

ATTACHMENT II
EXHIBIT II-A – Effective Date: October 1, 2014
MANAGED MEDICAL ASSISTANCE (MMA) PROGRAM

Section I. Definitions and Acronyms

The definitions and acronyms in Core Provisions Section I, Definitions and Acronyms apply to all MMA Managed Care Plans and Comprehensive LTC Managed Care Plans unless specifically noted otherwise in this Exhibit.

Section II. General Overview

The provisions in this Exhibit apply to all MMA Managed Care Plans and Comprehensive LTC Managed Care Plans. The provisions in this Exhibit also apply to all Specialty Plans unless provisions unique to a specific type of Specialty Plan are codified in the resulting Contract and its Exhibits.

In accord with the order of precedence listed in Attachment I, any additional items or enhancements listed in the Managed Care Plan's response to the Invitation to Negotiate are included in this Exhibit by this reference.

Section III. Eligibility and Enrollment

A. Eligibility

1. Mandatory Populations

a. In addition to the programs and eligibility categories specified in Section III, Eligibility and Enrollment, recipients in the following eligibility categories are required to enroll in a managed care plan:

- (1) Title XXI MediKids; and
- (2) Children between 100 - 133% of federal poverty level (FPL) who transfer from the state's Children's Health Insurance Program (CHIP) to Medicaid.

2. Voluntary Populations

In addition to the programs and eligibility categories specified in Section III, Eligibility and Enrollment, recipients in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan:

- a. SSI (enrolled in developmental disabilities home and community based waiver);
- b. MEDS (SOBRA) for children under one (1) year old and income between one-hundred eighty-five percent (185%) and two-hundred percent (200%) FPL;

- c. MEDS AD – (SOBRA) for aged and disabled – enrolled in DD home and community based waiver;
- d. Recipients with other creditable coverage excluding Medicare;
- e. Recipients age sixty-five (65) and older residing in mental health treatment facilities as defined in s. 394.455(32), F.S.;
- f. Residents of DD centers including Sunland and Tachacale;
- g. Refugee assistance;
- h. Recipients residing in group homes licensed under Chapter 393, F.S.; and
- i. Children receiving services in a prescribed pediatric extended care center (PPEC).

B. Enrollment

1. Notification of Enrollee Pregnancy

- a. The Managed Care Plan shall be responsible for newborns of pregnant enrollees from the date of their birth. The Managed Care Plan shall comply with all requirements set forth by the Agency or its agent related to unborn activation and newborn enrollment.
- b. Unborn activation shall occur through the following procedures:
 - (1) Upon identification of an enrollee's pregnancy through medical history, examination, testing, claims, or otherwise, the Managed Care Plan shall immediately notify DCF of the pregnancy and any relevant information known (for example, due date and gender). The Managed Care Plan must provide this notification by completing the DCF Excel spreadsheet and submitting it, via electronic mail, to the statewide DCF Customer Call Center address. The Managed Care Plan shall indicate its name and number as the entity initiating the referral. The DCF Excel spreadsheet and directions for completion and submission are located on the Medicaid web site: <http://ahca.myflorida.com/Medicaid/Newborn/index.shtml>.
 - (2) DCF will generate a Medicaid ID number for the unborn child. This information will be transmitted to the Medicaid fiscal agent. The Medicaid ID number will remain inactive until the child is born and DCF is notified of the birth.
 - (3) Upon notification that a pregnant enrollee has presented to the hospital for delivery, the Managed Care Plan shall inform the hospital, the pregnant enrollee's attending physician and the newborn's attending and consulting physicians that the newborn is an enrollee. At this time the Managed Care Plan or its designee shall complete and submit the Excel spreadsheet for unborn activation to DCF.
 - (4) E-mail submissions shall include the password-protected spreadsheet as an attachment, and the spreadsheet shall contain all pregnancy notifications and

newborn births for that Managed Care Plan (or that Managed Care Plan's designated subcontractor). Each Managed Care Plan (or Managed Care Plan-designated subcontractor) shall submit notifications as specified by the Agency to the statewide DCF customer call center address. (Refer to the Medicaid website referenced above for DCF customer call center information.)

- (5) When the baby's Medicaid ID has been activated the newborn will be enrolled in the Managed Care Plan retroactive to birth.
- c. If a pregnant enrollee presents for delivery without having an unborn eligibility record that is awaiting activation, the Managed Care Plan or designee shall submit the spreadsheet to DCF immediately upon birth of the child. The newborn will automatically become a Managed Care Plan enrollee retroactive to birth.
- d. Failure to use the unborn activation process for reporting pregnancies as specified by his Contract may result in sanctions as described in Section XI, Sanctions.

C. Disenrollment

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

D. Marketing

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

Section IV. Enrollee Services and Grievance Procedures

A. Enrollee Materials

1. Enrollee Handbook Requirements

- a. The Managed Care Plan shall include additional information in its handbook applicable to the MMA program, as follows:
 - (1) Information on the importance of selecting a PCP and the procedure for selecting a PCP (see s. 409.973(4)(a), F.S.);
 - (2) How to change PCPs;
 - (3) Information about how to select a newborn's PCP;
 - (4) An explanation to all potential enrollees that an enrolled family may choose to have all family members served by the same PCP or they may choose different PCPs based on each family member's needs;
 - (5) Emergency services and procedures for obtaining services both in and out of the Managed Care Plan's region, including explanation that prior authorization is not required for emergency or post-stabilization services, the locations of any emergency settings and other locations at which providers and hospitals

furnish emergency services and post-stabilization care services, use of the 911-telephone system or its local equivalent, and other post-stabilization requirements in s. 1932(b)(2)(A)(ii) of the Social Security Act and 42 CFR 438.114; and

- (6) The right to obtain family planning services from any participating Medicaid provider without prior authorization.
- b. The Managed Care Plan, subject to Agency approval, may include a separate section for behavioral health services. In such cases, its handbook shall provide the following information:
- (1) The extent to which and how after-hours and emergency coverage are provided and that the enrollee has a right to use any hospital or other setting for emergency care;
 - (2) Information that post-stabilization services are provided without prior authorization and other post-stabilization care services rules set forth in s. 1932(b)(2)(A)(ii) of the Social Security Act and 42 CFR 438.114;
 - (3) A clear statement that the enrollee may select an alternative mental health case manager or direct service provider within the Managed Care Plan, if one is available;
 - (4) A description of behavioral health services provided, including limitations, exclusions and out-of-network use;
 - (5) A description of emergency behavioral health services procedures both in and out of the Managed Care Plan's region;
 - (6) Information to help the enrollee assess a potential behavioral health problem;
 - (7) A clear statement that prior authorization or referral by a PCP is not required for behavioral health services;
 - (8) Information on the Managed Care Plan's healthy behavior programs, including how to participate, that incentives/rewards are non-transferrable, and that members will lose access to earned incentives/rewards if they voluntarily disenroll from the Managed Care Plan or lose Medicaid eligibility for more than one-hundred eighty (180) days (and thus are not automatically reinstated in the Managed Care Plan); and
 - (9) The Managed Care Plan's psychotropic drug informed consent requirements for enrollees under age thirteen (13) as provided for in s. 409.912(51), F.S.

B. Enrollee Services

1. Medicaid Redetermination Assistance

- a. The Agency will provide Medicaid recipient redetermination date information to the Managed Care Plan. This information shall be used by the Managed Care Plan only as indicated in this subsection.
- b. The Managed Care Plan shall notify the Agency, in writing, if it wants to participate in using this information. The Managed Care Plan's participation in using this information is voluntary.
- c. If the Managed Care Plan chooses to participate in the use of this information, it shall provide its policies and procedures regarding this subsection to the Agency for its approval along with its notification indicating it will participate.
- d. A Managed Care Plan that chooses to participate in the use of this information may decide to discontinue using it at any time and must so notify the Agency in writing thirty (30) days prior to the date it will discontinue such use.
- e. Regardless of whether the Managed Care Plan participates in the use of this information, the Managed Care Plan is subject to the sanctioning indicated in this subsection if the Managed Care Plan misuses the information at any time.
- f. A Managed Care Plan that chooses to participate in using this information shall use the redetermination date information only in the methods listed below and shall use either or both methods to communicate this information.
 - (1) The Managed Care Plan may 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. A Managed Care Plan that chooses to use this method to provide this information to its enrollees must adhere to the following requirements:
 - (a) 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;
 - (b) The Managed Care Plan shall use the Agency-provided 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; and
 - (c) The Managed Care Plan shall mail the redetermination date notice to each enrollee no more than sixty (60) days and no less than thirty (30) days before the redetermination date occurs.

- (2) The Managed Care Plan may use redetermination date information in automated voice response (AVR) or integrated voice response (IVR) automated messages sent to enrollees reminding them that their Medicaid eligibility may end soon and to reapply for Medicaid if needed. A Managed Care Plan that chooses to use this method to provide this information to its enrollees must adhere to the following requirements:
- (a) The Managed Care Plan shall send the redetermination date messages to each enrollee for whom that Managed Care Plan has received a redetermination date and for whom the Managed Care Plan has a telephone number. The Managed Care Plan may send an automated message 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/phone number;
 - (b) For the voice messages, the Managed Care Plan shall use only the language in the Agency's redetermination date notice template provided to the Managed Care Plan. The Managed Care Plan may add its name to the message but shall make no other changes, additions or deletions to the message text; and
 - (c) The Managed Care Plan shall make such automated calls to each enrollee no more than sixty (60) days and no less than thirty (30) days before the redetermination date occurs.
- g. The Managed Care Plan shall not include the redetermination date information in any file viewable by enrollee service or community outreach staff. This information shall be used only in the letter templates and automated scripts provided by the Agency and cannot be referenced or discussed by the Managed Care Plan with the enrollees, unless in response to an enrollee inquiry about the letter received, nor shall it be used at a future time by the Managed Care Plan. If the Managed Care Plan receives enrollee inquiries about the notices, such inquiries must be referred to the Department of Children and Families.
- h. 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 Section XI, Sanctions. In addition to any other sanctions available in Section XI, 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-day (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 XI, Sanctions. Additional or subsequent violations may result in the Agency's rescinding provision of redetermination date information to the Managed Care Plan.

C. Grievance System

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

Section V. Covered Services

A. Required MMA Benefits

1. Specific MMA Services to be Provided

- a. The Managed Care Plan shall provide the services listed below in accordance with the Florida Medicaid State Plan, the Florida Medicaid Coverage and Limitations Handbooks, the Florida Medicaid fee schedules, and the provisions herein, unless specified elsewhere in this Contract. The Managed Care Plan shall comply with all state and federal laws pertaining to the provision of such services. The following provisions highlight key requirements for certain covered services, including requirements specific to the MMA program:

(1) Advanced Registered Nurse Practitioner

- (a) The Managed Care Plan shall provide Advanced Registered Nurse Practitioner Services. Advanced Registered Nurse Practitioners (ARNPs) are licensed advanced practice registered nurses who work in collaboration with practitioners pursuant to Chapter 464, F.S., according to protocol, to provide diagnostic and interventional patient care.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Practitioner Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Practitioner Services Coverage and Limitations Handbook.

