Agency, prior to Contract execution and upon request, with sufficient evidence that the Managed Care Plan has the capacity to provide covered services to all enrollees up to the maximum enrollment level, including evidence that the Managed Care Plan:
 - a. Offers an appropriate range of services and accessible services to meet the needs of the maximum enrollment level; and
 - b. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients as specified in s. 1932(b)(5) of the Social Security Act, as enacted by s. 4704(a) of the Balanced Budget Act of 1997.
3. Prior to Contract execution and weekly thereafter, the Managed Care Plan shall submit a provider network file of all participating providers to the Agency or its agent in the manner and format determined by the Agency. See Attachment II, Core Contract Provisions, Exhibit 12, Reporting Requirements, Summary of Reporting Requirements Table.
4. The Managed Care Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments.
5. When establishing and maintaining the provider network or requesting enrollment level increases, the Managed Care Plan shall take the following into consideration as required by 42 CFR 438.206:
 - a. The anticipated number of enrollees;
 - b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented;
 - c. The numbers and types (in terms of training, experience and specialization) of providers required to furnish the covered services;
 - d. The numbers of participating providers who are not accepting new enrollees;
 - e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees and whether the location provides physical access for Medicaid enrollees with disabilities.
6. If the Managed Care Plan is unable to provide medically necessary services to an enrollee, the Managed Care Plan shall cover these services in an adequate and timely

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

7. The Managed Care Plan shall allow each enrollee to choose among participating providers to the extent possible and appropriate.
8. The Managed Care Plan shall require each provider to have a unique Florida Medicaid provider number. The Managed Care Plan shall require each provider to have a National Provider Identifier (NPI) in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The provider contract shall require providers to submit all NPIs to the Managed Care Plan within fifteen (15) business days of receipt. The Managed Care Plan shall file the providers' NPIs as part of its provider network file to the Agency or its agent, as set forth in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, and Exhibit 12. The Managed Care Plan need not obtain an NPI from an entity that does not meet the definition of "health care provider" found at 45 CFR 160.103:
 - a. Individuals or organizations that furnish atypical or nontraditional services that are only indirectly related to the provision of health care (examples include taxis, home modifications, home delivered meals and homemaker services); and
 - b. Individuals or businesses that only bill or receive payment for, but do not furnish, health care services or supplies (examples include billing services and reproducers).
9. The Managed Care Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification, in accordance with s. 1932(b) (7) of the Social Security Act (as enacted by s. 4704[a] of the Balanced Budget Act of 1997). The Managed Care Plan is not prohibited from including providers only to the extent necessary to meet the needs of the Managed Care Plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Managed Care Plan. If the Managed Care Plan declines to include individual providers or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
10. The Managed Care Plan shall establish and maintain a formal provider relations function to respond timely and adequately to inquiries, questions and concerns from participating providers.
11. The Managed Care Plan shall monitor the quality and performance of each participating provider. This shall include using performance measures adopted by and collected by the Agency as well as additional measures agreed upon by the provider and the Managed Care Plan. (See s. 409.982(3), F.S.)

B. Network Standards (See Attachment II, Core Contract Provisions, Exhibit 7)

C. Annual Network Development and Management Plan (See Attachment II, Core Contract Provisions, Exhibit 7)

The Managed Care Plan shall develop and maintain an annual network development and management plan (the plan). The Managed Care Plan shall submit this plan annually to the Agency. In general, the Managed Care Plan's annual network development and management plan must include the Managed Care Plan's processes to develop, maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.

1. The plan must include the process the Managed Care Plan utilizes to ensure that covered services are:
 - a. Available and accessible, at a minimum, in accordance with the access standards in the Contract;
 - b. Provided promptly and are reasonably accessible in terms of location and hours of operation;
2. The plan must also include a description or explanation of the following:
 - a. Evaluation of the prior year's plan including reference to the success of proposed interventions and/or the need for re-evaluation.
 - b. Current status of the network by each covered service at all levels including:
 - (1) How enrollees access services;
 - (2) Analysis of timely access to services; and
 - (3) Relationships between the various levels, focusing on provider-to-provider contact and facilitation of such by the Managed Care Plan (e.g., PCP, specialists, hospitals, behavioral health, ALFs, home health agencies).
3. The methodology used to identify barriers and network gaps and any current barriers and/or network gaps.
 - a. Immediate short-term interventions to address network gaps.
 - b. Longer-term interventions to fill network gaps and resolve barriers.
 - c. Outcome measures/evaluation of interventions to fill network gaps and resolve barriers.
 - d. Projection of changes in future capacity needs, by covered service.
 - e. Ongoing activities for network development based on identified gaps and future needs projection.

- f. Coordination between internal departments, including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (e.g., quality management, medical management/utilization management, grievances, finance, claims) that they represent on the committee.
- g. Coordination with outside organizations.
- h. A description of network design by region and county for the general population, including details regarding special populations as identified by the Managed Care Plan (e.g., medically complex). The description shall also cover:
 - (1) How enrollees access the system;
 - (2) Analysis of timely access to services; and
 - (3) Relationships among various levels of the system.
- i. The methodology(ies) the Managed Care Plan uses to collect and analyze enrollee, provider and staff feedback about the network designs and performance, and, when specific issues are identified, the protocols for handling them.

D. Regional Network Changes (See Attachment II, Core Contract Provisions, Exhibit 7)

1. The Managed Care Plan shall provide the Agency with documentation of compliance with access requirements at any time there has been a significant change in the Managed Care Plan's regional operations that would affect adequate capacity and services, including, but not limited to, the following:
 - a. Changes in Managed Care Plan services; and
 - b. Enrollment of a new population in the Managed Care Plan.
2. The Managed Care Plan shall notify the Agency within seven (7) business days of any significant changes to its regional network. A significant change is defined as:
 - a. Adverse changes to the composition of the network that impair, deny or can reasonably be foreseen to negatively impact, adequate access to providers;
 - b. Any change that would cause more than five percent (5%) of enrollees in the region to change the location where services are received or rendered;
3. The Managed Care Plan shall have procedures to address changes in the Managed Care Plan network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network. Significant changes in regional network composition that negatively impact enrollee access to services may be grounds for Contract termination or sanctions as determined by the Agency and in accordance with Attachment II, Core Contract Provisions, Section XIV, Sanctions.

4. If an enrollee is receiving prior authorized care from any provider who becomes unavailable to continue to provide services, the Managed Care Plan shall notify the enrollee in writing within ten (10) calendar days from the date the Managed Care Plan becomes aware of such unavailability. These requirements to provide notice prior to the effective dates of termination shall be waived in instances where a provider becomes physically unable to care for enrollees due to illness, death or leaving the Managed Care Plan's region(s) and fails to notify the Managed Care Plan, or when a provider fails credentialing. Under these circumstances, notice shall be issued immediately upon the Managed Care Plan's becoming aware of the circumstances.
5. The Managed Care Plan shall notify the Agency of any new participating providers by Wednesday 5 p.m. EST on a weekly basis following execution of the provider agreement and terminated providers by Wednesday 5 p.m. EST on a weekly basis following the termination effective date using the format provided in the MMA or LTC Report Guide (as applicable) referenced in Attachment II, Core Contract Provisions, Exhibit 12, Reporting Requirements, Summary of Reporting Requirements Table.

E. Provider Contract Requirements (See Attachment II, Core Contract Provisions, Exhibit 7)

1. The Managed Care Plan shall comply with all Agency procedures for provider contract review and approval submission.
 - a. All provider contracts must comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.
 - b. If the Managed Care Plan is capitated, it shall ensure that all providers are eligible for participation in the Medicaid program. If a provider is currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. If the Managed Care Plan is not capitated, its providers shall be enrolled as Florida Medicaid providers. Suspension and termination are described further in Rule 59G-9.070, F.A.C.
 - c. The Managed Care Plan shall not pay, employ or contract with individuals on the state or federal exclusions lists.
 - d. No provider contract that the Managed Care Plan enters into with respect to performance under this Contract shall in any way relieve the Managed Care Plan of any responsibility for the provision of services or duties under this Contract. The Managed Care Plan shall assure that all services and tasks related to the provider contract are performed in accordance with the terms of this Contract. The Managed Care Plan shall identify in its provider contract any aspect of service that may be subcontracted by the provider.
2. All provider contracts and amendments executed by the Managed Care Plan shall be in writing, signed and dated by the Managed Care Plan and the provider, and shall meet the following requirements:

- a. Prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of this Contract;
 - (1) Require the provider to look solely to the Managed Care Plan for compensation for services rendered, with the exception of nominal cost sharing and patient responsibility, pursuant to the Medicaid State Plan and the Medicaid Provider General and Coverage and Limitations Handbooks:
 - i. If a capitated Managed Care Plan, then to the capitated Managed Care Plan for compensation;
 - ii. If a FFS MMA or LTC Plan, then to the Agency or its Agent, unless the service is a transportation service for which the Managed Care Plan receives a capitation payment from the Agency. For such capitated transportation services, the Managed Care Plan shall require providers to look solely to the Managed Care Plan;
- b. Specify that any claims payment be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to: the enrollee's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of the Managed Care Plan;
- c. Specify that any contracts, agreements or subcontracts entered into by the provider for purposes of carrying out any aspect of this Contract shall include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of this Contract;
- d. Require the provider to cooperate with the Managed Care Plan's peer review, grievance, QI and UM activities, provide for monitoring and oversight, including monitoring of services rendered to enrollees, by the Managed Care Plan (or its subcontractor), and identify the measures that will be used by the Managed Care Plan to monitor the quality and performance of the provider. If the Managed Care Plan has delegated the credentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Managed Care Plan's and the Agency's credentialing requirements as found in Attachment II, Core Contract Provisions, Section VII, Provider Network, Item H., Credentialing and Recredentialing;
- e. Include provisions for the immediate transfer to another provider if the enrollee's health or safety is in jeopardy;
- f. Not prohibit a provider from discussing treatment or non-treatment options with enrollees that may not reflect the Managed Care Plan's position or may not be covered by the Managed Care Plan;
- g. Not prohibit a provider from acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee for the enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;

- h. Not prohibit a provider from advocating on behalf of the enrollee in any grievance system or UM process, or individual authorization process to obtain necessary services;
- i. Provide for continuity of treatment in the event a provider contract terminates during the course of an enrollee's treatment by that provider;
- j. Prohibit discrimination with respect to participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of such license or certification. This provision shall not be construed as an any willing provider law, as it does not prohibit the Managed Care Plan from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision does not interfere with measures established by the Managed Care Plan that are designed to maintain quality and control costs;
- k. Prohibit discrimination against providers serving high-risk populations or those that specialize in conditions requiring costly treatments;
- l. Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Managed Care Plan;
- m. Require that records be maintained for a period not less than six (6) years from the close of the Contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the provider contract is continuous;
- n. Specify that DHHS, the Agency, DOEA, MPI and MFCU shall have the right to inspect, evaluate, and audit all of the following related to this Contract:
 - (1) Pertinent books,
 - (2) Financial records,
 - (3) Medical/case records, and
 - (4) Documents, papers and records of any provider involving financial transactions;
- o. Specify covered services and populations to be served under the provider contract;
- p. Require that providers comply with the Managed Care Plan's cultural competency plan;
- q. Require that any community outreach materials related to this Contract that are displayed by the provider be submitted to the Agency for written approval before use;

- r. Provide for submission of all reports and clinical information required by the Managed Care Plan, including Child Health Check-Up reporting (if applicable);
- s. Require providers of transitioning enrollees to cooperate in all respects with providers of other managed care plans to assure maximum health outcomes for enrollees;
- t. Require providers to submit notice of withdrawal from the network at least ninety (90) calendar days before the effective date of such withdrawal;
- u. Require all providers to notify the Managed Care Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida statutes;
- v. Require providers to offer hours of operation that are no less than the hours of operation offered to commercial Managed Care Plan members or comparable Medicaid fee-for-service recipients if the provider serves only Medicaid recipients;
- w. Require safeguarding of information about enrollees according to 42 CFR 438.224;
- x. Require compliance with HIPAA privacy and security provisions;
- y. Require an exculpatory clause, which survives provider agreement termination, including breach of provider contract due to insolvency, which assures that neither Medicaid recipients nor the Agency shall be held liable for any debts of the provider;
- z. Require that the provider secure and maintain during the life of the provider contract workers' compensation insurance (complying with the Florida workers' compensation law) for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Managed Care Plan;
- aa. Make provisions for a waiver of those terms of the provider contract that, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract;
- bb. Contain no provision that in any way prohibits or restricts the provider from entering into a commercial contract with any other Managed Care Plan (see s. 641.315, F.S.);
- cc. Contain no provision requiring the provider to contract for more than one (1) Managed Care Plan product or otherwise be excluded (see s. 641.315, F.S.);
- dd. Require providers to cooperate fully in any investigation by the Agency, MPI, MFCU or other state or federal entity and in any subsequent legal action that may result from such an investigation involving this Contract;
- ee. Require providers to submit timely, complete and accurate encounter data to the Managed Care Plan in accordance with the requirements of Attachment II, Core

Contract Provisions, Section X, Administration and Management, Item D., Encounter Data;

- ff. Contain a clause indemnifying, defending and holding the Agency and the Managed Care Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the provider agreement. This clause must survive the termination of the agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Managed Care Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers shall be approved in writing by the Agency;
- gg. Require providers to immediately notify the Managed Care Plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims or otherwise;
- hh. Require all direct service providers to complete abuse, neglect and exploitation training;
 - ii. Require compliance with the background screening requirements of this Contract;
- jj. For nursing facility and hospice, include a bed hold days provision that comports with Medicaid FFS bed hold days policies and procedures;
- kk. Specify that in addition to any other right to terminate the provider contract, and notwithstanding any other provision of this Contract, the Agency or the Managed Care Plan may request immediate termination of a provider contract if, as determined by the Agency, a provider fails to abide by the terms and conditions of the provider contract, or in the sole discretion of the Agency, the provider fails to come into compliance with the provider contract within fifteen (15) calendar days after receipt of notice from the Managed Care Plan specifying such failure and requesting such provider abide by the terms and conditions thereof; and
- ll. Specify that any provider whose participation is terminated pursuant to the provider contract for any reason shall utilize the applicable appeals procedures outlined in the provider contract. No additional or separate right of appeal to the Agency or the Managed Care Plan is created as a result of the Managed Care Plan's act of terminating, or decision to terminate, any provider under this Contract. Notwithstanding the termination of the provider contract with respect to any particular provider, this Contract shall remain in full force and effect with respect to all other providers.
- mm. Specify that the provider shall comply with the requirements of Section IV, B., of Attachment II, Core Contract Provisions of this Contract.

F. Provider Termination

1. The Managed Care Plan shall comply with all state and federal laws regarding provider termination.
2. The Managed Care Plan shall notify enrollees in accordance with the provisions of this Contract and state and federal law regarding provider termination.
3. In a case in which a patient's health is subject to imminent danger or a provider's ability to practice medicine or otherwise provide services is effectively impaired by an action by the Board of Medicine or other governmental agency, notice to both the provider and the Agency shall be immediate. The Managed Care Plan shall work cooperatively with the Agency to develop and implement a plan for transitioning enrollees to another provider.
4. The Managed Care Plan shall notify the provider, the Agency and enrollees in active care at least sixty (60) calendar days before the effective date of the suspension or termination of a provider from the network. If the termination was for "cause," the Managed Care Plan shall provide to the Agency the reasons for termination.

G. Appointment Waiting Times and Geographic Access Standards (See Attachment II, Core Contract Provisions, Exhibit 7)

H. Continuity of Care (See Attachment II, Core Contract Provisions, Exhibit 7)

1. Notwithstanding the provisions in this subsection, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.
2. For continued care under this subsection, the Managed Care Plan and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated contract.
3. The requirements set forth in this subsection shall not apply to providers who have been terminated from the Managed Care Plan for cause.

I. Credentialing and Recredentialing (See Attachment II, Core Contract Provisions, Exhibit 7)

1. The Managed Care Plan shall be responsible for the credentialing and recredentialing of its provider network.
2. The Managed Care Plan shall establish and verify credentialing and recredentialing criteria for all providers that, at a minimum, meet the Agency's Medicaid participation standards. The Agency's criteria include:
 - a. A copy of each provider's current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualifications as specified in Attachment II, Core Contract Provisions, Exhibit 7, Item I.7.;

- b. No revocation, moratorium or suspension of the provider's state license by the Agency or the Department of Health, if applicable;
 - c. A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program;
 - (1) The Managed Care Plan shall ensure providers referenced above submit fingerprints electronically following the process described on the Agency's Background Screening website. The Managed Care Plan shall verify Medicaid eligibility through the background screening system.
 - (2) The Managed Care Plan shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;
 - (3) Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening.
 - (4) Individuals listed in s. 409.907(8)(a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.
 - d. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106);
 - e. Evidence of the provider's professional liability claims history. The Adult Family Care Home provider type, which must meet the requirements set forth in Attachment II, Core Contract Provisions, Exhibit 7, Table 1, is not required to carry professional liability insurance and is therefore exempt from this requirement;
 - f. Any sanctions imposed on the provider by Medicare or Medicaid;
 - g. The provider's Medicaid ID number, Medicaid provider registration number or documentation of submission of the Medicaid provider registration form.
3. The Managed Care Plan's credentialing and recredentialing files must document the education, experience, prior training and ongoing service training for each staff member or provider rendering behavioral health services.
 4. The Managed Care Plan's credentialing and recredentialing policies and procedures shall be in writing and include the following:
 - a. Formal delegations and approvals of the credentialing process;
 - b. A designated credentialing committee;

- c. Identification of providers who fall under its scope of authority;
 - d. A process that provides for the verification of the credentialing and recredentialing criteria required under this Contract;
 - e. Approval of new providers and imposition of sanctions, termination, suspension and restrictions on existing providers;
 - f. Identification of quality deficiencies that result in the Managed Care Plan's restriction, suspension, termination or sanctioning of a provider.
- 5. The Managed Care Plan shall develop and implement an appeal procedure for providers against whom the Managed Care Plan has imposed sanctions, restrictions, suspensions and/or terminations.
 - 6. The Managed Care Plan must submit disclosures and notifications to the federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) and to MPI in accordance with s. 1128, s. 1156, and s. 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in Section X, E.,11., Fraud and Abuse Prevention, of this Contract.

J. Provider Services (See Attachment II, Core Contract Provisions, Exhibit 7)

1. General Provisions

- a. The Managed Care Plan shall provide sufficient information to all providers in order to operate in full compliance with this Contract and all applicable federal and state laws and regulations.
- b. The Managed Care Plan shall monitor provider compliance with Contract requirements and take corrective action when needed to ensure compliance.

2. Provider Handbooks

- a. The Managed Care Plan shall issue a provider handbook to all providers at the time the provider credentialing is complete. The Managed Care Plan may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the handbook from the Managed Care Plan's website. This notification shall also detail how the provider can request a hard copy from the Managed Care Plan at no charge. The Managed Care Plan shall keep all provider handbooks and bulletins up to date and in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding Managed Care Plan covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are met. At a minimum, the provider handbook shall include the following information:

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

- (2) Listing of covered services;
- (3) Emergency service responsibilities;
- (4) Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Managed Care Plan to file a provider complaint, including complaints about claims issues, and which individual(s) has authority to review a provider complaint;
- (5) Required procedural steps in the enrollee grievance process, including the address, telephone number and office hours of the grievance staff; the enrollee's right to request continuation of benefits while utilizing the grievance system; and information about the Beneficiary Assistance Program. The Managed Care Plan shall specify telephone numbers to call to present a complaint, grievance or appeal. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the Managed Care Plan without undue delays.
- (6) Agency medical necessity standards and practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
- (7) Provider or subcontractor responsibilities;
- (8) Requirements regarding background screening;
- (9) Information on identifying and reporting abuse, neglect and exploitation of enrollees;
- (10) Prior authorization and referral procedures, including required forms;
- (11) Medical/case records standards;
- (12) Claims submission protocols and standards, including instructions and all information required for a clean or complete claim;
- (13) Protocols for submitting encounter data;
- (14) A summary of the Managed Care Plan's cultural competency plan and how to get a full copy at no cost to the provider;
- (15) Information on the Managed Care Plan's quality enhancement programs;
- (16) Enrollee rights and responsibilities (see 42 CFR 438.100);
- (17) Information notifying providers that the Managed Care Plan is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including its enrollment broker contractor(s) as a participating provider of the Managed Care Plan and

that the provider's submission of encounter data is accepted by the Florida MMIS and/or the state's encounter data warehouse; and

(18) Requirements regarding community outreach activities and marketing prohibitions.

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

3. Education and Training

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

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

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

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

4. Toll-Free Provider Help Line

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

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

c. The help line shall be staffed twenty-four hours a day, seven days a week (24/7) to respond to prior authorization requests. This help line shall have staff to respond to provider questions in all other areas, including but not limited to the provider complaint system and provider responsibilities, between the hours of 8

a.m. and 7 p.m. in the provider's time zone, Monday through Friday, excluding state holidays.

- d. The Managed Care Plan's call center systems shall have the capability to track call management metrics identified in Attachment II, Core Contract Provisions, Section IV, Enrollee Services, Community Outreach and Marketing, Item A., General Provisions, sub-item 11., Toll-free Enrollee Help Line.
- e. The Managed Care Plan shall ensure that after regular business hours the provider services line (not the prior authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for an enrollee with an emergency or urgent medical condition. This requirement shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

5. Provider Complaint System

- a. The Managed Care Plan shall establish and maintain a provider complaint system that permits a provider to dispute the Managed Care Plan's policies, procedures, or any aspect of a Managed Care Plan's administrative functions, including proposed actions, claims, billing disputes, and service authorizations. The Managed Care Plan's process for provider complaints concerning claims issues shall be in accordance with s. 641.3155, F.S. Disputes between the Managed Care Plan and a provider may be resolved as described in s. 408.7057. See Attachment II, Core Contract Provisions, Section IX for information regarding complaints as part of the enrollee grievance process.
- b. The Managed Care Plan shall include its provider complaint system policies and procedures in its provider handbook as described above.
- c. The Managed Care Plan shall also distribute the provider complaint system policies and procedures, including claims issues, to out-of-network providers upon request. The Managed Care Plan may distribute a summary of these policies and procedures, if the summary includes information about how the provider may access the full policies and procedures on the Managed Care Plan's website. This summary shall also detail how the provider can request a hard copy from the Managed Care Plan at no charge.
- d. As a part of the provider complaint system, the Managed Care Plan shall:
 - (1) Have dedicated staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems;
 - (2) Identify a staff person specifically designated to receive and process provider complaints;

- (3) Allow providers forty-five (45) calendar days to file a written complaint for issues that are not about claims;
- (4) Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
- (5) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the Managed Care Plan's written policies and procedures;
- (6) Document why a complaint is unresolved after fifteen (15) calendar days of receipt and provide written notice of the status to the provider every fifteen (15) calendar days thereafter;
- (7) Resolve all complaints within ninety (90) calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution; and
- (8) Ensure that Managed Care Plan executives with the authority to require corrective action are involved in the provider complaint process.
 - a. The Managed Care Plan shall report provider complaints monthly to the Agency by the fifteenth (15th) calendar day of the month following the report month as specified in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements. The Managed Care Plan shall submit the report using the Provider Complaint Log template in accordance with the Report Guide.

K. Medical/Case Records Requirements

1. The Managed Care Plan shall ensure maintenance of medical/case records for each enrollee in accordance with this section and with 42 CFR 456. Medical/case records shall include the quality, quantity, appropriateness and timeliness of services performed under this Contract.
2. Confidentiality of Medical/Case Records
 - a. The Managed Care Plan shall have a policy to ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA);
 - b. The Managed Care Plan shall have a policy to ensure the confidentiality of medical/case records in accordance with 42 CFR, Part 431, Subpart F.

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Section VIII
Quality Management

A. Quality Improvement (See Attachment II, Core Contract Provisions, Exhibit 8)

1. General Requirements

- a. The Managed Care Plan shall have an ongoing quality improvement program (QI program) that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. (See 42 CFR 438.204 and 438.240.)
- b. The Managed Care Plan shall develop and submit to the Agency, a written quality improvement plan (QI plan) within thirty (30) calendar days from execution of the initial Contract and resubmit it annually by April 1st of each Contract year for written approval. The QI plan shall describe:
 - (1) The QI program and committee structure;
 - (2) Monitoring and evaluation of quality and appropriateness of care provided to enrollees including, but not limited to, review of quality of care and service concerns, grievances, enrollee rights, adverse events, patient safety and utilization review processes;
 - (3) Monitoring and evaluation of network quality including, but not limited to, credentialing and recredentialing processes;
 - (4) Performance improvement projects;
 - (5) Performance measurement;
 - (6) Problem resolution and improvement approach and strategy;
 - (7) Annual program evaluation; and
 - (8) Metrics for monitoring the quality and performance of participating providers related to their continued participation in the network.
- c. The Managed Care Plan's written policies and procedures shall address components of effective health management including, but not limited to: anticipation, identification, monitoring, measurement, evaluation of enrollee's health care needs and effective action to promote quality of care.
- d. The Managed Care Plan shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization and focus on improved outcome management achieving the highest level of success.

- e. The Managed Care Plan, through its QI plan, shall demonstrate specific interventions in its health management to better manage the care and promote healthier enrollee outcomes.
- f. The Managed Care Plan shall cooperate with the Agency and the external quality review organization (EQRO). The Agency will set methodology and standards for quality improvement (QI) with advice from the EQRO.
- g. Prior to implementation of the QI plan, the Agency shall review and approve the Managed Care Plan's QI plan.

2. Specific Required Components of the QI Program

- a. The Managed Care Plan's governing body shall oversee and evaluate the QI program. The role of the Managed Care Plan's governing body shall include providing strategic direction to the QI program, as well as ensuring the QI plan is incorporated into operations throughout the Managed Care Plan. The written QI plan shall clearly describe the mechanism within the Managed Care Plan for strategic direction from the governing body to be provided to the QI program and for the QI program committee to communicate with the governing body.
- b. The Managed Care Plan shall have a QI program committee. The Managed Care Plan's medical director shall either chair or co-chair the committee. Other committee representatives shall be selected to meet the needs of the Managed Care Plan but must include: 1) the quality director; 2) the grievance coordinator; 3) the care coordination/case management manager; 4) the utilization review manager; 5) the credentialing manager; 6) the risk manager/infection control nurse; 7) the advocate representative (the Managed Care Plan is encouraged to include an advocate representative on the QI program committee); and 8) provider representation (either through providers serving on the committee or through a provider liaison position, such as a representative from the network management department). Individual staff members may serve in multiple roles on the committee if they also serve in multiple positions within the Managed Care Plan. (See Attachment II, Core Contract Provisions Exhibit 8.) The committee shall meet no less than quarterly. Its responsibilities shall include the development and implementation of a written QI plan, which incorporates the strategic direction provided by the governing body.
- c. The QI plan shall contain the following components:
 - (1) The Managed Care Plan's guiding philosophy for quality management. The plan should identify any nationally recognized, standardized approach that is used (e.g., PDCA, Rapid Cycle Improvement, FOCUS-PDCA, Six Sigma). Selection of performance indicators and sources for benchmarking also shall be described;
 - (2) A description of the Managed Care Plan positions assigned to the QI program, including a description of why each position was chosen to serve on the committee and the roles each position is expected to fulfill. The resumes of QI

program committee members shall be made available upon the Agency's request;

- (3) Specific training about quality that will be provided by the Managed Care Plan to staff serving in the QI program. At a minimum, the training shall include protocols developed by CMS regarding quality. CMS protocols may be obtained from:

www.cms.hhs.gov/MedicaidManagCare

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

- (4) The role of its providers in giving input to the QI program, whether that is by membership on the committee, its sub-committees or other means;
- (5) A standard for how the Managed Care Plan shall assure that QI program activities take place throughout the Managed Care Plan and document results of QI program activities for reviewers. Protocols for assigning tasks to individual staff persons and selection of time standards for completion shall be included;
- (6) A description of methods for assessment of the quality and appropriateness of care provided to enrollees with timely resolution of problems and new or continued improvement activities addressing:
 - i. Service availability and accessibility;
 - ii. Quality of services;
 - iii. Network quality;
 - iv. Care planning and implementation;
 - v. Coordination and continuity of care;
 - vi. Member safety; and
 - vii. A standard describing the process the QI program will use to review and suggest new and/or improved QI activities.
- (7) The process for selecting and directing task forces, committees or other Managed Care Plan activities to review areas of concern in the provision of health care services to enrollees;
- (8) The process for selecting evaluation and study design procedures;
- (9) The process to report findings to appropriate executive authority, staff and departments within the Managed Care Plan as well as relevant stakeholders,

such as participating providers. The QI plan also shall include how this communication will be documented for Agency review;

- (10) The process to direct and analyze periodic review of enrollee service utilization patterns (including detection of under and over utilization of services);
 - (11) Monitoring and evaluation of non-clinical aspects of service with timely resolution of problems and improvement in processes;
 - (12) Description of the health management information systems that will be used to support the quality improvement program; and
 - (13) The process for annual QI program evaluation.
- d. The Managed Care Plan shall maintain minutes of all QI committee and sub-committee meetings and make the minutes available for Agency review on request. The minutes shall demonstrate resolution of items or be brought forward to the next meeting.
- e. The Managed Care Plan shall have a peer review process that results in:
- (1) Review of a provider's practice methods and patterns, morbidity/mortality rates, and all grievances filed against the provider relating to medical treatment;
 - (2) Evaluation of the appropriateness of care rendered by providers;
 - (3) Implementation of corrective action(s) when the Managed Care Plan deems it necessary to do so;
 - (4) Development of policy recommendations to maintain or enhance the quality of care provided to enrollees;
 - (5) Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider's medical/case records, adherence to standards generally accepted by a provider's peers and the process and outcome of a provider's care;
 - (6) Appointment of a peer review committee, as a sub-committee to the QI program committee, to review provider performance when appropriate. The medical director or a designee shall chair the peer review committee. Its membership shall be drawn from the provider network and include peers of the provider being reviewed;
 - (7) Receipt and review of all written and oral allegations of inappropriate or aberrant service by a provider; and
 - (8) Education of enrollees and Managed Care Plan staff about the peer review process, so that enrollees and the Managed Care Plan staff can notify the peer review authority of situations or problems relating to providers.

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3. Managed Care Plan QI Activities (**See Attachment II, Core Contract Provisions, Exhibit 8**)

a. The Managed Care Plan shall monitor, evaluate and improve the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees through peer review, performance improvement projects (PIP), medical/case record audits, performance measures, surveys and related activities.

b. PIPs — Annually, by January 1st of each Contract year, the Agency shall determine and notify the Managed Care Plan if there are changes in the number and types of PIPs the Managed Care Plan shall perform for the coming Contract year. The Managed Care Plan shall perform four (4) Agency-approved statewide performance improvement projects as specified in Exhibit 8. There must at least one (1) clinical PIP and one (1) non-clinical PIP per population.

(1) Each PIP shall include a sample size sufficient to produce a statistically significant result.

(2) All PIPs shall achieve, through ongoing measurements and intervention, significant improvement to the quality of care and service delivery, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at the ninety-five percent (95%) confidence level and must be sustained for a period of two (2) additional re-measurements. Measurement periods and methodologies shall be submitted to the Agency for approval before initiation of the PIP. PIPs that have successfully achieved sustained improvement, as approved by the Agency, shall be considered complete and shall not meet the requirement for one (1) of the four (4) PIPs, although the Managed Care Plan may wish to continue to monitor the performance indicator as part of its overall QI program. In this event, the Managed Care Plan shall select a new PIP and submit it to the Agency for approval.

(3) PIP Documentation

i. PIP Proposal

- Within ninety (90) calendar days after initial Contract execution, the Managed Care Plan shall submit to the Agency in writing, a proposal for each planned PIP.
- Each initial PIP proposal shall be submitted using the most recent version of the EQRO PIP validation form. Instructions for using the form to submit PIP proposals and updates may be obtained from the Agency.
- Activities 1 through 6 of the EQRO PIP validation form must be addressed in the PIP proposal.
- In the event the Managed Care Plan elects to modify a portion of the PIP proposal after initial Agency approval, a written request to do so must be submitted to the Agency.

- Annual PIP Submission
 - The Managed Care Plan shall submit ongoing PIPs annually by August 1st to the Agency for review and approval.
 - The Managed Care Plan shall update the EQRO PIP validation form in its annual submission to reflect the Managed Care Plan's progress. The Managed Care Plan is not required to transfer ongoing PIPs to a new, updated EQRO form.
 - The Managed Care Plan shall submit the Agency-approved EQRO PIP validation form to the EQRO upon its request for validation. The Managed Care Plan shall not make changes to the Agency-approved PIP being submitted to the EQRO unless expressly permitted and approved by the Agency in writing.
- (4) The Managed Care Plan's PIP methodology must comply with the most recent protocol set forth by CMS, Conducting Performance Improvement Projects, available from the websites listed in Item A., sub-item 2.c.(3), above.
- (5) Populations selected for study under the PIP shall be specific to this Contract and shall not include Medicaid recipients from other states, or enrollees from other lines of business. If the Managed Care Plan contracts with a separate entity for management of particular services, PIPs conducted by the separate entity shall not include enrollees for other managed care plans served by that entity.
- (6) The Managed Care Plan's PIPs shall be subject to review and validation by the EQRO. The Managed Care Plan shall comply with any recommendations for improvement requested by the EQRO, subject to approval by the Agency.
- c. Performance Measures (PMs) (See Attachment II, Core Contract Provisions, Exhibit 8)
- (1) The Managed Care Plan shall collect statewide data on enrollee PMs, as defined by the Agency and as specified in Exhibit 8, the MMA or LTC Report Guide (as applicable) and Performance Measures Specifications Manual.
- (2) The Agency may add or remove reporting requirements with sixty (60) days' advance notice.
- (3) By July 1st of each Contract year, the Managed Care Plan shall deliver to the Agency a report on performance measure data and a certification by a National Committee for Quality Assurance (NCQA) certified HEDIS auditor that the performance measure data reported for the previous calendar year are fairly and accurately presented. (See Attachment II, Core Contract Provisions, Section XII, Reporting.) The report shall be certified by the HEDIS auditor, and the auditor must certify the actual file submitted to the Agency. Extensions to the due date may be granted by the Agency for up to thirty (30) days and require a written request signed by the Managed Care Plan CEO or designee. The request must be received by the Agency before the report due date and the delay must be due to unforeseen and unforeseeable factors

beyond the Managed Care Plan's control. Extensions will not be granted on oral requests.

- (4) A report, certification or other information required for PM reporting is incomplete when it does not contain all data required by the Agency or when it contains inaccurate data. A report that is incomplete or contains inaccurate data shall be considered deficient and each instance shall be subject to administrative penalties pursuant to Attachment II, Core Contract Provisions, Section XIV, Sanctions. A report or certification is "false" if done or made with the knowledge, of the preparer or a superior of the preparer, that it contains data or information that is not true or not accurate. A report that contains an "NR" due to bias for any or all measures by the HEDIS auditor, or is "false," shall be considered deficient and will be subject to administrative penalties pursuant to Attachment II, Core Contract Provisions, Section XIV, Sanctions. The Agency may refer cases of inaccurate or "false" reports to its Bureau of Medicaid Program Integrity.
- (5) The Managed Care Plan shall meet Agency-specified performance targets for all PMs. For HEDIS and Agency-defined measures, the Agency will establish performance targets prior to execution of the Contract. The Agency may change these targets and/or change the timelines associated with meeting the targets. The Agency shall make these changes with sixty (60) days' advance notice to the Managed Care Plan.
- (6) If the Agency determines that the Managed Care Plan performance relative to the performance targets is not acceptable, the Agency may require the Managed Care Plan to submit a performance measure action plan (PMAP) within thirty (30) calendar days after the notice of the determination in the format prescribed by the Agency. If the Managed Care Plan fails to provide a PMAP within the time and format specified by the Agency or fails to adhere to its own PMAP, the Agency may sanction the Managed Care Plan in accordance with the provisions of Section XIV, Sanctions, of this attachment. The Managed Care Plan shall submit reports to the Agency on the progress of all PMAPs as specified in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements.
- (7) If the Agency-defined or HEDIS PMs indicate that the Managed Care Plan's performance is not acceptable, the Agency may sanction the Managed Care Plan in accordance with the provisions of Attachment II, Core Contract Provisions, Section XIV, Sanctions. When considering whether to impose specific sanctions, such as applying civil monetary penalties or limiting enrollment activities or automatic assignments, the Agency may consider the Managed Care Plan's cumulative performance on all quality and performance measures.
- (8) If the Managed Care Plan's performance on Agency-defined and HEDIS performance measures is not acceptable and the Plan's performance measure report is incomplete or contains inaccurate data, the Agency may sanction the Plan under paragraphs (4) and (7) of this section, in accordance with the provisions of Attachment II, Core Contract Provisions, Section XIV, Sanctions. Acceptable performance under paragraph (7) will be determined using the initial performance measure submission, due July 1st, with its corresponding attestation of accuracy and completeness. In the event that the Plan later determines the submission contained errors, the Agency may

consider using the updated data for public reporting purposes. In that instance, however, both paragraphs (4) and (7) will apply. Likewise, eligibility for incentives and/or pay-for-performance initiatives will be determined based on the initial submission unless subsequent submissions indicate that the July 1st submission had inflated performance ratings.

d. Satisfaction and Experience Surveys

- (1) Consumer Assessment of Healthcare Providers and Systems (CAHPS) — The Managed Care Plan shall contract with a qualified, Agency-approved vendor to conduct an annual CAHPS survey.
 - i. The Agency will specify the survey requirements including specific CAHPS survey, applicable supplemental item sets and Agency-defined survey items. Annually, by January 1st of each Contract year, the Agency shall determine and notify the Managed Care Plan if there are changes in survey requirements.
 - ii. Within ninety (90) calendar days after initial Contract execution, the Managed Care Plan shall submit to the Agency, in writing, a proposal for survey administration and reporting that includes identification of survey administrator and status of CAHPS survey vendor certification; sampling methodology; administration protocol; analysis plan; and reporting description.
 - iii. The Managed Care Plan shall provide the survey results to the Agency with an action plan to address the results of the CAHPS survey by July 1st of each Contract year.
- (2) Provider Satisfaction Survey — The Managed Care Plan shall conduct an annual Provider Satisfaction survey. The Managed Care Plan shall submit a provider satisfaction survey plan (including tool and methodology) to the Agency for written approval within ninety (90) days after initial Contract execution and annually thereafter. The Managed Care Plan shall conduct the survey by the end of the first year of this Contract. The results of the survey shall be reported to the Agency within four (4) months of the beginning of the second year of this Contract. The survey tool should utilize a four-point likert scale and shall include the following domains:
 - i. Provider relations and communication;
 - ii. Clinical management processes;
 - iii. Authorization processes including denials and appeals;
 - iv. Timeliness of claims payment and assistance with claims processing;
 - v. Complaint resolution process; and
 - i. Care coordination support.

e. Medical/Case Record Review (See Attachment II, Core Contract Provisions, Exhibit 8)

- (1) The Managed Care Plan shall establish and implement a mechanism to ensure provider records meet established medical/case record standards. If the Managed Care Plan is not yet fully accredited by a nationally recognized accrediting body, the Managed Care Plan shall establish processes for medical/case record review that meet or exceed nationally recognized accrediting body medical/case record review standards to ensure that enrollees are provided high quality health care that is documented according to established standards, including subparagraph (2) below and Exhibit 8.
- (2) The standards, which must include all medical/case record documentation requirements addressed in this Contract, must be distributed to all providers.

4. Provider-Specific Performance Monitoring

The Managed Care Plan shall monitor the quality and performance of each participating provider. At the beginning of the Contract period, each plan shall notify all its participating providers of the metrics used by the Managed Care Plan for evaluating the provider's performance and determining continued participation in the network (see s. 409.975(3), F.S.).

5. Cultural Competency Plan

- a. In accordance with 42 CFR 438.206, the Managed Care Plan shall have a comprehensive written cultural competency plan (CCP) describing the Managed Care Plan's program to ensure that services are provided in a culturally competent manner to all enrollees, including all services and settings and including those with limited English proficiency. The CCP must describe how providers, Managed Care Plan employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of the individual enrollees and protects and preserves the dignity of each. The CCP shall be updated annually and submitted to the Agency by June 1st for approval for implementation by September 1st of each Contract year.
- b. The Managed Care Plan may distribute a summary of the CCP to participating providers if the summary includes information about how the provider may access the full CCP on the website. This summary shall also detail how the provider can request a hard copy of the cultural competency plan from the Managed Care Plan at no charge to the provider.
- c. The Managed Care Plan shall complete an annual evaluation of the effectiveness of its CCP. This evaluation may include results from the CAHPS or other comparative member satisfaction surveys, outcomes for certain cultural groups, member grievances, member appeals, provider feedback and Managed Care Plan employee surveys. The Managed Care Plan shall track and trend any issues identified in the evaluation and shall implement interventions to improve the provision of services. A description of the evaluation, its results, the analysis of

the results and interventions to be implemented shall be described in the annual CCP submitted to the Agency.

6. EQRO Coordination Requirements

- a. The Managed Care Plan shall provide all information requested by the EQRO, including, but not limited to, quality outcomes concerning timeliness of, and enrollee access to, covered services.
- b. The Managed Care Plan shall cooperate with the EQRO during the external quality review activities, which may include independent medical/case record review.
- c. If the EQRO indicates the Managed Care Plan's performance is not acceptable, the Agency may require the Managed Care Plan to submit a CAP and may restrict the Managed Care Plan's enrollment activities.

7. Agency Annual Medical/Case Record Audit and Onsite Monitoring

- a. The Managed Care Plan shall furnish specific data requested in order for the Agency to conduct the medical/case record audit, including audit of enrollee plan of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under this Contract.
- b. If the medical/case record audit and/or other document audits indicate that quality of care is not acceptable within the terms of this Contract, the Managed Care Plan shall correct the problem immediately and may be required to submit a CAP to address the problem. The CAP shall be time limited based upon the nature of the deficiency. Regardless of a CAP, health and safety issues, and problems not corrected, shall result in the Agency sanctioning the Managed Care Plan, in accordance with the provisions of Attachment II, Core Contract Provisions, Section XIV, Sanctions, and may immediately terminate all enrollment activities and mandatory assignments, until the Managed Care Plan attains an acceptable level of quality of care as determined by the Agency.

