

ATTACHMENT II
EXHIBITS – Effective Date: October1, 2014

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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) without other full Medicaid coverage;
 - (18) Special low-income beneficiaries (SLMB) without other full Medicaid coverage; and
 - (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.

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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

- a. The Managed Care Plan shall comply with the requirements in **Attachment II**, Core Contract Provisions, Section VIII, Quality Management, Item C., Transition of Care — LTC Plans Only, and **Exhibit 8**.
- b. For each new HCBS enrollee, the Managed Care Plan shall complete and submit to DCF a 2515 form (Certification of Enrollment Status HCBS) within five (5) business days after receipt of the applicable enrollment file from the Agency or its agent. The Managed Care Plan shall retain proof of submission of the completed 2515 form to DCF.

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.

14. Requirements for Nursing Home Admissions and Discharges

- a. The Managed Care Plan shall ensure the Florida Department of Children and Families (DCF) is notified of an LTC enrollee's admission to a nursing facility.
 - (1) The Managed Care Plan shall submit to DCF a properly completed CF-ES 2506A Form (Client Referral/Change) within ten (10) business days of the LTC enrollee's admission to the nursing facility.
 - (2) The Managed Care Plan may delegate the submission of the CF-ES 2506A Form (Client Referral/Change) to the nursing facility. The Managed Care Plan must obtain a copy of the completed CF-ES 2506A Form (Client Referral/Change) that the facility submitted to DCF.

- b. The Managed Care Plan shall ensure the Florida Department of Children and Families (DCF) is notified of an LTC enrollee's discharge from a nursing facility.
 - (1) The Managed Care Plan shall submit to DCF properly completed CF-ES 2515 Form (Certification of Enrollment Status, Home and Community Based Services (HCBS)) within ten (10) business days of the LTC enrollee's discharge from the nursing facility.
 - (2) The Managed Care Plan shall not delegate submission of the CF-ES 2515 Form (Certification of Enrollment Status, Home and Community Based Services (HCBS)) to the nursing facility, when the LTC enrollee is discharge from a nursing facility.
- c. The LTC Managed Care Plans and the LTC Comprehensive Plans shall submit reports on these transactions to the Agency as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. The Managed Care Plan shall retain proof of submission of each completed form in the enrollee's case record.

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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**). In addition, for each enrollee transitioning from a nursing facility into an ALF or other residence in the community, the Managed Care Plan shall complete and submit to DCF a 2515 form (Certification of Enrollment Status HCBS) within five (5) calendar days after the date the Managed Care Plan becomes aware of nursing facility discharge. The Managed Care Plan shall retain proof of submission of the completed 2515 form to DCF.
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. **Assistive 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.
- l. 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 or pharmacist of all prescriptions and over-the-counter medications taken by the enrollee, in conjunction with the enrollee's physician on at least an annual or as needed basis upon a significant change in the enrollee's condition. 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 are 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 II 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>);
- 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>);
- 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 required by Florida statute or rule (see, e.g., Chapter 440, F.S., and Rule 69L, F.A.C.), 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 June 1st. 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 II 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 II criminal history and/or background investigation; and
- (2) Master's degree in a human service, social science or health field and has a minimum of two (2) years' experience in case management, at least one (1) year of which 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.

- (5) The Managed Care Plan shall report to the Agency monthly on its case manager caseloads, including but not limited to the average and individual case manager caseloads for enrollees who reside in the community, enrollees who reside in a nursing facility, and for mixed caseloads, using the format provided in the LTC Report Guide and referenced in **Exhibit 12**, Reporting Requirements.

- 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. The Managed Care Plan shall ensure the enrollee or enrollee's representative's completion and signature of the Agency-approved Freedom of Choice Certification Form within the above time frames.