(2) Ambulatory Surgical Center Services

- (a) The Managed Care Plan shall provide Ambulatory Surgical Center Services. Ambulatory surgical centers (ASCs) provide scheduled, elective, medically necessary surgical care to patients who do not require hospitalization. Medicaid reimburses surgical procedures that have been approved by the federal Centers for Medicare and Medicaid Services and Florida Medicaid, provided in a licensed Medicare-approved, Medicaid-participating ASC entity that is separate and distinguishable from any other entity or type of facility, and is not part of a hospital. The reimbursed facility fee is all-inclusive of the following:
 - (i) Administrative, record keeping, and housekeeping items and services;
 - (ii) Blood, blood plasma, and components;
 - (iii) Diagnostic or therapeutic services or items directly related to providing surgical procedures;

- (iv) Drugs, biologicals, intraocular lenses, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to providing surgical procedures;
 - (v) Materials for anesthesia;
 - (vi) Nursing, technical, and related services; and
 - (vii) Use of ASC facilities.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Ambulatory Surgical Center Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Ambulatory Surgical Center Services Coverage and Limitations Handbook.

(3) Assistive Care Services

- (a) The Managed Care Plan shall provide Assistive Care Services. Assistive Care Services are an integrated set of 24-hour services only for Medicaid-eligible residents in assisted living facilities, adult family care homes and residential treatment facilities. Assistive Care Services require a health assessment by a licensed practitioner establishing medical necessity for at least two of the four service components and the need for at least one specific service each day. Components are health support, assistance with activities of daily living (ADL), assistance with instrumental activities of daily living (IADL), and assistance with self-administration of medication.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Assistive Care Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Assistive Care Services Coverage and Limitations Handbook.

(4) Behavioral Health Services

- (a) The Managed Care Plan shall provide a full range of medically necessary behavioral health services authorized under the State Plan and specified in the Florida Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook and the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook (the Handbooks) and by this Contract to all enrollees.
- (b) The Managed Care Plan shall provide the following services as described in the Handbooks and applicable fee schedules. The amount, duration and scope of such services shall not be more restrictive than that specified in the Handbooks. The Managed Care Plan shall not establish

service limitations that are lower than, or inconsistent with, the Handbooks.

- (i) Inpatient hospital services for behavioral health conditions;
 - (ii) Outpatient hospital services for behavioral health conditions;
 - (iii) Psychiatric physician services for behavioral health conditions and psychiatric specialty codes 42, 43, and 44;
 - (iv) Community behavioral health services for behavioral health conditions;
 - (v) Community behavioral health services for substance abuse conditions;
 - (vi) Mental Health Targeted Case Management ;
 - (vii) Mental Health Intensive Targeted Case Management;
 - (viii) Specialized therapeutic foster care;
 - (ix) Therapeutic group care services;
 - (x) Comprehensive behavioral health assessment;
 - (xi) Behavioral health overlay services in child welfare settings;
 - (xii) Residential care; and
 - (xiii) Statewide Inpatient Psychiatric Program (SIPP) services for individuals under age twenty-one (21).
- (c) The Managed Care Plan may provide substitute services to its enrollees as specified in this subsection. The Managed Care Plan is encouraged to provide substitute services that will enhance covered services. To the degree possible, the Managed Care Plan shall use existing community resources. Substitute services represent a downward substitution for services in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook and are not an expansion of behavioral health benefits. The Managed Care Plan shall make information on substitute services available to enrollees and require documentation of enrollee agreement before implementing such services. Managed Care Plans shall ensure providers use clinical rationale for determining the benefit of the service for the enrollee. The Managed Care Plan shall not require an enrollee to choose a substitute service over a Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook service. Substitute services must be prior approved by the Agency.

HCPCS Or Revenue Code	HCPCS Level II or Revenue Code Service Description	Service Description	Provider Qualifications	Documentation Required	Service Setting	Unit of Service	Reimbursement /Service Limits
0912	Psychiatric/Psychological Svcs: Partial Hosp - less intensive	Partial Hospitalization - Less intensive	Master's Level Practitioner, or Licensed Practitioner of the Healing Arts	Documentation must be sufficient to indicate that this Partial Hospitalization Service is clinically appropriate for the enrollee.	Face to Face in a Hospital	All inclusive Daily Per Diem	1 unit per day; 90 days annual limit for adults ages 21+; No annual limit for children under age 21.
1001	Residential treatment-psychiatric	Short Term Residential Treatment - Level I - (SRT when utilized as a medically necessary downward substitution for acute CSU). Services should be provided with the goal of giving the enrollee additional time to stabilize, recover and rehabilitate. These services are intended to Increase enrollees' ability to successful re-integrate into an independent community setting at the time of discharge.	Licensed SRTs	Documentation must be sufficient to indicate that the enrollee meets clinical criteria for this level of care. The enrollee must meet criteria for acute crisis stabilization services and documentation must indicate that this level of care is being utilized as a downward substitution.	Face-to-Face in a licensed SRT program	Per diem	1 unit per day. This benefit like CSU is flexed against the inpatient day limit of 45 days per fiscal year for adults over age 21. Note: 2 SRT days = 1 Inpatient day. No annual limit for children under age 21.
H0038	SELF-HELP/PEER SERVICES, PER 15 MINUTES	Services may include: peer specialist activities, peer mentoring, peer education, recovery coach services and behavioral health services provided by peers. Does not include: paperwork for consumers, attendance at NAMI	Those qualified by training & certification to perform this service under the supervision of a licensed master's level clinician	Services must provide a documented support and/or treatment benefit to PMHP enrollees. Services must be individualized and demonstrate a recovery and resiliency focus.	Face- to-Face with Client Present	15 minutes	16 units per day.

HCPCS Or Revenue Code	HCPCS Level II or Revenue Code Service Description	Service Description	Provider Qualifications	Documentation Required	Service Setting	Unit of Service	Reimbursement /Service Limits
		or other consumer support meetings, offering meeting space for consumer meetings, travel time or transportation of consumers, peer specialist time that is not spent on education or self-help activities, or other administrative services.					
H0046 HE	MENTAL HEALTH SERVICES, NOT OTHERWISE SPECIFIED; MENTAL HEALTH PROGRAM	Respite care services	Those qualified by 2 years of experience with the mental health population and have completed 30 hours of training which includes psychopathology, medication management, family dynamics, and crisis intervention or those licensed as a regular foster care home and certified as a specialized therapeutic foster home.	Enrollee must be in active treatment and there must be documentation to support that respite services will assist family or caregivers while providing an option to de-escalate a situation while avoiding hospitalization.	Services may be provided in the home, school, or community and must be provided face-to-face.	Daily rate	Minimum of 8 hours per day.
H2011 HO	PSYCHIATRIC HEALTH FACILITY SERVICE, PER DIEM; MASTERS DEGREE LEVEL	Mobile Crisis Assessment and Intervention for enrollees in the community	Provided by a master degree level clinician under the supervision of a licensed master's level clinician	Documentation of clinical intervention and outcome of intervention	Intervention by referral from MCO	15 minutes	96 units per year; maximum of 8 units per day.
H2015 HE	COMPREHENSIVE COMMUNITY SUPPORT SERVICES, PER 15 MINUTES; BEHAVIORAL HEALTH PROGRAM	Outreach Services; Services may include: activities designed to keep individuals out of the jail and juvenile justice system. Applies to both Children and Adults.	Bachelor's level practitioner or LPN	Services must provide a beneficial diversion from jail or juvenile justice system. Services must be targeted towards a specific recipient and encourage	Face- to-Face; Client Present	15 minutes	16 units per day.

HCPCS Or Revenue Code	HCPCS Level II or Revenue Code Service Description	Service Description	Provider Qualifications	Documentation Required	Service Setting	Unit of Service	Reimbursement /Service Limits
		Does not include: paperwork, travel time, transportation of consumers, phone calls, or other administrative services.		engagement in the treatment process to prevent involvement in the criminal justice system.			
H2019 HB	THERAPEUTIC BEHAVIORAL SERVICES, PER 15 MINUTES; ADULT PROGRAM	In-Home Counseling Adult - Therapy, rehabilitative and supportive counseling in the client's home	minimum of master's degree	documentation of services	Face-to-Face	encounter	No limit.
H2020 HB	Therapeutic Behavioral Services, per diem, adult program	A service that covers the medically necessary clinical support services of enrollees while residing in an SRT level of care. The goal of these services would be to provide stabilization, recovery, and rehabilitation services to enrollees to allow them to discharged to a community setting and increase their capacity for independent living.	Services must be provided by the appropriate level clinician. In a SRT setting. There must be a clinical supervisor and master's level clinician. Physicians and bachelor's level clinicians would be able to provide this service as well.	Enrollees must meet criteria for admission to SRT – Residential Level Treatment I. The program must also be licensed by SAMH as a short term residential treatment unit.	Services are face to face delivered in a residential level I (SRT) setting.	Per Diem	1 unit per day.
S5102 HE	DAY CARE SERVICES, ADULT; PER DIEM; MENTAL HEALTH PROGRAM	Drop-In Center - A social club offering peer support and flexible schedule of activities: may operate on weekdays, evenings and/ or weekends. Activities focus on support, social and behavioral skills.	BA level practitioner	Plan of care, activities and documented records	Face- to-Face	One day	365 days per year.

HCPCS Or Revenue Code	HCPCS Level II or Revenue Code Service Description	Service Description	Provider Qualifications	Documentation Required	Service Setting	Unit of Service	Reimbursement /Service Limits
T1023 HA	SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED PROGRAM, PROJECT OR TREATMENT PROTOCOL, PER ENCOUNTER; CHILD/ADOLESCENT PROGRAM	Infant Mental Health Pre and Post Testing Services - Tests, inventories, questionnaires, structured interviews, structured observations, and systematic assessments that are administered to help assess the caregiver-child relationship and to help aid in the development of the treatment plan	Masters level or above with 2 years' experience working with infant mental health OR MA level and under the supervision of a MA level or above with at least 2 years' experience working IMH. Individuals administering the tests are to be operating within the scope of their professional licensure, training, test protocols, and competencies, and in accordance with applicable statutes.	A written report of evaluation and testing results must be done by the individual rendering services and must be included in the child's medical record for all evaluation and testing services listed in the evaluation and testing section	Face-to-Face	15 minutes	For children ages 0 through 5 years, 40 units per year.
T1027	Family Training & Counseling for Child Development, per 15 minutes	Services may include: support groups for family members which provide education regarding SED, family education, psychosocial activities, and other education and support activities related to SED. Does not include paperwork or case management services, does not include telephone calls to families, travel time, transportation of consumers, services to support appointment	BA level practitioner	Services must support the family and child in treatment. They must be resiliency focused and provide meaningful supports to allow the family and caregivers, and child to participate fully in the treatment process.	Face- to-Face; Client Present	15 minutes.	16 units per day.