8. Plan Incentives

The Agency may offer incentives to high-performing managed care plans. The Agency will notify the Managed Care Plan annually on or before December 31st of the incentives that will be offered for the following calendar year. Incentives may be awarded to all high-performing managed care plans or may be offered on a competitive basis. Incentives may include, but are not limited to, quality designations, quality awards, and enhanced auto-assignments. The Agency, at its discretion, may disqualify a Managed Care Plan for any reason the Agency deems appropriate including, but not limited to, Managed Care Plans that received a monetary sanction for performance measures or any other sanctionable offense. In accordance with s. 409.967(3)(g), F.S., as part of the achieved savings rebate process, a plan that exceeds Agency-defined quality measures in the reporting period may retain an additional one percent (1%) of revenue.

B. Utilization Management (UM)

1. General Requirements

- a. The UM program shall be consistent with 42 CFR Parts 438 and 456 (as applicable), reflected in a written Utilization Management Program Description and include, but not be limited to:
 - (1) Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;
 - (2) Reporting fraud and abuse information identified through the UM program to the Agency's MPI as described in Attachment II, Core Contract Provisions, Section X, Administration and Management, and referenced in 42 CFR 455.1(a)(1);
 - (3) A procedure for enrollees to obtain a second medical opinion at no expense to the enrollee and for the Managed Care Plan to authorize claims for such services in accordance with s. 641.51, F.S.;
 - (4) The Managed Care Plan shall ensure that applicable evidence-based criteria are utilized with consideration given to characteristics of the local delivery systems available for specific members as well as member-specific factors, such as member's age, co-morbidities, complications, progress in treatment, psychosocial situation and home environment;
 - (5) Protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; objective evidence-based criteria to support authorization decisions; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting provider when appropriate; hospital discharge planning; physician profiling; and a retrospective review, meeting the predefined criteria below. The Managed Care Plan shall be responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate.
 - i. The Managed Care Plan shall obtain written approval from the Agency for its service authorization protocols and any changes.
 - ii. The Managed Care Plan's service authorization systems shall provide the authorization number and effective dates for authorization to providers and non-participating providers.
 - iii. The Managed Care Plan's service authorization systems shall provide written confirmation of all denials, service limitations and reductions of authorization to providers (See 42 CFR 438.210(c)).
 - iv. The Managed Care Plan shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration or

scope that is less than requested, are made by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease (see 42 CFR 438.210(b)(3)).

- v. Managed care plans shall have automated authorization systems, as required in s. 409.967(c)3., F.S., and may not require paper authorization in addition as a condition for providing treatment.
 - vi. The Managed Care Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Managed Care Plan is not required to approve claims for which it has received no written documentation.
- b. The Managed Care Plan must provide that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.
2. Practice Guidelines (See Attachment II, Core Contract Provisions, Exhibit 8)
- a. The Managed Care Plan shall adopt practice guidelines that meet the following requirements:
 - (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field;
 - (2) Consider the needs of the enrollees;
 - (3) Are adopted in consultation with providers; and
 - (4) Are reviewed and updated periodically, as appropriate (see 42 CFR 438.236(b)).
 - b. The Managed Care Plan shall disseminate any revised practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
 - c. The Managed Care Plan shall ensure consistency with regard to all decisions relating to UM, enrollee education, covered services and other areas to which the practice guidelines apply.
3. Changes to Utilization Management Components

The Managed Care Plan shall provide no less than thirty (30) calendar days' written notice to the Agency before making any changes to the administration and/or management procedures and/or authorization, denial or review procedures, including any delegations, as described in this section.

- C. Transition of Care – LTC Plans Only (See Attachment II, Core Contract Provisions, Exhibit 8)**
- D. Caregiver Support and Disease Management Program – LTC Plans Only (See Attachment II, Core Contract Provisions, Exhibit 8)**
- E. Disease Management Program – MMA Plans Only (See Attachment II, Core Contract Provisions, Exhibit 8)**

Section IX Grievance System

A. Grievance System

1. General Requirements

- a. Federal law requires Medicaid managed care organizations to have internal grievance procedures under which Medicaid enrollees, or providers acting as authorized representatives, may challenge denial of coverage of, or payment for, medical assistance. The Managed Care Plan's grievance system shall comply with the requirements set forth in s. 641.511, F.S., if applicable, and with all applicable federal and state laws and regulations, including 42 CFR 431.200 and 42 CFR Part 438, Subpart F, "Grievance System".
- b. For purposes of this Contract, these procedures must include an opportunity to file a complaint, a grievance and/or an appeal and to seek a Medicaid Fair Hearing through DCF.
 - (1) The Managed Care Plan may elect to have all of its grievance and appeal issues subject to external review processes by an independent review organization.
 - (2) The Plan must notify the Agency in writing if it elects to have all its contracts subject to such external review. (See s. 408.7056, F.S.)
- c. The Managed Care Plan shall refer all enrollees and/or providers on behalf of the enrollee (whether participating or non-participating) who are dissatisfied with the Managed Care Plan or its activities to the Managed Care Plan's grievance/appeal coordinator for processing and documentation of the issue.
- d. The Managed Care Plan shall include all necessary procedural steps for filing complaints, grievances, appeals and requests for a Medicaid Fair Hearing in the enrollee handbook.
- e. Where applicable, the Managed Care Plan's grievance system must include information for enrollees on seeking a state level appeal through the Beneficiary Assistance Program.
- f. The Managed Care Plan shall provide information about the grievance system to all providers and subcontractors in the provider handbook when they enter into a contract.
- g. The Managed Care Plan must maintain a record of grievances and appeals and submit reports, as specified in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, to the Agency.
- h. The Managed Care Plan shall address, log, track and trend all complaints, regardless of the degree of seriousness or whether the enrollee or provider expressly requests filing the concern.

- (1) The Managed Care Plan shall report on complaints monthly as specified in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, to the Agency.
 - (2) The log of complaints that do not become grievances must include date, complainant and enrollee name(s), Medicaid ID number, nature of complaint, description of resolution and final disposition. The Managed Care Plan shall submit this report upon request of the Agency.
- i. The Managed Care Plan shall acknowledge in writing within five (5) business days of receipt of each grievance and appeal unless the enrollee requests an expedited resolution. The Managed Care Plan shall notify enrollees in their primary language of grievance and appeal resolutions.
 - j. The Managed Care Plan shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision making and that all decision makers are health care professionals with clinical expertise in treating the enrollee's condition when deciding the following:
 - (1) Appeal of denial based on lack of medical necessity;
 - (2) Grievance of denial of expedited resolution of an appeal; and
 - (3) Grievance or appeal involving clinical issues.
 - k. A Managed Care Plan that covers transportation services through a subcontractor shall ensure that the subcontractor meets the complaint and grievance system requirements for problems related to transportation services.

2. Types of Issues

- a. A complaint is the lowest level of challenge and provides the Managed Care Plan an opportunity to resolve a problem without it becoming a formal grievance. Complaints shall be resolved by close of business the day following receipt or be moved into the grievance system.
- b. A grievance expresses dissatisfaction about any matter other than an action.
- c. An action is any denial, limitation, reduction, suspension or termination of service, denial of payment, or failure to act in a timely manner.
- d. An appeal is a request for review of an action.

3. Notices

- a. The Managed Care Plan shall provide the enrollee with a written notice of action that includes the following:

- (1) The action the Managed Care Plan or its subcontractor has taken or intends to take;
 - (2) The reasons for the action;
 - (3) The enrollee or provider's right to file an appeal with the Managed Care Plan;
 - (4) The enrollee's right to request a Medicaid Fair Hearing;
 - (5) The procedures for exercising the rights specified in the notice;
 - (6) The circumstances under which expedited resolution is available and how to request it;
 - (7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances in which the enrollee must have to pay the cost of those benefits.
- b. The Managed Care Plan shall mail the notice as follows:
- (1) For termination, suspension or reduction of previously authorized Medicaid covered services no later than ten (10) calendar days before the action is to take effect. Certain exceptions apply under 42 CFR 431.213 and 214;
 - (2) For denial of payment, at the time of any action affecting the claim;
 - (3) For standard service authorization decisions that deny or limit services no more than fourteen (14) calendar days following the request for service or within three (3) business days following an expedited service request;
 - (4) If the Managed Care Plan extends the timeframe for a service authorization decision, in which case it shall:
 - i. Notify the enrollee of the reason for extending the timeframe and advising of the right to file a grievance if the enrollee disagrees with the extension of time;
 - ii. Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires;
 - iii. Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.
 - (5) For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse action;
 - (6) For expedited service authorization decisions within the timeframes specified.

4. Filing Grievances and Appeals

- a. A grievance may be filed orally or in writing within one (1) year of the occurrence.
- b. An appeal may be filed orally or in writing within thirty (30) calendar days of the enrollee's receipt of the notice of action and, except when expedited resolution is required, must be followed with a written notice within ten (10) calendar days of the oral filing. The date of oral notice shall constitute the date of receipt.
- c. The Managed Care Plan shall provide any reasonable help to the enrollee in completing forms and following the procedures for filing a grievance or appeal or requesting a Medicaid Fair Hearing. This includes interpreter services, toll-free calling, and TTY/TTD capability.
- d. The Managed Care Plan shall handle grievances and appeals as follows:
 - (1) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.
 - (2) Ensure the enrollee understands any time limits that may apply.
 - (3) Provide opportunity before and during the process for the enrollee or an authorized representative to examine the case file, including medical/case records, and any other material to be considered during the process.
 - (4) Consider as parties to the appeal the enrollee or an authorized representative or, if the enrollee is deceased, the legal representative of the estate.

5. Resolution and Notification

- a. The Managed Care Plan shall follow Agency guidelines in resolving grievances and appeals as expeditiously as possible, observing required timeframes and taking into account the enrollee's health condition.
- b. A grievance shall be reviewed and notice of results sent to the enrollee no later than ninety (90) calendar days from the date the Managed Care Plan receives it.
- c. For standard resolution, an appeal shall be heard and notice of results sent to the enrollee no later than forty-five (45) calendar days from the date the Managed Care Plan receives it.
- d. The timeframe for a grievance or appeal may be extended up to fourteen (14) calendar days if:
 - (1) The enrollee asks for an extension, or the Managed Care Plan documents that additional information is needed and the delay is in the enrollee's interest;
 - (2) If the timeframe is extended other than at the enrollee's request, the Managed Care Plan shall notify the enrollee within five (5) business days of the determination, in writing, of the reason for the delay.

- e. The Managed Care Plan shall complete the grievance process in time to accommodate an enrollee's disenrollment effective date, which can be no later than the first day of the second month after the filing of a request for disenrollment.
- f. The Managed Care Plan shall provide written notice of disposition of an appeal. In the case of an expedited appeal denial, the Managed Care Plan also shall provide oral notice by close of business on the day of disposition, and written notice within two (2) calendar days of the disposition.
- g. Content of notice — The written notice of resolution shall include:
 - (1) The results of the resolution process and the date it was completed;
 - (2) If not decided in the enrollee's favor, information on the right to request a Medicaid Fair Hearing and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request;
 - (3) If the Managed Care Plan does not have an independent external review organization for its grievance process, the right to appeal an adverse decision on an appeal to the Beneficiary Assistance Program (BAP), including how to initiate such a review and the following:
 - i. Before filing with the BAP, the enrollee must complete the Managed Care Plan's appeal process;
 - ii. The enrollee must submit the appeal to the BAP within one (1) year after receipt of the final decision letter from the Managed Care Plan;
 - iii. The BAP will not consider an enrollee appeal that has already been to a Medicaid Fair Hearing;

The address and toll-free telephone number for enrollee appeals to the BAP are:

Agency for Health Care Administration
Beneficiary Assistance Program
Building 1, MS #26
2727 Mahan Drive
Tallahassee, Florida 32308
(850) 412-4502
(888) 419-3456 (toll-free)

- h. (e) That the enrollee may have to pay for the cost of those benefits if the Medicaid Fair Hearing upholds the Managed Care Plan's action.

6. Expedited Appeals

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

- b. The Managed Care Plan shall resolve each expedited appeal and provide notice to the enrollee, as quickly as the enrollee's health condition requires, within state established timeframes not to exceed seventy-two (72) hours after the Managed Care Plan receives the appeal request, whether the appeal was made orally or in writing.
- c. The Managed Care Plan shall ensure that no punitive action is taken against a provider who requests or supports a request for an expedited appeal.
- d. If the Managed Care Plan denies the request for expedited appeal, it shall immediately transfer the appeal to the timeframe for standard resolution and so notify the enrollee.

7. Medicaid Fair Hearings (see 65-2.042-2.069, F.A.C.)

- a. An enrollee may seek a Medicaid Fair Hearing without having first exhausted the Managed Care Plan's grievance and appeal process.
- b. An enrollee who chooses to exhaust the Managed Care Plan's grievance and appeal process may still file for a Medicaid Fair Hearing within ninety (90) calendar days of receipt of the Managed Care Plan's notice of resolution.
- c. An enrollee who chooses to seek a Medicaid Fair Hearing without pursuing the Managed Care Plan's process must do so within ninety (90) days of receipt of the Managed Care Plan's notice of action.
- d. Parties to the Medicaid Fair Hearing include the Managed Care Plan as well as the enrollee, or that person's authorized representative.
- e. The addresses and phone numbers for Medicaid Fair Hearings at the local Medicaid Area Offices can be found at:

https://portal.flmmis.com/FLPublic/Provider_ContactUs/tabId/38/Default.aspx

8. Continuation of Benefits

- a. The Managed Care Plan shall continue the enrollee's benefits if:
 - (1) The enrollee or the enrollee's authorized representative files an appeal with the Managed Care Plan regarding the Managed Care Plan's decision:
 - i. Within ten (10) business days after the notice of the adverse action is mailed; or
 - ii. Within ten (10) business days after the intended effective date of the action, whichever is later.
 - (2) The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;

- (3) The services were ordered by an authorized provider;
 - (4) The original period covered by the original authorization has not expired; and
 - (5) The enrollee requests extension of benefits.
- b. If, at the enrollee's request, the Managed Care Plan continues or reinstates the benefits while the appeal is pending, benefits must continue until one (1) of the following occurs:
- (1) The enrollee withdraws the appeal;
 - (2) Ten (10) business days pass after the Managed Care Plan sends the enrollee the notice of resolution of the appeal against the enrollee, unless the enrollee within those ten (10) days has requested a Medicaid Fair Hearing with continuation of benefits;
 - (3) The Medicaid Fair Hearing office issues a hearing decision adverse to the enrollee; or
 - (4) The time period or service limits of a previously authorized service have been met.
- c. If the final resolution of the appeal is adverse to the enrollee and the Managed Care Plan's action is upheld, the Managed Care Plan may recover the cost of services furnished to the enrollee while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.
- d. If the Medicaid Fair Hearing officer reverses the Managed Care Plan's action and services were not furnished while the appeal was pending, the Managed Care Plan shall authorize or provide the disputed services promptly.
- e. If the Medicaid Fair Hearing officer reverses the Managed Care Plan's action and the enrollee received the disputed services while the appeal was pending, the Managed Care Plan shall pay for those services in accordance with this Contract.

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Section X Administration and Management

A. General Provisions

1. The Managed Care Plan's governing body shall set forth policy and has overall responsibility for the organization of the Managed Care Plan.
2. The Managed Care Plan shall be responsible for the administration and management of all aspects of this Contract, including, but not limited to, delivery of services, provider network, provider education, claims resolution and assistance, and all subcontracts, employees, agents and services performed by anyone acting for or on behalf of the Managed Care Plan.
3. The Managed Care Plan shall have a centralized executive administration, which shall serve as the contact point for the Agency, except as otherwise specified in this Contract.
4. The Managed Care Plan must ensure adequate staffing and information systems capability to ensure the Managed Care Plan can appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter data or other information required by the Agency.

B. Staffing

The Managed Care Plan shall educate its staff about its policies and procedures and all applicable provisions of this Contract, including advance directives, situations in which advance directives may be of benefit to enrollees, and their responsibility to educate enrollees about this tool and assist them in making use of it.

1. **Minimum Staffing Requirements** — The positions described below represent the minimum management staff required for the Managed Care Plan. The Managed Care Plan shall report changes in the staff positions indicated below with one asterisk, within five (5) working days of the changes in staffing, to the Agency.
 - a. **Contract Manager***: The Managed Care Plan shall designate a Contract Manager to work directly with the Agency. The Contract Manager shall be a full-time employee of the Managed Care Plan with 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 the Contract. The Contract Manager cannot be designated to any other position in this section, including in other lines of business within the Managed Care Plan. The Managed Care Plan shall meet in person, or by telephone, at the request of Agency representatives to discuss the status of the Contract, Managed Care Plan performance, benefits to the state, necessary revisions, reviews, reports and planning. The Contract Manager shall be located in the State of Florida.
 - b. **Medical and Professional Support Staff**: (See Exhibit 10) The Managed Care Plan shall have medical and professional support staff sufficient to conduct daily business in an orderly manner, including having enrollee services staff directly available during

business hours for enrollee services consultation, as determined through management and medical reviews. The Managed Care Plan shall maintain sufficient medical staff, available 24/7, to handle emergency services and care inquiries.

- c. Medical Director*: The Medical Director shall be a full-time employee of the Managed Care Plan and shall be a physician with an active unencumbered Florida license in accordance with Chapter 458 or 459, F.S., and shall have experience providing services to the population served under this Contract. The Medical Director shall oversee and be responsible for the proper provision of covered services to enrollees, the quality management program and the grievance system. The Medical Director cannot be designated to serve in any other position; however, if the Managed Care Plan has both a long-term care Contract and a medical assistance Contract with the Agency, the Medical Director can serve both Contracts. Under that circumstance, the Medical Director must then have experience serving both long-term care and medical assistance populations.
- d. Medical/Case Records Review Coordinator: The Managed Care Plan shall have a designated person, qualified by training and experience, to ensure compliance with the medical/case records requirements as described in this Contract. The Medical/Case Records Review coordinator shall maintain medical/case record standards and direct medical/case record reviews according to the terms of this Contract.
- e. Data Processing and Data Reporting Coordinator*: The Managed Care Plan shall have a person trained and experienced in data processing, data reporting and claims resolution, as required, to ensure that computer system reports the Managed Care Plan provides to the Agency and its agents are accurate, and that computer systems operate in an accurate and timely manner.
- f. Community Outreach Oversight Coordinator: If the Managed Care Plan engages in community outreach, it shall have a designated person, qualified by training and experience, to ensure the Managed Care Plan adheres to the community outreach and marketing requirements of this Contract.
- g. QI Professional: The Managed Care Plan shall have a designated person, qualified by training and experience in QI and who holds the appropriate clinical certification and/or license.
- h. UM Professional*: The Managed Care Plan shall have a designated person, qualified by training and experience in UM and who holds the appropriate clinical certification and/or license.
- i. Grievance System Coordinator*: The Managed Care Plan shall have a designated person, qualified by training and experience, to process and resolve complaints, grievances and appeals and be responsible for the grievance system.
- j. Compliance Officer*: The Managed Care Plan shall have a designated full-time person qualified by training and experience in health care or risk management, to oversee the compliance program. The Compliance Officer shall also be qualified to oversee the plan's fraud and abuse program which is designed prevent and detect

fraud and abuse to pursuant to this Contract and state and federal law. If the Managed Care Plan has both a long-term care Contract and a medical assistance Contract with the Agency, the Compliance Officer can serve both Contracts.

- k. Care Coordination/Case Management Staff: The Managed Care Plan shall have sufficient care coordination/case management staff, qualified by training, experience and certification/licensure to conduct the Managed Care Plan's care coordination/case management functions. See Attachment II, Core Contract Provisions, Exhibit 5, Covered Services, Item I., Care Coordination/Case Management, for required case manager qualifications.
- l. Claims/Encounter Manager*: The Managed Care Plan shall have a designated person qualified by training and experience to oversee claims and encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness and completeness of processing payment and reporting.
- m. Fraud Investigative Unit (also known as Special Investigative Unit) Manager*: The Managed Care Plan shall have a designated person qualified by training and experience to oversee the special investigative unit for the investigation of possible fraud, abuse and overpayment and ensures mandatory reporting as required by this Contract, state and federal law.

C. Claims and Provider Payment (See Attachment II, Core Contract Provisions, Exhibits 10 and 13)

1. Claims

- a. Pursuant to s. 409.967(2)(i), F.S., the Managed Care Plan shall comply with ss. 641.315, 641.3155, and 641.513., F.S
- b. The Managed Care Plan shall have performance metrics, including those for quality, accuracy and timeliness, and include a process for measurement and monitoring, and for the development and implementation of interventions for improvement in regards to claims processing and claims payment. The Managed Care Plan shall keep documentation of the above and have these available for Agency review.
- c. The Managed Care Plan shall be able to accept electronically transmitted claims from providers in HIPAA compliant formats.
- d. For purposes of this subsection, electronic transmission of claims, transactions, notices, documents, forms and payments shall be used to the greatest extent possible by the Managed Care Plan and shall be HIPAA compliant.
- e. The Managed Care Plan shall ensure that claims are processed and comply with the federal and state requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.
- f. Pursuant to s. 409.967(2)(l), F.S., any claims payment to a provider by the Managed Care Plan must be accompanied by an itemized accounting of the

individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement and the identification of the Managed Care Plan.

- g. Pursuant to s. 409.967(2)(k), F.S., MMA and LTC PSNs must ensure that no entity licensed under Chapter 395, F.S., with a controlling interest in the PSN charges a Medicaid managed care plan more than the amount paid to that provider by the PSN for the same service.
- h. The Managed Care Plan is responsible for Medicare co-insurance and deductibles for covered long-term care services. The Plan shall reimburse providers or enrollees for Medicare deductibles and co-insurance payments made by the providers or enrollees, according to Medicaid guidelines referenced in the Florida Medicaid Provider General Handbook.
- i. The Managed Care Plan shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three (3) years.
- j. The Managed Care Plan shall have a process for handling and addressing the resolution of provider complaints concerning claims issues. The process shall be in compliance with s. 641.3155 F.S. Pursuant to s. 409.967(2)(m), F.S., disputes between the Managed Care Plan and a provider may be resolved as described in s. 408.7057, F.S.
- k. The Managed Care Plan shall not deny claims submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred sixty-five (365) days.
- l. Each quarter the Managed Care Plan shall submit an aging claims summary in accordance with Attachment II, Core Contract Provisions, Section XII, Reporting Requirements.
- m. The Managed Care Plan shall comply with the following requirements in conjunction with 1902(a)(13)(B) SSA:
 - (1) For Medicaid-only enrollees residing in a nursing facility and receiving hospice services, the Managed Care Plan shall pay the hospice provider the per diem rate set by the Agency for hospice services.
 - (2) For dually eligible enrollees residing in a nursing facility and receiving hospice services, the hospice provider shall bill Medicare for the per diem rate for hospice services.
 - (3) For both Medicaid-only and dually eligible enrollees residing in a nursing facility and receiving hospice services, the Managed Care Plan shall pay the hospice to cover the room and board costs of individuals who have elected

hospice and whose residence in a nursing facility would otherwise be covered by Medicaid.

2. Claims for Services for which Capitation is Received from the Agency

- a. The date of claim receipt is the date the Managed Care Plan receives the claim at its designated claims receipt location.
- b. The date of Managed Care Plan claim payment is the date of the check or other form of payment.
- c. For all electronically submitted claims for services, the Managed Care Plan shall:
 - (1) Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.
 - (2) Pursuant to s. 409.982(5), F.S., within ten (10) business days of receipt of nursing facility and hospice clean claims, pay or deny the claim.
 - (3) Within twenty (20) calendar days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
 - (4) Pay or deny the claim within ninety (90) calendar days after receipt of the non-nursing-facility/non-hospice claim. Failure to pay or deny the claim within one hundred twenty (120) calendar days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim. (See s. 641.3155, F.S.)
- d. For all non-electronically submitted claims for services, the Managed Care Plan shall:
 - (1) Within fifteen (15) calendar days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.
 - (2) Within forty (40) calendar days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
 - (3) Pay or deny the claim within one hundred twenty (120) calendar days after receipt of the claim. Failure to pay or deny the claim within one hundred forty (140) calendar days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim.

- e. The Managed Care Plan shall reimburse providers for the delivery of authorized services as described in s. 641.3155, F.S., including, but not limited to:
 - (1) The provider must mail or electronically transfer (submit) the claim to the Managed Care Plan within six (6) months after:
 - i. The date of service or discharge from an inpatient setting; or
 - ii. The date that the provider was furnished with the correct name and address of the Managed Care Plan.
 - (2) When the Managed Care Plan is the secondary payer, the provider must submit the claim to the Managed Care Plan within ninety (90) calendar days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook.

D. Encounter Data

1. Encounter data collection and submission is required from all capitated Managed Care Plans for all services rendered to their enrollees (excluding services paid directly by the Agency on a fee-for-service basis) and from all fee-for-service MMA and LTC PSNs for any transportation services capitated by the Agency. The Managed Care Plan shall submit encounter data that meets established Agency data quality standards as defined herein. These standards are defined by the Agency to ensure receipt of complete and accurate data for program administration and are closely monitored and enforced. The Agency will revise and amend these standards with sixty (60) calendar days' advance notice to the Managed Care Plan to ensure continuous quality improvement. The Managed Care Plan shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with Agency data quality standards as originally defined or subsequently amended.
2. The Managed Care Plan must be capable of sending and receiving any claims information directly to the Agency in standards and timeframes specified by the Agency within sixty (60) days' notice.
3. The Managed Care Plan must submit a Check Run Summary File for each provider payment adjudication cycle no later than seven (7) calendar days following each respective adjudication cycle and in a format specified by the Agency.
4. The Managed Care Plan must submit a Check Run Summary File reporting how total provider payment amounts reconcile with the encounter data submissions for each provider payment adjudication cycle. The Check Run Summary File must be submitted along with the encounter claims data submissions. The Check Run Summary file must be submitted in a format and in timeframes specified by the Agency.
5. For data acceptance purposes the Managed Care Plan must ensure the provider information it supplies to the Agency is sufficient to ensure providers are recognized in the Medicaid system (FMMIS) as either actively enrolled Medicaid providers or as Managed Care Plan registered providers. The Plan is responsible for ensuring

information is sufficient for accurate identification of participating network providers and non-participating providers who render services to Plan enrollees.

6. The encounter data submission standards required to support encounter data collection and submission are defined by the Agency in the Medicaid Companion Guides, Pharmacy Payer Specifications and this section. In addition, the Agency will post encounter data reporting requirements on the following website: <http://ahca.myflorida.com/Medicaid/meds/>
7. The Managed Care Plan shall adhere to the following requirements for the encounter data submission process:
 - a. For all non-pharmacy typical and atypical services, the Managed Care Plan shall submit encounter data no later than seven (7) calendar days following the date on which the Managed Care Plan adjudicated the claims.
 - b. Within thirty (30) calendar days after notice by the Agency or its fiscal agent of encounters failing X12 (EDI) edits or MMIS edits, the Managed Care Plan shall correct all encounters for which errors can be remedied.
 - c. The Managed Care Plan shall retain submitted historical encounter data for a period not less than six (6) years as specified in the Standard Contract, Section I., Item D., Retention of Records.
8. The Managed Care Plan shall have a comprehensive automated and integrated encounter data system capable of meeting the requirements below:
 - a. All Managed Care Plan encounters shall be submitted to the Agency in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P — Professional; I — Institutional; D — Dental), and, for pharmacy services, in the National Council for Prescription Drug Programs (NCPDP) format. Encounters must include Managed Care Plan paid amounts and shall be submitted for all providers (capitated and non-capitated).
 - b. The Managed Care Plan shall collect, and submit encounter data to the Agency's fiscal agent. The Managed Care Plan shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on their behalf.
 - c. The Managed Care Plan shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.
 - d. The Managed Care Plan shall provide complete and accurate encounter data to the Agency as defined below. The Managed Care Plan shall implement review procedures to validate encounter data submitted by providers.
 - (1) Complete: A Managed Care Plan submitting at least ninety-five percent (95%) of its encounter data. The Managed Care Plan shall strive to achieve a one-hundred percent (100%) complete submission rate.

- (2) Accurate (X12): Ninety-five percent (95%) of the records in a Managed Care Plan's encounter batch submission pass X12 EDI edits and MMIS edits as specified by the Agency.
 - (3) Accurate (NCPDP): Ninety-five percent (95%) of the records in a Managed Care Plan's encounter batch submission pass NCPDP edits and the pharmacy benefits system edits specified by the Agency. The NCPDP edits are described in the National Council for Prescription Drug Programs Telecommunications Standard Guides.
 - (4) The Managed Care Plan is responsible for correcting previously submitted X12 and NCPDP encounter data transactions to reflect the most current and accurate information within thirty (30) calendar days of any change such as recoupments and additional payments to providers.
9. The Managed Care Plan shall designate sufficient IT and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.
 10. Where a Managed Care Plan has entered into capitation reimbursement arrangements with providers, the Managed Care Plan shall comply with sub-item 4. of this section, above. The Managed Care Plan shall require timely submissions from its providers as a condition of the capitation payment.
 11. The Managed Care Plan shall participate in Agency-sponsored workgroups directed at continuous improvements in encounter data quality and operations.
 12. If the Managed Care Plan fails to comply with the encounter data reporting requirements of this Contract, the Agency may require the Managed Care Plan to submit a corrective action plan (CAP). Regardless of a CAP, the Agency shall apply sanctions in accordance with Attachment II, Core Contract Provisions, Section XIV, Sanctions.
 13. Encounter data submission timeframes specified in this section do not affect timeframes specified in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, for either pharmacy data encounter reporting, for risk adjustment, or behavioral health encounters (including pharmacy reporting).

E. Fraud and Abuse Prevention

1. The Managed Care Plan shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all state and federal program integrity requirements, including but not limited to, the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 74; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S., and 59A-12.0073, 59G and 69D-2, F.A.C.
2. The Managed Care Plan's compliance officer as described in Attachment II, Core Contract Provisions, Section X, Administration and Management, Item B., Minimum Staffing Requirements, sub-item 2.j., shall have unrestricted access to the Managed Care Plan's governing body for compliance reporting, including fraud and abuse and overpayment.

3. The Managed Care Plan shall have adequate staffing and resources to enable the compliance officer to investigate unusual incidents and develop and implement corrective action plans relating to fraud and abuse and overpayment.
 - a. The Managed Care Plan shall establish and maintain a fraud investigative unit to investigate possible acts of fraud, abuse or overpayment, or may subcontract such functions.
 - b. If a Managed Care Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Managed Care Plan shall file the following with the Bureau of Medicaid Program Integrity (MPI) for approval at least sixty (60) calendar days before subcontract execution:
 - (1) The names, addresses, telephone numbers, e-mail addresses and fax numbers of the principals of the entity with which the Managed Care Plan wishes to subcontract;
 - (2) A description of the qualifications of the principals of the entity with which the Managed Care Plan wishes to subcontract; and
 - (3) The proposed subcontract.
 - c. The Managed Care Plan shall submit to MPI such executed subcontracts, attachments, exhibits, addendums or amendments thereto, within thirty (30) calendar days after execution.
 - d. The Managed Care Plan shall notify MPI and provide a copy of any corporate integrity or corporate compliance agreements within thirty (30) calendar days after execution of such agreements.
 - e. The Managed Care Plan shall notify MPI and provide a copy of any corrective action plans required by the Department of Financial Services (DFS) and/or federal governmental entities, excluding AHCA, within thirty (30) calendar days after execution of such plans.
4. The Managed Care Plan's written fraud and abuse prevention program shall have internal controls and policies and procedures in place that are designed to prevent, reduce, detect, correct and report known or suspected fraud and abuse activities. This shall include reporting instances of fraud and abuse pursuant to Chapter 641, F.S., and s. 409.91212, F.S.
5. The Managed Care Plan shall submit its compliance plan, anti-fraud plan, and its fraud and abuse policies and procedures, or any changes to these items, to MPI for written approval at least forty-five (45) calendar days before those plans and procedures are implemented. (See s. 409.967(2)(f), F.S.)
 - a. At a minimum the compliance plan must include:

- (1) Written policies, procedures and standards of conduct that articulate the Managed Care Plan's commitment to comply with all applicable federal and state standards;
 - (2) The designation of a compliance officer and a compliance committee accountable to senior management;
 - (3) Effective training and education of the compliance officer and the Managed Care Plan's employees;
 - (4) Effective lines of communication between the compliance officer and the Managed Care Plan's employees;
 - (5) Enforcement of standards through well-publicized disciplinary guidelines;
 - (6) Provision for internal monitoring and auditing; and
 - (7) Provisions for prompt response to detected offenses and for development of corrective action initiatives.
- b. At a minimum, the Managed Care Plan shall submit its anti-fraud plan to MPI annually by September 1st. The anti-fraud plan shall comply with s. 409.91212, F.S., and, at a minimum, must include:
- (1) A written description or chart outlining the organizational arrangement of the Managed Care Plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse or fraud;
 - (2) A description of the Managed Care Plan's procedures for detecting and investigating possible acts of fraud, abuse and overpayment;
 - (3) A description of the Managed Care Plan's procedures for the mandatory reporting of possible overpayment, abuse or fraud to MPI;
 - (4) A description of the Managed Care Plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse and overpayment;
 - i. At a minimum, training shall be conducted within thirty (30) calendar days of new hire and annually thereafter;
 - ii. The Managed Care Plan shall have a methodology to verify training occurs as required; and
 - iii. The Managed Care Plan shall also include Deficit Reduction Act requirements in the training curriculum.
 - (5) The name, address, telephone number, e-mail address and fax number of the individual responsible for carrying out the anti-fraud plan; and

- (6) A summary of the results of the investigations of fraud, abuse, or overpayment which were conducted during the previous year by the Managed Care Plan's fraud investigative unit.
- c. At a minimum, the Managed Care Plan's compliance plan, anti-fraud plan, and fraud and abuse policies and procedures shall comply with s. 409.91212, F.S., and with the following:
- (1) Ensure that all officers, directors, managers and employees know and understand the provisions;
 - (2) Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. Nothing in this Contract shall require that the Managed Care Plan assure that non-participating providers are compliant with this Contract, but the Managed Care Plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected;
 - (3) Describe the Managed Care Plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols. Such internal investigational methodology and reporting protocols shall ensure the unit's primary purpose is for the investigation (or supervision of the investigation) of suspected insurance/Medicaid fraud and fraudulent claims;
 - (4) Incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including, but not limited to:
 - i. An effective pre-payment and post-payment review process, including but not limited to data analysis, claims and other system edits, and auditing of participating providers (see s. 409.967(2)(f), F.S.);
 - ii. A description of the method(s), including detailed policies and procedures, for verifying enrollees' identity and if services billed by providers were actually received. Such methods must be either the use of electronic verification or biometric technology but may also include sending enrollee explanations of Medicaid benefits (EOMB), contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses;
 - iii. Provider profiling, credentialing, and recredentialing, and ongoing provider monitoring including a review process for claims and encounters that shall include providers and non-participating providers who:
 - a) Demonstrate a pattern of submitting falsified encounter data or service reports;

- b) Demonstrate a pattern of overstated reports or up-coded levels of service;
 - c) Alter, falsify or destroy clinical record documentation;
 - d) Make false statements relating to credentials;
 - e) Misrepresent medical information to justify enrollee referrals;
 - f) Fail to render medically necessary covered services they are obligated to provide according to their provider contracts;
 - g) Charge enrollees for covered services; and
 - h) Bill for services not rendered.
 - iv. Prior authorization;
 - v. Utilization management;
 - vi. Subcontract and provider contract provisions;
 - vii. Provisions from the provider and the enrollee handbooks; and
 - viii. Standards for a code of conduct.
- (5) Contain provisions pursuant to this section for the confidential reporting of Managed Care Plan violations to MPI and other agencies as required by law;
- (6) Include provisions for the investigation and follow-up of any reports;
- (7) Ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud and abuse;
- (8) Require all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to: Managed Care Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under state and/or federal law be reported to MPI within fifteen (15) calendar days of detection. Additionally, any final resolution reached by the Managed Care Plan shall include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter;
- (9) Ensure that the Managed Care Plan and all providers and subcontractors, upon request and as required by state and/or federal law, shall:
- i. Make available to all authorized federal and state oversight agencies and their agents, including but not limited to, the Agency, the Florida Attorney General, and DFS any and all administrative, financial and medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended; and

- ii. Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to, the Agency, the Florida Attorney General, and DFS to any place of business and all medical/case records and data, as required by state and/or federal law. Access shall be during normal business hours, except under special circumstances when the Agency, the Florida Attorney General, and DFS shall have after-hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances.
- (10) Ensure that the Managed Care Plan shall cooperate fully in any investigation by federal and state oversight agencies and any subsequent legal action that may result from such an investigation;
- (11) Ensure that the Managed Care Plan does not retaliate against any individual who reports violations of the Managed Care Plan's fraud and abuse policies and procedures or suspected fraud and abuse;
- (12) Not knowingly have affiliations with individuals debarred or excluded by federal agencies under ss. 1128 and 1128A of the Social Security Act and 42 CFR 438.610 or subcontractors on the discriminatory vendor list maintained by the Department of Management Services in accordance with s. 287.134, F.S.;
- (13) On at least a monthly basis check current staff, subcontractors and providers against the federal List of Excluded Individuals and Entities (LEIE) and the federal Excluded Parties List System (EPLS) or their equivalent, to identify excluded parties. The Managed Care Plan shall also check the Agency's listing of suspended and terminated providers at the Agency website below, to ensure the Managed Care Plan does not include any non-Medicaid eligible providers in its network:

[http://apps.ahca.myflorida.com/dm_web/\(S\(xrohgczyhedzok1lg2bntiov\)\)/default.aspx](http://apps.ahca.myflorida.com/dm_web/(S(xrohgczyhedzok1lg2bntiov))/default.aspx).

The Managed Care Plan shall also conduct these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. The Managed Care Plan shall not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act;

- (14) Provide details and educate employees, subcontractors and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:
- i. The Federal False Claim Act;
 - ii. The penalties and administrative remedies for submitting false claims and statements;
 - iii. Whistleblower protections under federal and state law;

- iv. The entity's role in preventing and detecting fraud, waste and abuse;
- v. Each person's responsibility relating to detection and prevention; and
- vi. The toll-free state telephone numbers for reporting fraud and abuse.

(15) If the Managed Care Plan is approved to provide telemedicine, the Plan shall include a review of telemedicine in its fraud and abuse detection activities.

6. The Managed Care Plan shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI.
7. In accordance with s. 6032 of the federal Deficit Reduction Act of 2005, the Managed Care Plan shall make available written fraud and abuse policies to all employees. If the Managed Care Plan has an employee handbook, the Managed Care Plan shall include specific information about s. 6032, the Managed Care Plan's policies, and the rights of employees to be protected as whistleblowers.
8. The Managed Care Plan shall comply with all reporting requirements as set forth below; and in s. 409.91212, F.S., Attachment II, Core Contract Provisions, Section XII, Reporting Requirements; and the MMA or LTC Report Guide (as applicable).
 - a. The Managed Care Plan shall report on a quarterly basis a comprehensive fraud and abuse prevention activity report regarding its investigative, preventive and detective activity efforts.
 - b. The Managed Care Plan shall, by September 1st of each year, report to MPI its experience in implementing an anti-fraud plan, and on conducting or subcontracting for investigations of possible fraudulent or abusive acts during the prior state fiscal year. The report must include, at a minimum:
 - (1) The dollar amount of Managed Care Plan losses and recoveries attributable to overpayment, abuse and fraud; and
 - (2) The number of Managed Care Plan referrals to MPI.
9. The Managed Care Plan shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect and overpayment issues.
10. Notwithstanding any other provisions related to the imposition of sanctions or fines in this Contract, including any attachments, exhibits, addendums or amendments hereto, the following sanctions will be applied:
 - a. If the Managed Care Plan fails to timely submit an acceptable anti-fraud plan or fails to timely submit the annual report referenced in Section X, E., 8.b. of this Attachment, a sanction of \$2,000 per calendar day, from the date the report is due to the Agency, shall be imposed under this Contract until MPI deems the Managed Care Plan to be in compliance.

- b. If the Managed Care Plan fails to implement an anti-fraud plan or investigative unit, a sanction of \$10,000 shall be imposed under this Contract.
 - c. If the Managed Care plan fails to timely report, or report all required information for all suspected or confirmed instances of provider or recipient fraud or abuse within fifteen (15) calendars after detection to MPI, a sanction of \$1,000 per calendar day will be imposed under this Contract, until MPI deems the Managed Care Plan to be in compliance.
11. The Managed Care Plan shall notify DHHS OIG and MPI within ten (10) business days of discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per s. 1128, s. 1156, and s.1892 of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1.
- a. In accordance with 42 CFR 455.106, the Managed Care Plan shall disclose to DHHS OIG, with a copy to MPI within ten (10) business days after discovery, the identity of any person who:
 - (1) Has ownership or control interest in the Managed Care Plan, or is an agent or managing employee of the Managed Care Plan; and
 - (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XXI services program since the inception of those programs.
 - b. In addition to the disclosure required under 42 CFR 455.106, the Managed Care Plan shall also disclose to DHHS OIG with a copy to MPI within ten (10) business days after discovery, the identity of any person described in 42 CFR 1002.3 and 42 CFR 1001.1001(a)(1), and to the extent not already disclosed, to additionally disclose any person who:
 - (1) Has ownership or control interest in a Managed Care Plan participating provider, or subcontractor, or is an agent or managing employee of a Managed Care Plan participating provider or subcontractor; and
 - (2) Has been convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XXI services program since the inception of those programs;
 - (3) Has been denied initial entry into the Managed Care Plan's network for program integrity-related reasons; or
 - (4) Is a provider against whom the Managed Care Plan has taken any action to limit the ability of the provider to participate in the Managed Care Plan's provider network, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program or Managed Care Plan provider network to avoid a formal sanction.