- (1) 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.
 - (2) 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.
 - (3) 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.
 - (4) All contacts attempted and made with, or regarding, an enrollee must be documented in the enrollee's case file.
 - (5) 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 shall report such inability to locate enrollees to the Agency, as specified in Section XII, Reporting Requirements, and the Managed Care Plan Report Guide 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. The Managed Care Plan shall not transition enrollees into home and community-based LTC services who have not been released from the LTC wait list or who have not resided in a nursing facility for a minimum of sixty (60) consecutive days prior to transition.
 - iii. 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.
 - iv. 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.
 - z. Documentation of choice between institutional and home and community-based services.
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 Florida Abuse Hotline (1-800-96A-BUSE) (see s. 415.1034, F.S.). The DCF Adult Protective Services Program has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities, once a report has been accepted by the Abuse Hotline. If the investigation requires the enrollee to move from his/her current location(s), the Managed Care Plan shall assist the investigator in finding a safe living environment or another participating provider of the enrollee's choice.
2. After receiving an intake from the Florida Abuse Hotline, the Adult Protective Investigator assigns a risk-level designation of "low," "intermediate" or "high" for each referral. If the enrollee needs immediate protection from further harm, which can be

accomplished completely or in part with the provision of home and community-based services, the referral is designated "high" risk. The Managed Care Plan shall serve enrollees who have been designated "high" risk within seventy-two (72) hours after being referred to the Managed Care Plan from the Florida Adult Protective Services Unit or designee, as mandated by Florida Statute. To ensure that Adult Protective Investigators can easily contact the Managed Care Plan, the Managed Care Plan shall provide Adult Protective Services a primary and back-up contact person, including a telephone number, for "high" risk referrals. Managed Care Plan contacts shall return calls from Adult Protective Services within twenty-four (24) hours of initial contact.

3. The Managed Care Plan shall require non-participating providers to coordinate with respect to payment and must ensure that the cost to the enrollee is no greater than it would be if the covered services were furnished within the network.
4. 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. This documentation will consist of only the necessary elements for the treatment of, and service delivery to a vulnerable adult. Such file shall be made available to the Agency upon request.
5. 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;
 - (13) Review of complaint and the quality remediation to resolve and prevent problems; and;
 - (14) The Managed Care Plan shall report the number and frequency of enrollees having executed Freedom of Choice Certification Forms in the enrollees' case record, as specified in **Attachment II**, Core Contract Provisions, Exhibit 12, Reporting Requirements, Summary of Reporting Requirements Table, Section XII, Reporting Requirements, and the Managed Care Plan Report Guide.
- 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. 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.

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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.
 9. The Managed Care Plan shall report monthly to the Agency results of its internal monitoring, 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. This report shall be submitted as specified in Section XII, Reporting Requirements, and the Managed Care Plan Report Guide.

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 II 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 II 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 II 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 local AHCA 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 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., and ALF must agree to offer facility	At least two (2) providers serving each county of the	At least two (2) providers serving each county of the

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
		services with home-like characteristics	region and one (1) licensed bed for each enrollee in the applicable max enrollment.	region and one (1) licensed bed for each enrollee in the applicable max enrollment.
Assistive Care Services	Adult Family Care Home (AFCH)	Licensed per Ch. 429, Part II, F.S., and Adult Family Care Home (AFCH) must agree to offer facility services with home-like characteristics	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.
Attendant Care	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services	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.		
	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Ch. 464, F.S.		
	Nurse Registry	Licensed per 400.506, F.S. Services shall be provided by a licensed RN or LPN.		
Behavior	Clinical Social Worker,	Licensed per Ch. 491, F.S.	At least two (2) providers	At least two (2) providers

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
Management	Mental Health Counselor		serving each county of the region.	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 shall have a minimum of two (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.		
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services		
Caregiver Training	CCE Provider	As defined in Ch. 410 or 430, F.S.	At least two (2) providers serving each county of the	At least two (2) providers serving each county of the
	Clinical Social Worker,			

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
	Mental Health Counselor	Licensed per Ch. 491, F.S.	region.	region.
	RN, LPN	Licensed per Ch. 400, Part III, F.S.		
	Home Health Agency	Optional to meet Federal Conditions of Participation under 42 CFR 484.		
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services		
Case Management	Case Managers employed or contracted by Managed Care Plans	Either: 2+ yrs. of relevant experience and; (1) BA or BS in Social Work, Sociology, Psychology, Gerontology or related social services field; (2) RN licensed in FL; (3) BA or BS in unrelated field, OR: 4+ yrs. relevant experience and LPN licensed in FL, OR: Professional human services experience can be substituted on a year-for-year basis for the educational requirements. All shall have four (4) hrs. of in-service training in identifying and reporting abuse, neglect and exploitation.	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	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.