HCPCS Or Revenue Code	HCPCS Level II or Revenue Code Service Description	Service Description	Provider Qualifications	Documentation Required	Service Setting	Unit of Service	Reimbursement /Service Limits
		coordination, or other administrative services.					
H0046 HK	BEHAVIORAL HEALTH SERVICES, NOT OTHERWISE SPECIFIED; SPECIALIZED BEHAVIORAL HEALTH PROGRAMS FOR HIGH-RISK POPULATIONS	Specialized therapeutic in-home service is a flexible in-home support service designed for children in the child welfare system, ages 5 through 17, who are stepping down from or at high risk for residential care and institutional services. Providing therapeutic support in addition to helping parents in developing parenting skills, specialized therapeutic in-home services are designed to aid in the transition to community-based outpatient services by providing intensive therapeutic services plus 24 hour crisis response services for an anticipated length of stay of up to 120 days.	The specialized therapeutic in-home services team is led by a licensed clinician who coordinates the services of the treatment team, which includes a mental health targeted case manager, master's level therapist and psychiatrist.	Individualized treatment plans within 14 days of admission, treatment plan reviews biweekly by the treatment team with the youth and family and updated as needed. Weekly written progress updates are provided in addition to a weekly face-to-face or telephonic staffing with the Community Based Care agency responsible for the child's care.	Specialized therapeutic in-home services will be reimbursed on a weekly basis. A minimum of four face-to-face contacts per week are required and must include both individual and family therapy. A minimum of three contacts per week are to be made in the home by the primary clinician.	1 unit per week	1 unit per week.
S9475	AMBULATORY SETTING SUBSTANCE ABUSE TREATMENT OR DETOXIFICATION SERVICES	The ambulatory detoxification service includes clinical and medical management of the physical and psychological process of	Licensed ambulatory detoxification facility.	Documentation must be sufficient to indicate that the enrollee meets clinical criteria for this level of care. The enrollee must meet criteria for	Face-to-face in a licensed ambulatory detoxification facility.	Per diem	3 hours per day for up to 30 days.

HCPCS Or Revenue Code	HCPCS Level II or Revenue Code Service Description	Service Description	Provider Qualifications	Documentation Required	Service Setting	Unit of Service	Reimbursement /Service Limits
		<p>withdrawal from alcohol and other drugs on an outpatient basis in a community based setting. This service is intended to stabilize the recipient physically and psychologically using accepted detox protocols.</p>		<p>detoxification and documentation must indicate that this level of care is being utilized as a downward substitution.</p>			
<p>H2022</p>	<p>Community-Based Wrap-Around Services</p>	<p>Wraparound is an intensive level of community-based services in order to prevent residential treatment. The wraparound service delivery model is built around family team planning. Wraparound services include frequent assessment and treatment plan progress reviews, and treatment team meetings must include the full complement of professionals working with the family. Meeting frequency of child and family teams is guided by the family's needs and level of risk. Included in the wraparound services include intensive targeted case management,</p>	<p>Provider type 91 and certified to provide children's mental health targeted case management; Provider type 05—Community Behavioral Health Provider</p>	<p>All Wraparound team meetings shall be documented in the form of formal meeting minutes. All collateral contacts shall be documented in the form of contact/progress notes. Treatment and TCM services documented according to handbook standards for PT-05 and PT-91.</p>	<p>Services may be provided in the home, school, or community and must be provided face-to-face.</p>	<p>Per diem</p>	<p>No annual limit for children under age 21.</p>

HCPCS Or Revenue Code	HCPCS Level II or Revenue Code Service Description	Service Description	Provider Qualifications	Documentation Required	Service Setting	Unit of Service	Reimbursement /Service Limits
		in-home intervention, crisis intervention, parenting, peer support, psychiatric services, and behavior analytical services.					

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- (d) The Managed Care Plan shall adhere to the following requirements regarding evaluation and treatment services for enrolled children/adolescents:
 - (i) The Managed Care Plan shall provide all medically necessary evaluations, psychological testing and treatment services for children/adolescents referred to the Managed Care Plan by DCF, DJJ and schools (elementary, middle, and secondary schools);
 - (ii) The Managed Care Plan shall provide court-ordered evaluation and treatment required for children/adolescents who are enrollees. See specifications in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook; and
 - (iii) The Managed Care Plan or designee shall develop a process to participate in interagency staffings (for example, DCF and DJJ) or school staffings that may result in the provision of behavioral health services to an enrolled child/adolescent. The Managed Care Plan or designee shall participate in such staffings upon request.

(5) Birth Center and Licensed Midwife Services

- (a) The Managed Care Plan shall provide Birth Center and Licensed Midwife Services. Birth centers and licensed midwives provide services appropriate to the care of Medicaid recipients during low-risk pregnancies, deliveries and the postpartum period. Birth center birth center must meet all state licensure requirements pursuant to the guidelines set forth in Chapter 59A-11, F.A.C. and Chapter 383, F.S. to provide obstetrical, postpartum, gynecological, and family planning services and Child Health Check-Up screenings (newborn evaluations only). Licensed midwives must meet all state licensure requirements pursuant to the guidelines set forth in Chapter 467, F.S. to provide obstetrical and postpartum care and Child Health Check-Up screenings (newborn evaluations only).
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Birth Center and Licensed Midwife Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Birth Center and Licensed Midwife Services Coverage and Limitations Handbook.

(6) Clinic Services

- (a) The Managed Care Plan shall provide Rural Health Clinic Services. Rural Health Clinics provide ambulatory primary care to a medically underserved population in a rural geographical area. A Rural Health Clinic provides primary health care and related diagnostic services. In addition, Rural Health Clinics may provide Adult Health Screening Services, Child Health Check-Up Screenings, Chiropractic Services, Family Planning

Services, Family Planning Waiver Services, Immunization Services, Medical Primary Care Services, Mental Health Services, Optometric Services, and Podiatry Services.

- (b) The Managed Care Plan shall comply with provisions of the Medicaid Rural Health Clinic Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Rural Health Clinic Services Coverage and Limitations Handbook.
- (c) The Managed Care Plan shall provide Federally Qualified Health Center Services. A Federally Qualified Health Center provides primary health care and related diagnostic services. In addition, an Federally Qualified Health Center may provide Adult health screening services, Child Health Check-Up, Chiropractic services, Dental services, Family planning services, Medical primary care, Mental health services, Optometric services, and Podiatric services.
- (d) The Managed Care Plan shall comply with provisions of the Medicaid Federally Qualified Health Center Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Federally Qualified Health Center Services Coverage and Limitations Handbook.
- (e) The Managed Care Plan shall provide County Health Department Services. County Health Departments provide public health services in accordance with Chapter 154, F.S. Medicaid County Health Department services consist of primary and preventive health care, related diagnostic services, and dental services.
- (f) The Managed Care Plan shall comply with provisions of the Medicaid County Health Department Program Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid County Health Department Program Coverage and Limitations Handbook.

(7) Chiropractic Services

- (a) The Managed Care Plan shall provide Chiropractic Services. Chiropractic services include evaluation and medically necessary treatment performed on one or more areas of the body. Treatment consists of manual manipulation or adjustment with application of controlled force to re-establish normal articular function. Manual manipulation is used to restore optimum mobility and range of motion to the spine. A doctor of

chiropractics (D.C.) is an individual who is licensed to engage in the practice of chiropractic medicine, as defined in Chapter 460, F.S.

- (b) The Managed Care Plan shall comply with provisions of the Medicaid Chiropractic Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Chiropractic Services Coverage and Limitations Handbook.

(8) Dental Services

- (a) The Managed Care Plan shall provide Dental Services to enrollees under the age of 21 years, emergency dental services to enrollees age 21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all enrollees. The Managed Care Plan shall provide medically-necessary, emergency dental procedures to alleviate pain or infection to enrollees age 21 and older. Emergency dental care for enrollees 21 years of age and older is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable partial dentures and denture-related services are also covered services for enrollees 21 years of age and older. The Managed Care Plan shall provide full dental services for all enrollees age 20 and below. The Managed Care Plan shall provide medically necessary oral and maxillofacial surgery for all eligible Medicaid recipients regardless of age.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Dental Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Dental Services Coverage and Limitations Handbook.

(9) Child Health Check Up

- (a) The Managed Care Plan shall provide Child Health Check-Up Services. The Managed Care Plan shall provide a health screening evaluation that shall consist of: comprehensive health and developmental history (including assessment of past medical history, developmental history and behavioral health status); comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for enrollees beginning at age three or earlier as indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate. A Child Health Check-Up is a comprehensive, preventive

health screening service. Child Health Check-Ups are performed according to a periodicity schedule that ensures that children have a health screening on a routine basis. In addition, a child may receive a Child Health Check-Up whenever it is medically necessary or requested by the child or the child's parent or caregiver. If a child is diagnosed as having a medical problem, the child is treated for that problem through the applicable Medicaid program, such as physician, dental and therapy services.

- (b) The Managed Care Plan shall comply with provisions of the Medicaid Child Health Check-Up Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Child Health Check-Up Coverage and Limitations Handbook.
- (c) For children/adolescents whom the Managed Care Plan identifies through blood lead screenings as having abnormal levels of lead, the Managed Care Plan shall provide care coordination/case management follow-up services as required in Chapter Two of the Child Health Check-Up Services Coverage and Limitations Handbook. Screening for lead poisoning is a required component of this Contract. The Managed Care Plan shall require all providers to screen all enrolled children for lead poisoning at ages 12 months and 24 months. In addition, children between the ages of 12 months and 72 months must receive a screening blood lead test if there is no record of a previous test. The Managed Care Plan shall provide additional diagnostic and treatment services determined to be medically necessary to a child/adolescent diagnosed with an elevated blood lead level. The Managed Care Plan shall recommend, but shall not require, the use of paper filter tests as part of the lead screening requirement.
- (d) The Managed Care Plan shall inform enrollees of all testing/screenings due in accordance with the periodicity schedule specified in the Medicaid Child Health Check-Up Services Coverage and Limitations Handbook. The Managed Care Plan shall contact enrollees to encourage them to obtain health assessment and preventive care.
- (e) The Managed Care Plan shall authorize enrollee referrals to appropriate providers within four (4) weeks of these examinations for further assessment and treatment of conditions found during the examination. The Managed Care Plan shall ensure that the referral appointment is scheduled for a date within six (6) months of the initial examination, or within the time periods set forth in Section VI, Provider Network, as applicable.
- (f) The Managed Care Plan shall cover fluoride treatment by a physician or a dentist for children/adolescents. Fluoride varnish application in a physician's office is limited to children up four (4) years of age.

- (g) The Managed Care Plan shall offer transportation to enrollees in order to assist them to keep, and travel to, medical appointments.
- (h) The CHCUP program includes the maintenance of a coordinated system to follow the enrollee through the entire range of screening and treatment, as well as supplying CHCUP training to medical care providers.
- (i) Pursuant to s. 409.975(5), F.S., the Managed Care Plan shall achieve a CHCUP screening rate of at least eighty percent (80%) for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1 – September 30). This screening compliance rate shall be based on the CHCUP data reported by the Managed Care Plan in its CHCUP (CMS-416) and FL 80% Screening Report and due to the Agency as specified in Section XIV, Reporting Requirements. The data shall be monitored by the Agency for accuracy, and, if the Managed Care Plan does not achieve the eighty percent (80%) screening rate, the Agency may require the Managed Care Plan to submit a corrective action plan (CAP). Failure to meet the eighty percent (80%) screening requirement may result in sanctions (see Section XI, Sanctions). Any data reported by the Managed Care Plan that is found to be inaccurate shall be disallowed by the Agency, and the Agency shall consider such findings as being in violation of the Contract and may sanction the Managed Care Plan accordingly.
- (j) The Managed Care Plan shall adopt annual participation goals to achieve at least an eighty percent (80%) CHCUP participation rate, as required by the Centers for Medicare & Medicaid Services. This participation compliance rate shall be based on the CHCUP data reported by the Managed Care Plan in its CHCUP (CMS-416) and FL 80% Screening Report (see sub-item H.2.i. above) and/or supporting encounter data. Upon implementation and notice by the Agency, the Managed Care Plan shall submit additional data, as required by the Agency for its submission of the CMS-416, to the Centers for Medicare & Medicaid Services, within the schedule determined by the Agency. For each federal fiscal year that the Managed Care Plan does not meet the eighty percent (80%) participation rate, the Agency may require the Managed Care Plan to submit a CAP. Any data reported by the Managed Care Plan that is found to be inaccurate shall be disallowed by the Agency, and the Agency shall consider such findings as being in violation of the Contract and shall sanction the Managed Care Plan accordingly. (See s. 1902(a)(43)(D)(iv) of the Social Security Act.)
- (k) The Managed Care Plan shall achieve a preventive dental services rate of at least twenty-eight percent (28%) for those enrollees who are continuously eligible for CHCUP for ninety (90) continuous days. This rate shall be based on the CHCUP data reported by the Managed Care Plan in its CHCUP (CMS-416) audited report and/or supporting encounter data. Beginning with the report for federal fiscal year 2015, failure to meet the 28% preventive dental services rate may result in a corrective action plan and liquidated damages (see Section XIII, Liquidated Damages).