- c. The Managed Care Plan shall submit the written notification referenced above to DHHS OIG via email to: floridaexclusions@oig.hhs.gov and copy MPI via email to: mpifo@ahca.myflorida.com. Document information examples include, but are not limited to, court records such as indictments, plea agreements, judgments and conviction/sentencing documents.
- d. In lieu of an e-mail notification, a hard copy notification is acceptable to DHHS OIG at:

Attention: Florida Exclusions
Office of the Inspector General
Office of Investigations
7175 Security Boulevard, Suite 210
Baltimore, MD 21244

With a copy to MPI at:

Attention: Florida Exclusions
Office of the Inspector General
Medicaid Program Integrity
2727 Mahan Drive, M.S. #6
Tallahassee, FL 32308-5403

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Section XI Information Management and Systems

A. General Provisions

1. **Systems Functions.** The Managed Care Plan shall have information management processes and information systems that enable it to meet Agency and federal reporting requirements, other Contract requirements, and all applicable Agency policies, state and federal laws, rules and regulations, including HIPAA.
2. **Systems Capacity.** The Managed Care Plan's system(s) shall possess capacity sufficient to handle the workload projected for the begin date of operations and will be scalable and flexible so to be adapted as needed, within negotiated timeframes, in response to changes in Contract requirements, increases in enrollment estimates, etc.
3. **E-Mail System.** The Managed Care Plan shall provide a continuously available electronic mail communication link (e-mail system) with the Agency. This system shall be:
 - a. Available from the workstations of the designated Managed Care Plan contacts; and
 - b. Capable of attaching and sending documents created using software products other than the Managed Care Plan's systems, including the Agency's currently installed version of Microsoft Office and any subsequent upgrades as adopted.
4. **Participation in Information Systems Work Groups/Committees.** The Managed Care Plan shall meet as requested by the Agency, to coordinate activities and develop cohesive systems strategies across vendors and agencies.
5. **Connectivity to the Agency/State Network and Systems.** The Managed Care Plan shall be responsible for establishing connectivity to the Agency's/state's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency and/or state policies, standards and guidelines.

B. Data and Document Management Requirements

1. **Adherence to Data and Document Management Standards**
 - a. The Managed Care Plan's systems shall conform to the standard transaction code sets specified in the Contract.
 - b. The Managed Care Plan's systems shall conform to HIPAA standards for data and document management.
 - c. The Managed Care Plan shall partner with the Agency in the management of standard transaction code sets specific to the Agency. Furthermore, the Managed Care Plan shall partner with the Agency in the development and implementation planning of future standard code sets not specific to HIPAA or other federal efforts and shall conform to these standards as stipulated in the plan to implement the standards.

2. Data Model and Accessibility. Managed Care Plan systems shall be structured query language (SQL) and/or open database connectivity (ODBC) compliant. Alternatively, the Managed Care Plan's systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain them.
3. Data and Document Relationships. The Managed Care Plan shall house indexed images of documents used by enrollees and providers to transact with the Managed Care Plan in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data.
4. Information Retention. Information in the Managed Care Plan's systems shall be maintained in electronic form for three (3) years in live systems and for six (6) years in live and/or archival systems, or longer for audits or litigation as specified elsewhere in this Contract.
5. Information Ownership. All information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract is owned by the Agency. The Managed Care Plan is expressly prohibited from sharing or publishing the Agency information and reports without the prior written consent of the Agency. In the event of a dispute regarding the sharing or publishing of information and reports, the Agency's decision on this matter shall be final and not subject to change.

C. System and Data Integration Requirements

1. Adherence to Standards for Data Exchange
 - a. The Managed Care Plan's systems shall be able to transmit, receive and process data in HIPAA-compliant formats that are in use as of the Contract execution date.
 - b. The Managed Care Plan's systems shall be able to transmit, receive and process data in the Agency-specific formats and/or methods that are in use on the Contract execution date.
 - c. The Managed Care Plan's systems shall conform to future federal and/or Agency-specific standards for data exchange within one-hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or the Agency. The Managed Care Plan shall partner with the Agency in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the Managed Care Plan shall conform to these standards as stipulated in the Agency agreed-upon plan to implement such standards.
2. HIPAA Compliance Checker

All HIPAA-conforming transactions between the Agency and the Managed Care Plan shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

3. Data and Report Validity and Completeness

The Managed Care Plan shall institute processes to ensure the validity and completeness of the data, including reports, it submits to the Agency. At its discretion, the Agency will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include, but are not limited to: enrollee ID, date of service, assigned Medicaid provider ID, category and subcategory (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and (if and when applicable) date of claim payment. Control totals shall also be reviewed and verified.

4. State/Agency Website/Portal Integration

Where deemed that the Managed Care Plan's web presence will be incorporated to any degree to the Agency's or the state's web presence (also known as a portal), the Managed Care Plan shall conform to any applicable Agency or state standard for website structure, coding and presentation.

5. Functional Redundancy with FMMIS

The Managed Care Plan's systems shall be able to transmit and receive transaction data to and from FMMIS as required for the appropriate processing of claims and any other transaction that could be performed by either system.

6. Data Exchange in Support of the Agency's Program Integrity and Compliance Functions

The Managed Care Plan's systems shall be capable of generating files in the prescribed formats for upload into Agency systems used specifically for program integrity and compliance purposes.

7. Address Standardization

The Managed Care Plan's system(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

8. Eligibility and Enrollment Data Exchange Requirements

- a. The Managed Care Plan shall receive, process and update enrollment files sent daily by the Agency or its agent.
- b. The Managed Care Plan shall update its eligibility/enrollment databases within twenty-four (24) hours after receipt of said files.
- c. The Managed Care Plan shall transmit to the Agency or its agent, in a periodicity schedule, format and data exchange method to be determined by the Agency, specific data it may garner from an enrollee including third party liability data.
- d. The Managed Care Plan shall be capable of uniquely identifying a distinct Medicaid recipient across multiple systems within its span of control.

D. Systems Availability, Performance and Problem Management Requirements

1. Availability of Critical Systems Functions

The Managed Care Plan shall ensure that critical systems functions available to enrollees and providers, functions that if unavailable would have an immediate detrimental impact on enrollees and providers, are available twenty-four hours a day, seven days a week (24/7), except during periods of scheduled system unavailability agreed upon by the Agency and the Managed Care Plan. Unavailability caused by events outside of a Managed Care Plan's span of control is outside the scope of this requirement. The Managed Care Plan shall make the Agency aware of the nature and availability of these functions prior to extending access to these functions to enrollees and/or providers.

2. Availability of Data Exchange Functions

The Managed Care Plan shall ensure that the systems and processes within its span of control associated with its data exchanges with the Agency and/or its agent(s) are available and operational according to specifications and the data exchange schedule.

3. Availability of Other Systems Functions

The Managed Care Plan shall ensure that at a minimum all other system functions and information is available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., in the time zone where the user is located, Monday through Friday.

4. Problem Notification

- a. Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the Managed Care Plan and the Agency and/or its agent(s), the Managed Care Plan shall notify the applicable Agency staff via phone, fax and/or electronic mail within one (1) hour of such discovery. In its notification, the Managed Care Plan shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes.
- b. The Managed Care Plan shall provide to appropriate Agency staff information on system unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

5. Recovery from Unscheduled System Unavailability

Unscheduled system unavailability caused by the failure of systems and telecommunications technologies within the Managed Care Plan's span of control will be resolved, and the restoration of services implemented, within forty-eight (48) hours of the official declaration of system unavailability.

6. Exceptions to System Availability Requirement

The Managed Care Plan shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Managed Care Plan's span of control.

7. Information Systems Corrective Action Plan

If at any point there is a problem with a critical systems function, at the request of the Agency, the Managed Care Plan shall provide to the Agency full written documentation that includes a corrective action plan (CAP) that describes how problems with critical systems functions will be prevented from occurring again. The CAP shall be delivered to the Agency within five (5) business days of the problem's occurrence. Failure to submit a CAP and to show progress in implementing the CAP shall make the Managed Care Plan subject to sanctions, in accordance with Attachment II, Core Contract Provisions, Section XIV, Sanctions.

8. Business Continuity-Disaster Recovery (BC-DR) Plan

- a. Regardless of the architecture of its systems, the Managed Care Plan shall develop, and be continually ready to invoke, a BC-DR plan that is reviewed and prior-approved by the Agency. If the approved plan is unchanged from the previous year, the Managed Care Plan shall submit a certification to the Agency that the prior year's plan is still in place annually by April 30th of each Contract year. Changes in the plan are due to the Agency within ten (10) business days after the change.
- b. At a minimum, the Managed Care Plan's BC-DR plan shall address the following scenarios: (1) the central computer installation and resident software are destroyed or damaged; (2) system interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage; (3) system interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of data maintained in a live or archival system; (4) system interruption or failure resulting from network, operating hardware, software or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability.
- c. The Managed Care Plan shall periodically, but no less than annually, by April 30th of each Contract year, perform comprehensive tests of its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the Agency that it can restore system functions per the standards outlined in the Contract.
- d. In the event that the Managed Care Plan fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Managed Care Plan shall be required to submit to the Agency a corrective action plan in accordance with Attachment II, Core Contract Provisions,

Section XIV, Sanctions, that describes how the failure will be resolved. The corrective action plan shall be delivered within ten (10) business days of the conclusion of the test.

E. System Testing and Change Management Requirements

1. Notification and Discussion of Potential System Changes

The Managed Care Plan shall notify the Agency of the following changes to systems within its span of control at least ninety (90) calendar days before the projected date of the change. If so directed by the Agency, the Managed Care Plan shall discuss the proposed change with the applicable Agency staff. This includes: (1) software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management; and (2) conversions of core transaction management systems.

2. Response to Agency Reports of Systems Problems not Resulting in System Unavailability

a. The Managed Care Plan shall respond to Agency reports of system problems not resulting in system unavailability according to the following timeframes:

- (1) Within seven (7) calendar days of receipt, the Managed Care Plan shall respond in writing to notices of system problems.
- (2) Within twenty (20) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.

b. The Managed Care Plan shall correct the deficiency by an effective date to be determined by the Agency.

3. Valid Window for Certain System Changes

Unless otherwise agreed to in advance by the Agency as part of the activities described in this section, scheduled system unavailability to perform system maintenance, repair and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.

4. Testing

a. The Managed Care Plan shall work with the Agency pertaining to any testing initiative as required by the Agency.

b. Upon the Agency's written request, the Managed Care Plan shall provide details of the test regions and environments of its core production information systems, including a live demonstration, to enable the Agency to corroborate the readiness of the Managed Care Plan's information systems.

F. Information Systems Documentation Requirements

1. Types of Documentation

The Managed Care Plan shall develop, prepare, print, maintain, produce and distribute distinct system process and procedure manuals, user manuals and quick-reference guides, and any updates thereafter, for the Agency and other applicable Agency staff.

2. Content of System Process and Procedure Manuals

The Managed Care Plan shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

3. Content of System User Manuals

The system user manuals shall contain information about, and instructions for, using applicable system functions and accessing applicable system data.

4. Changes to Manuals

- a. When a system change is subject to the Agency's written approval, the Managed Care Plan shall draft revisions to the appropriate manuals prior to Agency approval of the change.
- b. Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) business days of the update's taking effect.

5. Availability of/Access to Documentation

All of the aforementioned manuals and reference guides shall be available in printed form and/or online. If so prescribed, the manuals will be published in accordance with the appropriate Agency and/or state standard.

G. Reporting Requirements

The Managed Care Plan shall extract and upload data sets, upon request, to an Agency-hosted secure FTP site to enable authorized Agency personnel, or the Agency's agent, on a secure and read-only basis, to build and generate reports for management use. The Agency and the Managed Care Plan shall arrange technical specifications for each data set as required for completion of the request.

H. Community Health Record/Continuity of Care Document/Electronic Medical/Case Record and Related Efforts

1. At such times that the Agency requires, the Managed Care Plan shall participate and cooperate with the Agency to implement, within a reasonable timeframe, secure, web-accessible, community health records for enrollees.

2. The design of the vehicle(s) for accessing the community health record/continuity of care document, the health record format and design shall comply with all HIPAA and related regulations.

The Managed Care Plan shall also cooperate with the Agency in the continuing development of the state's health care data site (www.FloridaHealthFinder.com).

I. Compliance with Standard Coding Schemes

1. Compliance with HIPAA-Based Code Sets

Managed Care Plan systems that are required to or otherwise contain the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed:

- a. Logical Observation Identifiers Names and Codes (LOINC);
- b. Healthcare Common Procedure Coding System (HCPCS);
- c. Home Infusion EDI Coalition (HEIC) Product Codes;
- d. National Drug Code (NDC);
- e. National Council for Prescription Drug Programs (NCPDP);
- f. International Classification of Diseases (ICD);
- g. Diagnosis Related Group (DRG);
- h. Claim Adjustment Reason Codes (CARC); and
- i. Remittance Advice Remarks Codes (RARC).

2. Compliance with Other Code Sets

Managed Care Plan systems that are required to or otherwise contain the applicable data type shall conform to the following non-HIPAA-based standard code sets:

- a. As described in all Agency Medicaid reimbursement handbooks, for all "covered entities," as defined under HIPAA, and which submit transactions in paper format (non-electronic format).
- b. As described in all Agency Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

J. Data Exchange and Formats and Methods Applicable to Managed Care Plans

1. HIPAA-Based Formatting Standards

Managed Care Plan systems shall conform to the following HIPAA-compliant standards for Electronic Data Interchange (EDI) of health care data effective the first day of operations in the applicable region. The Managed Care Plan shall submit and receive transactions, ASC X12N or NCPDP (for certain pharmacy transactions), including claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits and premium payment. The implementation specifications for ASC X12N standards may be obtained from the Washington Publishing Company on the Internet at <http://www.wpc-edi.com/>. Florida specifications may be obtained on the Florida Medicaid provider portal at:

http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx

Transaction types include, but are not limited to:

- a. ASC X12N 820 Payroll Deducted & Other Premium Payment
- b. ASC X12N 834 Enrollment and Audit Transaction
- c. ASC X12N 835 Claims Payment Remittance Advice Transaction
- d. ASC X12N 837I Institutional Claim/Encounter Transaction
- e. ASC X12N 837P Professional Claim/Encounter Transaction
- f. ASC X12N 837D Dental Claim/Encounter Transaction
- g. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
- h. ASC X12N 276 Claims Status Inquiry
- i. ASC X12N 277 Claims Status Response
- j. ASC X12N 278/279 Utilization Review Inquiry/Response
- k. NCPDP D.0 Pharmacy Claim/Encounter Transaction

2. Methods for Data Exchange

- a. The Managed Care Plan and the Agency and/or its agent shall make predominant use of secure file transfer protocol (SFTP) and electronic data interchange (EDI) in their exchanges of data.
- b. The Managed Care Plan shall encourage network providers to participate in the Agency's Direct Secure Messaging (DSM) service when it is implemented.

3. Agency-Based Formatting Standards and Methods

Managed Care Plan systems shall exchange the following data with the Agency and/or its agent in formats specified by the Agency:

- a. Provider network data;
- b. Case management fees, if applicable; and
- c. Payments.

K. Social Networking (See Attachment II, Core Contract Provisions, Exhibit 11)

L. Smartphone Applications

If the Managed Care Plan uses smartphone applications (apps) to allow enrollees direct access to Agency-approved member materials, the Managed Care Plan shall comply with the following:

1. The smartphone application shall disclaim that the app being used is not private and that no PHI or personally identifying information should be published on this application by the Managed Care Plan or end user; and
2. The Managed Care Plan shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines; for example:
 - a. OWASP [Open Web Application Security Project] Secure Coding Principles — http://www.owasp.org/index.php/Secure_Coding_Principles;
 - b. CERT Security Coding - <http://www.cert.org/secure-coding/>; and
 - c. Top 10 Security Coding Practices —

<https://www.securecoding.cert.org/confluence/display/seccode/Top+10+Secure+Coding+Practices>

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Section XII Reporting Requirements

A. Managed Care Plan Reporting Requirements (See Attachment II, Core Contract Provisions, Exhibit 12)

1. The Managed Care Plan shall comply with all reporting requirements set forth in this Contract. Managed Care Plan reports are summarized in the Summary of Reporting Requirements Table in Attachment II, Core Contract Provisions, Exhibit 12.
 - a. The Managed Care Plan is responsible for assuring the accuracy, completeness and timely submission of each report.
 - b. The Managed Care Plan's chief executive officer (CEO), chief financial officer (CFO) or an individual who reports to the CEO or CFO and who has delegated authority to certify the Managed Care Plan's reports, shall attest, based on his/her best knowledge, information and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful and complete (see 42 CFR 438.606(a) and (b)).
 - c. The Managed Care Plan shall submit its certification at the same time it submits the certified data reports (see 42 CFR 438.606(c)). The certification page shall be scanned and submitted electronically.
 - d. Deadlines for report submission referred to in this Contract specify the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.
 - e. If a reporting due date falls on a weekend or state holiday, the report shall be due to the Agency on the following business day.
 - f. All reports filed on a quarterly basis shall be filed on a calendar year quarter.
2. The Managed Care Plan shall use the MMA or LTC Managed Care Plan Report Guide (MMA or LTC Report Guide), as applicable, in submitting required reports, including the report formats, templates, instructions, data specifications, submission timetables and locations, and other materials contained in the guide. The MMA and LTC Report Guides will be posted on the Agency's website. The Agency shall furnish the Managed Care Plan with appropriate technical assistance in using the MMA or LTC Report Guide (as applicable).
3. Unless otherwise specified, all reports are to be submitted electronically, as prescribed in the reporting guidelines.
4. The Agency reserves the right to modify the reporting requirements, with a ninety (90) calendar day notice to allow the Managed Care Plan to complete implementation, unless otherwise required by law.
5. The Agency shall provide the Managed Care Plan with written notification of any modifications to the reporting requirements.

6. If the Managed Care Plan fails to submit the required reports accurately or within the timeframes specified, the Agency shall fine or otherwise sanction the Managed Care Plan in accordance with Attachment II, Core Contract Provisions, Section XIV, Sanctions, and 59A-12.0073, F.A.C.
7. Reports are to be transmitted electronically or hard copy as indicated in the MMA or LTC Report Guide (as applicable). PHI information must be submitted to the Agency SFTP sites.

B. Other Managed Care Plan Submissions (See Attachment II, Core Contract Provisions, Exhibit 12)

The Managed Care Plan shall comply with all submission requirements set forth in this Contract. These requirements are summarized in the Summary of Submission Requirements Table in Attachment II, Core Contract Provisions, Exhibit 12.

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**Section XIII
Method of Payment**

See Attachment II, Core Contract Provisions, Exhibit 13

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Section XIV Sanctions

A. General Provisions

1. The Managed Care Plan shall comply with all requirements and performance standards set forth in this Contract.
 - a. In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Managed Care Plan pursuant to any of the following: s. 409.912 (21), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR part 438 subpart I (Sanctions) and s.1932 of the Social Security Act or s.1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to Section XVII.
 - b. For purposes of this section, violations involving individual, unrelated acts shall not be considered arising out of the same action.
 - c. In addition to imposing sanctions for a Contract violation or other non-compliance, the Agency may require the Managed Care Plan to submit to the Agency a performance measure action plan (PMAP) within a timeframe specified by the Agency. The Agency may also require the Managed Care Plan to submit a Corrective Action Plan (CAP) for a violation of or any other non-compliance with this Contract.
2. As allowed in Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item I., Disputes, the Managed Care Plan may appeal any notice of sanction to the Deputy Secretary for Medicaid (Deputy Secretary) but must do so within twenty-one (21) calendar days from receipt of the notice of sanction.
3. If the Agency imposes monetary sanctions, the Managed Care Plan must pay the monetary sanctions to the Agency within thirty (30) calendar days from receipt of the notice of sanction. If the Deputy Secretary determines that the Agency should reduce or eliminate the amount imposed, the Agency will return the appropriate amount to the Managed Care Plan within sixty (60) days from the date of a final decision rendered.

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

1. If a PMAP or CAP is required as determined by the Agency, the Agency will either approve or disapprove a proposed PMAP or CAP from the Managed Care Plan. If the Agency disapproves the PMAP or CAP, the Managed Care Plan shall submit a new PMAP or CAP within ten (10) business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency.
2. Upon receiving Agency approval of the CAP, the Managed Care Plan will implement the action steps set forth in the CAP within the timeframes specified by the Agency.
3. The Agency may impose a monetary sanction of \$200 per calendar day on the Managed Care Plan for each calendar day that the Managed Care Plan does not implement, to the satisfaction of the Agency, the approved PMAP or CAP. Managed Care Plans shall

receive a monetary sanction for measures for which their scores meet the thresholds reflected in Attachment II, Core Contract Provisions, Exhibit 14 for the second offense and subsequent offenses.

C. Other Sanctions (See Attachment II, Core Contract Provisions, Exhibit 14)

1. Pursuant to s. 409.967(2)(h)2., F.S., if the Managed Care Plan fails to comply with the encounter data reporting requirements as specified in this Contract for thirty (30) calendar days, the Agency shall assess the Managed Care Plan a fine of five thousand dollars (\$5,000) per day for each day of noncompliance beginning on the thirty-first (31st) calendar day. On the thirty-first (31st) calendar day, the Agency must notify the Managed Care Plan that the Agency will initiate Contract termination procedures on the ninetieth (90th) calendar day unless the Managed Care Plan comes into compliance before that date.
2. Fraud and Abuse – See Section X, Item E., sub-item 10.

D. Notice of Sanction

1. Except as noted in 42 CFR part 438, subpart I (Sanctions), before imposing any of the sanctions specified in this section, the Agency will give the Managed Care Plan written notice that explains the basis and nature of the sanction, cites the specific contract section(s) and/or provision of law and the methodology for calculation of any fine.
2. If the Agency decides to terminate the Managed Care Plan's Contract for cause, the Agency will provide advance written notice of intent to terminate including the reason for termination and the effective date of termination. The Agency will also notify Managed Care Plan enrollees of the termination along with information on their options for receiving services following Contract termination.
3. Unless the Agency specifies the duration of a sanction, a sanction will remain in effect until the Agency is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.
4. For non-risk Managed Care Plans, the Agency reserves the right to withhold all or a portion of the Managed Care Plan's monthly administrative allocation for any amount owed pursuant to this section.

E. Disputes

1. To dispute an Agency's interpretation of the Contract, the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute. The Managed Care Plan must submit, within twenty-one (21) calendar days after the issuance of a Contract Interpretation, a written dispute of the Contract Interpretation directly to the Deputy Secretary or designee; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation and exhibits). The Managed Care Plan waives any dispute not raised within twenty-one (21) calendar days of receiving the Contract Interpretation. It also waives any arguments it fails to raise in writing within twenty-one (21) calendar days of receiving a Contract Interpretation, and waives the right to use any

materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission submitted within the twenty-one (21) calendar days following its receipt of the Contract Interpretation in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

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

F. Performance Measure Sanctions (See Attachment II, Core Contract Provisions, Exhibit 14)

The Agency may sanction the Managed Care Plan for failure to achieve minimum performance scores on performance measures specified by the Agency after the first year of poor performance, as specified in Attachment II, Core Contract Provisions, Exhibit 14. The Agency will develop performance measures and may impose monetary sanctions for some or all of performance measures. The Agency will develop performance targets for each performance measure with a methodology for application of sanction specified by the Agency.

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**Section XV
Financial Requirements**

See Attachment II, Core Contract Provisions, Exhibit 15

A. Insolvency Protection — (See Attachment II, Core Contract Provisions, Exhibit 15)

B. Insolvency Protection Account Waiver

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

C. Surplus Start Up Account

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

D. Surplus Requirement (See Attachment II, Core Contract Provisions, Exhibit 15)

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

E. Interest

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

F. Inspection and Audit of Financial Records

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

a description of certain transactions with parties of interest as defined in s. 1318(b) of the Public Health Services Act.

G. Third Party Resources (See Attachment II, Core Contract Provisions, Exhibit 15)

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

H. Fidelity Bonds

The Managed Care Plan shall secure and maintain during the life of this Contract a blanket fidelity bond from a company doing business in the State of Florida on all personnel in its employment. The bond shall be issued in the amount of at least \$250,000 per occurrence. Said bond shall protect the Agency from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of the Managed Care Plan and subcontractors, if any. Proof of coverage shall be submitted to the Issuing Officer within sixty (60) calendar days after execution of the Contract and prior to the delivery of health care. To be acceptable to the Agency for fidelity bonds, a surety company shall comply with the provisions of Chapter 624, F.S.

I. Financial Reporting

1. The Managed Care Plan shall submit to the Agency an annual audited financial report and quarterly unaudited financial statements in accordance with Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, and the MMA and LTC Report Guides, as applicable.
2. The Managed Care Plan shall submit to the Agency the audited financial statements no later than three (3) calendar months after the end of the calendar year, and submit the quarterly statements no later than forty-five (45) calendar days after each calendar quarter and shall use generally accepted accounting principles in preparing the statements.
3. The Managed Care Plan shall submit annual and quarterly financial statements that are specific to the operations of the Managed Care Plan rather than to a parent or umbrella organization.

J. Patient Responsibility — LTC Plans Only (See Attachment II, Core Contract Provisions, Exhibit 15)

K. Performance Bond

A performance bond in the amount of \$1,000,000.00 shall be furnished to the Agency for each region in which the Managed Care Plan is awarded a contract. If the Managed Care Plan is awarded a contract in more than one (1) region, the Managed Care Plan shall furnish a single bond for the total amount (e.g., if the Managed Care Plan is awarded a contract in two (2) regions, the Managed Care Plan shall submit one (1) bond for \$2,000,000.00). The bond will be furnished to the Agency's Procurement Office, Building 2, MS#15, 2727 Mahan

Drive, Tallahassee, FL 32308, within thirty (30) calendar days after execution of this Contract and prior to commencement of any work under this Contract.

No payments will be made to the Managed Care Plan until the performance bond is in place and approved by the Agency in writing. The performance bond shall remain in effect for the full term of the Contract, including any extension. The Agency shall be named as the beneficiary of the Managed Care Plan's bond. The bond shall provide that the insurer or bonding company(s) shall pay losses suffered by the Agency due to termination directly to the Agency.

The cost of the performance bond will be borne by the Managed Care Plan.

Should the Managed Care Plan terminate the resulting contract prior to the end of the contract period or be terminated by the Agency (with cause), an assessment against the bond will be made by the Agency to cover the costs of issuing a new solicitation and selecting a new managed care plan. The Managed Care Plan agrees that the Agency's damages in the event of termination by the Managed Care Plan or the Agency shall be considered to be for the full amount of the bond allocated to the region for which the contract was terminated. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

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Section XVI Terms and Conditions

A. Agency Contract Management

1. The Agency) shall be responsible for management of the Contract. The Agency shall make all statewide policy decisions or Contract interpretation. In addition, the Agency shall be responsible for the interpretation of all federal and state laws, rules and regulations governing, or in any way affecting, this Contract. Contract management shall be conducted in good faith, with the best interest of the state and the Medicaid recipients it serves being the prime consideration. The Agency shall provide final interpretation of general Medicaid policy. When interpretations are required, the Managed Care Plan shall submit written requests to the Agency's Deputy Secretary for Medicaid.
2. The terms of this Contract do not limit or waive the ability, authority or obligation of the Office of Inspector General, MPI, its contractors, DOEA, or other duly constituted government units (state or federal) to audit or investigate matters related to, or arising out of this Contract.
3. The Contract shall be amended only as follows (unless specified elsewhere in this Contract):
 - a. The parties cannot amend or alter the terms of this Contract without a written amendment and/or change order to the Contract.
 - b. The Agency and the Managed Care Plan understand that any such written amendment to amend or alter the terms of this Contract shall be executed by an officer of each party, who is duly authorized to bind the Agency and the Managed Care Plan.
 - c. The Agency reserves the right to amend this Contract within the scope set forth in the procurement (to include original Contract and all attachments) in order to clarify requirements or if it is determined by the Agency that modifications are necessary to better serve or provide covered services to the eligible population.

B. Applicable Laws and Regulations

1. The Managed Care Plan shall comply with all applicable federal and state laws, rules and regulations including but not limited to: Title 42 CFR Chapter IV, Subchapter C; Title 45 CFR Part 74, General Grants Administration Requirements; Chapters 409 and 641, F.S.; all applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 USC 1857, et seq.); Title VI of the Civil Rights Act of 1964 (42 USC 2000d) in regard to persons served; Title IX of the education amendments of 1972 (regarding education programs and activities); 42 CFR 431, Subpart F; s. 409.907(3)(d), F.S., and Rule 59G-8.100 (24)(b), F.A.C. in regard to the Contractor safeguarding information about enrollees; Title VII of the Civil Rights Act of 1964 (42 USC 2000e) in regard to employees or applicants for employment; Rule 59G-8.100, F.A.C.; Section 504 of the Rehabilitation Act of 1973, as amended, 29 USC 794 (which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting

from federal financial assistance); the Age Discrimination Act of 1975, as amended, 42 USC 6101 et. seq. (which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance); the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance; Medicare - Medicaid Fraud and Abuse Act of 1978; the federal Omnibus Budget Reconciliation Acts; Americans with Disabilities Act (42 USC 12101, et seq.); the Newborns' and Mothers' Health Protection Act of 1996, the Balanced Budget Act of 1997, the Health Insurance Portability and Accountability Act of 1996; 45 CFR 74 relating to uniform administrative requirements; 45 CFR 92 providing for cooperative agreements with state, local and tribal governments; s. 508 of the Federal Water Pollution Control Act as amended (33 U.S.C. 1251, et seq); Executive Order 11738 as amended; where applicable, Environmental Protection Agency regulations 40.CFR 30; 2 CFR 215 and Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR 60 and 45 CFR 92, if applicable; the Pro-Children Act of 1994 (20 U.S.C. 6081; 2 CFR 180 and Executive Orders 12549 and 12689 "Debarment and Suspension; the Immigration and Nationality Act (8 U.S.C. 1324a); Immigration Reform and Control Act of 1986 (8 U.S.C. 1101); 2 CFR 175 relating to trafficking in persons; 2 CFR 170.110(b) relating to the Transparency Act; and 45 CFR 92.36(i)(10) regarding examination of records.

2. The Managed Care Plan is subject to any changes in federal and state law, rules or regulations and federal Centers for Medicare and Medicaid Services waivers applicable to this Contract and shall implement such changes in accordance with the required effective dates upon notice from the Agency without waiting for a Contract amendment.

C. Assignment

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

1. When a merger or acquisition of a Managed Care Plan has been approved, the Agency shall approve the assignment or transfer of the appropriate Medicaid Managed Care Plan Contract upon the request of the surviving entity of the merger or acquisition if the Managed Care Plan and the surviving entity have been in good standing with the Agency for the most recent twelve (12) month period, unless the Agency determines that the assignment or transfer would be detrimental to Medicaid recipients or the Medicaid program (see s. 409.912, F.S.). The entity requesting the assignment or transfer shall notify the Agency of the request ninety (90) calendar days before the anticipated effective date.
2. Entities regulated by the Department of Financial Services, Office of Insurance Regulation (OIR), must comply with provisions of s. 628.4615, F.S., and receive OIR approval before a merger or acquisition can occur.

3. For the purposes of this section, a merger or acquisition means a change in controlling interest of a Managed Care Plan, including an asset or stock purchase.
4. To be in good standing, a Managed Care Plan shall not have failed accreditation or committed any material violation of the requirements of s. 641.52, F.S., and shall meet the Medicaid Contract requirements.
5. The Managed Care Plan requesting the assignment or transfer of its enrollees and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, as required by the Agency and to ensure a seamless transition for enrollees, particularly those hospitalized, those requiring care coordination/case management and those with complex medication needs. The Managed Care Plan requesting assignment or transfer of its enrollees shall perform as follows:
 - a. Notice its enrollees, providers and subcontractors of the change in accordance with this Contract; and
 - b. Provide to the Agency the data needed, including encounter data, by the Agency to maintain existing case relationships.

The notice to enrollees shall contain the same information as required for a notice of termination according to Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item P., Termination Procedures.

D. Attorney's Fees

In the event of a dispute, each party to the Contract shall be responsible for its own attorneys' fees, except as otherwise provided by law.

E. Conflict of Interest

This Contract is subject to the provisions of Chapter 112, F.S. Within ten (10) business days of discovery, the Managed Care Plan shall disclose to the Agency within ten (10) business days of discovery the name of any officer, director or agent who is an employee of the State of Florida, or any of its agencies. Further, within this same timeframe, the Managed Care Plan shall disclose the name of any state employee who owns, directly or indirectly, an interest of five percent (5%) or more in the Managed Care Plan or any of its affiliates. The Managed Care Plan shall disclose the name of any Agency or DOEA employee who owns, directly or indirectly, an interest of one percent (1%) or more in the Managed Care Plan or any of its affiliates. The Managed Care Plan covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of the services hereunder. The Managed Care Plan further covenants that in the performance of the Contract, no person having any such known interest shall be employed. No official or employee of the Agency and no other public official of the State of Florida or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking of carrying out the Contract shall, prior to completion of this Contract, voluntarily acquire any personal interest, direct or indirect, in this Contract or proposed Contract.

F. Contract Variation

If any provision of the Contract (including items incorporated by reference) is declared or found by the Agency or the judiciary to be illegal, unenforceable or void, then both the Agency and the Managed Care Plan shall be relieved of all obligations arising under such provisions. If the remainder of the Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended and the Agency or the judiciary interpret the changes to render the fulfillment of the Contract impossible or economically infeasible, both the Agency and the Managed Care Plan shall be discharged from further obligations created under the terms of the Contract. However, such declaration or finding shall not affect any rights or obligations of either party to the extent that such rights or obligations arise from acts performed or events occurring prior to the effective date of such declaration or finding.

G. Court of Jurisdiction or Venue

For purposes of any legal action occurring as a result of, or under, this Contract, between the Managed Care Plan and the Agency, the place of proper venue shall be Leon County.

H. Damages for Failure to Meet Contract Requirements

In addition to remedies available through this Contract, in law or equity, the Managed Care Plan shall reimburse the Agency for any federal disallowances or sanctions imposed on the Agency as a result of the Managed Care Plan's failure.

I. Disputes

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

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

J. Force Majeure

The Agency shall not be liable for any excess cost to the Managed Care Plan if the Agency's failure to perform the Contract arises out of causes beyond the control and without the result of fault or negligence on the part of the Agency. In all cases, the failure to perform must be beyond the control without the fault or negligence of the Agency. The Managed Care Plan shall not be liable for performance of the duties and responsibilities of the Contract when its ability to perform is prevented by causes beyond its control. These acts must occur without the fault or negligence of the Managed Care Plan. These include destruction to the facilities due to hurricanes, fires, war, riots and other similar acts.

K. Legal Action Notification

The Managed Care Plan shall give the Agency, by certified mail, immediate written notification (no later than thirty (30) calendar days after service of process) of any action or suit filed or of any claim made against the Managed Care Plan by any subcontractor, vendor, or other party that results in litigation related to this Contract for disputes or damages exceeding the amount of \$50,000. In addition, the Managed Care Plan shall immediately advise the Agency of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor.

L. Licensing

In accordance with s. 409.962, F.S., the Managed Care Plan shall be one of the following:

1. A health insurer licensed in accordance with Chapter 624, F.S., that meets the requirements of a PSN (MMA only or an LTC PSN).
2. An exclusive provider organization (EPO) licensed in accordance with Chapter 627, F.S.
3. An HMO licensed in accordance with the provisions of Part I and Part III of Chapter 641, F.S.
4. A PSN (MMA only or an LTC PSN) that is licensed as, or contracts with, a licensed third party administrator (TPA) or health insurer in order to adjudicate claims. A PSN (MMA only or an LTC PSN) shall operate in accordance with s. 409.912(4)(d), and s. 409.962(13), F.S., and LTC PSNs shall operate in accordance with s. 409.962(8) and s. 409.981(1), F.S. PSNs (MMA only or LTC PSNs) are exempt from licensure under Chapter 641, F.S.; however, they shall be responsible for meeting certain standards in Chapter 641, F.S., as required in this Contract.

5. An Accountable Care Organization (ACO) that meets the requirements of an MMA or LTC PSN (as applicable depending on whether the ACO is contracting for the MMA or LTC component of the SMMC program).

M. Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or Managed Care Plan may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Medicaid," "Agency for Health Care Administration," or "Department of Elder Affairs," except as required in the Agency's Standard Contract, Section I., Item N., Sponsorship, unless prior written approval is obtained from the Agency. Specific written authorization from the Agency is required to reproduce, reprint, or distribute any Agency form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or Agency or DOEA terms does not provide a defense. Each piece of mail or information constitutes a violation.

N. Offer of Gratuities

By signing this agreement, the Managed Care Plan signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Florida, the Government Accountability Office, DHHS, CMS, or any other federal agency has or shall benefit financially or materially from this procurement. This Contract may be terminated by the Agency if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the state, its agents, or employees.

O. Subcontracts

The Managed Care Plan shall be responsible for all work performed under this Contract, but may, with the prior written approval of the Agency, enter into subcontracts for the performance of work required under this Contract.

1. All subcontracts must comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106. All subcontracts and amendments executed by the Managed Care Plan shall meet the following requirements:
 - a. If the Managed Care Plan is capitated, all subcontractors must be eligible for participation in the Medicaid program; however, the subcontractor is not required to participate in the Medicaid program as a provider. If the Managed Care plan is FFS, all health care subcontractors must be enrolled in the Medicaid program as a provider.
 - b. If a subcontractor was involuntarily terminated from the Medicaid program other than for purposes of inactivity, that entity is not considered an eligible subcontractor.
 - c. The Agency encourages use of minority business enterprise subcontractors. See Attachment II, Core Contract Provisions, Section VII, Provider Network, Item D., Provider Contract Requirements, for provisions and requirements specific to

provider contracts. See Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item W., Minority Recruitment and Retention Plan, for other minority recruitment and retention plan requirements.

- d. Subcontractors are subject to background checks. The Managed Care Plan shall consider the nature of the work a subcontractor or agent will perform in determining the level and scope of the background checks.
 - e. The Managed Care Plan shall document compliance certification (business-to-business) testing of transaction compliance with HIPAA for any subcontractor receiving enrollee data.
 - f. No subcontract that the Managed Care Plan enters into with respect to performance under the Contract shall, in any way, relieve the Managed Care Plan of any responsibility for the performance of duties under this Contract. The Managed Care Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract and shall provide the Agency with its monitoring schedule annually by December 1st of each Contract year. The Managed Care Plan shall identify in its subcontracts any aspect of service that may be further subcontracted by the subcontractor.
2. All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall be in writing, signed, and dated by the Managed Care Plan and the subcontractor and meet the following requirements:
- a. Identification of conditions and method of payment:
 - (1) The Managed Care Plan agrees to make payment to all subcontractors pursuant to all state and federal laws, rules and regulations, including s. 409.967, F.S., s. 409.975(6), F.S., s. 409.982, F.S., s. 641.3155, F.S., 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (5) and (6);
 - (2) Provide for prompt submission of information needed to make payment;
 - (3) Provide for full disclosure of the method and amount of compensation or other consideration to be received from the Managed Care Plan;
 - (4) Require any claims payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Managed Care Plan.
 - (5) Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Managed Care Plan;
 - (6) Specify that the subcontractor may not seek payment from a Medicaid Pending enrollee on behalf of the Managed Care Plan; and

- (7) Specify that the Managed Care Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with Attachment II, Core Contract Provisions, Section XV, Financial Requirements.
- b. Provisions for monitoring and inspections:
- (1) Provide that the Agency and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;
 - (2) Provide for inspections of any records pertinent to the Contract by the Agency and DHHS;
 - (3) In addition to record retention requirements for practitioner or provider licensure, require that records be maintained for a period not less than ten (10) years from the close of the Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the subcontract is continuous.);
 - (4) Provide for monitoring and oversight by the Managed Care Plan and the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the Managed Care Plan's and the Agency's credentialing requirements as found in Attachment II, Core Contract Provisions, Section VII, Provider Network, Item H., Credentialing and Recredentialing, if the Managed Care Plan has delegated the credentialing to a subcontractor; and
 - (5) Provide for monitoring of services rendered to Managed Care Plan enrollees through the subcontractor.
- c. Specification of functions of the subcontractor:
- (1) Identify the population covered by the subcontract;
 - (2) Provide for submission of all reports and clinical information required by the Managed Care Plan, including CHCUP reporting (if applicable); and
 - (3) Provide for the participation in any internal and external quality improvement, utilization review, peer review and grievance procedures established by the Managed Care Plan.
- d. Protective clauses:
- (1) Require safeguarding of information about enrollees according to 42 CFR, Part 438.224.
 - (2) Require compliance with HIPAA privacy and security provisions.

- (3) Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that Medicaid recipients or the Agency will not be held liable for any debts of the subcontractor.
- (4) If there is a Managed Care Plan physician incentive plan, include a statement that the Managed Care Plan shall make no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care;
- (5) Require full cooperation in any investigation by the Agency, MPI, MFCU, DOEA, or other state or federal entity or any subsequent legal action that may result from such an investigation;
- (6) Contain a clause indemnifying, defending and holding the Agency, its designees and the Managed Care Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency may waive this requirement for itself, but not Managed Care Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency;
- (7) Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Managed Care Plan. Such insurance shall comply with Florida's Workers' Compensation Law;
- (8) Specify that if the subcontractor delegates or subcontracts any functions of the Managed Care Plan, that the subcontract or delegation includes all the requirements of this Contract;
- (9) Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract;
- (10) Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate;
- (11) Provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the

individual or entity to deny, limit or discontinue medically necessary services to any enrollee; and

(12) Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:

- i. The False Claim Act;
- ii. The penalties for submitted false claims and statements;
- iii. Whistleblower protections; and
- iv. The law's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

e. In conjunction with the Standard Contract, Section III., Item B., Termination, all provider contracts and subcontracts shall contain termination procedures.

P. Termination Procedures

1. In conjunction with the Standard Contract, Section III, Item B., Termination, all provider contracts and subcontracts shall contain termination procedures. The Managed Care Plan agrees to extend the thirty (30) calendar day termination notice found in the Standard Contract, Section III., Item B.1., Termination at Will, to one-hundred eighty (180) calendar days' notice. Depending on the volume of Managed Care Plan enrollees affected, the Agency may require an extension of the termination date. Once the Agency receives the request for termination, the Agency will remove the Managed Care Plan from receipt of new voluntary enrollments, mandatory assignments and reinstatements going forward.

a. The Managed Care Plan will work with the Agency to create a transition plan that shall ensure the orderly and reasonable transfer of enrollee care and progress whether or not the enrollees are hospitalized, under care coordination/case management, and/or have complex medication needs. The Managed Care Plan shall perform as follows:

- (1) Notice its enrollees, providers and subcontractors of the change in accordance with this Contract; and
- (2) Provide to the Agency the data needed by the Agency to maintain existing case/care relationships.

b. The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination shall specify the nature of termination, the extent to which performance of work under the Contract is terminated, and the date on which such termination shall become effective. In accordance with s. 1932(e)(4), Social Security Act, the Agency shall provide the Managed Care Plan with an

opportunity for a hearing prior to termination for cause. This does not preclude the Agency from terminating without cause.