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
	Center for Independent Living	Either: 2+ yrs. of relevant experience and; (1) BA or BS in Social Work, Sociology, Psychology, Gerontology or related social services field; (2) RN licensed in FL; (3) BA or BS in unrelated field, OR: 4+ yrs. relevant experience and LPN licensed in FL, OR: Professional human services experience can be substituted on a year-for-year basis for the educational requirements. All shall have four (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, Gerontology or related social services field; (2) RN licensed in FL; (3) BA or BS in unrelated field, OR: 4+ yrs. relevant experience and LPN licensed in FL, OR: Professional human services experience can be substituted on a year-for-year basis for the educational requirements. All shall have four (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.;	At least two (2) providers serving each county of the	At least two (2) providers serving each county of the

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
		Licensed by local city and/or county occupational license boards for the type of work being performed. Required to furnish proof of current insurance.	region.	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.		
Home Delivered Meals	Food Establishment Older Americans 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.
	Older American's Act (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/Companion	Registration in accordance with Ch.		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
	Agency	400.509, F.S.		
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F. S.		
Hospice	Hospice Organizations	Hospice providers shall 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.		
	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.		
	Nurse Registry	Licensed per 400.506, F.S.		
	Pharmacist	Licensed per Ch. 465, F.S.		
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 shall be an 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 shall		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
		be an RN or LPN.		
	Licensed Nurse, LPN	Licensed per Ch. 464, F.S.		
	Pharmacist	Licensed per Ch. 465, 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.		
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.		
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services		
Nursing Facility	See State Plan	See State Plan Requirements.	At least two (2) providers	At least two (2) providers

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
Care	Requirements.		serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment	serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment
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.		
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services		
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.		
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.		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
Long-Term Care Plan Benefit	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.; 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 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.
	Occupational Therapist Assistant	Licensed per Ch. 468, Part III, F.S.		
	Occupational Therapist	Licensed per Ch. 468, Part III, F.S.		
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services		
	Hospital Outpatient	Licensed per Ch. 395, Part I and 408,		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
	Department	Part II, F.S., and required licensure or be under supervision of a licensed professional qualified to provide the service.		
	Nursing Facility	Licensed per Ch. 400, 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 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.
	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.		
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services		
	Hospital Outpatient Department	Licensed per Ch. 395, Part I and 408, Part II, F.S., and required licensure or be under supervision of a licensed professional qualified to provide the service.		
	Nursing Facility	Licensed per Ch. 400, Part III, F.S.;		
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	At least two (2) providers serving each county of the region AND at least (1) provider within 30 minutes	At least two (2) providers serving each county of the region AND at least (1) provider within 60 minutes

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
		may meet Federal conditions of Participation under 42 CFR 484 or individuals licensed per Chapter 468, F. S. as certified respiratory therapists.	travel time.	travel time.
	Respiratory Therapist	Licensed per Ch. 468, F.S.		
	Health Care Service Pools	Licensed per Chapter 400, Part IX, F. S.		
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if required, to perform the waiver services		
	Hospital Outpatient Department	Licensed per Ch. 395, Part I and 408, Part II, F.S., and required licensure or be under supervision of a licensed professional qualified to provide the service.		
	Nursing Facility	Licensed per Ch. 400, Part III, 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 30 minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within 30 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.		
	Center for Independent Living	As defined under Chapter 413.371, F.S.; have licensed direct care staff, if		

Long-Term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications	Minimum Network Adequacy Requirements	
			Urban Counties	Rural Counties
		required, to perform the waiver services		

* The Agency reserves the right to change Minimum Provider Qualifications and Minimum Network Adequacy Requirements.

**Additional qualifications: See Exhibit 5, Section V.A.6.g. 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 eighteen (18) 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 Contract.

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 39 and 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.
- (8) The Managed Care Plan, shall report to the Agency as specified in Section XII, Reporting Requirements, and the Managed Care Plan Report Guide, all serious enrollee injuries occurring through health services within fifteen (15) days after the Managed Care Plan received information about the injury.