(10) Immunizations

- (a) The Managed Care Plan shall provide immunizations in accordance with the Recommended Childhood Immunization Schedule for the United States, or when medically necessary for the enrollee's health.
- (b) The Managed Care Plan shall provide for the simultaneous administration of all vaccines for which an enrollee under the age of 21 is eligible at the time of each visit.
- (c) The Managed Care Plan shall follow only contraindications established by the Advisory Committee on Immunization Practices (ACIP), unless:
 - (i) In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or
 - (ii) The particular requirement is not in compliance with Florida law, including Florida law relating to religious or other exemptions.
- (d) The Managed Care Plan shall participate, or direct its providers to participate, in the Vaccines For Children Program ("VFC"). See s. 1905(r)(1)(B)(iii) of the Social Security Act. The VFC is administered by the Department of Health, Bureau of Immunizations. The VFC provides vaccines at no charge to physicians and eliminates the need to refer children to CHDs for immunizations. Title XXI MediKids enrollees do not qualify for the VFC program. The Managed Care Plan shall advise providers to bill Medicaid fee-for-service directly for immunizations provided to Title XXI MediKids participants.
- (e) The Managed Care Plan shall submit an attestation with accompanying documentation annually, by October 1 of each Contract year, to the Agency that the Managed Care Plan has advised its providers to enroll in the VFC program. The Agency may waive this requirement in writing if the Managed Care Plan provides documentation to the Agency that the Managed Care Plan is enrolled in the VFC program.
- (f) The Managed Care Plan shall provide coverage and reimbursement to the participating provider for immunizations covered by Medicaid, but not provided through VFC.
- (g) The Managed Care Plan shall ensure that providers have a sufficient supply of vaccines if the Managed Care Plan is enrolled in the VFC program. The Managed Care Plan shall direct those providers that are directly enrolled in the VFC program to maintain adequate vaccine supplies.
- (h) The Managed Care Plan shall pay no more than the Medicaid program vaccine administration fee. For dates of service through December 31, 2014, the Managed Care Plan, in accordance with the Patient Protection and Affordable Care Act (ACA), shall pay no more than the Medicaid program vaccine product code and administration fee, per administration,

as specified in the Florida Medicaid Physician Primary Care Rate Increase Fee Schedule at: http://portal.flmmis.com/FLPublic/Tab/125/content/public/fee%20schedule/s/2014_01_01_phys_primary_care_rates_v1_1.pdf.spage, and Section V, Covered Services, unless another rate is negotiated with the participating provider.

- (i) The Managed Care Plan shall pay no less than the Medicaid program vaccine administration fee when an enrollee receives immunizations from a non-participating provider so long as:
 - (i) The non-participating provider contacts the Managed Care Plan at the time of service delivery;
 - (ii) The Managed Care Plan is unable to provide documentation to the non-participating provider that the enrollee has already received the immunization; and
 - (iii) The non-participating provider submits a claim for the administration of immunization services and provides medical records documenting the immunization to the Managed Care Plan.
- (j) The Managed Care Plan shall encourage PCPs to provide immunization information about enrollees requesting temporary cash assistance from DCF, upon request by DCF and receipt of the enrollee's written permission. This information is necessary in order to document that the enrollee has met the immunization requirements for enrollees receiving temporary cash assistance.

(11) Emergency Services

- (a) The Managed Care Plan shall provide pre-hospital and hospital-based trauma services and emergency services and care to enrollees. See ss. 395.1041, 395.4045 and 401.45, F.S.
- (b) When an enrollee presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. See ss. 409.9128, 409.901, F.S. and 641.513, F.S.
 - (i) The physician, or the appropriate personnel, shall indicate on the enrollee's chart the results of all screenings, examinations and evaluations.
 - (ii) The Managed Care Plan shall cover all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the enrollee's condition is an emergency medical condition.

- (iii) If the provider determines that an emergency medical condition does not exist, the Managed Care Plan is not required to cover services rendered subsequent to the provider's determination unless authorized by the Managed Care Plan.
- (c) If the provider determines that an emergency medical condition exists, and the enrollee notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is an enrollee of the Managed Care Plan, the hospital must make a reasonable attempt to notify:
 - (i) The enrollee's PCP, if known; or
 - (ii) The Managed Care Plan, if the Managed Care Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.
- (d) If the hospital, or any of its affiliated providers, do not know the enrollee's PCP, or have been unable to contact the PCP, the hospital must:
 - (i) Notify the Managed Care Plan as soon as possible before discharging the enrollee from the emergency care area; or
 - (ii) Notify the Managed Care Plan within twenty-four (24) hours or on the next business day after the enrollee's inpatient admission.
- (e) If the hospital is unable to notify the Managed Care Plan, the hospital must document its attempts to notify the Managed Care Plan, or the circumstances that precluded the hospital's attempts to notify the Managed Care Plan. The Managed Care Plan shall not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.
- (f) If the enrollee's PCP responds to the hospital's notification, and the hospital physician and the PCP discuss the appropriate care and treatment of the enrollee, the Managed Care Plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the enrollee within the scope of the physician's hospital staff privileges.
- (g) The Managed Care Plan shall advise all enrollees of the provisions governing emergency services and care. The Managed Care Plan shall not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, the Managed Care Plan shall not deny payment for treatment obtained when a representative of the Managed Care Plan instructs the enrollee to seek emergency services and care in accordance with s. 743.064, F.S.
- (h) The Managed Care Plan shall not:
 - (i) Require prior authorization for an enrollee to receive pre-hospital transport or treatment or for emergency services and care;

- (ii) Specify or imply that emergency services and care are covered by the Managed Care Plan only if secured within a certain period of time;
 - (iii) Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or
 - (iv) Deny payment based on a failure by the enrollee or the hospital to notify the Managed Care Plan before, or within a certain period of time after, emergency services and care were given.
- (i) Notwithstanding any other state law, a hospital may request and collect from an enrollee any insurance or financial information necessary to determine if the patient is an enrollee of the Managed Care Plan, in accordance with federal law, so long as emergency services and care are not delayed in the process.
 - (j) The Managed Care Plan shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as the Managed Care Plan can safely transport the enrollee to a participating facility. The Managed Care Plan may transfer the enrollee, in accordance with state and federal law, to a participating hospital that has the service capability to treat the enrollee's emergency medical condition. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.
 - (k) In accordance with 42 CFR 438.114 and s. 1932(b)(2)(A)(ii) of the Social Security Act, the Managed Care Plan shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service within or outside the Managed Care Plan's network for the following situations:
 - (i) Post-stabilization care services that were pre-approved by the Managed Care Plan;
 - (ii) Post-stabilization care services that were not pre-approved by the Managed Care Plan because the Managed Care Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request;
 - (iii) The treating provider could not contact the Managed Care Plan for pre-approval; and
 - (iv) Those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Managed Care Plan can choose not to cover them if they are provided by a non-

participating provider, except in those circumstances detailed above.

- (l) The Managed Care Plan shall not deny claims for the provision of emergency services and care submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred and sixty-five (365) days.
- (m) Pursuant to s. 409.967(2)(b), F.S., the Managed Care Plan shall pay for services required by ss. 395.1041 and 401.45, F.S. provided to an enrollee under this section by a non-participating provider. The Managed Care Plan must comply with s. 641.3155, F.S. Reimbursement for services under this paragraph is the lesser of:
 - (i) The non-participating provider's charges;
 - (ii) The usual and customary provider charges for similar services in the community where the services were provided;
 - (iii) The charge mutually agreed to by the Managed Care Plan and the non-participating provider within sixty (60) days after the non-participating provider submits a claim; or
 - (iv) The rate the Agency would have paid on the most recent October 1.
- (n) Notwithstanding the requirements set forth in this section, the Managed Care Plan shall approve all claims for emergency services and care by non-participating providers pursuant to the requirements set forth in s. 641.3155, F.S., and 42 CFR 438.114.
- (o) The Managed Care Plan shall provide timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. The Managed Care Plan may not require paper authorization as a condition of receiving treatment. Written follow-up documentation of the approval must be provided to the non-participating provider within one (1) business day after the approval. Enrollees shall be liable for the cost of such unauthorized use of covered services from non-participating providers.
- (p) In accordance with ss. 409.912(18) and 409.967(2), F.S., the Managed Care Plan shall reimburse any hospital or physician that is outside the Managed Care Plan's authorized service area for Managed Care Plan-authorized services at a rate negotiated with the hospital or physician or according to the lesser of the following:
 - (i) The usual and customary charge made to the general public by the hospital or provider; or

- (ii) The Florida Medicaid reimbursement rate established for the hospital or provider.
- (q) The Managed Care Plan shall reimburse all non-participating providers as described in s. 641.3155, F.S.
- (r) Unless otherwise specified in this Contract, where an enrollee uses non-emergency services available under the Managed Care Plan from a non-participating provider, the Managed Care Plan shall not be liable for the cost of such services unless the Managed Care Plan referred the enrollee to the non-participating provider or authorized the out-of-network service.

(12) Emergency Behavioral Health Services

- (a) The Managed Care Plans shall provide emergency behavioral health services pursuant, but not limited, to s. 394.463, F.S.; s. 641.513, F.S.; and Title 42 CFR Chapter IV. Emergency service providers shall make a reasonable attempt to notify the Managed Care Plan within twenty-four (24) hours of the enrollee's presenting for emergency behavioral health services. In cases in which the enrollee has no identification, or is unable to orally identify himself/herself when presenting for behavioral health services, the provider shall notify the Managed Care Plan within twenty-four (24) hours of learning the enrollee's identity.
- (b) In addition to the requirements outlined in s. 641.513, F.S., the Managed Care Plan will ensure:
 - (i) The enrollee has a follow-up appointment scheduled within seven (7) days after discharge; and
 - (ii) All required prescriptions are authorized at the time of discharge.
- (c) The Managed Care Plan shall operate, as part of its crisis support/emergency services, a crisis emergency hotline available to all enrollees twenty-four hours a day, seven days a week (24/7).
- (d) For each county it serves, the Managed Care Plan shall designate an emergency service facility that operates twenty-four hours a day, seven days a week, (24/7) with Registered Nurse coverage and on-call coverage by a behavioral health specialist.