2. Upon receipt of final notice of termination, on the date and to the extent specified in the notice of termination, the Managed Care Plan shall:
 - a. Continue work under the Contract until the termination date unless otherwise required by the Agency;
 - b. Cease enrollment of new enrollees under the Contract;
 - c. Terminate all community outreach activities and subcontracts relating to community outreach;
 - d. Assign to the state those subcontracts as directed by the Agency's contracting officer including all the rights, title and interest of the Managed Care Plan for performance of those subcontracts;
 - e. In the event the Agency has terminated the Managed Care Plan's Medicaid participation in one region, complete the performance of this Contract in all other regions in which the Managed Care Plan's participation was not terminated;
 - f. Take such action as may be necessary, or as the Agency's contracting officer may direct, for the protection of property related to the Contract that is in the possession of the Managed Care Plan and in which the Agency has been granted or may acquire an interest;
 - g. Not accept any payment after the Contract ends, unless the payment is for the time period covered under the Contract. Any payments due under the terms of this Contract may be withheld until the Agency receives from the Managed Care Plan all written and properly executed documents as required by the written instructions of the Agency;
 - h. At least sixty (60) calendar days before the termination effective date, provide written notification to all enrollees of the following information: the date on which the Managed Care Plan will no longer participate in the state's Medicaid program and instructions on contacting the Agency's enrollment broker help line to obtain information on enrollment options and to request a change in managed care plans.
3. If the Managed Care Plan fails to disclose any business relationship, as defined in s. 409.966(3)(b), F.S., with another managed care plan in the same region during the procurement process, the Agency shall terminate this Contract and all other SMMC contracts with the Managed Care Plan.
4. In the event the Agency terminates the Managed Care Plan's participation in more than one region due to non-compliance with Contract requirements, the Agency shall also terminate all of the Managed Care Plan's participation in other regions by terminating this entire Contract, in accordance with s. 409.967(2)(h)3., F.S.

5. If the Managed Care Plan received an additional award pursuant to s. 409.966(3)(e), F.S., and is subject to penalties pursuant to s. 409.967(2)(h), F.S., for activities in Region 1 or Region 2, the additional awarded regions shall automatically be terminated from this Contract one-hundred eighty (180) days after the imposition of the penalties. The Managed Care Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities.
6. If the Managed Care Plan fails to meet regional plan readiness criteria by the Agency's specified monthly enrollment calculation date prior to the region becoming operational in SMMC, the Agency shall terminate the Managed Care Plan from participation in that region. In addition the following requirements apply to the Managed Care Plan:
 - a. If the Managed Care Plan received an additional award pursuant to s. 409.966(3)(e), F.S., and fails to meet plan readiness criteria in Region 1 or Region 2, the Agency shall terminate the additional awarded region(s) within one-hundred eighty (180) days after the respective Region 1 and/or Region 2 termination from the Contract.
 - b. If the Managed Care Plan has been terminated from participation in all regions of its Contract, the Agency shall terminate this entire Contract with thirty (30) calendar days' notice, as specified in the Standard Contract, Section III, Item B., Termination at Will.
7. If the FFS Managed Care Plan fails to convert from a FFS Managed Care Plan to a capitated managed care plan within the timeframes specified in Contract and required under s. 409.912(4)(d)1., F.S., the Agency shall terminate the Contract accordingly. See Attachment II, Core Contract Provisions-D, Section II, C., Responsibilities of the State of Florida (state), and D., General Responsibilities of the Managed Care Plan.
8. If the Managed Care Plan Contract is terminated by either the Managed Care Plan or the Agency (with cause) prior to the end of the Contract period, the Agency will assess the performance bond required under this Contract to cover the costs of issuing a solicitation and selecting a new Managed Care Plan. The Agency's damages in the event of termination shall be considered to be the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

Q. Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the Contract shall be waived except by written agreement of the parties, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity notwithstanding any such forbearance or indulgence.

R. Withdrawing Services from a Region

1. If the Managed Care Plan intends to withdraw services from a region, the Managed Care Plan shall provide the Agency with one-hundred eighty (180) calendar days' notice. Once the Agency receives the request for withdrawal, the Agency will remove the Managed Care Plan from receipt of new voluntary enrollments, mandatory assignments and reinstatements going forward.
2. The Managed Care Plan shall work with the Agency to develop a transition plan for enrollees, particularly those in the hospital, those under care coordination/case management and those with complex medication needs. The Managed Care Plan withdrawing from a Region shall perform as follows:
 - a. Notice its enrollees, providers and subcontractors of the change at least sixty (60) calendar days before the last day of service; and
 - b. Provide to the Agency the data, including encounter data, needed by the Agency to maintain existing case relationships.
3. The notice to enrollees shall contain the same information as required for a notice of termination according to Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item P., Termination Procedures.
4. If the Managed Care Plan withdraws from a region before the end of the term of this Contract, the Managed Care Plan shall pay the costs and penalties specified in s. 409.967(2)(h)1, F.S., and Attachment II, Core Contract Provisions, Section XIV, Sanctions, and the Contract through which the Managed Care Plan operates in any other region will be terminated in accordance with the termination procedures in s. 409.967(2)(h)3, F.S., Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item P., Termination Procedures, and Attachment II, Core Contract Provisions, Section XIV, Sanctions.

S. MyFloridaMarketPlace Vendor Registration

The Managed Care Plan is exempt under Rule 60A-1.030(3)d(ii), F.A.C., from being required to register in MyFloridaMarketPlace for this Contract.

T. MyFloridaMarketPlace Vendor Registration and Transaction Fee Exemption

The Managed Care Plan is exempt from paying the one percent (1%) transaction fee per 60A-1.032(1)(g), F.A.C., for this Contract.

U. Ownership and Management Disclosure

The Managed Care Plan shall fully disclose any business relationships, ownership, management and control of disclosing entities in accordance with state and federal law.

1. Pursuant to s. 409.966(3)(b), F.S., as part of the SMMC procurement, the Managed Care Plan was required to disclose any business relationship, as defined in s. 409.966(3)(b), F.S., that it had with any other eligible plan that responded to the

invitation to negotiate. If the Managed Care Plan failed to disclose a business relationship or is considering a business relationship with a managed care plan that has a contract with the Agency under the SMMC program, the Managed Care Plan shall immediately disclose such business relationship to the Agency within five (5) calendar days after discovery. The disclosure shall include but not be limited to: the identifying information for each managed care plan, the nature of the business relationship, the regions served by each managed care plan, and the signature of the authorized representative for each managed care plan.

2. Disclosure shall be made on forms prescribed by the Agency for the areas of ownership and control interest (42 CFR 455.104, Form CMS 1513); business transactions (42 CFR 455.105); conviction of crimes (42 CFR 455.106); public entity crimes (s. 287.133(3)(a), F.S.); and disbarment and suspension (52 Fed. Reg., pages 20360-20369, and Section 4707 of the Balanced Budget Act of 1997). The forms are available through the Agency and are to be submitted to the Agency by September 1st of each Contract year. In addition, the Managed Care Plan shall submit to the Agency full disclosure of ownership and control of the Managed Care Plan and any changes in management within five (5) calendar days of knowing the change will occur and at least sixty (60) calendar days before any change in the Managed Care Plan's ownership or control takes effect.
3. The following definitions apply to ownership disclosure:
 - a. A person with an ownership interest or control interest means a person or corporation that:
 - (1) Owns, indirectly or directly, five percent (5%) or more of the Managed Care Plan's capital or stock, or receives five percent (5%) or more of its profits;
 - (2) Has an interest in any mortgage, deed of trust, note or other obligation secured in whole or in part by the Managed Care Plan or by its property or assets and that interest is equal to or exceeds five percent of the total property or assets; or
 - (3) Is an officer or director of the Managed Care Plan, if organized as a corporation, or is a partner in the Managed Care Plan, if organized as a partnership.
 - b. The percentage of direct ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the Managed Care Plan's assets used to secure the obligation. Thus, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of the Managed Care Plan's assets, the person owns six percent (6%) of the Managed Care Plan.
 - c. The percent of indirect ownership or control is calculated by multiplying the percentage of ownership in each organization. Thus, if a person owns ten percent (10%) of the stock in a corporation, which owns eighty percent (80%) of the Managed Care Plan's stock, the person owns eight percent (8%) of the Managed Care Plan.

4. The following definitions apply to management disclosure:
 - a. Changes in management are defined as any change in the management control of the Managed Care Plan. Examples of such changes are those listed below and in Section X, Attachment II, Core Contract Provisions, or equivalent positions by another title.
 - b. Changes in the board of directors or officers of the Managed Care Plan, medical director, chief executive officer, administrator and chief financial officer.
 - c. Changes in the management of the Managed Care Plan where the Managed Care Plan has decided to contract out the operation of the Managed Care Plan to a management corporation. The Managed Care Plan shall disclose such changes in management control and provide a copy of the contract to the Agency for approval at least sixty (60) calendar days prior to the management contract start date.
5. By September 1st of each Contract Year, the Managed Care Plan shall conduct an annual background check with the Florida Department of Law Enforcement on all persons with five percent (5%) or more ownership interest in the Managed Care Plan, or who have executive management responsibility for the Managed Care Plan, or have the ability to exercise effective control of the Managed Care Plan (see ss. 409.912 and 435.04, F.S.).
 - a. The Managed Care Plan shall submit, prior to execution of this Contract, complete sets of fingerprints of principals of the Managed Care Plan to the Agency for the purpose of conducting a criminal history record check (see s. 409.907, F.S.).
 - b. Principals of the Managed Care Plan shall be as defined in s. 409.907, F.S.
 - c. The Managed Care Plan shall submit to the Agency Contract Manager complete sets of fingerprints of newly hired principals (officers, directors, agents, and managing employees) within thirty (30) calendar days of the hire date.
6. The Managed Care Plan shall submit to the Agency, within five (5) business days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Managed Care Plan who has been found guilty of, regardless of adjudication, or who entered a plea of *nolo contendere* or guilty to, any of the offenses listed in s. 435.04, F.S. The Managed Care Plan shall submit information to the Agency for such persons who have a record of illegal conduct according to the background check. The Managed Care Plan shall keep a record of all background checks to be available for Agency review upon request.
7. The Agency shall not contract with a Managed Care Plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Managed Care Plan, who has committed any of the above listed offenses (see ss. 409.912 and 435.04, F.S.). In order to avoid termination, pursuant to a timeline as determined by the Agency, the Managed Care Plan shall submit a corrective action plan, acceptable to the Agency, which ensures that such person is divested of all interest and/or control and has no role in the operation and/or management of the Managed Care Plan.

8. The Managed Care Plan shall submit to the Agency a quarterly report regarding current administrative subcontractors and affiliates, within fifteen (15) calendar days after the end of each quarter, using the format and according to the schedule provided in the MMA or LTC Report Guide (as applicable) and as referenced in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements.

V. Minority Recruitment and Retention Plan

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

W. Independent Provider

It is expressly agreed that the Managed Care Plan and any agents, officers, and/or employees of the Managed Care Plan or any subcontractors, in the performance of this Contract shall act in an independent capacity and not as officers, employees or agents of the Agency or the State of Florida. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Managed Care Plan or any subcontractor and the Agency and the State of Florida.

X. General Insurance Requirements

The Managed Care Plan shall obtain and maintain the same adequate insurance coverage including general liability insurance, professional liability and malpractice insurance, fire and property insurance, and directors' omission and error insurance. All insurance coverage for the Managed Care Plan must comply with the provisions set forth for HMOs in Rule 69O-191.069, F.A.C., excepting that the reporting, administrative and approval requirements shall be to the Agency rather than to the Department of Financial Services, Office of Insurance Regulation (OIR). All insurance policies must be written by insurers licensed to do business in the State of Florida and in good standing with OIR. All policy declaration pages must be submitted to the Agency annually upon renewal. Each certificate of insurance shall provide for notification to the Agency in the event of termination of the policy.

Y. Workers' Compensation Insurance

The Managed Care Plan shall secure and maintain during the life of the Contract, workers' compensation insurance for all of its employees connected with the work under this Contract. Such insurance shall comply with the Florida Workers' Compensation Law (see Chapter 440, F.S.). Policy declaration pages shall be submitted to the Agency annually upon renewal.

Z. State Ownership

The Agency shall have the right to use, disclose or duplicate all information and data developed, derived, documented or furnished by the Managed Care Plan resulting from this Contract. Nothing herein shall entitle the Agency to disclose to third parties data or information that would otherwise be protected from disclosure by state or federal law.

AA. Emergency Management Plan

Before beginning operations and annually by May 31st of each Contract year, the Managed Care Plan shall submit to the Agency for approval an emergency management plan specifying what actions the Managed Care Plan shall conduct to ensure the ongoing provision of covered services in a disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. If the emergency management plan is unchanged from the previous year, and was approved by the Agency, the Managed Care Plan shall submit a certification to the Agency that the prior year's plan is still in place.

BB. Indemnification (Standard Contract applies)

CC. Authority to Act

Any person executing this Contract or any documents, instruments or assurances, created, presented or reasonably necessary or appropriate to carry out the full intent and purpose of this Contract, in a representative capacity, hereby warrants to the Agency that it has implied, express or delegated authority to enter into, execute, attest or certify this Contract or aforementioned documents on behalf of such party which it represents. The Managed Care Plan shall not raise the fact that a person executing a document, instrument or assurance as set forth herein lacks authority to bind the Managed Care Plan for which it is representing as a defense to the enforcement of this Contract or other document executed in connection with this Contract.

DD. Proof of Execution by Electronic Copy or Facsimile

For purposes of executing this Contract or any documents, instruments and assurances created, presented or reasonably necessary or appropriate to carry out the full intent and purpose of this Contract, a document signed or electronically signed and transmitted by facsimile, e-mail or other form of electronic transmission is to be treated as an original document. The signature or electronic signature of any party thereon, for purposes hereof, is to be considered as an original signature, and the document transmitted is to be considered to have the same binding effect as an original signature on an original document. At the request of the Agency, any document transmitted by facsimile, telecopy, e-mail or other form of electronic transmission is to be executed in original form by the Managed Care Plan. The Managed Care Plan shall not raise the fact that any signature was transmitted through the use of a facsimile, e-mail or other form of electronic transmission as a defense to the enforcement of this Contract or other document executed in connection with this Contract.

EE. Remedies Cumulative

Except as otherwise expressly provided herein, all rights, powers and privileges conferred hereunder upon the Managed Care Plan are cumulative and not restrictive of those given by law. No remedy herein conferred is exclusive of any other available remedy; but each and every such remedy is cumulative and is in addition to every other remedy given by Contract or now or hereafter existing at law, in equity or by statute.

FF. Accreditation

Pursuant to s. 409.967(2)€3., F.S., the Managed Care Plan must be accredited by a nationally recognized accrediting body, or have initiated the accreditation process within one (1) year after this Contract was executed. If the Managed Care Plan is not accredited within eighteen (18) months after executing this Contract the Agency may terminate the Contract for failure to comply with the Contract. The Agency shall suspend all assignments until the Plan is accredited by a nationally recognized body.

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Section XVII Liquidated Damages

1. Damages

1. If the Managed Care Plan breaches this Contract, the Agency will be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Agency will impose liquidated damages in writing against the Managed Care Plan. In the event of a breach the Agency will assess liquidated damages against the Managed Care Plan regardless of whether the breach is the fault of the Managed Care Plan (including the Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach.
2. The liquidated damages prescribed in this section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the Agency's projected financial loss and damage resulting from the Managed Care Plan's nonperformance, including financial loss as a result of project delays. Accordingly, in the event the Managed Care Plan fails to perform in accordance with the Contract, the Agency may assess liquidated damages as provided in this section.
3. If the Managed Care Plan fails to perform any of the services described in the Contract, the Agency may assess liquidated damages for each occurrence listed in the below table in Item B., Issues and Amounts. Any liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) calendar days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. All interpretations of the Contract are handled by Deputy Secretary for Medicaid or his/her delegate.
4. The Agency may elect to collect liquidated damages:
 - a. Through direct assessment and demand for payment delivered to the Managed Care Plan; or
 - b. By deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Managed Care Plan or that become due at any time after assessment of the liquidated damages. The Agency will make deductions until it has collected the full amount payable by the Managed Care Plan.
5. The Managed Care Plan will not pass through liquidated damages imposed under this Contract to a provider and/or subcontractor, unless the provider and/or subcontractor caused the damage through its own action or inaction. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.
6. All liquidated damages imposed pursuant to this Contract, whether paid or due, shall be paid by the Managed Care Plan out of administrative costs and profits.

7. To dispute the imposition of liquidated damages under the Contract, the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid hear and decide the dispute. The Managed Care Plan must submit, within twenty-one (21) calendar days after the notice of the imposition of liquidated damages, a written dispute of the Contract Interpretation directly to the Deputy Secretary; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation and exhibits). The Managed Care Plan waives any dispute not raised within twenty-one (21) calendar days of receiving a notice of imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) calendar days of receiving a notice of the imposition of liquidated damages, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission submitted within the twenty-one (21) calendar days following its receipt of the notice of the imposition of liquidated damages in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).
8. The Deputy Secretary or his/her designee will decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Managed Care Plan. This written decision will be final.
9. The exclusive venue of any legal or equitable action that arises out of or relating to the Contract, including an appeal of the final decision of the Deputy Secretary or his/her designee, will be Circuit Court in Leon County, Florida; in any such action, the Managed Care Plan agrees that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Agency will notice the Managed Care Plan of the appropriate administrative remedy.
10. Issues and Amounts (**See Attachment II, Core Contract Provisions, Exhibit 18**)

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2013 – 2018 Long-Term Care Health Plan Model Contract

**ATTACHMENT II
EXHIBITS**

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ATTACHMENT II
EXHIBIT 1
Definitions and Acronyms — LTC Plans

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

N/A

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**ATTACHMENT II
EXHIBIT 2
General Overview — LTC Plans**

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Section II, General Overview, Item C., Responsibilities of the State of Florida (state)

21. The Department of Elder Affairs shall assist the Agency in determining clinical eligibility for enrollment in LTC plans, monitor LTC plan performance and measure quality of service delivery, assist enrollees and their families to address complaints with the LTC plans, facilitate working relationships between LTC plans and providers serving elders and adults with disabilities, and perform other functions specified in a memorandum of agreement between the Agency and DOEA.
22. Managed Care Plans shall contract with and maintain a provider network, as specified by the Contract, sufficient to meet the recipient enrollment levels, by region, as indicated in the Region Required Enrollment Levels, as specified in Attachment I, Scope of Services, Exhibit 2.
 - a. If the Managed Care Plan requests an increase in the regional enrollment level pursuant to Exhibit 2, General Overview, Item C., Responsibilities of the Managed Care Plan, sub-item 26., the Agency will review such request and approve it in writing if the Agency determines its regional provider network is sufficient to meet the increased enrollment level requested and the Managed Care Plan has satisfactorily performed the terms of the Contract, and the Agency has approved the Health Plan's administrative, financial and service resources, as specified in this Contract, in support of the requested enrollment level. If after an enrollment increase is approved by the Agency and a Managed Care Plan determines lower enrollment levels are desired, the Managed Care Plan may request an enrollment level decrease, as long as the decrease requested is not below the required enrollment levels for the region, as indicated in the Region Required Enrollment Levels as specified in Attachment I, Scope of Services, Exhibit 2.
 - b. The Agency does not guarantee that the Managed Care Plan will receive any particular enrollment level; however, the enrollment level may not be exceeded unless a plan-specific enrollment level increase has been approved by the Agency.

Section II, General Overview, Item D., Responsibilities of the Managed Care Plan

26. The Managed Care Plan shall contract with and maintain a provider network, as specified in this Contract, sufficient to meet the recipient enrollment levels, by region, as indicated in the table in Exhibit 2, General Overview, Item C., Responsibilities of the State of Florida (state), sub-item 22.
 - a. The Managed Care Plan may request a higher regional enrollment level, in writing, to the Agency; however, the Managed Care Plan must be able to serve the enrollment level requested (see Exhibit 2, General Overview, Item C.,

Responsibilities of the State of Florida (state), sub-item 22., for approval requirements).

- b. If the Agency has approved the Managed Care Plan's regional enrollment level increase, the Health Plan must then maintain a provider network, as specified in this Contract, sufficient to meet the increased recipient enrollment level, and this enrollment level shall become the Managed Care Plan's maximum enrollment level.

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ATTACHMENT II
EXHIBIT 3
Eligibility and Enrollment — LTC Plans

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Section III, Eligibility and Enrollment, Item A., Eligibility

The eligibility requirements listed below must be met in addition to those specified in Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment, unless otherwise noted below. Only recipients age eighteen (18) years or older who have been determined by CARES to meet the nursing facility level of care are eligible for the long-term care component of the SMMC program.

1. Mandatory Populations

- a. Eligible recipients age eighteen (18) or older in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:
 - (1) Temporary Assistance to Needy Families (TANF);
 - (2) SSI (Aged, Blind and Disabled);
 - (3) Institutional Care;
 - (4) Hospice;
 - (5) Aged/Disabled Adult waiver;
 - (6) Individuals who age out of Children's Medical Services and meet the following criteria for the Aged/Disabled Adult waiver:
 - i. Received care from Children's Medical Services prior to turning age 21;
 - ii. Age 21 and older;
 - iii. Cognitively intact;
 - iv. Medically complex; and
 - v. Technologically dependent.
 - (7) Assisted Living waiver;
 - (8) Nursing Home Diversion waiver;
 - (9) Channeling waiver;

- (10) Low Income Families and Children;
- (11) MEDS (SOBRA) for children born after 9/30/83 (age 18 — 20);
- (12) MEDS AD (SOBRA) for aged and disabled;
- (13) Protected Medicaid (aged and disabled);
- (14) Dually Eligibles (Medicare and Medicaid);
- (15) Individuals enrolled in the Frail/Elderly Program component of United Healthcare HMO; and
- (16) Medicaid Pending for Long-Term Care Managed Care HCBS waiver services.

2. Voluntary Populations

Eligible recipients eighteen (18) years or older in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

- a. Traumatic Brain and Spinal Cord Injury waiver;
- b. Project AIDS Care (PAC) waiver;
- c. Adult Cystic Fibrosis waiver;
- d. Program of All-Inclusive Care for the Elderly (PACE) plan members;
- e. Familial Dysautonomia waiver;
- f. Model waiver (age 18 — 20);
- g. Developmental Disabilities waiver (iBudget and Tiers 1-4);
- h. Medicaid for the Aged and Disabled (MEDS AD) — Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled — enrolled in Developmental Disabilities (DD) waiver; and
- i. Recipients with other creditable coverage excluding Medicare.

3. Excluded Populations

- a. Recipients in any eligibility category not listed in sub-items A.1. or A.2. above are excluded from enrollment in a Managed Care Plan. This includes, but is not limited to, recipients in the following eligibility categories:
 - (1) Supplemental Security Income (SSI) (enrolled in a DD waiver);
 - (2) Model waiver (under age 18);

- (3) Presumptive Newborns (PEN);
 - (4) Foster Care;
 - (5) Institutional Care — Transfer of Assets;
 - (6) MediKids;
 - (7) MEDS (SOBRA) for children born after 9/30/83 (under age 18);
 - (8) MEDS (SOBRA) for pregnant women;
 - (9) Presumptively eligible pregnant women;
 - (10) Medically needy;
 - (11) Refugee assistance;
 - (12) Family planning waiver;
 - (13) Women enrolled through the Breast and Cervical Cancer Program;
 - (14) Emergency shelter/Department of Juvenile Justice (DJJ) residential;
 - (15) Emergency assistance for aliens;
 - (16) Qualified Individual (QI) 1;
 - (17) Qualified Medicare beneficiary (QMB);
 - (18) Special low-income beneficiaries (SLMB);
 - (19) Working disabled;
- b. In addition, regardless of eligibility category, the following recipients are excluded from enrollment in an LTC Managed Care Plan:
- (1) Recipients residing in residential commitment facilities operated through DJJ or mental health facilities;
 - (2) Recipients residing in DD centers including Sunland and Tacachale;
 - (3) Children receiving services in a prescribed pediatric extended care center (PPEC);
 - (4) Children with chronic conditions enrolled in the Children's Medical Services Network; and
 - (5) Recipients in the Health Insurance Premium Payment (HIPP) program.

4. Medicaid Pending for Home and Community-Based Services

- a. The Managed Care Plan shall authorize and provide services to Medicaid Pending enrollees as specified in Attachment II, Core Contract Provisions, Exhibit 5, Covered Services.
- b. Medicaid Pending recipients may choose to disenroll from a Managed Care Plan at any time, but the Managed Care Plan shall not encourage the enrollee to do so. However, Medicaid Pending recipients may not change Managed Care Plans until full financial Medicaid eligibility is complete.
- c. The Managed Care Plan shall be responsible for reimbursing subcontracted providers for the provision of home and community-based services (HCBS) during the Medicaid Pending period, whether or not the enrollee is determined financially eligible for Medicaid by DCF. The Managed Care Plan shall assist Medicaid Pending enrollees with completing the DCF financial eligibility process.
- d. The Agency shall notify Managed Care Plans in a format to be determined by the Agency of Medicaid Pending recipients that have chosen to enroll in the Managed Care Plan on a schedule consistent with the X-12 834 monthly enrollment files. On the first of the month after the notification, the Managed Care Plan shall provide services as indicated in Attachment II, Core Contract Provisions, Exhibit 5, Covered Services. The Managed Care Plan shall not deny or delay services covered under this Contract to Medicaid Pending enrollees based on their Medicaid eligibility status.
- e. The Agency will notify the Managed Care Plan if and when Medicaid Pending enrollees are determined financially eligible by DCF via the X-12 834 enrollment files. If full Medicaid eligibility is granted by DCF, the Managed Care Plan will be reimbursed a capitated rate, by whole months, retroactive to the first of the month in which the recipient was enrolled into the plan as a Medicaid Pending enrollee. At the request of the Agency, the Managed Care Plan shall provide documentation to prove all medically necessary services were provided for the Medicaid Pending recipient during their pending status.
- f. If DCF determines the recipient is not financially eligible for Medicaid, the Managed Care Plan may terminate services and seek reimbursement from the enrollee. In this instance only, the Managed Care Plan may seek reimbursement only from the individual for documented services, claims, copayments and deductibles paid on behalf of the Medicaid Pending enrollee for services covered under this Contract during the period in which the Managed Care Plan should have received a capitation payment for the enrollee in a Medicaid Pending status. The Managed Care Plan shall send the affected enrollee an itemized bill for services. The itemized bill and related documentation shall be included in the enrollee's case notes. The Managed Care Plan shall not allow subcontractors to seek payment from the Medicaid Pending enrollee on behalf of the Managed Care Plan.

Section III, Eligibility and Enrollment, Item B., Enrollment, Sub-Item 1., General Provisions

- f. For long-term care eligibles who fail to make an affirmative plan choice, the Agency will assign them to a LTC Managed Care Plan with which they have a previous relationship for purposes of long-term care services.

Section III, Eligibility and Enrollment, Item C., Disenrollment, Sub-Item 1., General Provisions

This provision is in addition to Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment, Item C., Disenrollment, sub-item 4.a, Involuntary Disenrollment requests.

- (4). The enrollee will not relocate from an assisted living facility or adult family care home that does not, and will not, conform to HCB requirements contained in Exhibit 5 of this Contract.

This provision replaces Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment, Item C., Disenrollment, sub-item 1.f., General Provisions.

- f. On the first day of the month after receiving notice from FMMIS that the enrollee has moved to another region, the Agency will automatically disenroll the enrollee from the Managed Care Plan and treat the recipient as if the recipient is a new Medicaid recipient eligible to choose another managed care plan pursuant to the Agency's enrollment process (see s. 409.969(2)d., F.S.) but without having to be placed on the long-term care wait list.

Section III, Eligibility and Enrollment, Item D., Enrollee Reporting Requirements

The Managed Care Plan (MCP) shall submit a monthly summary report of all enrollees and their place of care in accordance with Attachment II, Core Contract Provisions, Exhibit 12, Reporting Requirements. The monthly summary report should include the required demographic information for Medicaid Pending and Non-Pending enrollees, and the total number of enrollees by residential facility. The report is due within fifteen (15) calendar days of the end of the reporting month.

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ATTACHMENT II
EXHIBIT 4
Enrollee Services, Community Outreach and Marketing — LTC Plans

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services

3. New Enrollee Materials

- d. As long as the materials are provided within five (5) calendar days as specified in Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services, sub-item A., 3., a. of Attachment II, Core Contract Provisions, the Managed Care Plan may provide new enrollee materials to enrollees as part of the initial case management visit (see Attachment II, Core Contract Provisions, Section V, Covered Services).

5.a. Additional Enrollee Handbook Requirements for LTC Plans

- (25) An explanation of the role of the case manager and how to access a case manager;
- (26) Instructions on how to access services included in an enrollee's plan of care;
- (27) Information regarding how to develop the enrollee disaster/emergency plan including information on personal and family plans and shelters, dealing with special medical needs, local shelter listings, special needs registry, evacuation information, emergency preparedness publications for people with disabilities, and information for caregivers, all of which is available at the web site www.floridadisaster.org;
- (28) Information regarding how to develop a contingency plan to cover gaps in services;
- (29) A signature page for signature of the enrollee/authorized representative;
- (30) Instructions on how to access appropriate state or local educational and consumer resources providing additional information regarding residential facilities and other long-term care providers in the Managed Care Plan's network. At a minimum, the Managed Care Plan shall include the current website addresses for the Agency's Health Finder website (www.FloridaHealthFinder.gov) and the Department of Elder Affairs' Florida Affordable Assisted Living consumer website (<http://elderaffairs.state.fl.us/faal/>).
- (31) Information regarding participant direction for the following services:

- i. Attendant care services,
- ii. Homemaker services,
- iii. Personal care services,
- iv. Adult companion care services, and
- v. Intermittent and skilled nursing.

(32) Patient responsibility obligations for enrollees residing in a residential facility.

6. Provider Directory

- g. The provider directory shall include, at a minimum, information relating to residential providers and community based long-term care providers.

7. New Enrollee Procedures

The Managed Care Plan shall comply with the requirements in Attachment II, Core Contract Provisions, Section VIII, Quality Management, Item C., Transition of Care, and Exhibit 8.

8. Enrollee Assessments

The Managed Care Plan shall comply with the requirements in Attachment II, Core Contract Provisions, Section V, Covered Services, and Exhibit 5 regarding conducting assessments as part of care coordination/case management.

10. Toll-Free Help Line

This requirement replaces of Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services, sub-item 10.g., as follows:

- g. The enrollee help line shall be staffed twenty-four hours a day, seven days a week (24/7) to handle care related inquiries from enrollees and caregivers.

13. Medicaid Redetermination Notices

- a. The Managed Care Plan shall develop a process for tracking eligibility redetermination and documenting the assistance provided by the Managed Care Plan to ensure continuous Medicaid eligibility, including both financial and medical/functional eligibility.

- b. The Managed Care Plan's assistance shall include:

- (1) Within the requirements provided in sub-item 16.c. below, using Medicaid recipient redetermination date information provided by the Agency to remind enrollees that their Medicaid eligibility may end soon and to reapply for Medicaid if needed;

- (2) Assisting enrollees to understand applicable Medicaid income and asset limits and, as appropriate and needed, supporting enrollees to meet verification requirements;
 - (3) Assisting enrollees to understand any patient responsibility obligation they may need to meet to maintain Medicaid eligibility;
 - (4) Assisting enrollees to understand the implications of their functional level of care as it relates to the eligibility criteria for the program;
 - (5) Having staff that has received Agency-specified training complete the Agency-defined re-assessment form and submit it to CARES staff to review and determine whether the enrollee continues to meet nursing facility level of care; and
 - (6) If appropriate and needed, assisting enrollees to obtain an authorized representative.
- c. The Agency will provide Medicaid recipient redetermination date information to the Managed Care Plan.
- (1) The Managed Care Plan must train all affected staff, prior to implementation, on its policies and procedures and the Agency's requirements regarding the use of redetermination date information. The Managed Care Plan must document such training has occurred, including a record of those trained, for the Agency's review within five (5) business days after the Agency's request.
 - (2) The Managed Care Plan shall use redetermination date information in written notices to be sent to their enrollees reminding them that their Medicaid eligibility may end soon and to reapply for Medicaid if needed. The Managed Care Plan must adhere to the following requirements:
 - i. The Managed Care Plan shall mail the redetermination date notice to each enrollee for whom it has received a redetermination date. The Managed Care Plan may send one (1) notice to the enrollee's household when there are multiple enrollees within a family who have the same Medicaid redetermination date, provided that these enrollees share the same mailing address.
 - ii. The Managed Care Plan shall use the Agency-provided LTC template for its redetermination date notices. The Managed Care Plan may put this template on its letterhead for mailing; however, the Managed Care Plan shall make no other changes, additions or deletions to the letter text.
 - iii. The Managed Care Plan shall mail the redetermination date notice to each enrollee no more than sixty (60) calendar days and no less than thirty (30) calendar days before the redetermination date occurs.

- (3) The Managed Care Plan shall keep the following information about each mailing made available for the Agency's review within five (5) business days after the Agency's request. For each month of mailings, a dated hard copy or pdf of the monthly template used for that specific mailing shall include;
- i. A list of enrollees to whom a mailing was sent. This list shall include each enrollee's name and Medicaid identification number, the address to which the notice was mailed, and the date of the Agency's enrollment file used to create the mailing list; and
 - ii. A log of returned, undeliverable mail received for these notices, by month, for each enrollee for whom a returned notice was received.
- (4) The Managed Care Plan shall keep up-to-date and approved policies and procedures regarding the use, storage and securing of this information as well as address all requirements of this subsection.
- (5) Should any complaint or investigation by the Agency result in a finding that the Managed Care Plan has violated this subsection, the Managed Care Plan will be sanctioned in accordance with Attachment II, Core Contract Provisions, Section XIV, Sanctions. In addition to any other sanctions available in Section XIV, Sanctions, the first such violation will result in a thirty (30) day suspension of use of Medicaid redetermination dates; any subsequent violations will result in thirty (30) day incremental increases in the suspension of use of Medicaid redetermination dates. In the event of any subsequent violations, additional penalties may be imposed in accordance with Section XIV, Sanctions. Additional or subsequent violations may result in the Agency's rescinding provision of redetermination date information to the Managed Care Plan.

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ATTACHMENT II
EXHIBIT 5
Covered Services — LTC Plans

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Section V, Covered Services, Item A., Covered Services

4. The Managed Care Plan shall be responsible for tracking individuals that transition from the nursing facility into an ALF or other residence in the community, as well as those individuals that transition from the ALF or other residence in the community into a nursing facility. The Managed Care Plan shall notify DCF of the date of nursing facility/ALF admission/discharge prior to the respective admission/discharge date. The Managed Care Plan shall submit monthly reports to the Agency using the reporting mechanism developed by the Agency (see Exhibit 12).
5. The Managed Care Plan shall ensure the provision of the following covered services, including those covered under s. 409.98(1) through (19), F.S.
 - a. Adult Companion Care — Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.
 - b. Adult Day Health Care — Services provided pursuant to Chapter 429, Part III, F.S. Services furnished in an outpatient setting which encompass both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems and planned group therapeutic activities. Adult day health care includes nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene, are also a component of this service. The inclusion of physical, occupational and speech therapy services, and nursing services as components of adult day health services does not require the Managed Care Plan to contract with the adult day health provider to deliver these services when they are included in an enrollee's plan of care. The Managed Care Plan may contract with the adult day health care provider for the delivery of these services or the Managed Care Plan may contract with other providers qualified to deliver these services pursuant to the terms of this Contract.

- c. Assistedive Care Services -- An integrated set of twenty-four (24) hour services only for Medicaid-eligible residents in adult family care homes in accordance with Attachment II, Core Contract Provisions, Section I, Definitions and Acronyms.
- d. Assisted Living — A service comprising personal care, homemaker, chore, attendant care, companion care, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in an assisted living facility, licensed pursuant to Chapter 429 Part I, F.S., in conjunction with living in the facility. Service providers must ensure enrollees reside in a facility offering care with home-like environmental characteristics congruent with Exhibit 5 of this Contract. This service includes twenty-four (24) hour onsite response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity independence, and to provide supervision, safety and security. Individualized care is furnished to persons who reside in their own living units (which may include dual occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The resident has a right to privacy. Living units may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing that the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door and all protections have been met to ensure individuals' rights have not been violated. The facility must have a central dining room, living room or parlor, and common activity areas, which may also serve as living rooms or dining rooms. The resident retains the right to assume risk, tempered only by a person's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. The LTC plan may arrange for other authorized service providers to deliver care to residents of assisted living facilities in the same manner as those services would be delivered to a person in their own home. ALF administrators, direct service personnel and other outside service personnel such as physical therapists have a responsibility to encourage enrollees to take part in social, educational and recreational activities they are capable of enjoying. All services provided by the assisted living facility shall be included in a care plan maintained at the facility with a copy provided to the enrollee's case manager. The LTC plan shall be responsible for placing enrollees in the appropriate assisted living facility setting based on each enrollee's choice and service needs.
- e. Attendant Care — Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.
- f. Behavioral Management — This service provides behavioral health care services to address mental health or substance abuse needs of long-term-care plan members. These services are in excess of those listed in the Community Behavioral Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case

Management Coverage and Limitations Handbook. The services are used to maximize reduction of the enrollee's disability and restoration to the best possible functional level and may include, but are not limited to: an evaluation of the origin and trigger of the presenting behavior; development of strategies to address the behavior; implementation of an intervention by the provider; and assistance for the caregiver in being able to intervene and maintain the improved behavior.

- g. Caregiver Training — Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to enrollees. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship or support to an enrollee. This service may not be provided to train paid caregivers. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the enrollee at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the enrollee. All training for individuals who provide unpaid support to the enrollee must be included in the enrollee's plan of care.
- h. Care Coordination/Case Management -- Services that assist enrollees in gaining access to needed waiver and other State plan services, as well as other needed medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provision as prescribed in each enrollee's plan of care.
- i. Home Accessibility Adaptation Services — Physical adaptations to the home required by the enrollee's plan of care which are necessary to ensure the health, welfare and safety of the enrollee or which enable the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies, which are necessary for the welfare of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair or central air conditioning. Adaptations which add to the total square footage of the home are not included in this service. All services must be provided in accordance with applicable state and local building codes.
- j. Home Delivered Meals — Nutritionally sound meals to be delivered to the residence of an enrollee who has difficulty shopping for or preparing food without assistance. Each meal is designed to provide a minimum thirty-three and three tenths percent (33.3%) of the current Dietary Reference Intake (DRI). The meals shall meet the current Dietary Guidelines for Americans, the USDA My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.
- k. Homemaker Services — General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual

regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

- I. Hospice — Services are forms of palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill recipients and their families. Hospice care focuses on palliative care rather than curative care. An individual is considered to be terminally ill if he has a medical diagnosis with a life expectancy of six (6) months or less if the disease runs its normal course.

- m. Intermittent and Skilled Nursing — The scope and nature of these services do not differ from skilled nursing furnished under the State Plan. This service includes the home health benefit available under the Medicaid state plan as well as expanded nursing services coverage under this waiver. Services listed in the plan of care that are within the scope of Florida's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Skilled nursing services must be listed in the enrollee's plan of care and are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or whose need is predictable.

- n. Medical Equipment and Supplies — Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls or appliances that enable the enrollee to perceive, control or communicate the environment in which he or she lives; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address enrollee functional limitations; (e) necessary medical supplies not available under the State Plan including consumable medical supplies such as adult disposable diapers. This service includes the durable medical equipment benefits available under the state plan service as well as expanded medical equipment and supplies coverage under this waiver. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

- o. Medication Administration — Pursuant to s. 400.4256, F.S., assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from where it is stored and delivering it to the enrollee; removing a prescribed amount of medication from the container and placing it in the enrollee's hand or another container; helping the enrollee by lifting the container to their mouth; applying topical medications; and keeping a record of when an enrollee receives assistance with self-administration of their medications.

- p. Medication Management — Review by the licensed nurse of all prescriptions and over-the-counter medications taken by the enrollee, in conjunction with the enrollee's physician. The purpose of the review is to assess whether the enrollee's medication is accurate, valid, non-duplicative and correct for the diagnosis; that therapeutic

doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications and being assessed and prevented.

- q. Nutritional Assessment/Risk Reduction Services — An assessment, hands-on care, and guidance to caregivers and enrollees with respect to nutrition. This service teaches caregivers and enrollees to follow dietary specifications that are essential to the enrollee's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and food preparation.
- r. Nursing Facility Services — Services furnished in a health care facility licensed under Chapter 395 or Chapter 400, F.S. per the Nursing Facility Coverage and Limitation Handbook.
- s. Personal Care — A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.
- t. Personal Emergency Response Systems (PERS) — The installation and service of an electronic device that enables enrollees at high risk of institutionalization to secure help in an emergency. The PERS is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The enrollee may also wear a portable "help" button to allow for mobility. PERS services are generally limited to those enrollees who live alone or who are alone for significant parts of the day and who would otherwise require extensive supervision.
- u. Respite Care — Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility.
- v. Occupational Therapy — Treatment to restore, improve or maintain impaired functions aimed at increasing or maintaining the enrollee's ability to perform tasks required for independent functioning when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
- w. Physical Therapy — Treatment to restore, improve or maintain impaired functions by use of physical, chemical and other properties of heat, light, electricity or sound, and by massage and active, resistive or passive exercise. There must be an explanation that the patient's condition will be improved significantly (the outcome of the therapies must be measureable by the attending medical professional) in a reasonable (and generally predictable) period of time based on an assessment of restoration potential, or a determination that services are necessary to a safe and

effective maintenance program for the enrollee, using activities and chemicals with heat, light, electricity or sound, and by massage and active, resistive or passive exercise when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

- x. Respiratory Therapy — Treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Services include evaluation and treatment related to pulmonary dysfunction.
- y. Speech Therapy — The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism, or neurological conditions that effect oral motor functions. Therapy services include the evaluation and treatment of problems related to an oral motor dysfunction when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
- z. Transportation – Non-emergent transportation services shall be offered in accordance with the enrollee's plan of care and coordinated with other service delivery systems. Includes trips to and from services offered by the LTC Managed Care Plan and includes trips to and from the Managed Care Plan's expanded benefits.