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/Agency-defined	
1	Care for Older Adults (COA): Add age bands: – included components: advance care planning; medication review; and functional status assessment. 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
Agency - defined	
3	Required Record Documentation (RRD)
4	Face-To-Face Encounters (F2F)
5	Case Manager Training (CMT)
6	Timeliness of Services (TOS)
7	Prevalence of Antipsychotic Drug Use in Long-Stay Dementia Residents

*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.
- (12) The first Performance Measure Report is due to the Agency no later than July 1, 2014, covering the measurement period of calendar year 2013. Due to continuous enrollment requirements, several measures will not be reported for calendar year 2013. The measures that some managed care plans should be able to report are:
- (a) Face-to-Face Encounters (managed care plans with at least three (3) months of enrollment);
 - (b) Case Manager Training (managed care plans with case managers employed ninety (90) days or more as of December 31, 2013);

- (c) Timeliness of Services (managed care plans with at least one month of enrollment).
- c. Satisfaction and Experience Surveys
- (1) Enrollee Satisfaction Survey —
 - (a) The Managed Care Plan shall conduct an annual enrollee satisfaction survey for a time period specified by the Agency, using the revised Enrollee Survey for Long-term Care Plans provided February 20, 2014 and located at: http://ahca.myflorida.com/medicaid/statewide_mc/survey.shtml.
 - (b) The Managed Care Plan shall follow the Survey Administration Guidelines below:
 - i. Long-term Care Plans (LTC Plans) are required to contract with an Agency-approved independent survey vendor to administer the surveys. The minimum sample size is 1,700, with a target of 411 completed surveys. The survey should be administered according to the NCQA mixed mode protocol (mail with telephone follow-up).
 - ii. The first round of surveys will be of LTC Plan members residing in the community. A simple random sample per NCQA protocol should be used.
 - iii. To be included in the survey sample, enrollees must have been enrolled in the LTC plan for at least six months with no more than a 1-month gap in enrollment.
 - iv. LTC Plans are required to use the core LTC Plan Enrollee Survey. If they would like to add questions to the survey, those questions may be added to the end of the core survey. Additional questions must be submitted to the Agency contract manager for review and approval prior to being included in the survey.
 - v. LTC plans must submit an Excel file of the survey results (including the responses to each survey item for each respondent) as well as an Excel file report of the aggregate response rates for the plan for each survey item. Both of these items must be attested to by the plan's independent survey vendor and a plan attestation regarding the accuracy and completeness of the files must be submitted. The submission templates for each of these two files may be obtained from the Agency contract manager.
 - vi. The due dates for the LTC Plan Enrollee Survey Results submissions will be as follows:
 - (a) The first enrollee survey results submissions will be due to the Agency by December 31, 2014.

- (b) The second enrollee survey results submissions will be due to the Agency by October 1, 2015.
 - (c) The third submission is due by July 1, 2016.
 - (d) Thereafter, submissions are due to the Agency by July 1 of each Contract year.
 - vii. The Managed Care Plan shall submit to the Agency, in writing, by April 7, 2014, a proposal for survey administration and reporting that includes identification of the survey administrator/vendor; sampling methodology; administration protocol; analysis plan; and reporting description.
 - viii. The Managed Care Plan shall submit a corrective action plan, as required by the Agency, within sixty (60) days of the request from the Agency to address any deficiencies the annual enrollee satisfaction survey.
 - ix. The Managed Care Plan shall use the results of the annual member satisfaction survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities conducted by the Managed Care Plan pertaining to improving member satisfaction resulting from the annual enrollee satisfaction survey must be reported to the Agency on a quarterly basis.
- 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 fee schedule in **Attachment I**, Scope of Services, **Exhibit 4** for reimbursement for covered services provided to enrollees.

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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 SMMC Managed Care Plan Report Guide.

SUMMARY OF REPORTING REQUIREMENTS				
Report Name	Contract Attachment D-II, Location; Report Guide	Plan Type	Frequency	Submit To
Enrollee Roster and Facility Residence Report	Exhibit 3 Chapter 26	All LTC Plans	Monthly, due within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Marketing/Community Outreach Health Fairs/Public Events Notification	Section IV. B.4.b. Chapter 15	All LTC Plans	No later than the twentieth (20th) calendar day of month before event month; amendments two (2) weeks before event	SMMC SFTP Site
Marketing/Community Outreach Representative Report	Section IV.B.8.a. Chapter 16	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 18	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 19	All LTC Plans	Weekly, each Wednesday by 5 p.m. EST of the week following the report week	SMMC SFTP Site