(13) Family Planning Services and Supplies

- (a) The Managed Care Plan shall provide family planning services to help enrollees make comprehensive and informed decisions about family size and/or spacing of births. The Managed Care Plan shall provide the following services: planning and referral, education and counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care in accordance with

the Medicaid Practitioner Services Coverage and Limitations Handbook. Policy requirements include:

- (i) The Managed Care Plan shall furnish services on a voluntary and confidential basis.
 - (ii) The Managed Care Plan shall allow enrollees freedom of choice of family planning methods covered under the Medicaid program, including Medicaid-covered implants, where there are no medical contra-indications.
 - (iii) The Managed Care Plan shall render the services to enrollees under the age of 18 provided the enrollee is married, a parent, pregnant, has written consent by a parent or legal guardian, or, in the opinion of a physician, the enrollee may suffer health hazards if the services are not provided. See s. 390.01114, F.S.
 - (iv) The Managed Care Plan shall allow each enrollee to obtain family planning services from any provider and require no prior authorization for such services. If the enrollee receives services from a non-participating Medicaid provider, then the Managed Care Plan shall reimburse at the Medicaid reimbursement rate, unless another payment rate is negotiated.
 - (v) The Managed Care Plan shall make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, including discussion of all appropriate methods of contraception, counseling and services for family planning to all women and their partners. The Managed Care Plan shall direct providers to maintain documentation in the enrollee's medical records to reflect this provision. See ss. 409.912(34) and 409.967(2), F.S.
- (b) The provisions of this subsection shall not be interpreted so as to prevent a health care provider or other person from refusing to furnish any contraceptive or family planning service, supplies or information for medical or religious reasons. A health care provider or other person shall not be held liable for such refusal.
 - (c) Pursuant to s. 409.973(1)(h), F.S., and 42 CFR 438.102, the Managed Care Plan may elect to not provide these services due to an objection on moral or religious grounds, and must have notified the Agency of that election as specified in, Section V.C., Excluded Services.

(14) Healthy Start Services

- (a) Pursuant to s. 409.975(4)(b), F.S., the Managed Care Plan shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and

the Children's Medical Services program for children with special health care needs. In addition, the program for pregnant women and infants must be aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes. The Managed Care Plan shall provide the most appropriate and highest level of quality care for pregnant enrollees.

- (b) Florida's Healthy Start Prenatal Risk Screening – The Managed Care Plan shall ensure that the provider offers Florida's Healthy Start prenatal risk screening to each pregnant enrollee as part of her first prenatal visit, as required by s. 383.14, F.S., s. 381.004, F.S., and 64C-7.009, F.A.C.
 - (i) The Managed Care Plan shall ensure that the provider uses the Agency approved Healthy Start (Prenatal) Risk Screening Instrument.
 - (ii) The Managed Care Plan shall ensure that the provider keeps a copy of the completed screening instrument in the enrollee's medical record and provides a copy to the enrollee.
 - (iii) The Managed Care Plan shall ensure that the provider submits the Healthy Start (Prenatal) Risk Screening Instrument to the CHD in the county where the prenatal screen was completed within ten (10) business days of completion of the screening.
 - (iv) The Managed Care Plan shall collaborate with the Healthy Start care coordinator within the enrollee's county of residence to assure delivery of risk-appropriate care.
- (c) Florida's Healthy Start Infant (Postnatal) Risk Screening Instrument – Florida hospitals electronically file the Healthy Start (Prenatal) Risk Screening Instrument Certificate of Live Birth with the CHD in the county where the infant was born within five (5) business days of the birth. If the Managed Care Plan contracts with birthing facilities not participating in the Department of Health electronic birth registration system, the Managed Care Plan shall ensure that the provider files required birth information with the CHD within five (5) business days of the birth, keeps a copy of the completed Healthy Start (Prenatal) Risk Screening Instrument in the enrollee's medical record and mails a copy to the enrollee.
- (d) Pursuant to s. 409.975(4)(b), F.S., the Managed Care Plan shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs. The programs and procedures shall include agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants,

consistent with Agency policies in accordance with Agency policies and the MomCare Network.

- (e) Pregnant enrollees or infants who do not score high enough to be eligible for Healthy Start case management may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:
 - (i) If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the enrollee or infant is invited to participate based on factors other than score; or
 - (ii) If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance abuse or domestic violence.
- (f) The Managed Care Plan shall refer all infants, children up to age five (5), and pregnant, breast-feeding and postpartum women to the local WIC office. The Managed Care Plan shall ensure providers provide:
 - (i) A completed Florida WIC program medical referral form with the current height or length and weight (taken within sixty (60) days of the WIC appointment);
 - (ii) Hemoglobin or hematocrit; and
 - (iii) Any identified medical/nutritional problems.

For subsequent WIC certifications, the Managed Care Plan shall ensure that providers coordinate with the local WIC office to provide the above referral data from the most recent CHCUP.

Each time the provider completes a WIC referral form, the Managed Care Plan shall ensure that the provider gives a copy of the form to the enrollee and keeps a copy in the enrollee's medical record.

- (g) The Managed Care Plan shall ensure that providers give all women of childbearing age HIV counseling and offer them HIV testing. See Chapter 381, F.S.
 - (i) The Managed Care Plan shall ensure that its providers offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at twenty-eight (28) and thirty-two (32) weeks.
 - (ii) The Managed Care Plan shall ensure that its providers attempt to obtain a signed objection if a pregnant woman declines an HIV test. See s. 384.31, F.S. and 64D-3.019, F.A.C.

- (iii) The Managed Care Plan shall ensure that all pregnant women who are infected with HIV are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (Public Health Service Task Force Report entitled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States).
- (h) The Managed Care Plan shall ensure that its providers screen all pregnant enrollees receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit.
 - (i) The Managed Care Plan shall ensure that its providers perform a second HBsAg test between twenty-eight (28) and thirty-two (32) weeks of pregnancy for all pregnant enrollees who tested negative at the first prenatal visit and are considered high-risk for Hepatitis B infection. This test shall be performed at the same time that other routine prenatal screening is ordered.
 - (ii) All HBsAg-positive women shall be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.
- (i) The Managed Care Plan shall ensure that infants born to HBsAg-positive enrollees receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable, preferably within twelve (12) hours of birth, and shall complete the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.
 - (i) The Managed Care Plan shall ensure that its providers test infants born to HBsAg-positive enrollees for HBsAg and Hepatitis B surface antibodies (anti-HBs) six (6) months after the completion of the vaccine series to monitor the success or failure of the therapy.
 - (ii) The Managed Care Plan shall ensure that providers report to the local CHD a positive HBsAg result in any child age 24 months or less within twenty-four (24) hours of receipt of the positive test results.
 - (iii) The Managed Care Plan shall ensure that infants born to enrollees who are HBsAg-positive are referred to Healthy Start regardless of their Healthy Start screening score.
- (j) The Managed Care Plan shall report to the Perinatal Hepatitis B Prevention Coordinator at the local CHD all prenatal or postpartum enrollees who test HBsAg-positive. The Managed Care Plan also shall report said enrollees' infants and contacts to the Perinatal Hepatitis B Prevention Coordinator.

- (i) The Managed Care Plan shall report the following information – name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or estimated date of confinement, whether the enrollee received prenatal care, and immunization dates for infants and contacts.
- (ii) The Managed Care Plan shall use the Practitioner Disease Report Form (DH Form 2136) for reporting purposes.
- (k) The Managed Care Plan shall ensure that the PCP maintains all documentation of Healthy Start screenings, assessments, findings and referrals in the enrollees' medical records.
- (l) Prenatal Care – The Managed Care Plan shall:
 - (i) Require a pregnancy test and a nursing assessment with referrals to a physician, PA or ARNP for comprehensive evaluation;
 - (ii) Require care coordination/case management through the gestational period according to the needs of the enrollee;
 - (iii) Require any necessary referrals and follow-up;
 - (iv) Schedule return prenatal visits at least every four (4) weeks until week thirty-two (32), every two (2) weeks until week thirty-six (36), and every week thereafter until delivery, unless the enrollee's condition requires more frequent visits;
 - (v) Contact those enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care;
 - (vi) Assist enrollees in making delivery arrangements, if necessary; and
 - (vii) Ensure that all providers screen all pregnant enrollees for tobacco use and make certain that the providers make available to pregnant enrollees smoking cessation counseling and appropriate treatment as needed.
- (m) Nutritional Assessment/Counseling – The Managed Care Plan shall ensure that its providers supply nutritional assessment and counseling to all pregnant enrollees. The Managed Care Plan shall:
 - (i) Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes;
 - (ii) Offer a mid-level nutrition assessment;
 - (iii) Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment; and

- (iv) Ensure documentation of the nutrition care plan in the medical record by the person providing counseling.
- (n) Obstetrical Delivery – The Managed Care Plan shall develop and use generally accepted and approved protocols for both low-risk and high-risk deliveries reflecting the highest standards of the medical profession, including Healthy Start and prenatal screening, and ensure that all providers use these protocols.
 - (i) The Managed Care Plan shall ensure that all providers document preterm delivery risk assessments in the enrollee’s medical record by week twenty-eight (28).
 - (ii) If the provider determines that the enrollee’s pregnancy is high risk, the Managed Care Plan shall ensure that the provider’s obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and that the enrollee progresses through the final stages of labor and immediate postpartum care.
- (o) Newborn Care – The Managed Care Plan shall make certain that its providers supply the highest level of care for the newborn beginning immediately after birth. Such level of care shall include, but not be limited to, the following:
 - (i) Instilling of prophylactic eye medications into each eye of the newborn;
 - (ii) When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
 - (iii) Weighing and measuring of the newborn;
 - (iv) Inspecting the newborn for abnormalities and/or complications;
 - (v) Administering one half (.5) milligram of vitamin K;
 - (vi) APGAR scoring;
 - (vii) Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen; and
 - (viii) Any necessary newborn and infant hearing screenings (to be conducted by a licensed audiologist pursuant to Chapter 468, F.S., a physician licensed under Chapters 458 or 459, F.S., or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or a licensed audiologist).

- (p) Postpartum Care – The Managed Care Plan shall:
- (i) Provide a postpartum examination for the enrollee within six (6) weeks after delivery;
 - (ii) Ensure that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate; and
 - (iii) Ensure that continuing care of the newborn is provided through the CHCUP program component and documented in the child's medical record.

(15) Hearing Services

- (a) The Managed Care Plan shall provide Hearing Services. Hearing services include mandatory newborn hearing screenings; medically-necessary hearing evaluations, diagnostic testing, hearing aids, hearing aid fitting and dispensing, hearing aid repairs and accessories; and medically-necessary cochlear implant services including provision of the device, post-operative tuning of the headset, replacement and repairs furnished by physicians, audiologists and hearing aid specialists.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Hearing Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Hearing Services Coverage and Limitations Handbook.

(16) Home Health Services and Nursing Care

- (a) The Managed Care Plan shall provide Home Health Services. Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Home Health Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Home Health Services Coverage and Limitations Handbook.

(17) Hospice Services

- (a) The Managed Care Plan shall provide Hospice Services. 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 is an approach that focuses on palliative care rather than curative care.

- (b) The Managed Care Plan shall comply with provisions of the Medicaid Hospice Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Hospice Services Coverage and Limitations Handbook.