6. Enrollee Direction Option (PDO)

a. General Provisions

- (1) The Managed Care Plan is responsible for implementing and managing the Participant Direction Option (PDO) as defined in Attachment II, Core Contract Provisions, Section I. The Managed Care Plan shall ensure the PDO is available to all long-term care enrollees who have any PDO-qualifying service on their authorized care plan and who live in their own home or family home.
- (2) An enrollee's care plan must include one or more of the following services in order for the enrollee to be eligible to participate in the PDO: adult companion care, attendant care, homemaker services, intermittent and skilled nursing, or personal care. The enrollee may choose to participate in the PDO for one or more of the eligible PDO services, as outlined in their authorized care plan.
- (3) Enrollees who receive PDO services shall be called "participants" in any PDO specific published materials. The enrollee shall have employer authority. An enrollee may delegate their employer authority to a representative. The representative can neither be paid for services as a representative, nor be a direct service worker. For the purposes of this section, "enrollee" means the enrollee or their representative.
- (4) The Managed Care Plan shall develop PDO-specific policies and procedures that must be updated at least annually and shall obtain

Agency approval prior to distributing PDO materials to enrollees, representatives, direct service workers, and case managers.

- (5) The Managed Care Plan shall operate the PDO service delivery option in a manner consistent with the PDO Manual and the PDO Participant Guidelines provided by the Agency.
- (6) The Agency will provide templates for the following to the Managed Care Plan: PDO Consent Form, PDO Representative Agreement, PDO Participant Guidelines, PDO Training Evaluations, and PDO Pre-Screening Tool.
- (7) The Managed Care Plan shall maintain books, records, documents, and other evidence of PDO-related expenditures using Generally Accepted Accounting Principles (GAAP).
- (8) The Managed Care Plan shall submit a PDO Report monthly and within 15 days from the end of the reporting month as specified in Exhibit 12 of this Contract. The Plan shall provide ad-hoc PDO related information, records, and statistics, at the request of the Agency within the specified timeframe.
- (9) The Agency will conduct PDO satisfaction surveys on at least an annual basis and shall provide results to the Managed Care Plans for use in quality improvement plans.
- (10) The Managed Care Plan shall cooperate with, and participate in, ongoing evaluations and focus groups conducted by the Agency to evaluate the quality of the PDO.

b. Training Requirements

- (1) The Managed Care Plan shall ensure all applicable staff receives basic training on the PDO service delivery option
- (2) The Managed Care Plan shall designate staff to participate in PDO training conducted by the Agency.
- (3) The Managed Care Plan shall ensure an adequate number of case managers are trained extensively in the PDO. This extensive PDO training, beyond the general PDO informational training, is provided to case managers who serve enrollees and consists of training specific to PDO employer responsibilities, such as: completing federal and state tax documents, interviewing potential direct service workers, developing Emergency Back-up Plans, training direct service workers, completing the PDO Pre-Screening tool, evaluating direct service worker job performance, and completing and submitting timesheets.
- (4) The Managed Care Plan shall submit completed PDO Training Evaluations from all Managed Care Plan staff and case manager

trainings, to the Agency, on at least an annual basis. The Agency will supply a PDO Training Evaluation template to be distributed during all Managed Care Plan staff and case manager trainings.

- (5) The Managed Care Plan shall provide PDO-trained staff as part of the enrollee and provider call centers to be available during the business hours specified in this Contract.

c. PDO Case Management

- (1) The case manager is responsible for informing enrollees of the option to participate in the PDO when any of the PDO services are listed on the enrollee's authorized care plan.
- (2) The Managed Care Plan shall assign a case manager trained extensively in the PDO within two business days of an enrollee electing to participate in the PDO delivery option.
- (3) In addition to the other case manager requirements in this Contract, all case managers are responsible for:
 - i. Documenting the PDO was offered to the enrollee, initially and annually, upon reassessment. This documentation must be signed by the enrollee and included in the case file;
 - ii. Referring Managed Care Plan enrollees, who have expressed an interest in choosing the PDO, to available case managers who have received specialized PDO training.
- (4) In addition to the other case manager requirements in this Contract, case managers who have received extensive PDO training are responsible for:
 - i. Completing the PDO Pre-Screening Tool with each enrollee and prospective representative;
 - ii. Ensuring enrollees choosing the PDO understand their roles and responsibilities;
 - iii. Ensuring the Participant Agreement is signed by enrollees and included in the case file;
 - iv. Facilitating the transition of enrollees to, and from, the PDO service delivery system;
 - v. Ensuring PDO and non-PDO services do not duplicate;
 - vi. Training enrollees, initially, and as needed, on employer responsibilities such as: creating job descriptions, interviewing, hiring, training, supervising, evaluating job performance, and terminating employment of the direct service worker(s);

- vii. Assisting enrollees as needed with finding and hiring direct service workers;
 - viii. Assisting enrollee's with resolving disputes with direct service workers and/or taking employment action against direct service
 - ix. Assisting enrollees with developing emergency back-up plans including identifying Plan network providers and explaining the process for accessing network providers in the event of a foreseeable or unplanned lapse in PDO services;
 - x. Assisting and training enrollees as requested in PDO related subjects.
- d. Enrollee Employer Authority/Direct Service Workers
- (1) Enrollees may hire any individual who satisfies the minimum qualifications set forth in Exhibit 7 of this Contract including, but not limited to, neighbors, family members, or friends. The Managed Care Plan shall not restrict an enrollees' choice of direct service worker(s) or require them to choose providers in the plan's provider network.
 - (2) The Managed Care Plan shall inform enrollees, upon choosing the PDO, of the rate of payment for the PDO services. If the rate of payment changes for any PDO service, the Managed Care Plan shall provide a written notice to the applicable enrollees and direct service workers, at least thirty (30) days prior to the change.
 - (3) The Managed Care Plan shall ensure the enrollees update their Participant/Direct Service Worker Agreement indicating any changes in rate of payment.
 - (4) The Managed Care Plan shall provide instructions to the enrollee regarding the submission of timesheets.
 - (5) The Managed Care Plan shall ensure the Participant/Direct Service Worker Agreement includes, at a minimum, include the following:
 - i. Service(s) to be provided,
 - ii. Hourly rate,
 - iii. Direct service worker work schedule,
 - iv. Relationship of the direct service worker to the enrollee,
 - v. Job description and duties,
 - vi. Agreement statement,

- vii. Dated signatures of the case manager, enrollee, and direct service worker.
- (6) The Managed Care Plan shall pay for Level 2 background screening for at least one representative (if applicable) per enrollee and at least one direct service worker for each service per enrollee, per Contract year. The Managed Care Plan shall receive the results of the background screening and make a determination of clearance, adhering to all requirements in Chapters 435 and 408.809 F.S.
 - (7) The Managed Care Plan shall monitor over and under use of services based on payroll and an enrollee's approved care plan and provide reports to the Agency, or its designee.
- e. Fiscal/Employer Agent
- (1) The Managed Care Plan shall be the Fiscal/Employer Agent (F/EA) for PDO enrollee's or may sub-contract this function. Should any of the F/EA duties be sub-contracted, the following shall be performed:
 - i. The Managed Care Plan and its subcontractor shall execute an IRS Form 8655, Reporting Agent Authorization; and
 - ii. The Managed Care Plan shall obtain informed consent from the enrollee, informing them that the Managed Care Plan will utilize a subcontractor to perform certain F/EA duties.
 - (2) The Managed Care Plan shall meet all applicable PDO-related Federal and State requirements and shall be operated in accordance with Section 3504 of the Internal Revenue Code, per Revenue Procedure 70-6 and Section 3504 Agent Employment Tax Liability proposed regulations (REG-137036-08) issued by the IRS on January 13, 2010.
 - (3) The Managed Care Plan remain abreast of all federal and state F/EA requirements and tax forms, and shall ensure all materials distributed to enrollees, representatives, direct service workers, and case managers are current, and in accordance with the appropriate federal and state regulations.
 - (4) The Managed Care Plan shall have a separate Federal Employer Identification Number (FEIN) that is used only for purposes of representing enrollees as employers. This FEIN should not be used to file or pay taxes for the Managed Care Plan's staff.
 - (5) The Managed Care Plan shall complete the following payroll and F/EA tasks:
 - i. Develop a pay schedule and distribute it to all enrollees at least annually;
 - ii. Collect and process timesheets submitted by the enrollee. Resolve any timesheet issues with the enrollee and/or direct service worker;

- iii. Disburse payroll (no less than twice per month) by direct deposit or pre-paid card to each direct service worker who has a complete and current Hiring Packet on file and has provided services to an enrollee as authorized in the enrollee's care plan and the Participant/ Direct Service Worker Agreement by the published pay date;
- iv. Maintain payroll documentation for all direct service workers;
- v. Compute, maintain, and appropriately withhold all employer and direct service worker taxes pursuant to federal and state law. All payments that are not in compliance with federal and state tax withholding, reporting, and payment requirements shall be corrected within two (2) business days of identifying an error;
- vi. Process applicable direct service worker garnishments, liens, and levies in accordance with state and federal garnishment rules. Submit payments and reports to applicable agencies per garnishment instructions;
- vii. Deposit direct service worker aggregate payroll deductions per federal and state tax deposit requirements. Federal Income Tax, Social Security and Medicare and enrollee Federal Social Security and Medicare (FICA) taxes in the aggregate per deposit frequency required by _____ an _____ F/EA.(see <http://www.irs.gov/businesses/small/article/0,,id=98818,00.html>);
- viii. Deposit employer aggregate tax deductions per federal and state tax deposit requirements. Federal Unemployment Tax (FUTA) must be deposited in the aggregate per F/EA deposit frequency. (see <http://www.irs.gov/businesses/small/article/0,,id=98818,00.html>);
- ix. Refund over-collected FICA for direct service workers who earn less than the Federal FICA threshold for the calendar year (See IRS Publication 15, Circular E for threshold information);
- x. File a single IRS Form 941, Employer's Quarterly Tax Return in the aggregate on behalf of all enrollees represented by the Managed Care Plan. Form 941 is completed using the Managed Care Plan's separate F/EA, FEIN. Wages and taxes reported represent total, aggregate wages and taxes for all enrollees represented by the Managed Care Plan. Schedule B should be completed per rules. The Managed Care Plan must also complete and submit Schedule R with the Form 941. Schedule R disaggregates each enrollee's employer wages and federal tax liability;
- xi. Adjust Forms 941 as applicable by completing and filing IRS Form 941-X.

- xii. File a single IRS Form 940, Employer's Annual Federal Unemployment Tax Return in the aggregate on behalf of all enrollees represented by the Managed Care Plan. Form 940 is completed using the Managed Care Plan's separate FEIN. Wages and FUTA tax reported represent total, aggregate wages and taxes for all enrollees represented by the Managed Care Plan. Note: Even Managed Care Plans incorporated with a nonprofit 501c3 status MUST file and pay FUTA on behalf of enrollees;
- xiii. Process and distribute IRS Forms W-2 to the direct service workers and submit them electronically according to IRS Form W-2 instructions, per IRS rules and regulations;
- xiv. Track payroll disbursed to all direct service workers and provide reports as may be required by the Agency or its designee in accordance with this Contract;
- xv. Provide written notification to the case manager and enrollee if utilization is less than 10% of the monthly hours as approved on the authorized care plan for more than one month;
- xvi. Obtain workers' compensation coverage for the enrollee's direct service workers, if there are four or more direct service workers, which shall be funded by the Managed Care Plan;
- xvii. Comply with, and support enrollee compliance with, state workers' compensation audits as applicable;
- xviii. Prepare for and support enrollee preparation for unemployment claim proceedings, as applicable;
- xix. Maintain records in compliance with Fair Labor Standards Act requirements for employers;
- xx. Ensure a payroll system with maximum data integrity in which direct service workers are not paid above authorized hours as prescribed in the enrollee's care plan and the Participant/Direct Service Worker Agreement;
- xxi. Respond to requests for direct service worker employment verification;
- xxii. Perform all duties regarding disenrollment of an enrollee from the PDO, including final federal and state tax filings and payments and revocation of accounts, numbers, and authorizations previously obtained by the Managed Care Plan. This includes retiring the FEIN and State Unemployment Tax Account (SUTA) Number;
- xxiii. Provide a transitioning enrollee's new plan with the enrollee's FEIN and SUTA numbers.

f. PDO Monitoring

- (1) The Managed Care Plan shall monitor for compliance with PDO requirements, and shall report to the Agency or its designee upon request for an annual F/EA Quality Assessment and Performance Review including:
 - i. Whether timesheets are signed by the enrollee (or representative, if applicable) and the direct service worker;
 - ii. Utilization of services based on payroll and an enrollee's approved care plan;
 - iii. Whether services, duties, and hours listed on the Participant/Direct Service Worker Agreement are in compliance with the authorized care plan;
 - iv. Whether direct service workers are qualified pursuant to the PDO Participant Guidelines and the PDO Manual, prior to providing services to an enrollee;
 - v. Duplication of PDO and non-PDO services.

g. Home-Like Environment and Community Inclusion - (HCB Characteristics)

- a. Each enrollee is guaranteed the right to receive home and community-based services in a home-like environment and participate in his or her community regardless of his or her living arrangement.
- b. The Managed Care Plan shall ensure enrollees who reside in assisted living facilities and adult family care homes reside in a home-like environment, and are integrated into their community as much as possible, unless medical, physical, or cognitive impairments restrict or limit exercise of these options which, at a minimum, includes:
 - (1) Choice of: private or semi-private rooms; roommate for semi-private rooms; locking door to living unit; access to telephone and length of use; eating schedule; and participation in facility and community activities.
 - (2) Ability to have unlimited visitation; and snacks as desired.
 - (3) Ability to prepare snacks as desired; and maintain personal sleeping schedule.
- c. The Managed Care Plan shall include language in the enrollee handbook explaining the enrollee's right to receive home and community-based services in a HCB compliant setting regardless of their living arrangement. It shall provide enrollees with information regarding the community integration goal planning process and their participation in that process.

- d. The case manager shall work with the enrollee and their providers as appropriate to facilitate the enrollee's personal goals and community activities. The case manager is responsible for continuously educating the enrollee of their rights and documenting their efforts in the case file for Agency review.
- e. The case manager shall discuss these rights with enrollees residing in assisted living facilities and adult family care homes at least annually and document this in the case file for Agency review.
- f. The Managed Care Plan shall include language provided by the Agency pursuant to HCB requirements in its provider contract agreements with assisted living facility and adult family care home providers, and must require these providers to be in compliance with the Assisted Care Communities Resident Bill of Rights per s. 429.28, Florida Statutes.
- g. The Managed Care Plan shall verify during the credentialing and recredentialing process that assisted living facilities and adult family care homes conform to the HCB requirements as described herein. Verification must include on-site review of the facilities by the managed care plan staff prior to the plan offering the provider as a provider choice to enrollees.
- h. The Managed Care Plan shall include documentation of all network assisted living facility and adult family care homes' compliance with the requirements of this contract in each provider's credentialing and recredentialing file for Agency review.
- i. The Managed Care Plan shall take corrective action as necessary if the plan or the Agency concludes an assisted living facility or adult family care home does not meet the HCB requirements.
- j. Upon receipt of finding an assisted living facility or adult family care home is not in compliance with and part of the HCB requirements, the Managed Care Plan shall have fifteen (15) business days to both ensure the deficiencies are rectified and submit accompanying documentation to the Agency, or if required, to submit a corrective action plan.
- k. The Managed Care Plan shall not place, shall not continue to place, and shall not receive reimbursement for, enrollees in an assisted living facility or adult family care home that does not meet the HCB requirements and/or does not have an effective provider agreement including the HCB language provided by the Agency.
- l. The Managed Care Plan shall transition enrollee's out of assisted living facilities and adult family care homes that do not meet HCB requirements and do not take corrective action if the enrollee wishes to remain enrolled in the plan.

- m. The Managed Care Plan may involuntarily disenroll an enrollee who wishes to remain in an assisted living facility or adult family care home that does not comply with HCB requirements pursuant to Attachment II, Core Contract Provisions-D, Section III, Eligibility and Enrollment, and Exhibit 3 of this Contract.

Section V, Covered Services, Item B., Expanded Benefits

1. The Managed Care Plan may offer expanded benefits and may amend the expanded benefits offered each Contract year, as approved by the Agency, and as specified below.
 - a. The Managed Care Plan's approved expanded benefits under this Contract are listed in Attachment I, Scope of Services, Table 3 and Exhibit 17.
 - b. The Managed Care Plan shall submit to the Agency for approval, by the date specified by the Agency, of each Contract year, any changes requested to the expanded benefits as follows:
 - (1) Such changes in expanded benefits shall only be for additional expanded benefits or, if reducing or removing expanded benefits, must be determined actuarially equivalent as specified in Attachment II, Core Contract Provisions and its Exhibit 5.
 - (2) These benefits may be changed on a Contract year basis and only as approved in writing by the Agency.
2. Examples of expanded benefits include, but are not limited to, preventive dental and an over-the-counter expanded drug benefit, not to exceed fifteen dollars (\$15) per individual, per month. Such benefits shall be limited to nonprescription drugs containing a national drug code (NDC) number, vitamins and birth control supplies. Such benefits must be offered directly through the Managed Care Plan's fulfillment house or through a subcontractor. The Managed Care Plan shall make payments for the over-the-counter drug benefit directly to the subcontractor, if applicable.

Section V, Covered Services, Item C., Copayments and Required Service Level

1. **(Capitated LTC Managed Care Plans Only)** – The Managed Care Plan shall deliver Medicaid-covered services at the Medicaid State Plan level, except the Plan shall not require a copayment or cost sharing for all covered services listed in the Contract, including expanded benefits, nor may the Plan charge enrollees for missed appointments. The Plan agrees that the cost of the services and deliverables specified in Attachment II, Core Contract Provisions, Section V, Covered Services, represents the total cost to the state and the Agency for the contracted services and deliverables and that no additional charges, fees or costs may be added to this amount or sought from the state, the Agency or the enrollee.
2. **(Fee-for-Service LTC Managed Care Plans Only)** – The Managed Care Plan shall deliver Medicaid-covered services at the Medicaid State Plan level. The Plan may offer to waive copayments or cost sharing for all covered services listed in the Contract as an expanded benefit. If copayments and cost sharing are not waived as an expanded

benefit, the Plan agrees that the cost of the services and deliverables specified in Attachment II, Core Contract Provisions, Section V, Covered Services, represents the total cost to the state and the Agency for the contracted services and deliverables and that no additional charges, fees, or costs (excluding copayments and cost sharing) may be added to this amount or sought from the state, the Agency or the enrollees. If copayments and cost sharing are waived as an expanded benefit, the Plan agrees that the cost of the services and deliverables specified in Attachment II, Core Contract Provisions, Section V, Covered Services, represents the total cost to the state and the Agency for the contracted services and deliverables and that no additional charges fees or costs may be added to this amount or sought from the state, the Agency or the enrollees. See Attachment I, Scope of Services of this Contract for Agency-authorized expanded benefits.

Section V, Covered Services, Item H., Quality Enhancements

In addition to the covered services specified in Section V, Covered Services, the Managed Care Plan shall offer quality enhancements (QE) to enrollees as specified below.

6. Safety concerns in the home and fall prevention;
7. Disease management, including education on the enrollee assessment of health risks and chronic conditions;
8. End of life issues, including information on advanced directives; and
9. Ensuring that case managers and providers screen enrollees for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.

Section V, Covered Services, Item I., Care Coordination/Case Management

1. The Managed Care Plan shall submit a Case Management Program Description annually to the Agency by [Date]. The Case Management Program Description must address:
 - a. How the Managed Care Plan will implement and monitor the case management program and standards outlined in this Exhibit;
 - b. A description of the methodology for assigning and monitoring case management caseloads and emergency preparedness plans; and
 - c. An evaluation of the Managed Care Plan's case management program from the previous year, highlighting lessons learned and strategies for improvement.
2. Case Management Staff Qualifications and Experience
 - a. Case managers shall meet one of the following qualifications:

- (1) Case Managers with the following qualifications shall also have a minimum of two (2) years of relevant experience:
 - i. Bachelor's degree in social work, sociology, psychology, gerontology or a related social services field;
 - ii. Registered nurse, licensed to practice in the state;
 - iii. Bachelor's degree in a field other than social science.
- (2) Case Managers with the following qualifications shall also have a minimum of four (4) years of relevant experience:
 - i. Licensed Practical Nurse, licensed to practice in the state.
- (3) Case Managers without the aforementioned qualifications may substitute professional human service experience may substitute on a year-for-year basis for the educational requirement. Case Managers without a bachelor's degree shall have a minimum of six (6) years of relevant experience.
- (4) All Case Managers are required to obtain a successful Level 2 criminal history and/or background investigation.
- (5) All Case Managers must have at least four (4) hours of in-service training in the identification of abuse, neglect and exploitation and shall complete this training requirement annually.
- (6) The Managed Care Plan shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources within the Managed Care Plan's Contract region(s). This individual must be available to assist case managers with up-to-date information designed to aid enrollees in making informed decisions about their independent living options.

3. Case Management Supervision:

a. Supervision of case managers:

A supervisor-to-case-manager ratio must be established that is conducive to a sound support structure for case managers. Supervisors must have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers. A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of enrollee assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, must be documented and made available to the Agency upon request.

b. Case management supervisor qualifications:

- (1) Successful completion of a Level 2 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 must be related to the elderly and disabled 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 must be related to the elderly and disabled 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 must be related to case management, at least one (1) year of which must be related to elders and individuals with disabilities).

4. Training

- a. The Managed Care Plan must provide case managers with adequate orientation and ongoing training on subjects relevant to the population served. Documentation of training dates and staff attendance as well as copies of materials used must be maintained. The respondent must ensure that there is a training plan in place to provide uniform training to all case managers. This plan should include formal training classes as well as practicum observation and instruction for newly hired case managers.
- b. Newly hired case managers must be provided orientation and training in a minimum of the following areas:
 - (1) The role of the case manager in utilizing a person-centered approach to long-term care case management, including involving the enrollee and their family in decision making and care planning;
 - (2) Enrollee rights and responsibilities;
 - (3) Enrollee safety and infection control;
 - (4) Participant Direction Option (overview);
 - (4) Case management responsibilities as outlined in this Exhibit;
 - (5) Case management procedures specific to the Managed Care Plan;
 - (6) The long-term care component of SMMC and the continuum of long-term care services including available service settings and service restrictions/limitations;
 - (7) The Managed Care Plan's provider network by location, service type and capacity;

- (8) Information on local resources for housing, education and employment services/program that could help enrollees gain greater self-sufficiency in these areas;
 - (9) 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 adverse incidents (see Chapters 39 and 415, F.S.);
 - (10) General medical information, such as symptoms, medications and treatments for diagnostic categories common to the long-term care population serviced by the Managed Care Plan;
 - (11) Behavioral health information, including identification of enrollee's behavioral health needs and how to refer to behavioral health services;
 - (12) Reassessment processes using the Agency's required forms.
- c. In addition to review of areas covered in orientation, all case managers must also be provided with regular ongoing training on topics relevant to the population(s) served. The following are examples of topics that could be covered:
- (1) In-service training on issues affecting the aged and disabled population;
 - (2) Abuse, neglect and exploitation training;
 - (3) Alzheimer's disease and related disorders continuing education training from a qualified individual or entity, focusing on newly developed topics in the field;
 - (4) Policy updates and new procedures;
 - (5) Refresher training for areas found deficient through the Managed Care Plan;
 - (6) Interviewing skills;
 - (7) Assessment/observation skills;
 - (8) Cultural competency;
 - (9) Enrollee rights;
 - (10) Participant Direction Option (extensive);
 - (11) Critical incident and adverse event reporting;
 - (12) Medical/behavioral health issues; and/or
 - (13) Medication awareness (including identifying barriers to compliance and side effects).
- d. The Managed Care Plan shall ensure all case management staff hold current CPR certification.

5. Caseload and Contact Management

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

b. Caseload:

(1) The Managed Care Plan shall ensure that case manager caseloads do not exceed a ratio of sixty (60) enrollees to one case manager for enrollees that reside in the community and no more than a ratio of one-hundred (100) enrollees to one (1) case manager for enrollees that reside in a nursing facility. Where the case manager's caseload consists of enrollees who reside in the community and enrollees who reside in nursing facilities (mixed caseload), the Managed Care Plan (MCP) shall ensure the ratio of enrollees to one (1) case manager does not exceed sixty (60).

(2) The Managed Care Plan must have written protocols to ensure newly enrolled enrollees are assigned to a case manager immediately upon enrollment. The case manager assigned to special subpopulations (e.g., individuals with AIDS, dementia, behavioral health issues or traumatic brain injury) must have experience or training in case management techniques for such populations.

(3) The Managed Care Plan must ensure that case managers are not assigned duties unrelated to enrollee-specific case management for more than fifteen percent (15%) of their time if they carry a full caseload.

(4) Caseload Exceptions: The Managed Care Plan must receive authorization from the Agency prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established by the Managed Care Plan and do not require authorization.

c. Initial Contact:

(1) An onsite visit to develop an individualized plan of care must be completed by the Managed Care Plan within five (5) business days of the enrollee's effective date of enrollment for enrollees in the community (including ALFs and AFCHs) and within seven (7) business days of the effective date of enrollment for those enrolled in a nursing facility. If information obtained during the initial contact or during the eligibility determination indicates the enrollee has more immediate needs for services, the onsite visit should be completed as soon as possible. Services covered under this Contract may not be denied based on an incomplete plan of care.

(2) The Managed Care Plan shall follow up with the enrollee or the enrollee's authorized representative by telephone within seven (7) business days after initial contact and care plan development to ensure that services were started on the first of the month, if applicable.

- (3) The enrollee must be present for, and be included in, the onsite visit. The enrollee representative must be contacted for care planning, including establishing service needs and setting goals, if the enrollee is unable to participate due to cognitive impairment, or the enrollee has a designated representative or a legal guardian.
 - (4) If the case manager is unable to locate/contact an enrollee via telephone, visit or letter, or through information from the enrollee's relatives, neighbors or others, another letter requesting that the enrollee contact the case manager should be left at, or sent to, the enrollee's residence. If there is no contact within thirty (30) calendar days from the enrollee's date of enrollment, the case must be referred to the Agency Contract manager via e-mail or phone call.
 - (5) All contacts attempted and made with, or regarding, an enrollee must be documented in the enrollee's case file.
 - (6) The case manager is responsible for explaining the enrollee's rights and responsibilities including the procedures for filing a grievance, appeal or fair hearing, including continuation of benefits during the fair hearing process.
- d. Frequency and type of ongoing minimum contact requirements include:
- (1) Maintain, at a minimum, monthly telephone contact with the enrollee to verify satisfaction and receipt of services;
 - (2) The case manager must evaluate and document the HCB requirements as part of the care planning process and update of the plan of care for enrollees residing in ALFs and AFCHs during face-to-face visits every ninety (90) calendar days. The responses to the home-like characteristics queries and enrollee limitations shall become part of the case record documentation of the update;
 - (3) Review the plan of care in a face-to-face visit every ninety (90) days and, if necessary, update the enrollee's plan of care;
 - (4) Review the plan of care in a face-to-face visit more frequently than once every ninety (90) days if the enrollee's condition changes or requires it; and
 - (5) Have an annual face-to-face visit with the enrollee to complete the annual re-assessment using Agency-required forms and to determine the enrollee's functional status, satisfaction with services, changes in service needs and develop a new plan of care.
- e. If the enrollee is not capable of making his/her own decisions, but does not have a legal representative or enrollee representative available, the case manager must refer the case to the Public Guardianship Program or other available resource. If a guardian/fiduciary is not available, the reason must be documented in the file.
- f. If the case manager is unable to contact an enrolled enrollee to schedule an ongoing visit, a letter must be sent to the enrollee 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 must send the Agency a notice in a format specified by the Agency indicating loss of contact for possible disenrollment from the LTC component of SMMC.

- g. Access to case managers and back-up case managers:
 - (1) Enrollee must be able to contact the case manager during business hours with emergency or back-up through an after-hours telephone line.
 - (2) A system of back-up case managers must be in place and enrollees who contact an office when their case manager is unavailable must be given the opportunity to be referred to a back-up for assistance.
 - (3) There must be a mechanism to ensure enrollees, representatives and providers receive timely communication when messages are left for case managers.

Section V, Covered Services, Item J., Case Management of Enrollees

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

1. Person-centered approach

Case managers are expected to use a person-centered approach regarding the enrollee assessment and needs, taking into account not only covered services, but also other needed services and community resources, regardless of payor source, as applicable. Elements of the case management process include:

- a. Identification;
- b. Outreach;
- c. Contact and visits;
- d. Initial (immediate care needs) and ongoing (care needs necessary after immediate care needs stabilized);
- e. Enrollee packet/informing enrollee;
- f. Comprehensive assessment;
- g. Core assessment criteria (applicable to all plans);
- h. Assessment of risks and barriers;
- i. CARES assessment;
- j. Plan of care and coordination of services; and
- k. Assistance to enrollees living in the community in developing a personal emergency plan and determining whether they need to register with a Special Needs Shelter.

2. Needs Assessment Standard

- a. The case manager must review and utilize Agency-required forms when completing the initial assessment of the enrollee and developing the initial plan of care.
- b. Assessment will include an individual risk assessment to identify safety, health and behavioral risks that should be addressed in developing the plan of care.

3. Care Planning Standard

- a. The case manager shall develop a single, comprehensive, person centered plan of care specific to the enrollee's needs and goals that are identified using, at a minimum, the assessment form(s) provided to the Managed Care Plan by the Agency and the Managed Care Plan's assessment tool, if applicable. The enrollee or legal guardian and the guardian advocate, caregiver, primary care provider or other enrollee-authorized representative must be consulted in the development of the plan of care.
- b. Care planning includes, but is not limited to, face-to-face discussion with the enrollee, the enrollee's representative and any other enrollee-approved person, that includes a systematic approach to the assessment of the enrollee's strengths and needs in at least the following areas:
 - (1) Functional abilities;
 - (2) Medical conditions;
 - (3) Physical and cognitive functioning;
 - (4) Behavioral health;
 - (5) Personal goals;
 - (6) Social/environmental/cultural factors;
 - (7) Existing support system;
 - (8) End-of life decisions;
 - (9) Recommendations of the enrollee's primary care provider (PCP); and
 - (10) Input from service providers, as applicable.
- c. The plan of care template must at a minimum include:
 - (1) Enrollee's Name and Medicaid ID number and SSN;
 - (2) Plan of care effective date (the first date a recipient is enrolled in the Managed Care Plan);

- (3) Plan of care review date (at a minimum, every ninety (90) days);
 - (4) Services needed, including routine medical and waiver services;
 - (5) Each service authorization begin and end date;
 - (6) All the services and supports to be provided regardless of the funding source;
 - (7) All service providers;
 - (8) The enrollee's assisted living service components provided by the ALF as well as the amount and frequency of those services if the enrollee resides in an ALF;
 - (9) The number of units of each service to be provided;
 - (10) The date on which the Managed Care Plan will submit the completed Agency-required reassessment tool and required medical documentation to CARES;
 - (11) Case Manager's' signature; and
 - (12) Enrollee or authorized representative's signature and date.
- d. The plan of care (reviewed face-to-face with the enrollee at a minimum every three (3) months) shall also include:
- (1) Goals and objectives;
 - (2) Service schedules;
 - (3) Medication management strategies;
 - (4) Barriers to progress; and
 - (5) Detail of interventions.
- e. The Managed Care Plan must submit the plan of care template that includes these minimum components to the Agency for approval forty-five (45) days prior to implementation.
- f. Together, the case manager and enrollee must develop goals that address the issues that are identified in the care planning process, including, goals that ensure the enrollee is integrated into the community. Goals should be built on the enrollee's strengths and include steps that the enrollee will take to achieve the goal. Goals must be written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes. Enrollee goals must:
- (1) Be enrollee specific;
 - (2) Be measurable;
 - (3) Specify a plan of action/interventions to be used to meet the goals;

- (4) Include a timeframe for the attainment of the desired outcome; and
- (5) Be reviewed at each assessment visit and progress must be documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.
- g. The case manager is responsible for identifying the enrollee's primary care provider (PCP) and specialists involved in the enrollee's treatment and obtaining the required authorizations for release of information in order to coordinate and communication with the primary care provider and other treatment providers.
- h. The case manager is responsible for informing enrollees' primary care and other treatment providers that recipients should be encouraged to adopt healthy habits and maintain their personal independence.
- i. Upon the enrollee's or enrollee representative's agreement to the plan of care, the case manager is responsible for coordinating the services with appropriate providers.
- j. Copies of the plan of care must be forwarded to the enrollee's primary care provider and, if applicable, to the facility where the enrollee resides within ten (10) business days of development.
- k. The plan of care must document that the process for enrollee grievance and appeals was clearly explained. It must be noted for each service whether the frequency/quantity of the service has changed since the previous plan of care. The enrollee or representative must indicate whether they agree or disagree with each service authorization and sign the plan of care at initial development and when there are changes in services. The case manager must provide a copy of the plan of care to the enrollee or representative and maintain a copy in the case file.
- l. Enrollees who reside in "own home" settings should be encouraged, and assisted as indicated, by the case manager to have a disaster/emergency plan for their household that considers the special needs of the enrollee. If applicable, this plan must be placed in the enrollee's case file. Informational materials are available at the Federal Emergency Management Agency's (FEMA) website at www.fema.gov or www.ready.gov. Enrollees should also be encouraged to register with the state's Emergency Preparedness Special Needs Shelter Registry. For more information go to <http://www.doh.state.fl.us/phnursing/SpNS/SpecialNeedsShelter.html>
- m. At initial plan of care development and when there are changes in services, the case manager must create a Plan of Care Summary. The case manager shall provide the enrollee or enrollee's representative with a plan of care summary containing the following minimum components:
 - (1) The enrollee's name;
 - (2) The enrollee's date of birth and Medicaid ID Number;
 - (3) Covered services provided including routine medical and HCBS services;

- (4) Begin date of services;
- (5) Providers;
- (6) Amount and frequency;
- (7) Case manager's signature; and
- (8) Enrollee or the enrollee's authorized representative's signature and date.

4. Placement/Service Planning Standard

- a. Service authorizations must reflect services as specified in the plan of care. When developing service authorizations, case managers must authorize ongoing services within timeframes specified in the plan of care.
- b. The authorization time period must be consistent with the end date of the services as specified in the plan of care.
- c. When service needs are identified, the enrollee must be given information about the available providers so that an informed choice of providers can be made. The entire care planning process must be documented in the case record.
- d. The case manager must ensure that the enrollee or representative understands that some long-term care services (such as home health nurse, home health aide or durable medical equipment (DME) must be prescribed by the PCP.
- e. The case manager is responsible for coordinating physician's orders for those services requiring a physician's order.
- f. If the enrollee does not have a PCP or wishes to change PCP, it is the case manager's responsibility to coordinate the effort to obtain a PCP or to change the PCP.
- g. The case manager must also verify that medically necessary services are available in the enrollee's community. If a service is not currently available, the case manager must substitute a combination of other services in order to meet the enrollee's needs until such time as the desired service becomes available. A temporary alternative placement may be needed if services cannot be provided to safely meet the enrollee's needs.
- h. Enrollees cannot be required to enter an alternative residential placement/setting because it is more cost-effective than living in his/her home.
- i. If the enrollee disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the enrollee with a written notice of action that explains the enrollee's right to file an appeal regarding the placement or plan of care determination.

- j. If the case manager and PCP or attending physician do not agree regarding the need for a change in level of care, placement or physician's orders for medical services, the case manager must refer the case to the Managed Care Plan's Medical Director for review. The Medical Director is 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. The enrollee or enrollee representative must be notified in writing of any denial, reduction, termination or suspension of services, that varies from the type, amount, or frequency of services detailed on the Plan of Care that the enrollee or his/her representative has signed. Refer to Section IX, Grievance System.
- l. The Managed Care Plan shall submit a monthly summary report of all enrollees whose services have been denied, reduced, or terminated for any reason in accordance with Attachment II, Core Contract Provisions, Exhibit 12, Reporting Requirements.

5. Reassessment Standard

- a. The Managed Care Plan shall submit quarterly reports to the Agency on those enrollees receiving annual level of care redeterminations, within 365 days of the previous determination, enrollees having current level of care based on the Agency-required assessment tool and required medical documentation and on enrollees requesting a fair hearing related to their level of care, as specified in Attachment II, Core Contract Provisions, Section XII, Reporting Requirements.
- b. Case managers are responsible for ongoing monitoring of 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.
- c. Case managers are responsible for ensuring that an enrollee's care is coordinated, including, but not limited to:
 - (1) Ensuring each enrollee has an ongoing source of primary care appropriate to his/her needs;
 - (2) Coordinating the services furnished to the enrollee with services the enrollee receives from any other managed care entity or any other health care payor source;
 - (3) Conducting long-term care planning and face-to-face reassessments for level-of-care determination as required by this Contract;
 - (4) Tracking level-of-care redeterminations to ensure enrollees are reassessed face-to-face with the Agency-required assessment tool and required medical documentation and a new level of care determination authorized annually. Enrollees residing and remaining in the nursing home setting are exempt from the annual level of care redetermination requirement. If the Agency-required assessment tool is not submitted to the state in a timely manner and the level of

care expires, the case manager is responsible for ensuring that a new Agency-required certification form is completed, signed and dated by a physician.

- i. For enrollees residing and remaining in the community, the Managed Care Plan shall conduct the annual reassessment, and required medical documentation and submit to CARES no earlier than sixty (60), and no later than thirty (30), calendar days prior to the one (1) year anniversary date of the previous Notification of Level of Care form.
 - ii. For enrollees transitioned from the nursing facility into the community within twelve (12) months of their initial level of care determination, the Managed Care Plan must submit the reassessment thirty (30) calendar days prior to the date on the initial Notification of Level of Care form.
 - iii. For enrollees that reside in a nursing facility more than twelve (12) months before being transitioned into the community, the reassessment shall be due thirty (30) calendar days prior to the anniversary date of discharge from the nursing facility.
- (5) Tracking an enrollee's Medicaid financial eligibility on annual basis, and are responsible for helping the enrollee continuously maintain Medicaid financial eligibility. If the enrollee loses Medicaid financial eligibility due to inaction or lack of follow-through with the DCF redetermination process, the case manager shall help the enrollee regain Medicaid financial eligibility.
- (6) Referring pregnant enrollees to appropriate maternity and family services and notifying medical service payers of enrollee status for further eligibility determination for the enrollee and unborn infant.
- d. Case managers must conduct a face-to-face review within five (5) business days following an enrollee's change of placement type (e.g., from HCBS to an institutional setting, own home to assisted living facility or institutional setting to HCBS). This review must be conducted to ensure that appropriate services are in place and that the enrollee agrees with the plan of care as authorized.
 - e. The case manager must meet face-to-face at least every three (3) months with the enrollee and/or representative, in order to:
 - (1) Discuss the type, amount and providers of authorized services. If any issues are reported or discovered, the case manager must take and document action taken to resolve these as quickly as possible;
 - (2) Assess needs, including any changes to the enrollee's informal support system;
 - (3) Discuss the enrollee's perception of his/her progress toward established goals;
 - (4) Identify any barriers to the achievement of the enrollee's goals;
 - (5) Develop new goals as needed;

- (6) Review, at least annually, the enrollee handbook to ensure enrollees/representatives are familiar with the contents, especially as related to the grievance and reporting abuse, neglect, and exploitation, appeals process, covered services and their rights/responsibilities;
 - (7) Document the enrollee's current functional, medical, behavioral and social strengths; and
 - (8) Complete the Agency-required assessment form and medical documentation annually.
- f. The enrollee representative must be involved for the above if the enrollee is unable to participate due to a cognitive impairment or if the enrollee has a legal guardian.
 - g. The case manager must document contacts and face-to-face visits at the time of each visit or contact and when there are any changes in services. The enrollee or representative must indicate whether they agree or disagree with each service authorization and sign the plan of care each time changes occur. The enrollee must be given a copy of each signed plan of care.
 - h. The enrollee's HCBS providers must be contacted at least annually to discuss their assessment of the enrollee's needs and status. Contact should be made as soon as possible to address problems or issues identified by the enrollee/representative or case manager. This should include providers of such services as personal or attendant care, home delivered meals, therapy, etc.

Section V, Covered Services, Item K., Case File Documentation

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

- 1. The enrollee's case record documents all activities and interactions with the enrollee and any other provider(s) involved in the support and care of the enrollee. The record must include, at a minimum, the following information:
 - a. Enrollee demographic data including emergency contact information, guardian contact data, if applicable, permission forms and copies of assessments, evaluations, and medical and medication information;
 - b. Legal data such as guardianship papers, court orders and release forms;
 - c. Copies of eligibility documentations, including level of care determinations by CARES;
 - d. Identification of the enrollee's PCP;
 - e. Information from quarterly onsite assessments that addresses at least the following:
 - (1) Enrollee's current medical/functional/behavioral health status, including strengths and needs;

- (2) Identification of family/informal support system or community resources and their availability to assist the enrollee, including barriers to assistance;
 - (3) Enrollee's ability to participate in the review and/or who case manager discusses service needs and goals with if the enrollee was unable to participate, and
 - (4) Environmental and/or other special needs.
- f. Needs assessments, including all physician referrals;
 - g. Documentation of home-like characteristic for enrollees in ALFs and AFCHs. The responses to the home-like characteristics queries and enrollee limitations must be documented;
 - h. Documentation of interaction and contacts (including telephone contacts) with enrollee, family of enrollees, service providers or others related to services;
 - i. 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 plan of care;
 - j. Residential agreements between facilities and the enrollee;
 - k. Problems with service providers must be addressed in the narrative with a planned course of action noted;
 - l. Copies of eligibility documents, including LOC determinations;
 - m. Record of Service authorizations;
 - n. CARES assessment documents;
 - o. Documentation that the enrollee has received and signed, if applicable, all required plan and program information (including copies of the enrollee handbook, provider directory, etc);
 - p. Documentation of the discussion of Advanced Directives and Do Not Resuscitate orders;
 - q. Documentation of the discussion with the enrollee on the procedures for filing complaints and grievances;
 - r. Documentation of the choice of a participant-directed care option;
 - s. Notices of Action sent to the enrollee regarding denial or changes to services (discontinuance, termination, reduction or suspension);
 - t. Enrollee-specific correspondence;

- u. Physician's orders for long-term care services and equipment;
 - v. Provider evaluations/assessments and/or progress reports (e.g., home health, therapy, behavioral health);
 - w. Case notes including documentation of the type of contact made with the enrollee and/or all other persons who may be involved with the enrollee's care (e.g., providers);
 - x. Other documentation as required by the Managed Care Plan; and
 - y. Copy of the contingency plan and other documentation that indicates the enrollee/representative has been advised regarding how to report unplanned gaps in authorized service delivery.
2. Case management enrollee file information must be maintained by the Managed Care Plan in compliance with state regulations for record retention. Per 42 CFR 441.303(c)(3), written and electronically retrievable documentation of all evaluations and re-evaluations shall be maintained as required in 45 CFR 92.42. The Managed Care Plan shall specify in policy where records of evaluation and re-evaluations of level of care are maintained and exchanged with the CARES unit.
 3. The Managed Care Plan must adhere to the confidentiality standards under the Health Insurance Portability and Accountability Act (HIPAA).
 4. Case files must be kept secured.
 5. All narratives in case records must be electronically signed and dated by the case manager. Electronic signatures with date stamps are allowable for electronic case records.