SUMMARY OF REPORTING REQUIREMENTS				
Report Name	Contract Attachment D-II, Location; Report Guide	Plan Type	Frequency	Submit To
Provider Complaint Report	Section VII Chapter 17	All LTC Plans	Quarterly within fifteen (15) calendar days after the end of reporting quarter	SMMC SFTP Site
Critical Incident Report	Section VIII Chapter 10	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 11	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
Performance Measures - LTC	Section VIII and Exhibit 5 and 8 Chapter 16	All LTC Plans	Annually, by July 1st	SMMC SFTP Site
Enrollee Complaints, Grievance, and Appeals Report	Section IX and Exhibit 12 Chapter 12	All LTC Plans	Monthly, within fifteen (15) calendar days after end of the reporting month	SMMC SFTP Site
Quarterly Fraud & Abuse Activity Report	Section X Chapter 20	All LTC Plans	Quarterly, within fifteen (15) calendar days after the end of reporting quarter	OIG MPI Web-based Application Site
Annual Fraud and Abuse Activity Report	Section X Chapter 6	All LTC Plans	Annually, by September 1st	MPI SFTP Site
Suspected/ Confirmed Fraud and Abuse Reporting	Section X Chapter 21	All LTC Plans	Within fifteen (15) calendar days of detection	Agency's Online Electronic Data Entry Complaint Form

SUMMARY OF REPORTING REQUIREMENTS				
Report Name	Contract Attachment D-II, Location; Report Guide	Plan Type	Frequency	Submit To
Claims Aging Report and Supplemental Filing Report	Section X Chapter 8	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 31	All LTC Plans	Annually, by October 1st for the prior Contract year	SMMC SFTP Site
Audited Annual and Unaudited Quarterly Financial Reports	Section XV Chapter 7	All LTC Plans	Audited — Annually by April 1st 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 4	All LTC Plans	Quarterly within fifteen (15) calendar days of end of quarter	SMMC SFTP Site
Denial, Reduction, Suspension or Termination of Services Report	Exhibit 5 Chapter 25	All LTC Plans	Monthly, due fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Participant Direction Option (PDO) Roster Report	Exhibit 5 Chapter 30	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 22	All LTC Plans	Quarterly — due within thirty (30) calendar days of the end of the reporting quarter	SMMC SFTP Site

SUMMARY OF REPORTING REQUIREMENTS				
Report Name	Contract Attachment D-II, Location; Report Guide	Plan Type	Frequency	Submit To
Case Management Monitoring and Evaluation Report	Exhibit 5 Chapter 23	All LTC Plans	Quarterly with annual roll-up — due within thirty (30) calendar days of the end of the reporting quarter	SMMC SFTP Site
Case Manager Caseload Report	Exhibit 5 Chapter 24	All LTC Plans	Monthly, due within fifteen (15) calendar days after the end of the reporting month	SMMC SFTP Site
Missed Services Report	Exhibit 5 Chapter 28	All LTC Plans	Monthly, due thirty (30) calendar days after the end of the reporting month	SMMC SFTP Site
Unable to Locate Report	Exhibit 5 Chapter 33	All LTC Plans	Monthly	SMMC SFTP Site
Freedom of Choice Selection Report	Exhibit 5 Chapter 34	All LTC Plans	Quarterly	SMMC SFTP Site

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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.

6. Community High Risk Pool (CHRP)

- a. The Community High Risk Pool (CHRP) for the SMMC Long-Term Care (LTC) program, implemented July 1, 2014, recognizes the disproportionate enrollment of high cost home and community-based (HCBS) recipients. The CHRP operates as a revenue neutral redistribution of plan reimbursement associated with community enrollees. The risk pool is funded through a small withhold amount applied to the pre-transition adjusted HCBS enrollment for the LTC contractor. Encounter data submissions are required in accordance with **Attachment II**, Core Contract Provisions, Section VIII, Administration and Management, E., Encounter Data Requirements. The Agency shall analyze the LTC encounter data submitted by the LTC plans.
 - (1) Only HCBS services will be used to evaluate the SMMC LTC risk pool for an enrolled recipient.
 - (2) Costs associated with nursing home services and hospice services are explicitly excluded from the distribution of the risk pool.