(18) Hospital Services

- (a) The Managed Care Plan shall provide Inpatient Hospital Services. Inpatient services are medically necessary services ordinarily furnished by a state-licensed acute care hospital for the medical care and treatment of inpatients provided under the direction of a physician or dentist in a hospital maintained primarily for the care and treatment of patients with disorders other than mental diseases.
- (b) Inpatient services include, but are not limited to, rehabilitation hospital care (which are counted as inpatient hospital days), medical supplies, diagnostic and therapeutic services, use of facilities, drugs and biologicals, room and board, nursing care and all supplies and equipment necessary to provide adequate care. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than the Medicaid Hospital Services Coverage & Limitations Handbook.
- (c) Inpatient services also include inpatient care for any diagnosis including tuberculosis and renal failure when provided by general acute care hospitals in both emergent and non-emergent conditions.
- (d) The Managed Care Plan shall cover physical therapy services when medically necessary and when provided during an enrollee's inpatient stay.
- (e) The Managed Care Plan shall provide up to twenty-eight (28) inpatient hospital days (calendar) in an inpatient hospital substance abuse treatment program for pregnant substance abusers who meet ISD (intensity, severity, discharge screens) Criteria with Florida Medicaid modifications, as specified in InterQual Level of Care Acute Criteria-Pediatric and/or InterQual Level of Care Acute Criteria-Adult (McKesson Health Solutions, LLC, "McKesson"), the most current edition, for use in screening cases admitted to rehabilitative hospitals and CON-approved rehabilitative units in acute care hospitals.
- (f) In addition, the Managed Care Plan shall provide inpatient hospital treatment for severe withdrawal cases exhibiting medical complications that meet the severity of illness criteria under the alcohol/substance abuse system-specific set which generally requires treatment on a medical unit where complex medical equipment is available. Withdrawal cases (not meeting the severity of illness criteria under the

alcohol/substance abuse criteria) and substance abuse rehabilitation (other than for pregnant women), including court ordered services, are not covered in the inpatient hospital setting.

- (g) The Managed Care Plan shall coordinate hospital and institutional discharge planning for substance abuse detoxification to ensure inclusion of appropriate post-discharge care.
- (h) The Managed Care Plan shall adhere to the provisions of the Newborns and Mothers Health Protection Act (NMHPA) of 1996 regarding postpartum coverage for mothers and their newborns. Therefore, the Managed Care Plan shall provide for no less than a forty-eight (48) hour hospital length of stay following a normal vaginal delivery, and at least a ninety-six (96) hour hospital length of stay following a Cesarean section. In connection with coverage for maternity care, the hospital length of stay is required to be decided by the attending physician in consultation with the mother.
- (i) The Managed Care Plan shall prohibit the following practices:
 - (i) Denying the mother or newborn child eligibility, or continued eligibility, to enroll or renew coverage under the terms of the Managed Care Plan, solely for the purpose of avoiding the NMHPA requirements;
 - (ii) Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum protections available under NMHPA;
 - (iii) Penalizing or otherwise reducing or limiting the reimbursement of an attending physician because the physician provided care in a manner consistent with NMHPA;
 - (iv) Providing incentives (monetary or otherwise) to an attending physician to induce the physician to provide care in a manner inconsistent with NMHPA; and
 - (v) Restricting any portion of the forty-eight (48) hour, or ninety-six (96) hour, period prescribed by NMHPA in a manner that is less favorable than the benefits provided for any preceding portion of the hospital stay.
- (j) The Managed Care Plan shall cover any medically necessary duration of stay in a non-contracted facility that results from a medical emergency until such time as the Managed Care Plan can safely transport the enrollee to a Managed Care Plan participating facility.
- (k) For all child/adolescent enrollees (up to age 21) and pregnant adults, the Managed Care Plan shall be responsible for providing up to three-hundred and sixty-five (365) days of health-related inpatient care, including behavioral health, for each state fiscal year. For all non-

pregnant adults, the Managed Care Plan shall be responsible for up to forty-five (45) days of inpatient coverage and up to three-hundred sixty-five (365) days of emergency inpatient care, including behavioral health, in accordance with the Medicaid Hospital Services Coverage and Limitations Handbook, for each state fiscal year.

- (i) The Managed Care Plan shall count inpatient days based on the lesser of the actual number of covered days in the inpatient hospital stay and the average length of stay for the relevant All Patient Refined Diagnosis Related Group (APR-DRG or DRG). This requirement applies whether or not the Managed Care Plans uses DRGs to pay the provider. DRGs can be found at the following website: http://ahca.myflorida.com/Medicaid/cost_reim/index.shtml.
 - (ii) If an enrollee has not yet met his/her forty-five day (45-day) hospital inpatient limit per state fiscal year for non-pregnant adults, at the start of a new hospital admission, the entire new stay must be covered by the Managed Care Plan in which the enrollee was enrolled on the date of admission. This requirement applies even if the actual or average length of stay for the DRG puts the person over the inpatient limit. There is no proration of inpatient days.
- (l) Pursuant to section 2702 of the Patient Protection and Affordable Care Act (ACA), the Florida Medicaid State Plan and 42 CFR 434.6(12) and 447.26, the Managed Care Plan shall comply with the following requirements:
- (i) Require providers to identify Provider-Preventable Conditions (PPCs) in their claims;
 - (ii) Deny reimbursement for PPCs occurring after admission in any inpatient hospital or inpatient psychiatric hospital setting, including CSUs, as listed under Forms at http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml;
 - (iii) Ensure that non-payment for PPCs does not prevent enrollee access to services;
 - (iv) Ensure that documentation of PPC identification is kept and accessible for reporting to the Agency;
 - (v) Ensure encounter data submissions include PPC information in order to meet the PPC identification requirements;
 - (vi) Amend all hospital provider contracts to include PPC reporting requirements; and
 - (vii) Relative to all above requirements, not:

- (a) Limit inpatient days for services that are unrelated to the PPC diagnosis present on admission (POA);
 - (b) Reduce authorization to a provider when the PPC existed prior to admission;
 - (c) Deny reimbursement to inpatient hospitals and inpatient psychiatric hospitals, including CSUs, for services occurring prior to the PPC event;
 - (d) Deny reimbursement to surgeons, ancillary and other providers that bill separately through the CMS 1500;
 - (e) Deny reimbursement for health care settings other than inpatient hospital and inpatient psychiatric hospital, including CSUs; or
 - (f) Deny reimbursement for clinic services provided in clinics owned by hospitals.
- (m) The Managed Care Plan shall provide medically necessary transplants and related services as outlined in the chart below. For transplant services specified with one (1) asterisk, Managed Care Plans are paid by the Agency through kick payments. See Section IX, Method of Payment, for payment details. Transplant services specified with two (2) asterisks are covered through fee-for-service Medicaid and not by the Managed Care Plan.

SUMMARY OF RESPONSIBILITY		
Transplant Service	Adult (21 and Over)	Pediatric (20 and Under)
Evaluation	Managed Care Plan	Managed Care Plan
Bone Marrow	Managed Care Plan	Managed Care Plan
Cornea	Managed Care Plan	Managed Care Plan
Heart	Managed Care Plan*	Managed Care Plan*
Intestinal/ Multivisceral	Medicaid**	Medicaid**
Kidney	Managed Care Plan	Managed Care Plan

Liver	Managed Care Plan*	Managed Care Plan*
Lung	Managed Care Plan*	Managed Care Plan*
Pancreas	Managed Care Plan	Managed Care Plan
Pre- and Post-Transplant Care, including Transplants <u>Not</u> Covered by Medicaid	Managed Care Plan	Managed Care Plan
Other Transplants <u>Not</u> Covered by Medicaid	Not Covered	Not Covered

- (n) The Managed Care Plans shall be responsible for the reimbursement of care for enrollees who have been diagnosed with Tuberculosis disease, or show symptoms of having Tuberculosis and have been designated a threat to the public health by the FDOH Tuberculosis Program and shall observe the following:
- (i) Said enrollees shall be hospitalized and treated in a hospital licensed under Chapter 395 F.S. and under contract with the FDOH pursuant to 392.62, Florida Statutes;
 - (ii) Treatment plans and discharge determinations shall be made solely by FDOH and the treating hospital;
 - (iii) For enrollees determined to be a threat to public health and receiving Tuberculosis treatment at an FDOH contracted hospital, the Managed Care Plan shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and FDOH, and shall also pay any wrap-around costs not included in the per-diem rate; and
 - (iv) Reimbursement shall not be denied for failure to prior authorize admission, or for services rendered pursuant to 392.62 F.S.
- (o) With the exception of hospitalization pursuant to section (n) above, the Managed Care Plan may provide services in a nursing facility as downward substitution for inpatient services. Such services shall not be counted as inpatient hospital days.
- (p) The Managed Care Plan shall provide Outpatient Hospital Services. Outpatient hospital services consist of medically necessary preventive, diagnostic, therapeutic or palliative care under the direction of a physician or dentist at a licensed acute care hospital. Outpatient hospital services include medically necessary emergency room services, dressings, splints,

oxygen and physician-ordered services and supplies for the clinical treatment of a specific diagnosis or treatment.

- (i) The Managed Care Plan shall provide emergency services and care without any specified dollar limitations.
 - (ii) The Managed Care Plan shall have a procedure for the authorization of dental care and associated ancillary medical services provided in an outpatient hospital setting if that is provided under the direction of a dentist at a licensed hospital and, although not usually considered medically necessary, is considered medically necessary to the extent that the outpatient hospital services must be provided in a hospital due to the enrollee's disability, behavioral health condition or abnormal behavior due to emotional instability or a developmental disability.
- (q) The Managed Care Plan shall provide medically necessary ancillary medical services at the hospital without limitation. Ancillary hospital services include, but are not limited to, radiology, pathology, neurology, neonatology, and anesthesiology.
- (i) When the Managed Care Plan or its authorized physician authorizes these services (either inpatient or outpatient), the Managed Care Plan shall reimburse the provider of the service at the Medicaid line item rate, unless the Managed Care Plan and the hospital have negotiated another reimbursement rate.
 - (ii) The Managed Care Plan shall authorize payment for non-participating physicians for emergency ancillary services provided in a hospital setting.
- (r) The Managed Care Plan shall cover medically necessary dental care and associated ancillary services provided in licensed ambulatory surgical center settings if that care is provided under the direction of a dentist as described in the Florida Medicaid State Plan.
- (s) Crisis stabilization units (CSU) may be used as a substitute service for inpatient psychiatric hospital care when determined medically appropriate. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If CSU beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Managed Care Plan shall demonstrate adequate capacity for psychiatric inpatient hospital care in anticipation of such transfers.

(19) Laboratory and Imaging Services

- (a) The Managed Care Plan shall provide laboratory, portable x-ray, and advanced diagnostic imaging services as medically necessary.

- (b) Laboratory services are clinical laboratory procedures provided in freestanding laboratory facilities. A clinical laboratory is defined as a facility that examines materials taken from the human body for the purpose of providing information to assist in the diagnosis, prevention, or treatment of disease or assessment of health. A freestanding or independent facility is one that is not controlled, managed or supervised by a hospital or a hospital's organized medical staff, or the treating health care practitioner.
- (c) Portable x-ray services are diagnostic x-ray services provided at the residence of a recipient who is unable to travel to a physician's office or outpatient hospital's radiology facility. The recipient's residence must be one of the following: recipient's private home, assisted living facility (ALF), nursing facility, or intermediate care facility for the developmentally disabled (ICF/DD).
- (d) Advanced diagnostic imaging services include magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET) studies.
- (e) The Managed Care Plan shall comply with provisions of the Medicaid Independent Laboratory Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Independent Laboratory Services Coverage and Limitations Handbook and the Portable X-Ray Services Coverage and Limitations Handbook.