Section V, Covered Services, Item L., Case Closure Standard

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

1. Case managers are required to provide community referral information on available services and resources to meet the needs of enrollees who are no longer eligible for the long-term care component of the SMMC program.
2. If a service is closed because the Managed Care Plan has determined that it is no longer medically necessary, the enrollee must be given a written Notice of Action regarding the intent to discontinue the service that contains information about his/her rights with regards to that decision.
3. When the enrollee's enrollment will be changed to another Managed Care Plan, the case manager must coordinate a transfer between the managed care plans. This includes transferring case management records from the prior twelve (12) months to the new managed care plan.

4. The case manager is responsible for notification of and coordination with service providers to assure a thorough discharge planning process and transition case management.
5. Case notes must be updated to reflect closure activity, including, but not limited to:
 - a. Reason for the closure;
 - b. Enrollee's status at the time of the closure; and
 - c. Referrals to community resources if the enrollee is no longer Medicaid eligible.

Section V, Covered Services, Item M., Abuse/Neglect and Adverse Incident Reporting Standard

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

1. Suspected cases of abuse, neglect and/or exploitation must be reported to the state's Adult Protective Services Unit. The Florida Adult Protective Services has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities. If the investigation required the enrollee to move from his/her current locations, the Managed Care Plan will coordinate with the investigator to find a safe living environment or another participating ALF of the enrollee's choice.
2. The Managed Care Plan must ensure that all staff and providers are required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours of the incident. Reporting will include information including the enrollee's identity, description of the incident and outcomes including current status of the enrollee. If the event involves a health and safety issue, the Managed Care Plan and case manager will arrange for the enrollee to move from his/her current location or change providers to accommodate a safe environment and provider of the enrollee's choice.
3. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee's case file, that is designated as confidential. Such file shall be made available to the Agency upon request.
4. Enrollee quality of care issues must be reported to and a resolution coordinated with the Managed Care Plan's Quality Management Department.

Section V, Covered Services, Item N., Monitoring of Care Coordination and Services

1. The Managed Care Plan will describe inter-departmental interface with UM, Care Coordination, Quality Management and inter-agency coordination (e.g., DOEA, AHCA) in the Case Management Program Description. Interface shall include electronic and written reports and verbal communication required for coordination of care planning activities.
2. Service Gap Identification and Contingency Plan

- a. The Managed Care Plan shall ensure the case manager review, with the enrollee and/or representative, the Managed Care Plan's process for immediately reporting any unplanned gaps in service delivery at the time of each plan of care review for each HCBS enrollee receiving in-home HCBS.
- b. The Managed Care Plan shall develop a standardized system for verifying and documenting the delivery of services with the enrollee or representative after authorization. The case manager shall verify the Managed Care Plan's documentation of assisted living services components and their delivery as detailed in the plan of care during each face-to-face review.
- c. The Managed Care Plan shall develop a form for use as a Service Gap Contingency and Back-Up Plan for enrollees receiving HCBS in the home. A gap in in-home HCBS is defined as the difference between the number of hours of home care worker critical service scheduled in each enrollee's HCBS plan of care and the hours of the scheduled type of in-home HCBS that are actually delivered to the enrollee. This form shall be reviewed and approved by the Agency prior to implementation. The Service Gap Contingency and Back-Up Plan must also be completed for those enrollees who will receive any of the following HCBS services that allow the enrollee to remain in their own home:
 - (1) Personal Care/Attendant Care Services, including participant directed services;
 - (2) Homemaker;
 - (3) In-Home Respite; and/or
 - (4) Skilled and Intermittent Nursing.
- d. The following situations are not considered gaps:
 - (1) The enrollee is not available to receive the service when the service provider arrives at the enrollee's home at the scheduled time;
 - (2) The enrollee refuses the caregiver when s/he arrives at the enrollee's home, unless the service provider's ability to accomplish the assigned duties is significantly impaired by the caregiver's condition or state (e.g., drug and/or alcohol intoxication);
 - (3) The enrollee refuses services;
 - (4) The provider agency or case manager is able to find an alternative service provider for the scheduled service when the regular service provider becomes unavailable;
 - (5) The enrollee and regular service provider agree in advance to reschedule all or part of a scheduled service; and/or
 - (6) The service provider refuses to go or return to an unsafe or threatening environment at the enrollee's residence.

- e. The contingency plan must include information about actions that the enrollee and/or representative should take to report any gaps and what resources are available to the enrollee, including on-call back-up service providers and the enrollee's informal support system, to resolve unforeseeable gaps (e.g., regular service provider illness, resignation without notice, transportation failure, etc.) within three (3) hours unless otherwise indicated by the enrollee. The informal support system must not be considered the primary source of assistance in the event of a gap, unless this is the enrollee's/family's choice.
- f. The Managed Care Plan's contingency plan must include the telephone numbers for provider and/or Managed Care Plan that will be responded to promptly twenty-four hours per day, seven days per week (24/7).
- g. In those instances where an unforeseeable gap in in-home HCBS occurs, it is the responsibility of the Managed Care Plan to ensure that in-home HCBS are provided within three hours of the report of the gap. If the provider agency or case manager is able to contact the enrollee or representative before the scheduled service to advise him/her that the regular service provider will be unavailable, the enrollee or representative may choose to receive the service from a back-up substitute service provider, at an alternative time from the regular service provider or from an alternate service provider from the enrollee's informal support system. The enrollee or representative has the final say in how (informal versus paid service provider) and when care to replace a scheduled service provider who is unavailable will be delivered.
- h. When the Managed Care Plan is notified of a gap in services, the enrollee or enrollee representative must receive a response acknowledging the gap.
- i. The contingency plan must be discussed with the enrollee/representative at least quarterly. A copy of the contingency plan must be given to the enrollee when developed and at the time of each review visit and updated as necessary.

3. Monitoring Activities

- a. The Managed Care Plan shall implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file 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. This information shall be submitted to the Agency on a quarterly basis, thirty (30) days after the close of each quarter.
- b. The case management case file audit tool to be used by the Managed Care Plan must be approved by the Agency prior to implementation and revision.
- c. At a minimum the case file and plan of care audit tool must include:
 - (1) Verification of participant eligibility;

- (2) Proper completion of assessment;
 - (3) Evidence of special screening for and monitoring of high risk persons and conditions;
 - (4) Comprehensive plan of care consistent with assessment and properly completed and signed by the individual;
 - (5) Management of diagnosis;
 - (6) All assessment forms and plans of care are complete and comprehensive including all required signatures whenever appropriate;
 - (7) Appropriateness and timeliness of care;
 - (8) Use of services;
 - (9) Ongoing case narrative documenting case management visits and other contacts;
 - (10) Documentation of individual provider choice and Medicaid Fair-Hearing information;
 - (11) Evidence of quality monitoring and improvement;
 - (12) Satisfaction survey; and
 - (13) Review of complaint and the quality remediation to resolve and prevent problems.
- d. 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.
- e. Utilization reporting shall include but not be limited to:
- (1) Reporting by level of service;
 - (2) Identification of HCBS enrollees not using services;
 - (3) Participant direction enrollment and activity report;
 - (4) Care coordination/case management activity report; and
 - (5) Case management file audit report.
- f. The Managed Care Plan shall provide reports demonstrating case management monitoring and evaluation including reporting results for the following performance measures but not limited to:

- (1) Level of care related reassessments within three-hundred thirty-five (335) days of previous level of care determination;
 - (2) Complete and accurate level of care forms for annual re-evaluations sent to CARES within thirty (30) calendar days of LOC due date;
 - (3) Number and percent of staff meeting mandated abuse, neglect and exploitation training requirements;
 - (4) Plan of Care audit results;
 - (5) Number and percentage of enrollee Plans of Care being distributed within ten (10) business days of development to the enrollee's PCP;
 - (6) Number and percentage of Plans of Care/summaries where enrollee participation is verified by signatures;
 - (7) Number and percentage of enrollee Plans of Care reviewed for changing needs on a face-to-face basis at least every three (3) months and updated as appropriate;
 - (8) Number and percentage of Plan of Care services delivered according to the plan of care as to service type, scope, amount and frequency;
 - (9) Number and percentage of enrollees with Plans of Care addressing all identified care needs;
 - (10) Number and frequency of enrollees having executed freedom of choice forms in their files;
 - (11) Number/percent of adverse/critical incidents reported within twenty-four (24) hours to the appropriate agency;
 - (12) Number and percent of case files that include evidence that advance directives were discussed with the enrollee; and
 - (13) Number and percent of enrollees requesting a Fair Hearing and outcomes.
- g. The Managed Care Plan shall develop an organized quality assurance and quality improvement program to enhance delivery of services through systemic identification and resolution of enrollee issues as specified in Attachment II, Core Contract Provisions, Section VIII, Quality Management.
- h. The Managed Care Plan shall develop a recording and tracking system log for enrollee complaints and resolutions and identify and resolve enrollee satisfaction issues, as specified in Section IX, Grievance System.

4. Missed Services

The Managed Care Plan (MCP) shall submit a monthly summary report of all missed Facility and Non-Facility services covered by the program for the previous month in accordance with Attachment II, Core Contract Provisions, Exhibit 12, Reporting Requirements. The monthly summary report should include the enrollee's name, authorized service units for the reported month, number of missed service units for the reported month and explanation for missed services and resolution of missed services. The report is due thirty (30) calendar days after the close of the month the missed services occurred. For months without missed services, the Managed Care Plan shall submit a report explaining that no authorized covered services were missed during the reported month.

5. Continuity of Care During Temporary Loss of Eligibility

The Managed Care Plan must provide covered services to enrollees who lose eligibility for up to sixty (60) calendar days. Likewise, care coordination/case management services must continue for such enrollees for up to sixty (60) calendar days.

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ATTACHMENT II
EXHIBIT 6
Behavioral Health — LTC Plans

Note: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

A. General Provisions

Behavioral health services will be provided to enrollees by other sources, including Medical Assistance managed care plans, Medicare, and state-funded programs and services. This will require coordination by the Managed Care Plan with other entities, including Medical Assistance managed care plans, Medicare plans, Medicare providers, and state-funded programs and services.

B. Responsibilities of the Managed Care Plan

The Managed Care Plan is responsible for coordinating with other entities available to provide behavioral health services including:

1. Developing and implementing a plan to ensure compliance with s. 394.4574, F.S., related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. A cooperative agreement, as defined in 429.02, F.S., must be developed with the ALF if an enrollee is a resident of the ALF;
2. Ensuring that appropriate behavioral health screening and assessment services are provided to plan enrollees and that medically necessary mental health targeted case management and behavioral health care services are available to all enrollees who reside in this type of setting;
3. Educating Managed Care Plan staff on screening; privacy and consent regulations and procedures; referral processes; and follow-up and provider coordination requirements;
4. Developing a systematic process for coordinating referrals to services for enrollees who request or who are identified by screening as being in need of behavior health care, by facilitating contact with the Medical Assistance managed care plan or other relevant entity or referring them to treatment providers for assessment and treatment;
5. Ensuring coordination of care of any specialized services identified in the PASRR;
 - a. Federal regulations (42CFR 483.100-483.138) require Preadmission Screening and Resident Review (PASRR) for all residents of Medicaid-certified nursing facilities, regardless of payer, based on s. 1919(e)(7) of the Social Security Act. The purpose is to ensure that nursing facility applicants and residents with serious mental illness (MI), mental retardation (MR), or a related condition receive a thorough evaluation, found to be appropriate for nursing facility placement, and will receive all specialized services necessary to meet their unique needs in the least restricting setting.

- b. The PASRR process includes:
 - i. PASRR Level I screening to identify possible MI/MR or related condition; and
 - ii. PASRR Level II evaluation and determination when:
 - A Level I screening indicates possible MI/MR or related condition, or
 - A Resident Review is required.
 - c. Detailed information and forms related to PASRR are available at the following website: http://elderaffairs.state.fl.us/doea/cares_pasrr.php
 - d. Medicaid reimbursement for nursing facility services requires providers to keep the following hard-copy documentation on file to support that:
 - 1. PASRR determined the recipient appropriate for the nursing facility setting;
 - 2. DCF determined the individual eligible for ICP; and
 - 3. DCF determined the monthly amount of the ICP-eligible recipient's patient responsibility.
 - e. Medicaid reimbursements are subject to recoupment, and providers are subject to sanctions and fines for any date of service:
 - 1. PASRR was not performed in a complete, timely and accurate manner;
 - 2. PASRR had not determined the individual appropriate for the nursing facility setting; or
 - 3. DCF had not determined the individual eligible for ICP.
6. Documenting all efforts to coordinate services, including the following:
- a. Authorizations for release of information;
 - b. Intake and referral;
 - c. Diagnosis and evaluation;
 - d. Needs assessment;
 - e. Plan of care development;
 - f. Resource assessment;
 - g. Plan of care implementation;

- h. Medication management;
 - i. Progress reports;
 - j. Reassessment and revision of plans of care; and
 - k. Routine monitoring of services by appropriate clinical staff.
7. Ensuring that a community living support plan, as defined in Section I, Definitions and Acronyms, of Attachment II, Core Contract Provisions, is developed and implemented for each enrollee who is a resident of an ALF or an AFCH, and that it is updated annually;
 8. Coordinating care (including communication of medication management, treatment plans and progress among behavioral health providers, medical specialists and long-term care providers);
 9. Ensure that a quarterly review of the enrollee's plan of care is conducted to determine the appropriateness and adequacy of services, and to ensure that the services furnished are consistent with the nature and severity of needs. Documentation of this quarterly review shall be maintained on file and provided at the Agency's request;
 10. Maintaining information about the enrollee's behavioral health condition, the types of services to be furnished, the amount, frequency and duration of each service, and the provider who will furnish each service;
 11. Provide training to the ALF staff and administrators of the procedures to follow should an urgent or emergent behavior health condition arise and ensuring that the procedures are followed; Assist the facility to develop and implement procedures for responding to urgent and emergent behavior health conditions, if none exist.
 12. Ensuring that facilities are fully compliant with the voluntary, involuntary and transport provisions of the Baker Act (see chapters 400 and 429, F.S.) for long-term care residents who are sent to a hospital or Baker Act receiving facility for psychiatric issues; and
 13. Ensuring through monitoring and reporting that facilities are fully compliant with Baker Act requirements (see s. 394.451, F.S.).
 14. Provide training to ALF staff which includes:
 - a. Signs and symptoms of mental illness;
 - b. Behavior management strategies;
 - c. Identification of suicide risk and management;
 - d. Verbal de-escalation strategies for aggressive behavior;
 - e. Trauma informed care;

- f. Documentation and reporting of behavior health concerns; and
- g. Abuse, neglect, exploitation and adverse incident reporting standards (as found in Attachment II, Core Contract Provisions, Section V, Covered Services, Item M.)

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**ATTACHMENT II
EXHIBIT 7
Provider Network — LTC Plans**

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Section VII, Provider Network, Item B., Network Standards

1. The Managed Care Plan shall enter into provider contracts with a sufficient number of long-term care providers to provide all covered services to enrollees and ensure that each covered service is provided promptly and is reasonably accessible.
2. In accordance with s. 409.982(4), F.S., and s. 409.98(1) - (19), F.S., the Managed Care Plan's network must include the following types of providers: (See Exhibit 7, Provider Network, Item I., Credentialing and Recredentialing, sub-item 7., LTC Provider Qualifications and Minimum Network Adequacy Requirements Table, for minimum waiver network standards).
 - a. Adult companion providers;
 - b. Adult day health care centers;
 - c. Adult family-care homes;
 - d. Assistive care service providers;
 - e. Assisted living facilities;
 - f. Attendant care providers;
 - g. Behavior management providers;
 - h. Caregiver training providers;
 - i. Case managers or case management agency;
 - j. Community care for the elderly lead agencies (CCEs);
 - k. Health care services pools;
 - l. Home adaptation accessibility providers;
 - m. Home health agencies;
 - n. Homemaker and companion service providers;
 - o. Hospices;
 - p. Medication administration providers;

- q. Medication management providers;
 - r. Medical supplies providers;
 - s. Nurse registries;
 - t. Nursing facilities;
 - u. Nutritional assessment and risk reduction providers;
 - v. Personal care providers;
 - w. Personal emergency response system providers;
 - x. Transportation providers; and
 - y. Therapy (occupational, speech, respiratory, and physical) providers.
3. In accordance with s. 409.982(1), F.S., the Managed Care Plan may limit the providers in its network based on credentials, quality and price; however, during the period between October 1, 2013 and September 30, 2014, the Managed Care Plan must, in good faith, offer a provider contract to all of the following providers in the region:
- a. Nursing facilities;
 - b. Hospices; and
 - c. Aging network services providers that previously participated in home and community-based waivers serving elders or community-service programs administered by DOEA, as identified in AHCA ITN 002-12/13, Attachment C, Exhibit 5.
4. In accordance with s. 409.982(1), after twelve (12) months of active participation in the Managed Care Plan's network, the Managed Care Plan may exclude any of the providers named in s. (3) above for failure to meet quality or performance criteria. 5. Unless otherwise provided in this Contract or authorized by the Agency, the Managed Care Plan shall ensure that each county in a region has at least two (2) providers available to deliver each covered HCBS. For HCBS provided in an enrollee's place of residence, the provider does not need to be located in the county of the enrollee's residence but must be willing and able to serve residents of that county. For adult day health care, the service provider does not have to be located in the enrollee's county of residence, but must meet the access standards for adult day health care specified in Item G. below.
5. The Managed Care Plan shall permit enrollees in the community to choose care through participant direction for allowable services as specified in Attachment II, Core Contract Provisions, Section V, and Exhibit 5. Such providers must agree to all applicable terms of the Managed Care Plan's policies and procedures. Such qualification requirements shall include all training and background screening

requirements. The Managed Care Plan shall develop any necessary policies, procedures, or agreements to allow providers to provide care to enrollees where appropriate.

6. The Managed Care Plan shall not continue to contract with providers designated as chronic poor performers, pursuant to the Managed Care Plan's policies and procedures.
7. The Managed Care Plan shall permit enrollees to choose from among all Managed Care Plan network residential facilities with a Medicaid-designated bed available. The Managed Care plan must inform the enrollee of any residential facilities that have specific cultural or religious affiliations. If the enrollee makes a choice, the Managed Care Plan shall make a reasonable effort to place the enrollee in the facility of the enrollee's choice. In the event the enrollee does not make a choice, the Managed Care Plan shall place the enrollee in a participating residential facility with a Medicaid-designated bed available within the closest geographical proximity to the enrollee's current residence. All Managed Care Plan enrollee placements into participating or non-participating residential facilities must be appropriate to the enrollees' needs.
8. The Managed Care Plan shall report to the Agency monthly, by the 15th calendar day of the month following the report month, the facility location of enrollee residing in a facility (including nursing facilities, assisted living facilities and adult family care homes) during the report month using the format provided in the LTC Report Guide referenced in Attachment II, Core Contract Provisions, Exhibit 12, Reporting Requirements, Summary of Reporting Requirements Table.

Section VII, Provider Network, Item C., Annual Network Development and Management Plan, 1.

- c. Home and community-based services (HCBS) are available on a seven (7) day a week basis, and for extended hours, as dictated by enrollee needs.

Section VII, Provider Network, Item D., Sub-Item 2., Regional Network Changes

- c. A loss of a nursing facility, adult day health care center, adult family care home or assisted living facility in a region where another participating nursing facility, adult day health care center, adult family care home or assisted living facility of equal service ability is not available to ensure compliance with the geographic access standards specified in Exhibit 7, Item G.

Section VII, Provider Network, Item D., Sub-Item 5., Regional Network Changes

6. If the Managed Care Plan excludes a provider in accordance with Attachment II, Core Contract Provisions, Exhibit 7, Item B.3., the Managed Care Plan must provide written notice to all enrollees who have chosen that provider for care, and the notice must be provided at least thirty (30) calendar days before the effective date of the exclusion

Section VII, Provider Network, Item E., Sub-Item 2., Provider Contract Requirements

- oo. Require that each provider 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.
- pp. Include requirements for residential facilities regarding collection of patient responsibility, including prohibiting the assessment of late fees.
- qq. For assisted living facilities and adult family care homes, that they must maintain a home-like environment pursuant to Exhibit 5 of this Contract.
The Managed Care Plan shall include the following statement verbatim in its provider contract agreements with assisted living facility and adult family care home providers:

(Insert ALF/AFCH identifier) will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

Enrollees residing in (insert ALF/AFCH identifier) must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms;
- Roommate for semi-private rooms;
- Locking door to living unit;
- Access to telephone and length of use;
- Eating schedule; and
- Participation in facility and community activities.

Ability to have:

- Unlimited visitation; and
- Snacks as desired.

Ability to:

- Prepare snacks as desired; and
- Maintain personal sleeping schedule.

- rr. The Managed Care Plan shall include the following statement in its provider contract agreements with assisted living facility providers:

(Insert ALF identifier) hereby agrees to accept monthly payments from (insert plan identifier) for enrollee services as full and final payment for all long-term care services detailed in the enrollee's plan of care which are to be provided by (insert ALF identifier). Enrollees remain responsible for the separate ALF room and board costs as detailed in their resident contract. As enrollees age in place and require more intense or additional long-term care services, (insert ALF identifier) may not

request payment for new or additional services from an enrollee, their family members or personal representative. (Insert ALF identifier) may only negotiate payment terms for services pursuant to this agreement with (insert plan identifier).

- ss. The Managed Care Plan shall include the following provision in its provider contract agreements with nursing facilities and hospices:
- The provider shall maintain active Medicaid enrollment and submit required cost reports to the Agency for the duration of this agreement.

Section VII, Provider Network, Item G., Appointment Waiting Times and Geographic Access Standards

1. The Managed Care Plan shall provide authorized HCBS within the timeframe prescribed in Attachment II, Core Contract Provisions, Section V, Covered Services, Item J., Case Management, and Exhibit 5. This includes initiating HCBS in the enrollee's plan of care within the timeframes specified in this Contract and continuing services in accordance with the enrollee's plan of care, including the amount, frequency, duration and scope of each service in accordance with the enrollee's service schedule.
2. Therapy, facility-based hospice, and adult day health care services must be available within an average of thirty (30) minutes from an enrollee's residence or other preferred location within the region. The Agency may waive this requirement, in writing, for rural areas and for areas where there is no applicable provider within a thirty (30) minute average travel time. Travel time requirements for adult day health care and therapy services are increased to sixty (60) minutes for rural areas.
3. Facility-based services are those services the enrollee receives from the residential facility in which they live. For purposes of this Contract assisted living facility, adult family care homes, assistive care, and nursing facility care services are facility-based.
4. The Managed Care Plan shall contract with at least two (2) facility-based service providers per county in the region(s) it serves and meet the licensed bed ratio requirement of one (1) licensed bed for each enrollee included in the applicable maximum enrollment level. If the Managed Care Plan demonstrates to the Agency's satisfaction that it is not feasible to meet either or both requirements within a specific county within a contracted region, the Agency may provide written authorization to use network facilities from one or more neighboring counties within the region to meet network requirements.
5. If the Managed Care Plan is able to demonstrate to the Agency's satisfaction that a region as a whole is unable to meet either or both network requirements for facility-based services, the Agency may waive the requirement at its discretion in writing. As soon as additional service providers become available, however, the Managed Care Plan shall augment its network to include such providers in order to meet the network adequacy requirements. Such a written waiver shall require attestation by the Managed Care Plan that it agrees to modify its network to include such providers as they become available.

6. Facilities from neighboring counties within the region are allowed as additional network providers above and beyond the required number. No state approval is required to include these additional providers in the Managed Care Plan network as long as minimum requirements specified in sub-paragraph G.,4., have been met.
7. The Managed Care Plan may not include facility-based service providers from outside the region as network providers unless the Managed Care Plan's provider agreement or subcontract specifies that it will serve the respective region(s); however, such providers may not be used to meet the region's minimum network requirements. A waiver from the Agency will be necessary if the Managed Care Plan cannot meet network requirements for facility-based services for a region using only providers located within that region.
8. In accordance with 42 CFR 438.206 (c), the Managed Care Plan shall establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.

Section VII, Provider Network, Item H., Continuity of Care

4. The Managed Care Plan shall allow enrollees to continue receiving medically necessary services from a not-for-cause terminated provider until the enrollee selects another provider, which shall not exceed sixty (60) calendar days after the termination of the provider's contract. The Managed Care Plan shall process provider claims for services rendered to such recipients during the sixty (60) calendar day period.

Section VII, Provider Network, Item I., Credentialing and Recredentialing, Sub-Item 2.

- h. Determination of whether the provider, or employee or volunteer of the provider, meets the definition of "direct service provider" and completion of a Level 2 criminal history background screening on each direct service provider to determine whether any have disqualifying offenses as provided for in s. 430.0402, F.S., and s. 435.04, F.S. Any provider or employee or volunteer of the provider meeting the definition of "direct service provider" who has a disqualifying offense is prohibited from providing services to enrollees. No additional Level 2 screening is required if the individual is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.)
 1. The Managed Care Plan must maintain a signed affidavit from each provider attesting to its compliance with this requirement, or with the requirements of its licensing agency if the licensing agency requires Level 2 screening of direct services providers.
 2. The Managed Care Plan must include compliance with this requirement in its provider contracts and subcontracts and verify compliance as part of its subcontractor and provider monitoring activity.

- i. Ensure that Assisted Living Facilities and Adult Family Care Homes meet the minimum home-like environment and community inclusion characteristics requirements as defined in Exhibit 5.

Section VII, Provider Network, Item I., Credentialing and Recredentialing

7. The Managed Care Plan's credentialing and recredentialing process must include ensuring that all long-term care providers are appropriately qualified, as specified in Table 1 - LTC Provider Qualifications & Minimum Network Adequacy Requirements, and Table 2 – PDO Provider Qualifications below:

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TABLE 1
LTC Provider Qualifications & Minimum Network Adequacy Requirements Table
Effective 08/01/2013 - 08/31/2018

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements*	
			Urban Counties	Rural Counties
Adult Companion	Community Care for the Elderly (CCE) Provider	As defined in Ch. 410 or 430, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Center for Independent Living	As defined under 413.371, F. S.		
	Homemaker/Companion Agency	Registration in accordance with 400.509, F.S.		
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	Nurse Registries	Licensed per Chapter 400.506, F. S.		
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F. S.		
Adult Day Care (Adult Day Health Care)	Assisted Living Facility (ALF)	Licensed per Ch. 429, Part I, F.S. with a written approval from 768 AHCA's HQA office to provide services under 429.905(2) F.S.	At least two (2) providers serving each county of the region AND at least (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within 60 minutes travel time.
	Adult Day Care Center	Licensed per Ch. 429, Part III, F.S.		
Assisted Living Facility Services	Assisted Living Facility	Licensed per Ch. 429, Part I, F.S. *	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Assistive Care Services	Adult Family Care Home (AFCH)	Licensed per Ch. 429, Part II, F.S. **	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements*	
			Urban Counties	Rural Counties
Attendant Care	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484. Services must be provided by a licensed RN or LPN.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Ch. 464, F.S.		
	Nurse Registry	Licensed per 400.506, F.S. Services must be provided by a licensed RN or LPN.		
Behavior Management	Clinical Social Worker, Mental Health Counselor	Licensed per Ch. 491, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Community Mental Health Center	Licensed per Ch. 394, F.S.		
	Home Health Agencies	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484. Direct service provider must have a minimum of 2 years direct experience working with adult populations diagnosed with Alzheimer's disease, other dementias or persistent behavioral problems.		
	Nurse Registries	Licensed per 400.506, F.S. Direct service provider must have a minimum of 2 years direct experience working with adult populations diagnosed with Alzheimer's disease, other dementias or persistent behavioral problems.		
	Psychologist	Licensed per Ch. 490, F.S.		

	Registered Nurse	Licensed per Ch. 464, Part I "Nurse Practice Act", F.S. and Ch. 64B9 "Board of Nursing", F.A.C.; Minimum of 2 years direct experience working with adult populations diagnosed with Alzheimer's disease, other dementias or persistent behavioral problems.		
Caregiver Training	CCE Provider	As defined in Ch. 410 or 430, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Clinical Social Worker, Mental Health Counselor	Licensed per Ch. 491, F.S.		
	RN, LPN	Licensed per Ch. 400, Part III, F.S.		
	Home Health Agency	Optional to meet Federal Conditions of Participation under 42 CFR 484.		

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Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements*	
			Urban Counties	Rural Counties
Case Management	Case Managers employed or contracted by LTC plans	Either 2+ yrs of relevant experience and: (1) BA or BS in Social Work, Sociology, Psychology, (2) RN licensed in FL, (3) BA or BS in unrelated field; or. (4) LPN with 4 yrs. of relevant experience; or (5) One year of additional relevant experience in lieu of each year of educational requirements plus 2 years of relevant experience. All must have 4 hrs. of in-service training in identifying and reporting Abuse, Neglect and Exploitation.	<u>Each case manager's caseload may not exceed sixty (60) for enrollees in HCBS settings, one hundred (100) for enrollees in nursing facilities or sixty (60) when the case manager has a mixed caseload.</u>	<u>Each case manager's caseload may not exceed sixty (60) for enrollees in HCBS settings, one hundred (100) for enrollees in nursing facilities or sixty (60) when the case manager has a mixed caseload.</u>
	Center for Independent Living	Either 2+ yrs of relevant experience and: (1) BA or BS in Social Work, Sociology, Psychology, (2) RN licensed in FL, (3) BA or BS in unrelated field; or. (4) LPN with 4 yrs. of relevant experience; or (5) One year of additional relevant experience in lieu of each year of educational requirements plus 2 years of relevant experience. All must have 4 hrs. of in-service training in identifying and reporting Abuse, Neglect and Exploitation.		
	Case Management Agency	Either 2+ yrs of relevant experience and: (1) BA or BS in Social Work, Sociology, Psychology, (2) RN licensed in FL, (3) BA or BS in unrelated field; or. (4) LPN with 4 yrs. of relevant experience; or (5) One year of additional relevant experience in lieu of each year of educational requirements plus 2 years of relevant experience. All must have 4 hrs. of in-service		

		training in identifying and reporting Abuse, Neglect and Exploitation. Designated a CCE Lead Agency by DOEA (per Ch. 430 F.S.) or other agency meeting comparable standards as determined by DOEA.		
Home Accessibility Adaptation	Independent Provider	Licensed per state and local building codes or other licensure appropriate to tasks performed. Ch. 205, F.S.; Licensed by local city and/or county occupational license boards for the type of work being performed. Required to furnish proof of current insurance.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Center for Independent Living	As defined under 413.371, F. S. and licensed under Ch. 205, F. S.		
	General Contractor	Licensed per 459.131, F.S.		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements*	
			Urban Counties	Rural Counties
Home Delivered Meals	Food Establishment Older American's Act	Permit under 500.12, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	(OAA) Provider	As defined in Rule 58A-1, F.A.C.		
	CCE Provider	As defined in Ch. 410 or 430, F.S.		
	Food Service Establishment	Licensed per S.509.241, F.S.		
Homemaker	Nurse Registry	Licensed per 400.506, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	CCE Provider	As defined in Ch. 410 or 430, F.S.		
	Center for Independent Living	As defined under 413.371, F. S.		
	Homemaker/Company Agency	Registration in accordance with Ch. 400.509, F.S.		
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F. S.		
Hospice	Hospice Organizations	Hospice providers must be licensed under Chapter 400, Part IV, F. S. and meet Medicaid and Medicare conditions of participation annually.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Intermittent and Skilled Nursing	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Medication Administration	RN, LPN	Licensed per Ch. 464, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	Nurse Registry	Licensed per 400.506, F.S.		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements*	
			Urban Counties	Rural Counties
	Unlicensed Staff Member Trained per 58A-5.0191(5), F.A.C.	Trained per 58A-5.0191(5), F.A.C.; demonstrate ability to accurately read and interpret a prescription label.		
Medication Management	Home Health Agencies	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484. Individuals providing services must be a RN or LPN.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Nurse Registries	Licensed per 400.506, F.S. Individuals providing services must be a RN or LPN.		
	Licensed Nurse, LPN	Licensed per Ch. 464, F.S.		
Medical Equipment & Supplies	Pharmacy	Licensed per Ch. 465, F.S.; Permitted per Ch. 465, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	Home Medical Equipment Company	Licensed per Ch. 400, Part VII, F.S if providing, or intends to provide, medical equipment and services. No license required if providing, or intends to provide, medical supplies only.		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements*	
			Urban Counties	Rural Counties
Nutritional Assessment and Risk Reduction	CCE Provider	As defined in Ch. 410 or 430, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	Nurse Registry	Licensed per 400.506, F.S.		
	Other Health Care Professional	Must practice within the legal scope of their practice.		
	Dietician/Nutritionist or Nutrition Counselor	Licensed per Ch. 468, Part X, F.S.		
Nursing Facility Care	See State Plan Requirements.	See State Plan Requirements.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Personal Care	Nurse Registry	Licensed per 400.506, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	CCE Provider	As defined in Ch. 410 or 430, F.S.		
Personal Emergency Response System	Alarm System Contractor	Certified per Ch. 489, Part II, F.S.	At least two (2) providers. Serving each county of the Region.	At least two (2) providers serving each county of the region.
	Low-Voltage Contractors and Electrical Contractors	Exempt from licensure in accordance with 489.503(15)(a-d), F.S. and 489.503(16), F.S.		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements*	
			Urban Counties	Rural Counties
Respite Care	CCE Provider	As defined in Ch. 410 or 430, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Nurse Registry	Licensed per 400.506, F.S.		
	Adult Day Care Center	Licensed per Ch. 429, Part III, F.S.		
	Assisted Living Facility**	Licensed per Ch. 429, Part I, F.S.		
	Nursing Facility	Licensed per Ch. 400, Part II, F.S.		
	Center for Independent Living	As defined under 413.371, F. S.		
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	Homemaker/Companion Agency	Registration in accordance with 400.509, F.S.		
Transportation	Independent (private auto, wheelchair van, bus, taxi)	Licensed per Ch. 322, F.S. or residential facility providers that comply with requirements of Ch. 427, F.S.	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
	Community Transportation Coordinator	Licensed per Chapter 316 and 322, F. S., in accordance with Chapter 41-2, F. A. C		
Occupational Therapy	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.	At least two (2) providers serving each county of the region AND at least (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within sixty (60) minutes travel time.
	Occupational Therapist	Licensed per Ch. 468, Part III, F.S.		
	Occupational Therapist Assistant	Licensed per Ch. 468, Part III, F.S.		
Physical Therapy	Physical Therapist	Licensed per Ch. 486, F.S.	At least two (2) providers serving each county of the region AND at least (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within sixty (60) minutes travel time.
	Physical Therapist Assistant	Licensed per Ch. 486, F.S.		
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements*	
			Urban Counties	Rural Counties
Respiratory Therapy	Home Health Agency	Home Health Agencies licensed per Chapter 400, Part III, F. S, employing certified respiratory therapists licensed under Chapter 468, F. S and may meet Federal Conditions of Participation under 42 CFR 484 or individuals licensed per Chapter 468, F. S. as certified respiratory therapists.	At least two (2) providers serving each county of the region AND at least (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within sixty (60) minutes travel time.
	Respiratory Therapist	Licensed per Ch. 468, F.S.		
Speech Therapy	Speech-Language Pathologist	Licensed per Ch. 468, Part I, F.S.	At least two (2) providers serving each county of the region AND at least (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within sixty (60) minutes travel time.
	Home Health Agency	Licensed per Ch. 400, Part III, F.S.; Optional to meet Federal Conditions of Participation under 42 CFR 484.		

* The Agency reserves the right to change Minimum Provider Qualifications and Minimum Network Adequacy Requirements.

**Additional qualifications: See Exhibit 5 for home-like environment and community inclusion requirements..

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Table 2

PDO Provider Qualifications

Effective 08/01/2013 - 08/31/2018

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications
Adult Companion	Individual	Non *
Attendant Care	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Homemaker	Individual	Non *
Intermittent/Skilled Nursing	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Personal Care	Individual	Non*

*Individuals of the enrollee's choosing may provide PDO services so long as they meet the minimum provider qualifications as above and are 16 years of age or older. PDO providers are also required to sign a Participant/Direct Service Worker Agreement and obtain a satisfactory Level II Background Check pursuant to Exhibit 4 of this agreement.

Section VII, Provider Network, Item J., Provider Services, Sub-Item 2.a., Provider Handbooks

- (19) The role of case managers;
- (20) Requirements for HCBS providers regarding critical incident reporting and management; and
- (21) Requirements for residential facilities regarding patient responsibility.

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ATTACHMENT II
EXHIBIT 8
Quality Management — LTC Plans

Note: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified

Section VIII, Quality Management, Item A., Quality Improvement

2. Specific Required Components of the QI Program

b. The Managed Care Plan shall appoint a Geriatrician to the QI program committee. The Geriatrician shall be a qualified geriatrician, with a current active unencumbered Florida license under Chapter 458 or 459, F.S., and further certified in Geriatric Medicine. The Geriatrician shall be responsible for establishing and monitoring the implementation and administration of geriatric management protocols to support long-term care requiring geriatric practice.

f. Critical Incidents

The Managed Care Plan shall develop and implement a critical and adverse incident reporting and management system for incidents that occur in a home and community-based long-term care service delivery setting, including: community-based residential alternatives; other HCBS provider sites; and an enrollee's home, if the incident is related to the provision of covered HCBS.

- (1) The Managed Care Plan shall require providers to report adverse incidents to the Managed Care Plans within twenty-four (24) hours of the incident.
- (2) The Managed Care Plan shall identify and track critical incidents and shall review and analyze critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues.
- (3) The Managed Care Plan shall report suspected abuse, neglect and exploitation of enrollees immediately in accordance with Chapter 415, F.S.
- (4) The Managed Care Plan shall implement and maintain a risk-management program.
- (5) The Managed Care Plan shall provide appropriate training and take corrective action as needed to ensure its staff, and participating providers, comply with critical incident requirements.
- (6) The Managed Care Plan shall report to the Agency, as specified in Section XII, Reporting Requirements, and in the LTC Report Guide, any death and any adverse incident that could impact the health or safety of an enrollee (e.g., physical or sexual abuse) within twenty-four (24) hours of detection or notification.

- (7) The Managed Care Plan shall report a summary of critical incidents in a monthly report to the Agency as identified in Attachment II, Core Contract Provisions, Reporting.

3. Managed Care Plan QI Activities

This provision replaces Attachment II, Core Contract Provisions, Section VIII, Quality Management, Item A., Quality Improvement, sub-item 3., Managed Care Plan QI Activities, sub-item b.

- a. PIPs — Annually, by January 1st of each Contract year, the Agency shall determine and notify the Managed Care Plan if there are changes in the number and types of PIPs the Managed Care Plan shall perform for the coming Contract year. The Managed Care Plan shall perform two (2) Agency-approved statewide performance improvement projects as specified in Attachment II, Core Contract Provisions, Exhibit 8. There must be one (1) clinical PIP and one (1) non-clinical PIP. One of the PIPs shall be the statewide Collaborative PIP as detailed by the Agency.

(1) LTC Performance Improvement Projects (PIPs) are as follows:

- i. The clinical PIP shall relate to care in a nursing facility.
- ii. The non-clinical PIP shall relate to care in a home and community-based setting.

(2) Each PIP shall include a sample size sufficient to produce a statistically significant result.

(3) All PIPs shall achieve, through ongoing measurements and intervention, significant improvement to the quality of care and service delivery, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at the ninety-five percent (95%) confidence level and must be sustained for a period of two (2) additional re-measurements. Measurement periods and methodologies shall be submitted to the Agency for approval before initiation of the PIP. If a PIP has successfully achieved sustained improvement, as approved by the Agency, it shall be considered complete and shall not meet the requirement for that PIP, although the Managed Care Plan may wish to continue to monitor the performance indicator as part of its overall QI program. In this event, the Managed Care Plan shall select a new PIP and submit it to the Agency for approval.

b. Performance Measures (PM)

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

HEDIS	
1	Care for Older Adults (COA): Add age bands: 18 to 60 years as of December 31 st of the measurement year* 61 to 65 years as of December 31 st of the measurement year* 66 years and older as of December 31 st of the measurement year
2	Call Answer Timeliness (CAT)
Agency — Defined	
	Call Abandonment (CAB) – Using the last issued specifications from the National Committee for Quality Assurance (NCQA).
3	Required Record Documentation (RRD)
4	Face-To-Face Encounters (F2F)
5	Case Manager Training (CMT)
6	Timeliness of Services (TOS)
7	Prevalence of prevalence of antipsychotic drug use in long-stay dementia residents
Survey-Based Measures	
8	CAHPS Nursing Home Survey — Long-Stay Resident: Staffing Composite (Items 10, 12-17)
9	CAHPS Nursing Home Survey — Long-Stay Resident: Recommend nursing home to others (Item 35)
10	Satisfaction with Long-Term Care Plan: CAHPS Supplemental Question and Enrollee Satisfaction Survey Item 11
11	Satisfaction with Care Manager: CAHPS Supplemental Question and Enrollee Satisfaction Survey Item 5
12	Rating of Quality of Services: CAHPS Supplemental Question and Enrollee Satisfaction Survey: Item 8

*Agency addition to HEDIS

- (10) The Managed Care Plan shall report results of PMs to the Agency as specified in Attachment II, Core Contract Provisions, Exhibit 12.
- (11) The Agency, at its sole discretion, may add and/or change required performance measures based on state and federal quality initiatives. These measures may include, but are not limited to, Medicare measures related to nursing home care and home-based care. Examples of measures that may be included are avoidable hospitalizations; hospital readmissions; prevalence of pressure ulcers; prevalence of use of restraints; rates of antipsychotic drug use; prevalence of dehydration among enrollees; and prevalence of Baker Act-related hospitalizations.

d. Medical/Case Record Review

- (3) The Managed Care Plan shall conduct these reviews at the following provider sites:

- i. Adult Family Care Homes (frequency of every other year); and
 - ii. Assisted Living Facilities (frequency of every other year).
- (4) The Managed Care Plan shall conduct these reviews at all provider and facility provider sites (provider sites refers to service providers such as home health agencies with multiple office locations serving a region and facility provider sites refers to assisted living facilities, adult family care homes and adult foster care facilities sites) that meet the criteria in this Exhibit.
- (5) The Managed Care Plan shall review each practice site (practice site refers to service providers with multiple office locations) at least once every three (3) years.
- (6) The Managed Care Plan shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews must be completed for large group practices or when additional data is necessary in specific instances.
- (7) The Managed Care Plan shall submit to the Agency for written approval, and maintain, a written strategy for conducting medical/case record reviews. The strategy must include, at a minimum, the following:
- i. Designated staff to perform this duty;
 - ii. Process for establishing inter-rater reliability;
 - iii. Sampling methodology for case selection;
 - iv. The anticipated number of reviews by practice site (non-facility service providers such as home health agencies with multiple offices locations serving the region);
 - v. Record confidentiality and security;
 - vi. The tool that the Managed Care Plan will use to review each site;
 - vii. Analysis and reporting, and
 - viii. How the Managed Care Plan shall link the information compiled during the review to other Managed Care Plan functions (e.g., QI, recredentialing, peer review).