- b. Effective July 1, 2014, the Agency will establish a withhold per-member-per-month (PMPM) on a quarterly basis.
 - (1) The withhold PMPM will use only state-plan or waiver approved services and exclude nursing facility and hospice services.
 - (2) The CHRP will be established by SMMC LTC region.
 - (3) The Agency may adjust the PMPM withhold value on a quarterly basis as necessary.
 - (4) The Agency shall communicate the terms of the CHRP including the threshold and coinsurance amount each quarter.
 - (5) The established CHRP withhold will be applied to the pre-transition HCBS enrollment on a monthly basis.

- c. The Agency will distribute the funds in the CHRP in proportion to each LTC Plan's reported or Agency adjusted expenditures in excess of the CHRP threshold average PMPM for HCBS recipients for the quarterly period.
 - (1) The Agency will utilize encounter data submitted by the LTC Plan and the enrollment maintained by the Agency to evaluate LTC plan expenditures for the purpose of distributing the CHRP funds. Encounter data shall be submitted in accordance with **Attachment II**, Core Contract Provisions, Section VIII, Administration and Management, E., Encounter Data Requirements.
 - (2) The Agency shall aggregate the qualified service expenditures from the encounter data by LTC Plan for the quarter based on incurred date reported on the encounter data for HCBS recipients who were eligible on the date of service. The Agency, at its discretion, may reprice encounter data based on what the Agency would have paid for the same services under fee-for-service.
 - (3) The first CHRP distribution will cover the months of July and August 2014, for incurred dates paid through November 2014, with payment in December 2014, after which distributions will occur every three (3) months) using the following schedule:
 - (a) February Disbursement – Claims incurred September – November, paid and submitted through January;
 - (b) May Disbursement – Claims incurred December – February, paid and submitted through April;
 - (c) August Disbursement – Claims incurred March – May, paid and submitted through July; and
 - (d) November Disbursement – Claims incurred June – August, paid and submitted through October.

- (4) At the end of each twelve (12) month period, in the event the eligible expenditures for the CHRP are less than the total amount withheld the balance of the withheld amount less any disbursement for eligible expenditures will be refunded to the LTC Plans participating in the region
 - (5) At the end of each twelve (12) month period, in the event the LTC Plan(s) in a region do not have any HCBS recipients whose expenditures meet the threshold the withheld amounts will be refunded to the LTC Plans participating in the region.
 - (6) At the end of each twelve (12) month period, the Agency will close the funds, eliminating any carry over balances, and return any unused portion of each regional fund to the LTC Plans operating in that region on a per member basis. The Agency, at its discretion, may distribute any unused portion of the funds from the pool before the end of the twelve (12) month period.
- d. The Agency may adjust prior CHRP distributions if the encounter data used for the original CHRP distribution has changed through adjustments submitted in the encounter data that may include but are not limited to voided and replaced encounters submitted by the LTC Plans or a recipients retro-active disenrollment from the SMMC LTC program. Twelve (12) months after the end of the quarter, the Agency will make no further post-payment adjustments.

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

H. Health Insurance Providers Fee

1. General

Pursuant to Section 26 CFR Part 57 (2013) (the applicable regulations providing guidance to section 9010 of the “Affordable Care Act”), the Health Plan is required to pay the “Health Insurance Providers” Fee annually. The Agency will pay the portion of this fee specifically related to the Health Plan’s performance of this Contract with an adjustment related to the federal and state income tax impact of this Fee using the methodology described below under the following conditions:

- a. The entity which comprises the Health Plan or of which the Health Plan is a part and which is required to submit the IRS Form 8963 pursuant to the above mentioned federal regulations (referred to hereinafter as the “Reporting Plan”) shall submit to the Agency a copy of the IRS Form 8963 submitted to the IRS by April 15 after each calendar year it intends to be reimbursed.
- b. The Reporting Plan shall submit to the Agency a copy of the IRS Notice of final fee calculation (as described in 26 CFR s. 57.7) by September 15 after each calendar year it intends to be reimbursed.
- c. The Reporting Plan shall submit its annual statement (which includes information pertinent to the tax impact of this subject fee) once it is issued for the preceding calendar year for which it intends to be reimbursed.
- d. All documents listed above and any additional data or information requested by the Agency shall be submitted with an attestation by the Reporting Plan in accordance with the certification requirements specified in Section XII, Reporting Requirements, of this Contract. Following the determination of the amount to be reimbursed and the federal and state income tax impact related to this health insurance providers fee, the capitated per member per month Fee for the plan will be timely reprocessed. This process is subject to approval by the Centers for Medicare and Medicaid Services and any change in federal or state law.