(20) Medical Supplies, Equipment, Prostheses and Orthoses

- (a) The Managed Care Plan shall provide medical supplies, equipment, prostheses and orthoses. Medical supplies are defined as medically-necessary medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home. Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA). DME also includes respiratory equipment Ventilator, oxygen, oxygen-related and respiratory equipment used to support the respiratory system. Orthotic devices are defined as medically-necessary devices or appliances that support or correct a weak or deformed body part, or restrict or eliminate motion in a diseased or injured body part. Prosthetic devices are defined as medically-necessary artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid DME and Medical Supply Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract,

the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid DME and Medical Supply Services Coverage and Limitations Handbook.

- (c) In the same manner as specified in s. 641.31, F.S., the Managed Care Plan shall provide coverage for medically necessary diabetes equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services, if the enrollee's PCP, or the physician to whom the enrollee has been referred who specializes in treating diabetes, certifies that the equipment, supplies and services are medically necessary. Outpatient self-management training and educational services shall be in accordance with American Diabetes Association standards for such services.

(21) Optometric and Vision Services

- (a) The Managed Care Plan shall provide Optometric and Vision Services. Optometric services are medically-necessary services that provide for examination, diagnosis, treatment and management of ocular and adnexal pathology. Visual examinations to determine the need for eyeglasses are also covered. Optometric services must be furnished by or under the direct supervision of a licensed optometrist or ophthalmologist. Visual services include the medically necessary provision of optical services and supplies such as eyeglasses, prosthetic eyes, and contact lenses; the fitting, dispensing, and adjusting of eyeglasses; and eyeglass repair services.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Optometric Services Coverage and Limitations Handbook and Medicaid Vision Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Optometric Services Coverage and Limitations Handbook and Medicaid Vision Services Coverage and Limitations Handbook.

(22) Physician Assistant Services

- (a) The Managed Care Plan shall provide Physician Assistant Services. Physician Assistant Services are services provided by a Physician Assistant (PA) certified to provide diagnostic and therapeutic patient care and fully licensed as a PA as defined in Chapter 458 or Chapter 459, Florida Statutes. The services must be provided in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, Florida Statutes.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Practitioner Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions

imposed by the Managed Care Plan be more stringent than those in the Medicaid Practitioner Services Coverage and Limitations Handbook.

(23) Physician Services

- (a) The Managed Care Plan shall provide Physician Services. Physician Services are those services rendered by licensed doctors of allopathic or osteopathic medicine. Services may be rendered in the practitioner's office, the patient's home, a hospital, a nursing facility, or other approved place of service as necessary to treat a particular injury, illness, or disease.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Practitioner Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Practitioner Services Coverage and Limitations Handbook.
- (c) The Managed Care Plan shall maintain a log of all hysterectomy, sterilization and abortion procedures performed for its enrollees. The log shall include, at a minimum, the enrollee's name and identifying information, date of procedure, and type of procedure. The Managed Care Plan shall provide abortions only in the following situations:
 - (i) If the pregnancy is a result of an act of rape or incest; or
 - (ii) The physician certifies that the woman is in danger of death unless an abortion is performed.
- (d) Primary Care Services
 - (i) The Managed Care Plan shall process claims for and pay certain physicians who provide Florida Medicaid-covered eligible primary care services in accordance with sections 1902(a)(13), 1902(jj), 1932(f), and 1905(dd) of the Social Security Act, as amended by the Affordable Care Act and 42 CFR sections 438, 441 and 447, for dates of service on or after January 1, 2013, through December 31, 2014. This provision also applies to any payments made through subcapitation arrangements. For Managed Care Plans with subcapitation arrangements, the Agency recommends that the Managed Care Plan shall implement a physician payment increase methodology similar to the Agency's payment methodology approved by CMS.
 - (ii) The Managed Care Plan shall ensure the physician payment specified in this section applies to such primary care services provided by physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine or related subspecialists. Physicians affected include the following:

- (a) A physician as defined in 42 CFR 440.50; or provider under the personal supervision of a physician who self-attests to a specialty designation of family medicine, general internal medicine or pediatric medicine; or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA); and
 - (b) A physician who self-attests that he/she is board certified with such a specialty or subspecialty and/or has furnished evaluation and management services and vaccine administration services under the codes listed below that equal at least sixty percent (60%) of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.
- (iii) The Managed Care Plan shall ensure that increased payments specified in this provision are not provided to physicians delivering primary care services at FQHCs, RHCs or CHDs.
 - (iv) The Managed Care Plan shall make increased physician payments according to this provision. The Managed Care Plan shall ensure that the full benefit of the payment increase is paid to eligible providers, regardless of the payment amount received by the Managed Care Plan from the Agency.
 - (v) The Managed Care Plan shall document physician eligibility for any increased payments made under this subsection for each calendar year as part of its credentialing information or by the use of a physician self-attestation form as follows:
 - (a) Enrolled Medicaid providers may use the Agency's online attestation form and certification process for the Affordable Care Act Primary Care Increase, as specified at <http://portal.flmmis.com/FLpublic/Default.aspx>. The Managed Care Plan may not require additional documentation to be submitted to the Managed Care Plan for Medicaid-enrolled physicians who have already self-attested using the Agency's web-portal process for each calendar year.
 - (b) For the January 1, 2014, through December 31, 2014, calendar year, the Managed Care Plan shall ensure written notification of the Managed Care Plan's attestation/eligibility process is given to eligible providers by June 15, 2014, in order to allow physicians time to complete the process. The capitated Managed Care Plan may direct its providers to print out and submit the Agency's online attestation form, use its own attestation form or use its credentialing information to document Medicaid-registered providers' eligibility for the increased physician payments.

- i. If the Managed Care Plan uses the notification language supplied by the Agency verbatim (except for specified insertions), the Managed Care Plan does not need Agency approval for this notice. If the Managed Care Plan uses the supplied notice language verbatim, the Managed Care Plan shall email AHCA of its intent to do so.
 - ii. The Managed Care Plan shall complete its initial review of credentialing information from eligible physicians by August 15, 2014.
 - iii. The Managed Care Plan shall ensure that physicians who complete the Managed Care Plan's eligibility process or the Agency's attestation process as specified above by August 15, 2014, will be eligible for the rate increase retroactively up to January 1, 2014. The Managed Care Plan shall ensure that physicians who complete the Managed Care Plan's eligibility process or the Agency's attestation process as specified above after August 15, 2014, are eligible for the fee increase on the first day of the month of documented eligibility.
- (c) The Managed Care Plan shall retain documentation of how its affected providers met the physician self-attestation and payment eligibility requirements, and make the documentation available to the Agency upon request.
- (vi) The Managed Care Plan shall ensure that payments to eligible providers are limited to the following primary care services, in accordance with the Florida Medicaid Affordable Care Act Fee Schedule:
 - (a) Evaluation and Management (E&M) codes 99201 through 99499; and
 - (b) Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474, and their successor codes.
- (vii) Notwithstanding the claims payment requirements in Section VIII.D, Claims and Provider Payment, the Managed Care Plan shall ensure physician payments related to this fee increase are made as follows: For dates of service in calendar year 2014, the Managed Care Plan shall ensure payments are paid within sixty (60) days of receipt of the Agency's supplemental payment to the Managed Care Plan.
- (viii) In order to provide accurate data reports of utilization and encounter data for physicians eligible for provider payments, including

vaccination administration payments, made to the physician relative to this subsection, the Managed Care Plan shall report utilization of eligible services to the Agency's Medicaid Program Analysis (MPA) secure file transfer protocol (SFTP) site as follows:

- (a) For calendar year 2014, the Managed Care Plan shall submit to the Agency quarterly reports that document the physician's eligibility and provider payments, including vaccination administration payments, made to the physician relative to this subsection, and as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. The Managed Care Plan shall not include PCP fee increases (differential) in its regular, ongoing encounter data submissions to the Agency (see Section VIII.E., Encounter Data Requirements); and
- (b) The Agency will review and evaluate all submissions, and provide feedback to the Managed Care Plan. Evaluation will consider: (1) adherence of submitted data to the format and content requirements as specified by the Agency; (2) consistency between the summary report and the supporting encounter data; (3) the number of submissions required for acceptability of data; and (4) adherence to reporting deadlines. If the Managed Care Plan's data is unacceptable, the Managed Care Plan shall make corrections and resubmit, potentially resulting in payment delays for eligible physicians and resulting in sanctions and/or liquidated damages to the Managed Care Plan.
- (ix) The Managed Care Plan shall submit any documentation as required by the Agency, by the date specified by the Agency, in order to ensure that increased provider payments are made as required by 42 CFR 438.6(c)(5)(vi)(A), to adequately document expenditures eligible for 100% FFP and to support all audit or reconciliation processes.
- (x) The Managed Care Plan shall provide its physicians that have received an increased payment pursuant to this subsection with an explanation of benefits (EOB).
- (xi) In accordance with the ACA PCP fee increase provisions of this Attachment, primary care services provided to MediKids are not eligible for this fee increase. Managed Care Plans shall not include such payments in the summary reports and encounter data supporting documentation submissions for the ACA PCP fee increase payments.

(24) Podiatric Services

(a) The Managed Care Plan shall provide Podiatric Services. Podiatry is the specialty concerned with the diagnosis and or the medical, surgical, mechanical, physical, and adjunctive treatment of the diseases, injuries, and defects of the human foot. Podiatry services may include routine care of the foot as well as care related to underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease, or injury, ulcers, wounds and infections.

(b) The Managed Care Plan shall comply with provisions of the Medicaid Podiatry Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Podiatry Services Coverage and Limitations Handbook.

(25) Prescribed Drug Services

(a) The Managed Care Plan shall provide those products and services associated with the dispensing of medicinal drugs pursuant to a valid prescription, as defined in Chapter 465, F.S. Prescribed drug services shall include all prescription drugs listed in the Agency's Medicaid Preferred Drug List (PDL). For prescribed drug services under this Contract, the Managed Care Plan shall not negotiate any drug rebates with pharmaceutical manufacturers during the time that the Managed Care Plan is utilizing the Agency's Medicaid PDL. The Agency will be the sole negotiator of pharmaceutical rebates, and all rebate payments will be made to the Agency. No sooner than the end of the first year of operation, the Managed Care Plan may develop a Managed Care Plan-specific PDL for the Agency's consideration, if requested by the Agency at that time. See s. 409.91195, F.S. and s. 409.912(37), F.S.

(b) The Managed Care Plan shall make available those drugs and dosage forms listed on the Agency's Medicaid PDL, and shall comply with the following requirements listed in s. 409.912(37)(a), F.S.:

(i) The requirements of s. 409.912(37)(a)1.a. and b., F.S., regarding responding to requests for prior authorization and 72-hour drug supplies;

(ii) The requirements of s. 409.912(37)(a)4., F.S., regarding limiting pharmacy networks;

(iii) The requirements of s. 409.912(37)(a)5., F.S., regarding the use of counterfeit-proof prescription pads;

(iv) The requirements of s. 409.912(37)(a)13., F.S., regarding promoting best practices and ensuring cost-effective prescribing practices; and

(v) The requirements of s. 409.912(37)(a)14., 15., and 16., F.S., regarding prior authorization.