Section VIII, Quality Management, Item B., Utilization Management

2. Practice Guidelines

- a. The Managed Care Plan shall adopt practice guidelines that meet the following requirements:

- (5) Licensed Clinical Social Workers, while classified as Health Care Professionals, are not permitted to make decisions to reduce, deny, suspend, or terminate services, unless it is within the scope of their license to do so according to Chapter 491, F.S. Under no circumstances will Licensed Clinical Social Workers diagnose and treat individuals as defined in Chapter 491, F.S.

Section VIII, Quality Management, Item C., Transition of Care

1. Transition to the Managed Care Plan

- a. The Managed Care Plan shall be responsible for coordination 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, 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.
- b. The Managed Care Plan shall provide continuation of such services until the enrollee receives an assessment, plan of care is developed and services arranged and authorized as required to address the long-term care needs of the enrollee, which shall be no more than sixty (60) days.

2. Transition from the Managed Care Plan

- a. The Managed Care Plan shall be responsible for coordination of care for enrollees transitioning to another Managed Care Plan or delivery system and shall assist the new Managed Care Plan with obtaining the enrollee's medical/case records.
- b. The Managed Care Plan shall implement a process determined by the Agency to ensure records and information are shared and passed to the new Managed Care Plan within thirty (30) days.
- c. As specified in s. 409.967(2)(h)1. F.S., if the Managed Care Plan intends to withdraw services from a region, the Managed Care Plan shall provide the Agency with one-hundred eighty (180) calendar days' notice and work with the Agency to develop a transition plan for enrollees, particularly those under case management and those with complex medication needs, and provide data needed to maintain existing case relationships.
- d. As specified in s. 409.967 (2)(h)1., F.S., Managed Care Plans that reduce enrollment levels or leave a region before the end of the Contract term must continue to provide services to the enrollee for ninety (90) days or until the enrollee is enrolled in another plan, whichever occurs first.

3. Transition of Care Policies and Procedures

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

- a. Appropriate support to case managers, and to enrollees and caregivers as needed, for referral and scheduling assistance for enrollees needing specialty health care, transportation or other service supports;
- b. Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting with assistance, as needed, by the Agency. Transfer of medical/case records in compliance with HIPAA privacy and security rules;
- c. Documentation of referral services in enrollee medical/case records, including reports resulting from the referral;
- d. Monitoring of enrollees with co-morbidities and complex medical conditions and coordination of services for high utilizers to identify gaps in services and evaluate progress of case management;
- e. Identification of enrollees with hospitalizations, including emergency care encounters and documentation in enrollee medical/case records of appropriate follow-up to assess contributing reasons for emergency visits and develop actions to reduce avoidable emergency room visits and potentially avoidable hospital admissions;
- f. Transitional care management that includes coordination of hospital/institutional discharge planning and post-discharge care, including conducting a comprehensive assessment of enrollee and family caregiver needs, coordinating the patient's discharge plan with the family and hospital provider team, collaborating with the hospital or institution's care coordinator/case manager to implement the plan in the patient's home and facilitating communication and the transition to community providers and services. The policy and procedures shall define reporting requirements for nursing facility transition, including reporting schedules for case management and submission to the Agency on a quarterly schedule.
- g. Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information.

D. Caregiver Support and Disease Management Program

1. The Managed Care Plan shall develop and implement an integrated program that combines elements of caregiver support and disease management. The integrated program shall be aimed at providing enrollee caregivers, circles of support for enrollees and the enrollee with support and education to help care for and improve the health and quality of life for the enrollee living with chronic conditions in the home. Examples of program components include:
 - a. Disease management including education based on the enrollee assessment of health risks and chronic conditions;

- b. Symptom management including addressing needs such as working with the enrollee on health goals such as smoking cessation, constipation prevention, pain management and other problems;
 - c. Medication support and safety in the home;
 - d. Emotional issues of the caregiver;
 - e. Behavioral management issues of the enrollee;
 - f. Safety concerns in the home and fall prevention;
 - g. Communicating effectively with providers;
 - h. Specific disease specific programs for:
 - (1) Dementia and Alzheimer's issues;
 - (2) Cancer;
 - (3) Diabetes; and
 - (4) Chronic Obstructive Pulmonary Disease (COPD); and
 - i. End of life issues, including information on advance directives.
2. The Managed Care Plan shall submit the Caregiver Support and Education Program Plan Description to the Agency before the beginning of the first month of this Contract and annually thereafter for review and approval by the Agency by a date specified by the Agency. The annual plan shall include an evaluation of program effectiveness.

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**ATTACHMENT II
EXHIBIT 9
Grievance System — LTC Plans**

Note: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

N/A

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**ATTACHMENT II
EXHIBIT 10
Administration and Management — LTC Plans**

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Section X, Administration and Management, Item B., Staffing, Sub-Item 2.b.

- b. Medical and Professional Support Staff: The Managed Care Plan shall maintain sufficient medical and professional support staff during non-business hours to respond to care-related inquiries from enrollees and caregivers.

FFS LTC PSNs

Section X, Administration and Management, Item C., Claims and Provider Payment, Sub-Item 1., Claims

- n. Providers shall submit claims to the Agency for Managed Care Plan-covered services provided to enrollees through the Managed Care Plan, unless other arrangements have been made with the Plan.
- o. Medicaid providers who are not participating in the Managed Care Plan and who provide Plan-authorized covered services to Plan enrollees must submit claims to the Agency or its fiscal agent through the Managed Care Plan.
- p. The provider must obtain prior authorization from the Managed Care Plan for each claim submitted for Plan-covered services for which prior authorization is required.
- q. The Managed Care Plan shall cooperate with the Agency and its fiscal agent in responding to provider inquiries, as well as acting as the intermediary between the fiscal agent and providers when there is disagreement between the two.
- r. The Managed Care Plan shall review the weekly electronic remittance voucher (ERV) for accuracy within ten (10) business days after receipt of the ERV.
 - (1) The Managed Care Plan shall notify the Agency of any systemic discrepancies found in its review of the ERV within five (5) business days after discovery. This notification shall be provided by the Managed Care Plan in writing to the Agency's Contract Manager.
 - (2) A systemic discrepancy is defined as a trend or pattern that indicates claims are inappropriately pending or denying or if the ERV is not received due to an error in the Managed Care Plan or the fiscal agent's claims processing system, software or management control.
 - (3) Failure to provide such notification to the Agency may lead to fines and/or other sanctions as detailed in Attachment II, Core Contract Provisions, Section XIV, Sanctions.

- s. The Managed Care Plan shall provide mechanisms for its staff to review contested claims in order to approve or deny specific line items or entire claims.
- t. The date of claim receipt is the date the Managed Care Plan receives the claim at its designated claims receipt location.
- u. Non-Capitated Services
 - (1) For all electronically submitted claims for non-capitated services, the Managed Care Plan shall:
 - i. Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim.
 - ii. Within ten (10) business days after receipt of the claim, authorize and forward the claim to the Medicaid fiscal agent or notify the provider or designee that the claim is contested. The notification to the provider or designee of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
 - (2) For all non-electronically submitted claims for non-capitated services, the Managed Care Plan shall, within fifteen (15) business days after receipt of the claim, perform the following:
 - i. Provide acknowledgement of receipt of the claim to the provider or designee or provide the provider or designee with access to the status of a submitted claim through such methods as, web portals, electronic reports or provider services telephonic inquiries.
 - ii. Authorize and forward the claim to the Medicaid fiscal agent or notify the provider or designee that the claim is contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
 - (3) The Agency, or its fiscal agent, shall reimburse fee-for-service Managed Care Plan providers for correct, authorized, clean claims according to the Florida Medicaid fee schedules for reimbursement for covered services provided to enrollees. The Agency or its fiscal agent shall also reimburse non-participating providers on a FFS basis for authorized services.

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**ATTACHMENT II
EXHIBIT 11
Information Management and Systems — LTC Plans**

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Section XI, Item K., Social Networking

1. The Managed Care Plan is prohibited from conducting social networking activities under this Contract.

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**ATTACHMENT II
EXHIBIT 12
Reporting Requirements — LTC Plans**

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

A. Managed Care Plan Reporting Requirements

- Managed Care Plan reports required by the Agency are as follows as indicated by plan type. These reports must be submitted as indicated in the Summary of Reporting Requirements table (below) and as specified in the LTC Report Guide.

Report Name	Contract Attachment D-II, Location; Report Guide Chapter	Plan Type	Frequency	Submit To
Enrollee Roster and Facility Residence Report	Exhibit 3; Chapter 22	All LTC Plans	Monthly, due within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Community Outreach Health Fairs/Public Events Notification	Section IV. B.4.b.; Chapter 6	All LTC Plans	No later than the twentieth (20 th) calendar day of month before event month; amendments two (2) weeks before event	SMMC SFTP Site
Community Outreach Representative Report	Section IV.B.8.a.; Chapter 7	All LTC Plans	Two (2) weeks before activity; Quarterly, forty-five (45) calendar days after end of reporting quarter	SMMC SFTP Site
Provider Network File	Section VII; Chapter 16	All LTC Plans	Weekly, each Thursday by 5 p.m. EST	Choice Counseling Vendor SFTP Site
Provider Termination and New Provider Notification Report	Section VII; Chapter 17	All LTC Plans	Weekly, each Wednesday by 5 p.m. EST of the week following the report week	SMMC SFTP Site
Provider Complaint Report	Section VII; Chapter 15	All LTC Plans	Quarterly within fifteen (15) calendar days after the end of reporting quarter	SMMC SFTP Site

Report Name	Contract Attachment D-II, Location; Report Guide Chapter	Plan Type	Frequency	Submit To
Critical Incident Report	Section VIII; Chapter 8	All LTC Plans	Immediately upon occurrence and no later than within twenty-four (24) hours of detection or notification	LTC MCP Contract Manager via email
Critical Incident Summary	Section VIII; Chapter 9	All LTC Plans	Monthly and rolled up for quarter and year — Due within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Cultural Competency Plan (and Annual Evaluation)	Section VIII; Chapter 10	All LTC Plans	Annually, by June 1	SMMC SFTP Site
Performance Measures - LTC	Section VIII and Exhibit 5 and 8; Chapter 27	All LTC Plans	Annually, by July 1	SMMC SFTP Site
Enrollee Complaints, Grievance, and Appeals Report	Section IX and Exhibit 12; Chapter 21	All LTC Plans	Quarterly, within fifteen (15) calendar days after end of the reporting quarter	SMMC SFTP Site
MPI — Quarterly Fraud & Abuse Activity Report	Section X; Chapter 13	All LTC Plans	Quarterly, within fifteen (15) calendar days after the end of reporting quarter	OIG MPI Web-based Application Site
MPI — Annual Fraud and Abuse Activity Report	Section X; Chapter 12	All LTC Plans	Annually, by September 1	MPI SFTP Site
MPI — Suspected/Confirmed Fraud and Abuse Reporting	Section X; Chapter 14	All LTC Plans	Within fifteen (15) calendar days of detection	Agency's Online Electronic Data Entry Complaint Form

Report Name	Contract Attachment D-II, Location; Report Guide Chapter	Plan Type	Frequency	Submit To
Claims Aging Report and Supplemental Filing Report	Section X; Chapter 5	All LTC Plans	Quarterly, forty-five (45) calendar days after end of reporting quarter; Capitated Plans, optional supplemental filing — one-hundred five (105) calendar days after end of reporting quarter	SMMC SFTP Site
Patient Responsibility Report	Section XV; Exhibit 15; Chapter 26	All LTC Plans	Annually, by October 1 for the prior Contract year	SMMC SFTP Site
Audited Annual and Unaudited Quarterly Financial Reports	Section XV; Chapter 4	All LTC Plans	Audited — Annually by April 1 for calendar year; Unaudited — Quarterly, forty-five (45) calendar days after end of reporting quarter	SMMC SFTP Site
Administrative Subcontractors and Affiliates Report	Section XVI; Chapter 3	All LTC Plans	Quarterly within fifteen (15) calendar days of end of quarter	SMMC SFTP Site
Nursing Facility Transfer Report (Number of Enrollees Transitioned)	Exhibit 5; Chapter 24	All LTC Plans	Monthly, within fifteen (15) calendar day following the end of the report month	SMMC SFTP Site
Denial, Reduction, Termination of Services Report	Exhibit 5; Chapter 20	All LTC Plans	Monthly, due fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site

Report Name	Contract Attachment D-II, Location; Report Guide Chapter	Plan Type	Frequency	Submit To
Utilization Reporting: <ul style="list-style-type: none"> • Home and community-based services (HCBS) • Nursing facility • Hospice Identification of HCBS enrollees not using services	Exhibit 5; Chapter 28	All LTC Plans	Quarterly with Annual Roll-up — due within thirty (30) calendar days of the end of the reporting quarter	SMMC SFTP Site
Participant Direction Option (PDO) Roster Report	Exhibit 5; Chapter 25	All LTC Plans	Monthly due within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Case Management File Audit Report	Exhibit 5; Chapter 18	All LTC Plans	Quarterly — due within thirty (30) calendar days of the end of the reporting quarter	SMMC SFTP Site
Case Management Monitoring and Evaluation Report	Exhibit 5; Chapter 19	All LTC Plans	Quarterly with annual roll-up — due within thirty (30) calendar days of the end of the reporting quarter	SMMC SFTP Site
Missed Services Report	Exhibit 5; Chapter 23	All LTC Plans	Monthly, due thirty (30) calendar days after the end of the reporting month	SMMC SFTP Site
Insolvency Protection Multiple Signatures Agreement Form	Exhibit 15; Chapter 11	All LTC Plans	Annually, by April 1; thirty (30) calendar days after any change	SMMC SFTP Site or LTC MCP Contract Manager via mail if changes made

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ATTACHMENT II
EXHIBIT 13
Method of Payment — LTC Plans

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Capitated LTC Plans

A. Fixed Price Unit Contract

This is a fixed price (unit cost) Contract awarded through procurement. The Agency, through its fiscal agent, shall make payment to the Managed Care Plan on a monthly basis for the Managed Care Plan's satisfactory performance of its duties and responsibilities as set forth in this Contract.

B. Capitation Rates

1. The Agency shall pay the applicable capitation rate for each eligible enrollee whose name appears on the HIPAA-compliant X12 820 file for each month, except that the Agency shall not pay for, and shall recoup, any part of the total payment for enrollment that exceeds the maximum authorized enrollment level(s) expressed in Attachment I, Scope of Services, as applicable. The total payment amount to the Managed Care Plan shall depend upon the number of enrollees in each eligibility category and each rate group, as provided for by this Contract, or as adjusted pursuant to the Contract when necessary. The Managed Care Plan is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the Managed Care Plan has received capitation payment or for whom the Agency has assured the Managed Care Plan that capitation payment is forthcoming.
2. In accordance with ss. 409.968 and 409.983, F.S., the capitation rates reflect historical utilization and spending for covered services projected forward and will be adjusted to reflect the level of care profile (risk) for enrollees in each Managed Care Plan.
3. The rates shall be actuarially sound in accordance with 42 CFR 438.6(c).
4. Pursuant to s. 409.966(3)(d), F.S., for the first year of the first Contract term, the Agency shall negotiate capitation rates in order to guarantee savings of at least five percent (5%). Determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the Agency paid managed care plans for similar populations in the same areas in the prior year. In a region without any capitated plans in the prior year, savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year. After the first year no further rate negotiations will be conducted.
5. The base capitation rates prior to risk adjustment are included as Attachment I, Scope of Services, Exhibit 3, titled "**ESTIMATED MANAGED CARE PLAN RATES; NOT FOR USE UNLESS APPROVED BY CMS.**"

- a. The Agency may use, or may amend and use these rates, only after certification by its actuary and approval by the Centers for Medicare and Medicaid Services. Inclusion of these rates is not intended to convey or imply any rights, duties or obligations of either party, nor is it intended to restrict, restrain or control the rights of either party that may have existed independently of this section of the Contract.
 - b. By signature on this Contract, the parties explicitly agree that this section shall not independently convey any inherent rights, responsibilities or obligations of either party, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by either party. In the event that the rates certified by the actuary and approved by CMS are different from the rates included in this Contract, the Managed Care Plan agrees to accept a reconciliation performed by the Agency to bring payments to the Managed Care Plan in line with the approved rates. The Agency may amend and use the CMS-approved rates by notice to the Managed Care Plan through an amendment to the Contract.
6. Unless otherwise specified in this Contract, the Managed Care Plan shall accept the capitation payment received each month as payment in full by the Agency for all services provided to enrollees covered under this Contract and the administrative costs incurred by the Managed Care Plan in providing or arranging for such services. Any and all costs incurred by the Managed Care Plan in excess of the capitation payment shall be borne in total by the Managed Care Plan.

C. Risk Adjustment

1. The Agency shall prospectively adjust the base capitation rates included in Attachment I, Scope of Services to reflect the Managed Care Plan's enrolled risk.
2. The Agency shall develop a pre-enrollment benchmark case mix for each region based on analysis of the most recent twelve (12) months of historical data that allows for three (3) months of claims run out. The enrollment distribution will be calculated using population segmentation logic consistent with that used in rate development. Recipients whose last care setting prior to the start of the capitation rate period was nursing facility will be classified as Non-HCBS. Recipients who become program-eligible after the start of the capitation rate period will be classified as Non-HCBS based on program codes that indicate Institutional Care Program eligibility. Enrollees not meeting the Non-HCBS classification criteria will be classified as HCBS. For rate purposes, for both the transitioned and new enrollees, the recipient's initial classification will remain valid through the duration of the capitation rate period.
3. Month 1: In each region, the Agency shall pay the Managed Care Plan a blended capitation rate that reflects the regional pre-enrollment benchmark case mix, adjusted for the Agency-required transition percentage, which is included as [Attachment I, Scope of Services, Exhibit 3. AHCA will later perform a reconciliation based on month one (1) actual enrollment and case mix for each plan.
4. Subsequent months: For the second month and each subsequent month of the contract payment period, AHCA will develop a blended capitation rate for the Managed Care Plan, adjusted for the new enrollments and disenrollments that occurred in the previous month, and adjusted for the Agency-required transition percentage.

5. Once ninety-five percent (95%) of regional eligible recipients are enrolled in managed care plans, the Agency shall ensure that the recalibrated rates are budget neutral to the State on a PMPM basis. The benchmark against which budget neutrality will be measured is the region-wide rate based on the pre-enrollment case mix with the Agency-required transition percentage.

D. Rate Adjustments and Reconciliations

1. The Managed Care Plan and the Agency acknowledge that the capitation rates paid under this Contract are subject to approval by the federal government.
2. The Managed Care Plan and the Agency acknowledge that adjustments to funds previously paid, and to funds yet to be paid, may be required. Funds previously paid shall be adjusted when capitation rate calculations are determined to have been in error, or when capitation rate payments have been made for enrollees who are determined not to have been eligible for Managed Care Plan membership during the period for which the capitation rate payments were made. In such events, the Managed Care Plan agrees to refund any overpayment and the Agency agrees to pay any underpayment.
3. Pursuant to ss. 409.983(6) and 409.983(7), F.S., the Agency shall reconcile the Managed Care Plan's payments to nursing facilities and hospices as follows:
 - a. Actual nursing facility payments shall be reconciled by the Agency to ensure actual claim payments are, at a minimum, the same as Medicaid fee-for-service (FFS) claim payments. Any Managed Care Plan provider payments to nursing homes in excess of FFS claim payment will not be reimbursed by the Agency or in any way increase per member per month payment to the Managed Care Plan in any current or future capitation rate setting period. The Managed Care Plan accepts and assumes all risks of excess payments as a cost of doing business and cannot seek additional Medicaid payments for such business decisions. Any inadvertent payments made by the Agency to a Managed Care Plan in excess of the FFS amount shall be overpayments and shall be recouped.
 - (1) For Capitated LTC plans the rate and patient responsibility collection reconciliation process required by the LTC waiver program and 409.983(6), Florida Statutes, is as follows:
 - i. Nursing Facilities: The Agency will set facility-specific payment rates based on the rate methodology outlined in the most recent version of the Florida Title XIX Long-Term Care Reimbursement Plan. Plans shall pay nursing homes an amount no less than the nursing facility specific payment rates set by the Agency and published on the Agency website. Plans shall use the published facility-specific rates as a minimum payment level for all future payments.
 - ii. Nursing facilities participating in LTC plans' networks must maintain their active Medicaid enrollment and submit required cost reports to the Agency.

iii. For changes in nursing facility payment rates that apply prospectively, the following process shall be used:

- The Agency will annually reconcile between the nursing facility payment rates used in the capitation rates and the actual published payment rates. This plan-specific reconciliation will be performed using each plan's own utilization, as reflected through encounter data that covers the capitation rate period dates of services with at least four (4) months of claims run out.
- The Plan shall review and provide written comments or a letter of concurrence to the Agency within forty-five (45) days after receipt of the reconciliation results. This reconciliation is considered final if the Plan concurs with the result.
- Comments and errors identified are limited to the published rates reviewed and related Plan nursing facility and hospice payments, methodology and/or calculations.
- If the Plan or the Agency comments that such an error has occurred, a new forty-five (45) calendar review period shall start on the date the Plan receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive. The Plan may dispute the Agency's decision as per Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, I. disputes, if it does not concur with the results.
 - If the Plan does not provide comments within the forty-five (45) calendar day period, no further opportunity for review consideration will be provided.

iv. For changes in nursing facility payment rates that apply retroactively, the following process shall be used:

- The Agency shall settle directly with nursing facilities that were overpaid for the prior period. The Managed Care Plan shall not collect such payments from the nursing facilities.
- The Agency may settle directly with nursing facilities that were underpaid for the prior period, or may send the payment to the appropriate Managed Care Plan for distribution to the affected service provider. If the Managed Care Plan is asked to distribute an underpayment to a nursing facility under this process, payment to the facility must be made within [fifteen] [15] days of receiving the payment from the Agency.

(2) Hospices: The Agency will set hospice level of care and room and board rates based upon the rate development methodology detailed in 42 CFR Part 418 for per diem rates and Chapter 409.906 (14), Florida Statutes and 59G-4.140,

Florida Administrative Code, for room and board rates. Plans shall pay hospices an amount no less than the hospice payment rates set by the Agency and published on the Agency website no later than October 1st of each year for per diem rates and January 1st and July 1st of each year for room and board rates for nursing home residents. Plans shall use the published hospice rates as a minimum payment level for all future payments.

- i. Hospices participating in the LTC plan networks must maintain their active Medicaid enrollment and submit room and board cost logs to the Agency.
 - ii. For changes in hospice per diem and room and board payment rates that apply prospectively, the following process shall be used:
 - The Agency will annually reconcile between the hospice per diem and room and board payment rates used in the capitation rates paid and the actual published payment rates. This hospice-specific reconciliation will be performed using each plan's own utilization, as reflected through encounter data that covers the capitation rate period dates of services with at least four (4) months of claims run out.
 - The Plan shall review and provide written comments or a letter of concurrence to the Agency within forty-five (45) days after receipt of the reconciliation results. This reconciliation is considered final if the Plan concurs with the result.
 - Comments and errors identified are limited to the published rates reviewed and related Plan hospice payments, and methodology. and/or calculations.
 - If the Plan or the Agency comments that such an error has occurred, a new forty-five (45) calendar review period shall start on the date the Plan receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive. The Plan may dispute the Agency's decision as per Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, I. disputes, if it does not concur with the results.
 - If the Plan does not provide comments within the forty-five (45) calendar day period, no further opportunity for review consideration will be provided.
- (3) Patient Responsibility Reconciliation All Plans shall have their annual patient responsibility collections and Home and Community-based Services (HCBS) waiver service costs report reviewed annually to verify the patient responsibility collections on a per capita basis did not exceed the cost of HCBS services. If the per capita patient responsibility collections exceed the HCBS waiver costs, the Agency will adjust the capitation to correct the plan overpayment.

- (4) Nursing Facility, Hospice and Patient Responsibility Collection Reconciliation Schedule. The state will announce the reconciliation schedule after the close of each capitation rate period. Plans must respond to any Agency requests for additional information concerning the reconciliation within fifteen (15) days of notification.
 - b. Actual hospice payments shall be reconciled by the Agency to ensure actual claim payments are, at a minimum, the same as Medicaid fee-for-service (FFS) claim payments. Any Managed Care Plan provider payments to hospices in excess of FFS claim payment will not be reimbursed by the agency or in any way increase per member per month payment to the Managed Care Plan in any current or future capitation rate setting period. The Managed Care Plan accepts and assumes all risks of excess payments as a cost of doing business and cannot seek additional Medicaid payments for such business decisions. Any inadvertent payments made by the Agency to a Managed Care Plan in excess of the FFS amount shall be overpayments and shall be recouped.
4. The Agency shall adjust capitation rates to reflect budgetary changes in the Medicaid program. The rate of payment and total dollar amount may be adjusted with a properly executed amendment when Medicaid expenditure changes have been established through the appropriations process and subsequently identified in the Agency's operating budget. Legislatively-mandated changes shall take effect on the dates specified in the legislation. The Agency may not approve any Managed Care Plan request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act. (See s. 409.968(3), F.S.).
5. In accordance with s. 409.967(3), F.S., the Agency shall verify the achieved savings rebate specified in Exhibit 15 of this Contract.

E. Errors

The Managed Care Plan shall carefully prepare all reports and monthly payment requests for submission to the Agency. If after preparation and electronic submission, the Managed Care Plan discovers an error, including, but not limited to, errors resulting in capitated payments above the Managed Care Plan's authorized levels, either by the Managed Care Plan or the Agency, the Managed Care Plan has thirty (30) calendar days from its discovery of the error, or thirty (30) calendar days after receipt of notice by the Agency, to correct the error and re-submit accurate reports and/or invoices. Failure to respond within the thirty-(30) calendar-day period shall result in a loss of any money due to the Managed Care Plan for such errors and/or sanctions against the Managed Care Plan pursuant to Attachment II, Core Contract Provisions, Section XIV, Sanctions.

F. Enrollee Payment Liability Protection

Pursuant to s. 1932 (b)(6), Social Security Act (as enacted by section 4704 of the Balanced Budget Act of 1997), the Managed Care Plan shall not hold enrollees liable for the following:

1. For debts of the Managed Care Plan, in the event of the Managed Care Plan's insolvency;

2. For payment of covered services provided by the Managed Care Plan if the Managed Care Plan has not received payment from the Agency for the covered services (excluding Medicaid Pending who are determined ineligible for Medicaid as specified in Exhibit 3 of this Contract), or if the provider, under contract or other arrangement with the Managed Care Plan, fails to receive payment from the Agency or the Managed Care Plan; and/or
3. For payments to a provider, including referral providers, that furnished covered services under a contract, or other arrangements with the Managed Care Plan, that are in excess of the amount that normally would be paid by the enrollee if the covered services had been received directly from the Managed Care Plan.

G. Achieved Savings Rebate

1. The capitated Managed Care Plan shall have an annual financial audit conducted for each calendar year ending December 31st in accordance with s. 409.0957(3), F.S., and as specified as follows:
 - a. An annual financial audit conducted by an independent certified public accountant (CPA) in accordance with generally accepted accounting principles (GAAP); and
 - b. For plans regulated by the Office of Insurance Regulation (OIR) an annual statement prepared in accordance with statutory accounting principles.
2. The capitated Managed Care Plan shall submit to the Agency the following documents by the due dates specified below:
 - a. Annual financial audit on or before June 1st for the preceding calendar year; and
 - b. For plans regulated by OIR, an annual statement on or before March 1st.
3. Each capitated Managed Care Plan shall pay to the Agency the expenses of the Agency's achieved savings rebate audit at the rates established by the Agency by rule. Expenses shall include actual travel expenses, reasonable living expense allowances, compensation of the CPA and necessary attendant administrative costs of the Agency directly related to the audit/examination. The Managed Care Plan shall pay the Agency within twenty-one (21) calendar days after presentation by the Agency of the detailed account of the charges and expenses.
4. At a Florida location by the date specified by the Agency's contracted CPA, the Managed Care Plan shall make available all books, accounts, documents, files and information that relate to the Managed Care Plan's Medicaid transactions.
 - a. The Managed Care Plan shall cooperate in good faith with the Agency and the CPA.
 - b. Records not in the Managed Care Plan's immediate possession must be made available to the Agency or the CPA in the Florida location specified by the Agency or the CPA within three (3) calendar days after a request is made by the Agency or the CPA.

- c. Failure to comply with such record requests shall be deemed a breach of Contract, and the Managed Care Plan shall be subject to sanctions as specified in Section XIV, Sanctions, of this Contract.
5. If the Managed Care Plan exceeds the Agency-defined quality measures specified in the Performance Measure Specification Manual for the reporting period, the Managed Care Plan may retain an additional one (1) percent of its revenue. Quality measures shall include Plan performance for preventing or managed complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments, in accordance with s. 409.7057(3)(g), F.S. The Agency will establish quality measures prior to Contract execution. The Agency may change those measures annually by a date specified by the Agency for the following Contract year.
6. The Agency CPA will validate the achieved savings rebate, and the results will be provided to the Agency. These results are dispositive.
7. The Agency will provide the results of the audit to the Managed Care Plan, and the Managed Care Plan shall pay the rebate to the Agency within thirty (30) calendar days after the results are provided.
 - a. The achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income ratios:
 - (1) One hundred (100) percent of income up to and including five (5) percent of revenue shall be retained by the plan.
 - (2) Fifty (50) percent of income above five (5) percent and up to ten (10) percent shall be retained by the plan, and the other fifty (50) percent refunded to the state.
 - (3) One hundred (100) percent of income above ten (10) percent of revenue shall be refunded to the state.
 - b. The following expenses are not allowable expenses in calculating costs:
 - (1) Payment of achieved savings rebates;
 - (2) Any financial incentive payments made to the Plan outside of the capitation rate;
 - (3) Any financial disincentive payments levied by the state or federal governments;
 - (4) Expenses associated with any lobbying or political activities;
 - (5) Cash value or equivalent cash value of bonuses of any type paid or awarded to the plan's executive staff other than base salary;
 - (6) Reserves and reserve accounts;
 - (7) Administrative costs, including but not limited to:

- (a) Reinsurance expenses;
- (b) Interest payments;
- (c) Depreciation expenses;
- (d) Bad debt expenses;
- (e) Outstanding claims expenses in excess of actuarially sound maximum amounts set by the Agency.

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8. The Achieved Savings Rebate shall be calculated in accordance with s. 409.967(3)(f), F.S., as illustrated below.

Note: The following three (3) increments shall be applied to the Managed Care Plan's pre-tax income (AKA: net operating income [NOI])

Achieved Savings Rebates Table – Effective 8/01/2013 – 8/31/2018			
	NOI Range Category	Amount Managed Care Plans will be allowed to keep	Amount Managed Care Plans will be required to refund to the Agency
I	NOI ranging from Zero (0) up to and including five (5) percent of the Plan's capitated premium revenue:	Managed Care Plans will be allowed to keep 100% of Net Operating Income within this range.	Managed Care Plans will not be required to refund any of their Net Operating Income.
II	NOI above five (5) percent and up to and including ten (10) percent of the Plan's capitated premium revenue:	Managed Care Plans will be allowed to keep 50% of the Net Operating Income within this range.	Managed Care Plans will be required to refund 50% of the Net Operating Income.
III	NOI above ten (10) percent of capitated premium revenue:	Managed Care Plans will not be allowed to keep any of the Net Operating Income.	Managed Care Plans will have to refund the Agency 100% of the Net Operating Income.

Example: If the Plan's capitated premium revenues are \$1,000,000 and expenses are \$850,000, the Plan is left with a pre-tax income (NOI) of \$150,000. The pre-tax income (NOI) of revenue is calculated to be 15% (NOI/Revenue):

	Allowed to keep:		Required to refund:	
Net Operating Income from 0.00% to 5.00% = \$50,000.00	100% of income within this range:	\$50,000.00	0% of income within this range:	\$0.00
Net Operating Income from 5.01% to 10.00% = \$50,000.00	50% of income within this range:	\$25,000.00	50% of income within this range:	\$25,000.00
Net Operating Income from 10.01% and above = \$50,000.00	0% of income within this range:	\$0.00	100% of income within this range:	\$50,000.00
TOTAL: \$150,000.00		\$75,000.00		\$75,000.00

A. Overview

In accordance with s. 409.912(4)(d)1., F.S., the PSN has the option to be reimbursed on a FFS basis with a shared savings settlement, for the first two (2) years of its operations. If the PSN chooses to be reimbursed on a FFS basis with a shared savings settlement, the Agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by a FFS PSN for the dates of service within the period being reconciled.

This is a fixed price (unit cost) Contract awarded through procurement. The Agency will manage this fixed price contract for the delivery of services to enrollees. The FFS PSN will be paid through the Medicaid fiscal agent in accordance with the terms of this Contract, subject to the availability of funds and the amount of shared cost savings, if any, experienced through this Contract. To accommodate payments, the FFS PSN shall be eligible for enrollment, and enrolled as a Medicaid provider with the fiscal agent. Payments made to the FFS PSN resulting from this Contract will include monthly administrative allocation payments, transportation capitation rates and shared cost savings, if any, as specified below.

1. Administrative Allocation. The Agency may make monthly payments to the FFS PSN as an allocation for administrative activities undertaken by the FFS PSN.
 - a. The amount of the administrative allocation is a PMPM amount for each person enrolled in the FFS PSN for the month. The administrative allocation is a percentage of the Per Capita Capitation Benchmark (PCCB) as defined below in sub-item 2. and as specified in Attachment I, Scope of Services, Item D., Method of Payment, of this Contract.
 - b. The FFS PSN is at risk for a maximum of fifty percent (50%) of each administrative allocation due from the Agency as indicated in Attachment II, Core Contract Provisions, Exhibit 13, Method of Payment, Item C., Annual Cost Reconciliation Process, below.
 - c. The Agency reserves the right to adjust the administrative allocation on an as-needed basis.
2. Per Capita Capitation Benchmark (PCCB). The Agency shall establish a PCCB for each region in which the FFS PSN provides services and for those services the FFS PSN provides. The PCCB is an Agency-established PMPM cost and, for purposes of this section, is considered to be the capitation rate that the Agency would have paid the FFS PSN if the FFS PSN had been capitated.
 - a. The PCCB is a rate that includes covered services consistent with Medicaid Managed Care Plan capitation rate methodology.
 - b. The PCCB is calculated in the same manner as the payments to capitated plans, reflecting a blend of the base HCBS and non-HCBS base rates shown in Attachment I, Scope of Services. The blend percentage will be based on the FFS PSN's case-

mix, adjusted by the region-specific Agency-required transition percentage shown in Attachment II, Core Contract Provisions.

- c. The Agency will make a downward adjustment to the PCCB to remove the value of the transportation capitation payment received by the FFS PSN from the Agency.
- d. The aggregate PCCB is the total sum of all PCCBs for all enrollees as calculated by the Agency.

B. Annual Utilization Data

For each twelve (12) months of FFS PSN operations, the Agency will provide the FFS PSN with a CD containing monthly summary spreadsheets with supporting documents and claims details.

C. Annual Cost Reconciliation Process

The Agency shall conduct annual cost reconciliations to determine the amount of cost savings achieved by the FFS PSN for the dates of service in the period being reconciled. The Agency shall calculate the aggregate amount of actual non-transportation payments made on behalf of the FFS PSN's enrollees. Only payments for covered services for dates of service within the reconciliation period and paid within six (6) months after the last date of service in the reconciliation period will be included. This allows for a complete payment of all claims for the reconciliation period. If the actual Medicaid costs for covered services are less than the aggregate PCCB, then cost savings have occurred, and the FFS PSN may receive a share of those cost savings. If the actual Medicaid costs for the covered services provided to the FFS PSN's enrollees are greater than the aggregate PCCB, then cost savings have not occurred and the FFS PSN may be required to refund a portion of the administrative allocation it received. The Agency will make the necessary adjustments to any amounts owed to or payable by the Agency based on the results of the annual cost reconciliation.

1. The Agency shall calculate and apply an IBNR adjustment to the paid claims.
2. The aggregated PCCB minus the aggregate adjusted actual payments for the dates of service included in the reconciliation period results in the savings pool.
3. If the savings pool is more than the total administrative allocation due to the FFS PSN for the dates of service included in the reconciliation, the Agency shall allocate one-hundred percent (100%) of the difference between the savings pool and the total administrative allocation due to the FFS PSN.
4. If the savings pool is less than the administrative allocation, the FFS PSN will refund to the Agency the lesser of:
 - a. The difference between the savings pool and the total administrative allocation due for the time period included in the reconciliation; or
 - b. Fifty percent (50%) of the total administrative allocation due.

5. If the administrative allocation has been garnished (withheld) by the Agency for sanctions incurred, the amount of the administrative allocation accounted for in the reconciliation will include the entire allocation, both paid and withheld.

D. Annual Reconciliation Review

The Agency will begin the annual reconciliation process six months after the last date of service in the reconciliation period and will provide the results to the FFS PSN within forty-five (45) days thereafter. The FFS PSN shall review and provide written comments or a letter of concurrence to the Agency within forty-five (45) calendar days after receipt of the reconciliation results. This reconciliation is considered final if the FFS PSN concurs with the results.

1. Comments and errors identified are limited to the claims completion, methodology and/or calculations.
2. If the FFS PSN or the Agency comments that such an error has occurred, a new forty-five (45) calendar day review period shall start on the date the FFS PSN receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive. The FFS PSN may dispute the Agency's decision as per Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, I. Disputes, if it does not concur with the results.
3. If the FFS PSN does not provide comments within the forty-five (45) calendar day period, no further opportunity for review consideration will be provided.
4. If the FFS PSN fails to timely submit any refund due, the Agency may garnish/withhold future allocations.

E. Reconciliation Upon Termination

Following the final reconciliation completed under this Contract, any money due to either party, per the terms of this Contract, will be distributed or collected.

1. Termination of this Contract prior to the Contract end date would not eliminate the reconciliation processes. All outstanding financial reconciliation processes will continue to occur, but will only apply to the months within the reconciliation period during which the FFS PSN had enrollees and received administrative allocation payments.
2. The Agency shall notify the FFS PSN of any refund due. The FFS PSN shall submit the refund to the Agency within thirty (30) calendar days after the date of the Agency's notice. If the FFS PSN has commented that an error in calculation has occurred, the thirty (30) calendar day period for the refund to be submitted shall start on the date the FFS PSN receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive.
3. If the FFS PSN fails to timely submit any refund due, the Agency may sanction the FFS PSN in accordance with Attachment II, Core Contract Provisions, Section XIV, Sanctions.

F. Capitation Payments for Transportation Services

1. The Agency shall pay the applicable transportation capitation rate for each eligible enrollee whose name appears on the HIPAA-compliant X12 820 file for each month, except that the Agency shall not pay for, and shall recoup, any part of the payment for the total enrollment that exceeds the maximum authorized enrollment level(s) expressed in Attachment I, Scope of Services as applicable. The total payment amount to the FFS PSN shall depend upon the number of enrollees in each eligibility category and each rate group, as provided for by this Contract, or as adjusted pursuant to the Contract when necessary. The FFS PSN is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the FFS PSN has received capitation payment or for whom the Agency has assured the FFS PSN that capitation payment is forthcoming.
2. The rates shall be actuarially sound in accordance with 42 CFR 438.6(c).
3. The transportation capitation rates are included as Attachment I, Scope of Services, Exhibit 3 titled **“ESTIMATED FFS PSN RATES; NOT FOR USE UNLESS APPROVED BY CMS.”**
 - a. The Agency may use, or may amend and use these rates, only after certification by its actuary and approval by the Centers for Medicare and Medicaid Services. Inclusion of these rates is not intended to convey or imply any rights, duties or obligations of either party, nor is it intended to restrict, restrain or control the rights of either party that may have existed independently of this section of the Contract.
 - b. By signature on this Contract, the parties explicitly agree that this section shall not independently convey any inherent rights, responsibilities or obligations of either party, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by either party. In the event that the rates certified by the actuary and approved by CMS are different from the rates included in this Contract, the FFS PSN agrees to accept a reconciliation performed by the Agency to bring payments to the FFS PSN in line with the approved rates. The Agency may amend and use the CMS-approved rates by notice to the FFS PSN through an amendment to the Contract.
4. Unless otherwise specified in this Contract, the FFS PSN shall accept the capitation payment received each month as payment in full by the Agency for all transportation services provided to enrollees covered under this Contract. Any and all transportation costs incurred by the FFS PSN in excess of the capitation payment shall be borne in total by the FFS PSN.

G. Enrollee Payment Liability Protection for Transportation Services

Pursuant to s. 1932 (b)(6), Social Security Act (as enacted by section 4704 of the Balanced Budget Act of 1997), the FFS PSN shall not hold enrollees liable for the following:

1. For debts of the FFS PSN, in the event of the FFS PSN's insolvency;
2. For payment of covered services provided by the FFS PSN if the FFS PSN has not received payment from the Agency for the covered services (excluding Medicaid)

Pending who are determined ineligible for Medicaid as specified in Exhibit 3 of this Contract), or if the provider, under contract or other arrangement with the FFS PSN, fails to receive payment from the Agency or the FFS PSN; and/or

3. For payments to a provider, including referral providers, that furnished covered services under a contract, or other arrangements with the FFS PSN, that are in excess of the amount that normally would be paid by the enrollee if the covered services had been received directly from the FFS PSN.

I. Rate Increases

The Agency may not approve any request from the FFS PSN for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act.