2. Health Insurance Providers Fee Methodology

- a. Table 1 would show revenue information for the data year related to the fee payment year. For example, Table 1 would include 2013 revenue information for the 2014 Health Insurance Providers fee. This approach is consistent with how the Health Insurance Providers fee amount is calculated by the IRS. Please note that the amounts designated as A through I are net of the exempted premiums amounts. The total premiums taken into account should be allocated proportionately to total premiums by state and line of business.
- b. The information in Table 1 will be used by the Agency to calculate the portion of the Health Insurance Providers Fee related to Medicaid activities for the Reporting Plan using the formula $(A / I) * J$. The proportion denoted by (A / I) represents the percentage of total premiums taken into account related to Medicaid for the Reporting Plan, and J represents the total Health Insurance Providers Fee amount allocated to the Reporting Plan as documented by the

Reporting Plan's IRS notice. Note that items I and J should be taken directly from the IRS memos received by the Reporting Plan.

Table 1 Florida AHCA Illustrative Health Insurance Providers Fee Information Collection			
Business Location	Medicaid Premiums Taken into Account	Other Health Insurance Premiums Taken into Account	Total Premiums Taken into Account
Florida	A	B	$C = A + B$
Other States	D	E	$F = D + E$
Total	G	H	$I = G + H$
Insurer Fee (Estimated or Final)		J	

3. Adjustment for federal and state income tax related to the Health Insurance Providers Fee Methodology
 - a. An actuarially sound approach will be developed to calculate the amount of income tax related to the Health Insurance Providers Fee.

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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.

FFS LTC PSNs

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.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
3	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.	\$500 per enrollee per occurrence.
4	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.	\$500 per enrollee per occurrence, not to exceed \$10,000,000.
5	Failure to timely submit audited annual and quarterly unaudited financial statements as described in Attachment II, Core Contract Provisions, Section XV of the Contract.	\$500 per calendar day for each day that reporting requirements as described in Section XV are not met.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
6	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 encounter records in a timely manner as required by the Agency).	\$25,000 per occurrence.
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 assessed 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.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
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 assessed 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.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
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	\$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.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
	described in Attachment II, Core Contract Provisions, Exhibit 5 of 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 the Contract and Exhibits 4, 5, 7, 8 and 10 of the Contract.	\$250 per calendar day for each day that staffing requirements are not met.
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.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
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-	\$1,000 per occurrence.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
	face reassessments for Level of Care as described in Attachment II, Core Contract Provisions, Exhibit 5 of the Contract.	
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 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 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	\$1,000 per calendar day for each day Contract requirements are not met.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
	Attachment II, Core Contract Provisions, Section XV and Exhibit 15 of the Contract.	
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 XII 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 XII and Exhibit 12 of the Contract	\$1,000 per occurrence.
40	Submission of inappropriate report certifications as described in Attachment II, Core Contract Provisions, Section XII of the Contract.	\$250 per occurrence.
41	Failure to respond to an Agency communication within the time prescribed by the Agency as described in	\$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

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
	Attachment II, Core Contract Provisions, Section II and XI of the Contract.	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 Provisions, Exhibits 4 and 5 of the Contract.	\$100 assessed for each enrollee who temporarily loses eligibility (for less than 60 days) pursuant to a redetermination.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
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	\$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

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
	Provisions, Sections V, VII and XVI and Exhibit 7 of the Contract.	amount paid to the 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 initiate a background screening via the Clearinghouse for newly hired principals as described in Attachment II, Core Contract Provisions, Section XVI of the Contract.	\$ 500 per occurrence.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
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

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
		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.

Liquidate Damages – Effective 8/01/2013 – 8/01/2018		
	PROGRAM ISSUES	DAMAGE
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.
73	Failure of a provider contract to comply with a requirement of this Contract.	\$1,000.00 per failure per provider contract
74	Failure to receive prior written Agency approval of delegation to a subcontractor	\$25,000.00 per occurrence
75	Failure of a subcontract to comply with a requirement of this Contract.	\$5,000.00 per failure per subcontract
76	Failure to comply with public records laws, in accordance with Section 119.0701, Florida Statutes	\$5,000.00 per occurrence

**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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