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**ATTACHMENT II
EXHIBIT 14
Sanctions — LTC Plans**

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Section XIV, Sanctions, Item C., Other Sanctions

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

Section XIV, Sanctions, Item F., Performance Measure Sanctions

1. The Agency shall sanction the Managed Care Plan for failure to achieve minimum scores on performance measures after the first year of poor performance on any measure as specified in the table below. The Agency may impose monetary sanctions and Performance Measure Action Plans (PMAP) or PMAPs alone as described below.
2. Two (2) HEDIS measures will be compared to the National Committee for Quality Assurance HEDIS National Means and Percentiles. The HEDIS Call Abandonment measure and Agency-defined measures have threshold rates (percentages) that may trigger a sanction. The Survey-based measures have threshold average ratings (from 0-10) that may trigger a sanction.

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Performance Measure Sanction Table – Effective 8/01/2013 – 8/31/2018	
HEDIS Measures	Rate and applicable sanction
Care for Older Adults	Rate < 25 th percentile - immediate monetary sanction and PMAP may be imposed Rate < 50 th percentile - PMAP may be required
Call Answer Timeliness	
Agency-defined Measures	Rate and applicable sanction
Call Abandonment	Rate > 5% - immediate monetary sanction and PMAP may be imposed
Required Record Documentation – numerators 1-4	Rate < 85% - immediate monetary sanction and PMAP may be imposed Rate < 90% - PMAP may be required
Face-to-Face Encounters	
Care Manager Training	
Timeliness of Service	
Survey-based Measures	Average rating and applicable sanction
Satisfaction with Long-Term Care Plan	Rate 4.0 or lower – immediate monetary sanction and PMAP may be imposed
Satisfaction with Care Manager	
Rating of Quality of Services	Rate 5.0 or lower – PMAP may be required

3. PMAP Sanctions

The Managed Care Plan may be required to complete a PMAP for measures that meet the thresholds given in the above table, as determined by the Agency.

4. Monetary sanctions

The Managed Care Plan may receive a monetary sanction for measures for which their scores meet the thresholds given in the above table for the first offense. Managed Care Plans shall receive a monetary sanction for measures for which their scores meet the thresholds given in the above table for the second offense and subsequent offenses. For the HEDIS and Agency-defined measures, if the Health Plan has a score/rate that triggers an immediate monetary sanction, the Health Plan may be sanctioned \$500.00 for each case in the denominator not present in the numerator. If the Health Plan fails to improve these performance measures in subsequent years, the Agency shall impose a sanction of \$1,000.00 per case. For each Survey-based measure in the table above for which the Health Plan has an average rate that triggers an immediate monetary sanction, the Health Plan may be sanctioned \$10,000.00.

- The Agency may amend the performance measure thresholds and sanctions and will notice the Managed Care Plans prior to the start of the applicable measurement year or with an amount of notice mutually agreed upon by the Agency and the Managed Care Plans. Amendments to the performance measure thresholds and sanctions may include, but are not limited to, adding and removing performance measures from the sanction strategy, changing thresholds for sanctions, and changing the monetary amounts of sanctions.

**ATTACHMENT II
EXHIBIT 15
Financial Requirements**

NOTE: This exhibit provides Managed Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

Capitated LTC Plans

Section XV, Financial Requirements, Item A., Insolvency Protection

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

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

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml
All such agreements or other signature cards shall be approved in advance by the Agency.

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

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

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

FFS LTC PSNs

Section XV, Financial Requirements, Item A., Insolvency Protection

1. The Managed Care Plan shall establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997), and s. 409.912, F.S. The Managed Care Plan shall deposit into that account five percent (5%) of the administrative allocation payments made by the Agency each month until a maximum total of two percent (2%) of the annualized total current Contract amount is reached and maintained. No interest may be withdrawn from this account until the maximum Contract amount is reached and withdrawal of the interest will not cause the balance to fall below the required maximum amount. This provision shall remain in effect as long as the Managed Care Plan continues to contract with the Agency.
2. The restricted insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by the Managed Care Plan and two (2) representatives of the Agency. The Multiple Signature Agreement Form shall be submitted to the Agency within thirty (30) calendar days of Contract execution and resubmitted within thirty (30) calendar days after a change in authorized Managed Care Plan personnel occurs. If the authorized persons remain the same, the Managed Care Plan shall submit an attestation to this effect annually by April 1st of each Contract year to the Agency along with a copy of the latest bank statement. The Managed Care Plan may obtain a sample Multiple Signature Verification Agreement form from the Agency or its agent or download from the Agency website at: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml All such agreements or other signature cards shall be approved in advance by the Agency.
3. In the event that a determination is made by the Agency that the Managed Care Plan is insolvent, as defined in Attachment II, Core Contract Provisions, Section I, Definitions and Acronyms, the Agency may draw upon the amount solely with the two (2) authorized signatures of representatives of the Agency and funds may be disbursed to meet financial obligations incurred by the Managed Care Plan under this Contract. A statement of account balance shall be provided by the Managed Care Plan within fifteen (15) calendar days of request of the Agency.

4. If the Contract is terminated, expired or not continued, the account balance shall be released by the Agency to the Managed Care Plan upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.
5. In the event the Contract is terminated or not renewed and the Managed Care Plan is insolvent, the Agency may draw upon the insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency including, but not limited to, overpayments made to the Managed Care Plan, and fines imposed under the Contract, for which a final order has been issued. In addition, if the Contract is terminated or not renewed and the Managed Care Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Managed Care Plan agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.
6. For its enrollees, the FFS Managed Care Plan shall submit to the Agency for approval a comprehensive plan for transitioning from a FFS Managed Care Plan to a capitated Managed Care Plan. Such transition plan shall be in accordance with Agency guidelines and shall be designed to ensure that the Managed Care Plan is capable of meeting all solvency, reserves and working capital requirements of Chapter 641 F.S. Although the Managed Care Plan shall not be required to be licensed in accordance with Chapter 641 F.S., the Managed Care Plan shall be required to comply with all solvency requirements of Medicaid HMOs, at such time as the Managed Care Plan transitions from a FFS Managed Care Plan to a capitated Managed Care Plan.
 - a. In the twentieth (20th) month after operations begin, the FFS Managed Care Plan shall begin funding the insolvency protection account in accordance with insolvency protection requirements specified for capitated managed care plans (five [5] percent of the estimated monthly capitation amount that would be paid to the Managed Care Plan by the agency each month until a maximum total of two [2] percent of the annualized total Contract amount). The insolvency protection account shall be fully funded no later than one hundred-twenty (120) days prior to the Plan's becoming capitated.
 - b. In accordance with s. 409.968(2). F.S., the FFS Managed Care Plan shall submit to the Agency a PSN conversion application to support its conversion to a capitated Managed Care Plan Contract by the first day of its second Contract year. The Managed Care Plan must transition to a capitated plan by the last day of its second year of operation in order to continue this Contract. The Agency will provide guidelines for developing a comprehensive plan for conversion to capitation.

Capitated LTC Plans

Section XV, Financial Requirements, Item D., Surplus Requirement

In lieu of the surplus requirements under Section XV, Financial Requirements, Item D., Surplus Requirements, the Agency may consider the following:

1. If the organization is a public entity, the Agency may take under advisement a statement from the public entity that a county supports the Managed Care Plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer or oversee the Managed Care Plan, either partly or wholly, through a county department or agency;
2. The state guarantees the solvency of the organization;
3. The organization is a federally qualified health center or is controlled by one (1) or more federally qualified health centers and meets the solvency standards established by the state for such organization pursuant to s. 409.912(4)(c), F.S.; or
4. The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 CFR 422.380 through 422.390 and the solvency requirements established in approved federal waivers or State Plan amendments.

Capitated LTC Plans

Section XV, Financial Requirements, Item G., Third Party Resources

1. The Managed Care Plan shall specify whether it will assume full responsibility for third party collections in accordance with this section.
2. The Managed Care Plan has the same rights to recovery of the full value of services as the Agency (see s. 409.910, F.S.). The following standards govern recovery:
 - a. If the Managed Care Plan has determined that third party liability exists for part or all of the services provided directly by the Managed Care Plan to an enrollee, the Managed Care Plan shall make reasonable efforts to recover from third party liable sources the value of services rendered.
 - b. If the Managed Care Plan has determined that third party liability exists for part or all of the services provided to an enrollee by a subcontractor or referral provider, and the third party is reasonably expected to make payment within one-hundred twenty (120) calendar days, the Managed Care Plan may pay the subcontractor or referral provider only the amount, if any, by which the subcontractor's allowable claim exceeds the amount of the anticipated third party payment; or, the Managed Care Plan may assume full responsibility for third party collections for service provided through the subcontractor or referral provider.
 - c. The Managed Care Plan may not withhold payment for services provided to an enrollee if third party liability or the amount of liability cannot be determined, or if payment shall not be available within a reasonable time, beyond one-hundred twenty (120) calendar days from the date of receipt.
 - d. When the Agency has a fee-for-service lien against a third party resource and the Managed Care Plan has also extended services potentially reimbursable from the same third party resource, the Agency's lien shall be entitled to priority.

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

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Section XV, Financial Requirements, Item G., Third Party Resources

1. The Managed Care Plan shall cost avoid all services that are subject to payment from a third party health insurance carrier, and may deny a service to an enrollee if the Managed Care Plan is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below. However, if a third party health insurance carrier requires the enrollee to pay any cost sharing amounts (e.g., copayment, coinsurance, deductible), the Managed Care Plan shall authorize claims for the cost sharing amounts, even if the services are provided outside the Managed Care Plan's network. The Managed Care Plan's authorization of claims for such cost sharing amounts shall not exceed the amount the Agency would have paid under the Medicaid FFS program.
2. Further, the Managed Care Plan shall not deny claims for services provided to an enrollee of third party liability, or the amount of third party liability, cannot be determined, or if payment will not be available within sixty (60) calendar days.
3. The requirement of cost avoidance applies to all covered services except claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services the Managed Care Plan shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Managed Care Plan shall then coordinate with the Agency or its agent to enable the Agency to recover payment from the potentially liable third party.
4. If the Managed Care Plan determines that third party liability exists for part or all of the services rendered, the Managed Care Plan shall:
 - a. Notify providers and supply third party liability data to a provider whose claim is denied for payment due to third party liability; and
 - b. Authorize the provider's claim for only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability.

Section XV, Financial Requirements, Item G., Third Party Resources

1. For transportation services for which a capitation payment is received from the Agency, the Managed Care Plan shall specify whether it will assume full responsibility for third party collections in accordance with this section.
2. For transportation services for which a capitation payment is received from the Agency, the Managed Care Plan has the same rights to recovery of the full value of services as the Agency, (see s. 409.910, F.S.) The following standards govern recovery:
 - a. If the Managed Care Plan has determined that third party liability exists for part or all of the transportation services provided directly by the Managed Care Plan to an enrollee, the Managed Care Plan shall make reasonable efforts to recover from third party liable sources the value of services rendered.
 - b. If the Managed Care Plan has determined that third party liability exists for part or all of the transportation services provided to an enrollee by a subcontractor or referral provider, and the third party is reasonably expected to make payment within one-hundred and twenty (120) calendar days, the Managed Care Plan may pay the subcontractor or referral provider only the amount, if any, by which the allowable claim exceeds the amount of the anticipated third party payment; or, the Managed Care Plan may assume full responsibility for third party collections for service provided through the subcontractor or referral provider.
 - c. The Managed Care Plan may not withhold payment for transportation services provided to an enrollee if third party liability or the amount of liability cannot be determined, or if payment shall not be available within a reasonable time, beyond one-hundred twenty (120) calendar days from the date of receipt.
 - d. When the Agency has a fee-for-service lien against a third party resource and the Managed Care Plan has also extended services potentially reimbursable from the same third party resource, the Agency's lien shall be entitled to priority.
 - e. The Agency may, at its sole discretion, offer to provide third party recovery services to the Managed Care Plan. If the Managed Care Plan elects to authorize the Agency to recover on its behalf, the Managed Care Plan shall be required to provide the necessary data for recovery in the format prescribed by the Agency. All recoveries, less the Agency's cost to recover, shall be income to the Managed Care Plan. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the Managed Care Plan elects to authorize the Agency to recover on its behalf.
 - f. All funds recovered from third parties shall be treated as income for the Managed Care Plan.

Section XV, Financial Requirements, Item J., Patient Responsibility

- a. The Managed Care Plan is responsible for collecting patient responsibility as determined by DCF and shall have policies and procedures to ensure that, where applicable, enrollees are assessed for and pay their patient responsibility. Some enrollees have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility.
- b. The Managed Care Plan may transfer the responsibility for collecting its enrollees' patient responsibility to residential providers and compensate these providers net of the patient responsibility amount. If the Managed Care Plan transfers collection of patient responsibility to the provider, the provider contract must specify complete details of both parties' obligations in the collection of patient responsibility. The Managed Care Plan must either collect patient responsibility from all of its residential providers, or transfer collection to all of its residential providers.
- c. The Managed Care Plan must have a system in place to track the receipt of patient responsibility at the enrollee level irrespective of which entity collects the patient responsibility. This data must be available upon request by the Agency. The Managed Care Plan or its providers shall not assess late fees for the collection of patient responsibility from enrollees.
- d. The Managed Care Plan shall submit a Patient Responsibility Report annually, in accordance with Attachment II, Core Contract Provisions, Exhibit 12, Reporting Requirements, indicating at the enrollee level: the total patient responsibility for the enrollee; the total cost of Medicaid Home and Community Based Services the enrollee received; and the total cost of other Medicaid services the enrollee received under this contract. The total cost of Medicaid Home and Community Based Services the enrollee received must be equal to or greater than the enrollee's total patient responsibility. If an enrollee's patient responsibility exceeds the reported Medicaid Home and Community Based service expenditure, the Agency will employ the reconciliation process detailed in Exhibit 13 of this agreement to determine if a payment adjustment is required.

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**ATTACHMENT II
EXHIBIT 16
Terms and Conditions — LTC Plans**

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

N/A

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ATTACHMENT II
EXHIBIT 17
Expanded Benefits — LTC Plans

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

1. The Managed Care Plan shall offer enrollees the Expanded Benefits as described as follows:

a. Assisted Living Facility or AFCH Bed Hold

The Managed Care Plan shall provide payment for up to two (2) weeks “bed hold” for enrollees who reside in an in-network assisted living facility or adult family care home if an enrollee leaves the facility for any reason to ensure the facility holds the enrollee’s placement. In order for the enrollee to receive this benefit the enrollee must have the intent of returning to the facility and continue to pay his or her room and board and any patient responsibility determined by the Department of Children and Families. The maximum benefit per episode is fourteen (14) days and the enrollee must reside in the facility for at least thirty (30) days between episodes.

This benefit does not apply in the following situations:

- Enrollee loses Medicaid eligibility;
- Enrollee is deceased;
- Enrollee is now located in a nursing facility for custodial care; or
- Managed Care Plan does not expect enrollee to return within thirty (30) days.

Providers are required to give notice to the Managed Care Plan within twenty-four (24) hours of an enrollee leaving the facility for any reason. If the provider has not provided notice within twenty-four (24) hours of the enrollee leaving the facility, the provider is not permitted to charge the enrollee the Managed Care Plan portion of the enrollee’s care during the fourteen (14) day period.

b. Over-The-Counter Medication/Supplies

The Managed Care Plan shall provide up to \$15.00 per month per enrollee to community-based enrollees for over-the-counter (OTC) medications and supplies, including allergy medications, pain relievers, and vitamins purchased pursuant to a physician ordered prescription.

The Managed Care Plan may require enrollees to use an established network of providers, approved by the Agency, to obtain OTC benefits as an Expanded Service under this Contract.

2. The Managed Care Plan shall administer the agreed upon Expanded Benefits in the same manner as Covered Services pursuant to this Contract.

**ATTACHMENT II
EXHIBIT 18
Liquidated Damages — LTC Plans**

NOTE: This exhibit provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

B. Issues and Amounts

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
1	Failure to comply with claims processing as described in Attachment II, Core Contract Provisions, Section X and Exhibit 10 of this Contract.	\$10,000 per month, for each month that the Agency determines that the Managed Care Plan is not in compliance with the requirements as described in Section X and Exhibit 10 of this Contract.
2	Failure by the Managed Care Plan to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Agency enrollee's PHI (See also ancillary business associate agreement requirements between the parties) as specified in Attachment II, Core Contract Provisions, in Sections XI and XVI and Attachment H, Exhibit 1 (Business Associate Agreement) of the Contract.	\$1,000 per enrollee per occurrence, AND if the State determines credit monitoring and/or identity theft safeguards are needed to protect those enrollees whose PHI was placed at risk by Managed Care plan's failure to comply with the terms of this Contract, the Managed Care Plan shall be liable for all costs associated with the provision of such monitoring and/or safeguard services.

3	<p>Failure by the Managed Care Plan to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party (See ancillary business associate agreement between the parties) pursuant to Attachment II, Core Contract Provisions, Sections XI and XVI and Attachment H, Exhibit 1 of the Contract.</p>	<p>\$500 per enrollee per occurrence.</p>
4	<p>Failure by the Managed Care Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach (See also ancillary business associate agreement between the parties) as described in Attachment II, Core Contract Provisions, Sections XI and XVI and Attachment H, Exhibit 1 of the Contract.</p>	<p>\$500 per enrollee per occurrence, not to exceed \$10,000,000.</p>
5	<p>Failure to timely submit audited annual and quarterly unaudited financial statements as described in Attachment II, Core Contract Provisions, Section XV of the Contract.</p>	<p>\$500 per calendar day for each day that reporting requirements as described in Section XV are not met.</p>
6	<p>Failure to comply in any way with encounter data submission requirements as described in Attachment II, Core Contract Provisions, Section X and Section II of the Contract (excluding the failure to address or resolve problems with individual</p>	<p>\$25,000 per occurrence.</p>

	encounter records in a timely manner as required by the Agency).	
7	Failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency and described in Attachment II, Core Contract Provisions, Section X of the Contract.	\$500 per calendar day, per occurrence.
8	Failure to provide continuation of services during the pendency of a Medicaid fair hearing and/ or the Managed Care Plan's grievance process where the enrollee has challenged a reduction or elimination of services as required by Attachment II, Core Contract Provisions, Section IX of the Contract, applicable state or federal law, and all court orders governing appeal procedures as they become effective.	The liquidated damages accessed for this failure to continue services during the pendency of a Medicaid fair hearing and/or the Managed Care Plan's (MCP's) grievance process where the enrollee has challenged the MCP's action shall equal the value of the reduced or eliminated services as determined by the Agency for the timeframe specified by the Agency and \$500 per day for each calendar day the MCP fails to provide continuation or restoration as required by the Agency.
9	Failure to provide restoration of services after the Plan receives an adverse determination as a result of a Medicaid fair hearing or the Managed Care Plan's grievance process as required by Attachment II, Core Contract Provisions, Section IX of the Contract, applicable state or federal law and all court orders governing appeal procedures as they become effective.	The liquidated damages accessed for this failure to provide program services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense in a timeframe specified by the Agency shall equal the value of the reduced or eliminated services as determined by the Agency and \$500 per day for each calendar day the MCP fails to provide continuation or restoration as required by the Agency.
10	Failure to acknowledge or act timely upon a request for prior authorization in accordance with Attachment II, Core Contract Provisions, Section IV, VII, VIII, and Exhibit 5 of the Contract.	\$1,000 per occurrence, plus \$1,000 for each day that it is determined the Managed Care Plan failed to acknowledge or act timely upon a request for prior authorization in accordance with Attachment II, Core Contract Provisions, Section VIII of the Contract.

11	Failure to comply with the timeframes for developing and approving a plan of care for transitioning or initiating home and community-based services as described in Attachment II, Core Contract Provisions, Sections V and VIII of the Contract and Attachment II, Core Contract Provisions, Exhibits 5, 7, and 8 of the Contract.	\$500 per day, per occurrence.
12	Failure to complete in a timely manner minimum care coordination contacts required for persons transitioned from a nursing facility to a community placement as described in Attachment II, Core Contract Provisions, Exhibit 5 of the Contract.	\$500 per day, per occurrence.
13	Failure to meet the performance standards established by the Agency regarding missed visits for personal care, attendant care, homemaker, or home-delivered meals for enrollees (referred to herein as "specified HCBS"). Pursuant to Attachment II, Core Contract Provisions, Exhibits 5 and 8 of the Contract.	\$500 per day, per occurrence.
14	Failure to provide continuity of care and a seamless transition consistent with the services in place prior to the individual's enrollment in the Managed Care Plan for a person transferring from another MCO as described in Attachment II, Core Contract Provisions, Sections XVI and Exhibits 6 and 8 of the Contract.	\$500 per day beginning on the next calendar day after default by the Managed Care Plan in addition to the cost of the services not provided These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the case management requirements as described in Section VI and VIII or the Contract.

15	Failure to complete a comprehensive assessment, develop a plan of care, and authorize and initiate all long-term care services specified in the plan of care for an enrollee within specified timelines as described in Attachment II, Core Contract Provisions, Exhibit 5 and 8 of the Contract.	\$500 per day for each service not initiated timely beginning on the next calendar day after default by the Managed Care Plan in addition to the cost of the services not provided. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the case management requirements as described in the Contract.
16	Failure to develop a person-centered plan of care for an enrollee that includes all of the required elements, and which has been reviewed with and signed and dated by the member or authorized representative, unless the member/representative refuses to sign, which shall be documented in writing as described in Attachment II, Core Contract Provisions, Exhibit 5 of the Contract.	\$500 per deficient plan of care. 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.
17	Failure to facilitate transfers between health care settings as described in Attachment II, Core Contract Provisions, Section XVI and Exhibits 5 and 8 of the Contract.	\$1,000 per occurrence. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the case management requirements as described in Section V and VIII and Exhibits 5 and 8 of the Contract.
18	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Attachment II, Core Contract Provisions, Sections II, VII, and VIII and Exhibits VIII of the Contract.	\$25,000 per occurrence.
19	Failure to meet any timeframe regarding care coordination for members as described in Attachment II, Core Contract Provisions, Sections V and VIII and Exhibit 5 of the Contract.	\$250 per calendar day, per occurrence.
20	Failure to comply in any way with staffing requirements as described in Attachment II, Core Contract Provisions, Sections IV, VII, VIII and X of	\$250 per calendar day for each day that staffing requirements are not met.

	the Contract and Exhibits 4, 5, 7, 8 and 10 of the Contract.	
21	Failure to comply with the medical/case records documentation requirements pursuant to Attachment II, Core Contract Provisions, Sections V, VII, and VIII and Exhibits 5 and 8 of the Contract.	\$500 per plan of care for members in Group 2 or 3 that does not include all of the required elements. \$500 per member file that does not include all of the required elements. \$500 per face-to-face visit where the care coordinator fails to document the specified observations. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the caseload and staffing requirements.
22	Failure to have a face-to-face contact between the Managed Care Plan case manager and each enrollee at least every ninety (90) days or following a significant change as described in Attachment II, Core Contract Provisions, Exhibit 5 of the Contract.	\$5,000 for each occurrence.
23	Failure to follow-up within seven (7) days of service authorization for the initial care plan to ensure that services are in place as described in Attachment II, Core Contract Provisions, Exhibit 5 of the Contract	\$5,000 for each occurrence.
24	Failure to notify enrollees of denials, reductions, or terminations of services within the timeframes specified in the Contract as described in Attachment II, Core Contract Provisions, Sections IV and IX of the Contract	\$1,000 per occurrence plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late.
25	Failure to provide a copy of the Care Plan to each enrollee's PCP and residential facility in the timeframes as described in Attachment II, Core Contract Provisions, Exhibit 5 of the Contract	\$500 per calendar day.

26	Failure to report enrollees that do not receive any long-term care services listed in the approved care plan for a month, failure to report the occurrence to the Agency as described in Attachment II, Core Contract Provisions, Exhibit 5 of the Contract.	For each enrollee, an amount equal to the capitation rate for the month in which the enrollee did not receive long-term care services.
27	Failure to comply with obligations and time frames in the delivery of annual face-to-face reassessments for Level of Care as described in Attachment II, Core Contract Provisions, Exhibit 5 of the Contract.	\$1,000 per occurrence.
28	Failure to provide proof of compliance to the Agency within five (5) calendar days of a directive from the Agency or within a longer period of time which has been approved by the Agency as described in Attachment II, Core Contract Provisions, Section XVI demonstration of good cause.	\$500 per day beginning on the next calendar day after default by the Managed Care Plan.
29	Failure to comply with conflict of interest or lobbying requirements as described in Attachment II, Core Contract Provisions, Section XVI of the Contract	\$10,000 per occurrence.
30	Failure to disclose lobbying activities and/or conflict of interest as required by the Contract, including Attachment IV, Certification Regarding Lobbying.	\$1,000 per day that disclosure is late.
31	Failure to obtain approval of member and Provider materials, and provider agreements, as required by Attachment II, Core Contract Provisions, Sections IV and VII and Exhibit 5 of the Contract.	\$500 per day for each calendar day that the Agency determines the Managed Care Plan has provided member or provider material, or provider agreements that had not been approved by the Agency.

32	Failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, as required in Attachment II, Core Contract Provisions, Sections IV and VII and Exhibit 4	\$5,000 for each occurrence.
33	Failure to achieve and/or maintain financial requirements as described in Attachment II, Core Contract Provisions, Section XV and Exhibit 15 of the Contract.	\$1,000 per calendar day for each day Contract requirements are not met.
34	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Attachment II, Core Contract Provisions, Sections IV, VII and XVI.	\$5,000 per provider disclosure/attestation for each disclosure/attestation that is not received timely as described in Sections VII and XVI or is not in compliance with the requirements outlined in 42 CFR 455, Subpart B.
35	Failure to maintain required insurance as required in Attachment II, Core Contract Provisions, Section XVI of this Contract	\$500 per calendar day
36	Failure to submit a Provider Network File that meets the Agency's specifications as described in Attachment II, Core Contract Provisions, Section VII and Exhibit 12 of the Contract.	\$250 per day after the due date that the Provider Enrollment File fails to meet the Agency's specifications.
37	Failure to comply with marketing requirements as described in Attachment II, Core Contract Provisions, Section IV of the Contract.	\$500 per recipient, per verified incident of promotion or marketing of Managed Care Plan.
38	Failure to timely file required reports as described in Attachment II, Core Contract Provisions, Section XI and Exhibit 12 of the Contract.	\$500 per day beyond the due date until submitted.
39	Failure to file accurate reports as described in Attachment II, Core Contract Provisions, Section XI and Exhibit 12 of the Contract	\$1,000 per occurrence.
40	Submission of inappropriate report certifications as	\$250 per occurrence.

	described in Attachment II, Core Contract Provisions, Section XII of the Contract.	
41	Failure to respond to an Agency communication within the time prescribed by the Agency as described in Attachment II, Core Contract Provisions, Section II and XI of the Contract.	\$500 for each calendar day beyond the due date until provided to the Agency. However, after three (3) instances during the Contract period, the liquidated damage amount is increased by \$1,000 per day.
42	Failure to respond to an Agency request or ad-hoc report for documentation (such as medical records, complaint logs, or Contract checklists) within the time prescribed by the Agency as described in Section II of the Contract.	\$500 per day for each calendar day beyond the due date until provided to the Agency. However, after three (3) instances during the Contract period, the liquidated damage amount is increased by \$1,000 per day.
43	Failure to update online provider directory in accordance with Contract requirements as described in Attachment II, Core Contract Provisions, Section IV of the Contract.	\$1,000 per occurrence.
44	Failure to timely report staff or community outreach representative violations as described in Attachment II, Core Contract Provisions, Section IV and Exhibit 4 of the Contract.	\$250 per occurrence.
45	Failure to timely report significant network changes as described in Attachment II, Core Contract Provisions, Section VII and Exhibit 7 of the Contract.	\$5,000 per occurrence.
46	Failure to timely report changes in staffing as described in Attachment II, Core Contract Provisions, Section X of the Contract.	\$500 per occurrence.
47	The Managed Care Plan shall ensure that for each enrollee all necessary paperwork is submitted to DCF within the timeframes included in Attachment II, Core Contract	\$100 assessed for each enrollee who temporarily loses eligibility (for less than 60 days) pursuant to a redetermination.

	Provisions, Exhibits 4 and 5 of the Contract.	
48	Failure to achieve and/or maintain insolvency requirements in accordance with Attachment II, Core Contract Provisions, Exhibit 15 of the Contract.	\$500 per calendar day for each day that financial requirements are not met.
49	Failure to comply with the notice requirements as described in Attachment II, Core Contract Provisions, Sections XIV and XVI of the Contract, the Agency rules and regulations, and all court orders governing appeal procedures, as they become effective.	<p>\$500 per occurrence in addition to \$500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Contract or required by the Agency.</p> <p>\$1,000 per occurrence if the Agency notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective.</p>
50	Failure to submit a timely notice of involuntary disenrollment to the enrollee as described in Attachment II, Core Contract Provisions, Section III of the Contract.	\$1,000 per occurrence if the enrollee notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective.
51	Failure to comply with member notice requirements as described in Attachment II, Core Contract Provisions, Sections III, IV, VII, VIII and IX and Exhibits 5, 7, 8 and 9 of the Contract.	\$1,000 per occurrence if the enrollee notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective \$500 per calendar day.
52	Failure to comply with licensure and background check requirements in Attachment II, Core Contract Provisions, Sections V, VII	\$5,000 per calendar day that staff/provider/driver/agent/subcontractor is not licensed or qualified as required by applicable state or local law plus the amount paid to the

	and XVI and Exhibit 7 of the Contract.	staff/provider/driver/agent/subcontractor during that period.
53	Failure to comply with fraud and abuse provisions as described in Attachment II, Core Contract Provisions, Section X of this Contract.	\$500 per calendar day.
54	Failure to report provider notice of termination of participation in the Managed Care Plan as described in Attachment II, Core Contract Provisions, Sections VII and XII and Exhibit 12 of the Contract.	\$500 per day, per occurrence.
55	Failure to cooperate fully with the Agency and/or state during an investigation of fraud or abuse, complaint, or grievances as described in Attachment II, Core Contract Provisions, Sections II, VII, X, XV, and XVI.	\$500 per incident for failure to fully cooperate during an investigation.
56	Failure to timely report notice of terminated providers due to imminent danger/impairment as described in Attachment II, Core Contract Provisions, Section VII and Exhibit 12 of the Contract.	\$5,000 per occurrence.
57	Failure to timely report termination or suspension of providers; for "for cause" terminations, including reasons for termination as described in Attachment II, Core Contract Provisions, Section VII of the Contract.	\$250 per occurrence.
58	Failure to timely submit fingerprints of newly hired principals as described in Attachment II, Core Contract Provisions, Section XVI of the Contract.	\$ 500 per occurrence.
59	Failure to timely report information about offenses listed in s. 435.04, F.S. as described in Attachment II, Core Contract Provisions, Section XVI of the Contract.	\$500 per occurrence.

60	Failure to timely report changes in ownership and control as described in Attachment II, Core Contract Provisions, Section XVI of the Contract.	\$5,000 per occurrence.
61	Failure to complete or comply with corrective action plans as described in Attachment II, Core Contract Provisions, Section XIV of the Contract.	\$500 per calendar day for each day the corrective action is not completed or complied with as required by Section XIV.
62	Failure to submit audited HEDIS, CAHPS, Agency-Defined Measures results annually by July 1 st as described in Attachment II, Core Contract Provisions, Section VIII	\$250 per day for every calendar day reports are late.
63	Failure to obtain and/or maintain national accreditation as described in Attachment II, Core Contract Provisions, Section XVI of the Contract.	\$500 per day for every calendar day beyond the day accreditation status must be in place as described in Section XVI of the Contract.
64	Failure to have a rate at or above the 25 th percentile for the HEDIS measures as described in Attachment II, Core Contract Provisions, Exhibit 14 of the Contract	\$500 per each case in the denominator not present in the numerator for the measure.
65	Performance Measure: Care for Older Adults and Call Answer Timeliness (Exhibit 14)	Failure to achieve a rate at the 25 th percentile (per the NCQA National Means and Percentiles, Medicare for the Care for Older Adults measure and Medicaid for the Call Answer Timeliness measure) or higher will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure. If the Managed Care Plan's rate remains below the 25 th percentile in subsequent years, damages will be \$1,000 per case.
66	Performance Measure: Failure to have a Call Abandonment rate of 5% or less, per the HEDIS measure specifications. (Exhibit 14)	Failure to have a Call Abandonment rate of 5% or less, per the HEDIS measure specifications, will result in liquidated damages of \$500 per each case in the denominator not present in the

		numerator for the measure. If the Managed Care Plan's rate remains above 5% in subsequent years, damages will be \$1,000 per case.
67	Performance Measure: Required Record Documentation – numerators 1-4. (Exhibit 14)	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.
68	Performance Measure: Face- to-Face Encounters (Exhibit 14)	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.
69	Performance Measure: Care Manager Training as required in (Exhibit 14)	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.
70	Performance Measure: Timeliness of Service (Exhibit 14)	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.
71	Performance Measure: Satisfaction with Care Manager (Exhibit 14)	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.

72	Performance Measure: Rating of Quality of Services (Exhibit 14)	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.
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**ATTACHMENT II
EXHIBIT 19
Special Conditions**

NOTE: This exhibit pertains to long-term care plans contracted pursuant to 409.981 F.S., and provides Long-Term Care Plan requirements in addition to Attachment II, Core Contract Provisions of this Contract, unless otherwise specified.

1. A Long-Term Care Plan contracted pursuant to s. 409.981, F.S. is limited to serving dually eligible enrollees in the plan who are eligible for enrollment in the LTC managed care program (as outlined in section 409.979, F.S.) as of June 29, 2012 and is not authorized to receive new enrollees.
2. This Contract may not be renewed; however, the Agency may extend the Contract term to cover any delays during the transition period.

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ATTACHMENT III BUSINESS ASSOCIATE AGREEMENT

The parties to this Attachment agree that the following provisions constitute a business associate agreement for purposes of complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Attachment is applicable if the Vendor is a business associate within the meaning of the Privacy and Security Regulations, 45 C.F.R. 160 and 164.

The Vendor certifies and agrees as to abide by the following:

1. Definitions. Unless specifically stated in this Attachment, the definition of the terms contained herein shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164.
 - 1.a. Protected Health Information. For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164, limited to the information created, received, maintained or transmitted by the Vendor from, or on behalf of, the Agency.
 - 1.b. Security Incident. For purposes of this Attachment, security incident shall mean any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity. See National Institute of Standards and Technology (NIST) Special Publication 800-61, "Computer Security Incident Handling Guide," for more information.
2. Applicability of HITECH and HIPAA Privacy Rule and Security Rule Provisions. As provided by federal law, Title XIII of the American Recovery and Reinvestment Act of 2009 (ARRA), also known as the Health Information Technology Economic and Clinical Health (HITECH) Act, requires a Business Associate (Vendor) that contracts with the Agency, a HIPAA covered entity, to comply with the provisions of the HIPAA Privacy and Security Rules (45 C.F.R. 160 and 164).
3. Use and Disclosure of Protected Health Information. The Vendor shall not use or disclose protected health information other than as permitted by this Contract or by federal and state law. The Vendor will use appropriate safeguards to prevent the use or disclosure of protected health information for any purpose not in conformity with this Contract and federal and state law. The Vendor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information the Vendor creates, receives, maintains, or transmits on behalf of the Agency.
4. Use and Disclosure of Information for Management, Administration, and Legal Responsibilities. The Vendor is permitted to use and disclose protected health information received from the Agency for the proper management and administration of the Vendor or to carry out the legal responsibilities of the Vendor, in accordance with 45 C.F.R. 164.504(e)(4). Such disclosure is only permissible where required by law, or where the Vendor obtains reasonable assurances from the person to whom the protected health information is disclosed that: (1) the protected health information will be held confidentially, (2) the protected health information will be used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and (3) the person notifies the

Vendor of any instance of which it is aware in which the confidentiality of the protected health information has been breached.

5. Disclosure to Third Parties. The Vendor will not divulge, disclose, or communicate protected health information to any third party for any purpose not in conformity with this Contract without prior written approval from the Agency. The Vendor shall ensure that any agent, including a subcontractor, to whom it provides protected health information received from, or created or received by the Vendor on behalf of, the Agency agrees to the same terms, conditions, and restrictions that apply to the Vendor with respect to protected health information.
6. Access to Information. The Vendor shall make protected health information available in accordance with federal and state law, including providing a right of access to persons who are the subjects of the protected health information in accordance with 45 C.F.R. 164.524.
7. Amendment and Incorporation of Amendments. The Vendor shall make protected health information available for amendment and to incorporate any amendments to the protected health information in accordance with 45 C.F.R. 164.526.
8. Accounting for Disclosures. The Vendor shall make protected health information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528. The Vendor shall document all disclosures of protected health information as needed for the Agency to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. 164.528.
9. Access to Books and Records. The Vendor shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the Vendor on behalf of the Agency, available to the Secretary of the Department of Health and Human Services or the Secretary's designee for purposes of determining compliance with the Department of Health and Human Services Privacy Regulations.
10. Reporting. The Vendor shall make a good faith effort to identify any use or disclosure of protected health information not provided for in this Contract.
 - 10a. To Agency. The Vendor will report to the Agency, within ten (10) business days of discovery, any use or disclosure of protected health information not provided for in this Contract of which the Vendor is aware. The Vendor will report to the Agency, within twenty-four (24) hours of discovery, any security incident of which the Vendor is aware. A violation of this paragraph shall be a material violation of this Contract. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the Vendor to have been, accessed, acquired, or disclosed during such breach.
 - 10b. To Individuals. In the case of a breach of protected health information discovered by the Vendor, the Vendor shall first notify the Agency of the pertinent details of the breach and upon prior approval of the Agency shall notify each individual whose unsecured protected health information has been, or is reasonably believed by the Vendor to have been, accessed, acquired or disclosed as a result of such breach. Such notification shall be in writing by first-

class mail to the individual (or the next of kin if the individual is deceased) at the last known address of the individual or next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. Where there is insufficient, or out-of-date contract information (including a phone number, email address, or any other form of appropriate communication) that precludes written (or, if specifically requested, electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting on the Web site of the covered entity involved or notice in major print or broadcast media, including major media in the geographic areas where the individuals affected by the breach likely reside. In any case deemed by the Vendor to require urgency because of possible imminent misuse of unsecured protected health information, the Vendor may also provide information to individuals by telephone or other means, as appropriate.

- 10c. To Media. In the case of a breach of protected health information discovered by the Vendor where the unsecured protected health information of more than 500 persons is reasonably believed to have been, accessed, acquired, or disclosed, after prior approval by the Agency, the Vendor shall provide notice to prominent media outlets serving the State or relevant portion of the State involved.
- 10d. To Secretary of Health and Human Services. The Vendor shall cooperate with the Agency to provide notice to the Secretary of Health and Human Services of unsecured protected health information that has been acquired or disclosed in a breach. If the breach was with respect to 500 or more individuals, such notice must be provided immediately. If the breach was with respect to less than 500 individuals, the Vendor may maintain a log of such breach occurring and annually submit such log to the Agency so that it may satisfy its obligation to notify the Secretary of Health and Human Services documenting such breaches occurring in the year involved.
- 10e. Content of Notices. All notices required under this Attachment shall include the content set forth Section 13402(f), Title XIII of the American Recovery and Reinvestment Act of 2009, except that references therein to a "covered entity" shall be read as references to the Vendor.
- 10f. Financial Responsibility. The Vendor shall be responsible for all costs related to the notices required under this Attachment.
11. Mitigation. Vendor shall mitigate, to the extent practicable, any harmful effect that is known to the Vendor of a use or disclosure of protected health information in violation of this Attachment.

12. Termination. Upon the Agency's discovery of a material breach of this Attachment, the Agency shall have the right to terminate this Contract.

12a. Effect of Termination. At the termination of this Contract, the Vendor shall return all protected health information that the Vendor still maintains in any form, including any copies or hybrid or merged databases made by the Vendor; or with prior written approval of the Agency, the protected health information may be destroyed by the Vendor after its use. If the protected health information is destroyed pursuant to the Agency's prior written approval, the Vendor must provide a written confirmation of such destruction to the Agency. If return or destruction of the protected health information is determined not feasible by the Agency, the Vendor agrees to protect the protected health information and treat it as strictly confidential.

The Vendor has caused this Attachment to be signed and delivered by its duly authorized representative, as of the date set forth below.

Vendor Name:

Signature

Date

Name and Title of Authorized Signer

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**ATTACHMENT IV
CERTIFICATION REGARDING LOBBYING
CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS**

The undersigned certifies, to the best of his or her knowledge and belief, that:

- (1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Signature

Date

Name of Authorized Individual

Application or Contract Number

Name and Address of Organization

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ATTACHMENT V

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each Vendor whose contract/subcontract equals or exceeds \$25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, Vendors who audit federal programs must also sign, regardless of the contract amount. The Agency for Health Care Administration cannot contract with these types of Vendors if they are debarred or suspended by the federal government.
2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.
3. The Vendor shall provide immediate written notice to the contract manager at any time the Vendor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.
5. The Vendor agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.
6. The Vendor further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed \$25,000 in federal monies, to submit a signed copy of this certification.
7. The Agency for Health Care Administration may rely upon a certification of a Vendor that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.
8. This signed certification must be kept in the contract manager's contract file. Subcontractor's certifications must be kept at the contractor's business location.

CERTIFICATION

- (1) The prospective Vendor certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.
- (2) Where the prospective Vendor is unable to certify to any of the statements in this certification, such prospective Vendor shall attach an explanation to this certification.

Signature

Date

2013 – 2018 Long-Term Care Health Plan Model Contract

ATTACHMENT V

Name and Title of Authorized Signer

2013 – 2018 Long-Term Care Health Plan Model Contract

**ATTACHMENT VI
VENDOR CERTIFICATION REGARDING
SCRUTINIZED COMPANIES LISTS**

Vendor Name: _____
Vendor FEIN: _____
Vendor's Authorized Representative Name and Title: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: _____
Email Address: _____

Section 287.135, Florida Statutes, prohibits agencies from contracting with companies, for goods or services over \$1,000,000, that are on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. Both lists are created pursuant to section 215.473, Florida Statutes.

As the person authorized to sign on behalf of the Vendor, I hereby certify that the company identified above in the section entitled "Vendor Name" is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. I understand that pursuant to section 287.135, Florida Statutes, the submission of a false certification may subject company to civil penalties, attorney's fees, and/or costs.

Certified By: _____,
who is authorized to sign on behalf of the above referenced company.
Authorized Signature Print Name and Title: _____