- (c) The Managed Care Plan shall not arbitrarily deny or reduce the amount, duration or scope of prescriptions solely based on the enrollee's diagnosis, type of illness or condition. The Managed Care Plan may place appropriate limits on prescriptions based on criteria such as medical necessity, or for the purpose of utilization control, provided the Managed Care Plan reasonably expects said limits to achieve the purpose of the prescribed drug services set forth in the Medicaid State Plan.
- (d) The Managed Care Plan shall make available those drugs not on the PDL, when requested and approved, if the drugs on the PDL have been used in a step therapy sequence or when other medical documentation is provided. The Managed Care Plan may adopt the Medicaid prior authorization criteria posted on the Agency website, or develop its own criteria. Prior authorization, step-edit therapy protocols for PDL drugs may not be more restrictive than that used by the Agency as indicated in the Florida Statutes, the Florida Administrative Code, the Medicaid State Plan and those posted on the Agency website.
- (e) The Managed Care Plan shall participate in the Medicaid Pharmaceutical and Therapeutics Committee by asking qualified plan administrators (MDs, DOs or pharmacists) to volunteer for committee appointment by the Governor's Office.
- (f) The Managed Care Plan shall ensure that antiretroviral agents and contraceptive drugs and items are not subject to the PDL.
- (g) The Managed Care Plan shall notify providers who may prescribe or are currently prescribing a drug that is being deleted from the PDL within thirty (30) days of the effective date of the change.
- (h) The Managed Care Plan may delegate any or all functions to one (1) or more PBMs. Before entering into a subcontract, the Managed Care Plan shall obtain the Agency's prior written approval of the delegation in accordance with Section VIII.B, Subcontracts. In addition, the Managed Care Plan shall work with the Agency's fiscal agent to ensure that the transfer of accurate and complete Managed Care Plan encounter prescription data is initiated within forty-five (45) days of PBM implementation. The Managed Care Plan acknowledges that the transfer of prescription data is required by federal law (Affordable Care Act) and that the Agency will invoice pharmaceutical manufacturers for federal rebates mandated under federal law, and for supplemental rebates negotiated by the Agency according to s. 409.912(37)(a)(7), F.S. The Managed Care Plan also acknowledges that failure to provide the necessary data to the Agency will result in immediate action by the Agency that may include (but not be limited to) sanctions, application of liquidated damages, or reduction of capitation payments in the amount of estimated combined federal and supplemental rebates. If there is a dispute between the Agency and a drug manufacturer regarding federal drug rebates, the Managed Care Plan shall assist the Agency in dispute resolution by providing information regarding claims and provider details. Failure to collect drug rebates due to the Managed Care Plan's failure to

assist the Agency will result in the Agency's recouping from the Managed Care Plan any determined uncollected rebates.

- (i) The Managed Care Plan shall continue the medication prescribed to the enrollee in a state mental health treatment facility for at least ninety (90) days after the facility discharges the enrollee, unless the Managed Care Plan's prescribing psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications:
 - (i) Are not medically necessary; or
 - (ii) Are potentially harmful to the enrollee.
- (j) The Managed Care Plan shall provide smoking cessation medications consistent with the Agency PDL to enrollees who want to quit smoking.
 - (i) The Managed Care Plan shall not cover barbiturates and benzodiazepines for dually eligible Medicare and Medicaid enrollees.
- (k) If the Managed Care Plan has authorization requirements for prescribed drug services, the Managed Care Plan shall comply with all aspects of the Settlement Agreement to *Hernandez, et al v. Medows* (case number 02-20964 Civ-Gold/Simonton) (HSA). An HSA situation arises when an enrollee attempts to fill a prescription at a participating pharmacy location and is unable to receive the prescription as a result of:
 - (i) An unreasonable delay in filling the prescription;
 - (ii) A denial of the prescription;
 - (iii) The reduction of a prescribed good or service; and/or
 - (iv) The expiration of a prescription.
- (l) The Managed Care Plan shall ensure that its enrollees are receiving the functional equivalent of those goods and services received by fee-for-service Medicaid recipients in accordance with the HSA.
- (m) The Managed Care Plan shall maintain a log of all correspondence and communications from enrollees relating to the HSA ombudsman process. The ombudsman log shall contain, at a minimum, the enrollee's name, address and telephone number and any other contact information, the reason for the participating pharmacy location's denial (an unreasonable delay in filling a prescription, a denial of a prescription and/or the termination of a prescription), the pharmacy's name (and store number, if applicable), the date of the call, a detailed explanation of the final resolution, and the name of the prescribed good or service. The ombudsman log report shall be submitted quarterly to the Agency, as required in Section XIV, Reporting Requirements, and specified in the Managed Care Plan Report Guide.

- (n) The Managed Care Plan's enrollees are third party beneficiaries for this section of the Contract.
- (o) The Managed Care Plan shall conduct annual HSA surveys of no less than five percent (5%) of all participating pharmacy locations to ensure compliance with the HSA.
 - (i) The Managed Care Plan may survey less than five percent (5%), with written approval from the Agency, if the Managed Care Plan can show that the number of participating pharmacies it surveys is a statistically significant sample that adequately represents the pharmacies that have contracted with the Managed Care Plan to provide pharmacy services.
 - (ii) The Managed Care Plan shall not include in the HSA survey any participating pharmacy location that the Managed Care Plan found to be in complete compliance with the HSA requirements within the past twelve (12) months.
 - (iii) The Managed Care Plan shall require all participating pharmacy locations that fail any aspect of the HSA survey to undergo mandatory training within six (6) months and then be re-evaluated within one (1) month of the training to ensure that the pharmacy location is in compliance with the HSA.
 - (iv) The Managed Care Plan shall ensure that it complies with all aspects and surveying requirements set forth in Policy Transmittal 06-01, Hernandez Settlement Requirements, an electronic copy of which can be found at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml
 - (v) The Managed Care Plan shall submit a report annually, by August 1 of each Contract year to the Agency, providing survey results following requirements in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.
- (p) The Managed Care Plan shall offer training to all new and existing participating pharmacy locations about the HSA requirements.
- (q) The Managed Care Plan shall ensure its PBM provides the following electronic message alerting the pharmacist to provide Medicaid recipients with the Hernandez notice/pamphlet when coverage is rejected due to the drug not being on the PDL:

Non-preferred drug; Contact provider for change to preferred drug or to obtain prior authorization. Give Medicaid pamphlet if not corrected.
- (r) The Managed Care Plan shall cover a brand-name drug if the prescriber:

- (i) Writes in his/her own handwriting on the valid prescription that the “Brand Name is Medically Necessary” (pursuant to s. 465.025, F.S.); and
 - (ii) Submits a completed “Multisource Drug and Miscellaneous Prior Authorization” form to the Managed Care Plan indicating that the enrollee has had an adverse reaction to a generic drug or has had, in the prescriber’s medical opinion, better results when taking the brand-name drug.
- (s) Hemophilia factor-related drugs identified by the Agency for distribution through the Comprehensive Hemophilia Disease Management Program are reimbursed on a fee-for-service basis. During operation of the Comprehensive Hemophilia Disease Management Program, the Managed Care Plan shall coordinate the care of its enrollees with Agency-approved organizations and shall not be responsible for the distribution of hemophilia-related drugs.
- (t) The Managed Care Plan may have a pharmacy lock-in program that conforms to the requirements in the Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook, provided it is submitted in writing and approved by the Agency in advance of implementation.
- (u) The Managed Care Plan shall require that prescriptions for psychotropic medication prescribed for an enrollee under the age of thirteen (13) be accompanied by the express written and informed consent of the enrollee’s parent or legal guardian. Psychotropic (psychotherapeutic) medications include antipsychotics, antidepressants, anti-anxiety medications, and mood stabilizers. Anticonvulsants and attention-deficit/hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included at this time. In accordance with s. 409.912(51), F.S., the Managed Care Plan shall ensure the following requirements are met:
- (i) The prescriber must document the consent in the child’s medical record and provide the pharmacy with a signed attestation of the consent with the prescription.
 - (ii) The prescriber must ensure completion of an appropriate attestation form.
 - (iii) Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link:

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

- (iv) The completed form must be filed with the prescription (hardcopy of imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years.
 - (v) Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
 - (vi) Every new prescription will require a new informed consent form.
 - (vii) The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents from birth through age seventeen (17).
- (v) The Managed Care Plan shall design and implement a drug utilization review (DUR) program designed to encourage coordination between an enrollee's primary care provider and a prescriber of a psychotropic or similar prescription drug for behavioral health problems. The Managed Care Plan's DUR program shall identify those medications for other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems), where this is a significant risk to the enrollee posed by potential drug interactions between drugs for these conditions and behavioral-related drugs. After the Managed Care Plan identifies the potential for such problems, the Managed Care Plan's DUR program shall notify all related prescribers that certain drugs may be contra-indicated due to the potential for drug interactions and shall encourage the prescribers to coordinate their care. Notice may be provided electronically or via mail, or by telephonic or direct consultation, as the Managed Care Plan deems appropriate.

(26) Renal Dialysis Services

- (a) The Managed Care Plan shall provide renal dialysis services. The services include in-center hemodialysis, in-center administration of the injectable medication Erythropoietin (Epogen or EPO), other Agency approved drugs, and home peritoneal dialysis. Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis. Both hemodialysis and peritoneal dialysis are acceptable modes of treatment for ESRD under Medicaid. Hemodialysis is a process by which blood passes through an artificial kidney machine and the waste products diffuse across a manmade membrane into a bath solution known as dialysate, after which the cleansed blood is returned to the patient's body. Hemodialysis is accomplished usually in three to four hour sessions, three times a week. Peritoneal dialysis is a process by which waste products pass from the patient's body through the peritoneal membrane into the peritoneal (abdominal) cavity where the bath solution (dialysate) is introduced and removed periodically. The dialysis treatment includes routine laboratory tests, dialysis-related supplies, and ancillary and parenteral items. These

services must be provided under the supervision of a physician licensed to practice allopathic or osteopathic medicine in Florida.

- (b) The Managed Care Plan shall comply with provisions of the Medicaid Freestanding Dialysis Center Coverage and Limitations Handbook and Medicaid Hospital Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Freestanding Dialysis Center Coverage and Limitations Handbook and Medicaid Hospital Services Coverage and Limitations Handbook.

(27) Therapy Services

- (a) The Managed Care Plan shall provide physical therapy services. Physical therapy (PT) is a specifically prescribed program to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance. PT services include evaluation and treatment of range-of motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.
- (b) The Managed Care Plan shall provide occupational therapy services. Occupational therapy (OT) is the provision of services that addresses the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development. OT services include evaluation and treatment to prevent or correct physical and emotional deficits or to minimize the disabling effect of these deficits. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.
- (c) The Managed Care Plan shall provide speech-language pathology services. Speech-language pathology (SLP) services involve the evaluation and treatment of speech-language disorders. Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies. Examples are techniques and instrumentation to evaluate the recipient's condition, remedial procedures to maximize the recipient's oral motor functions and communication via augmentative and alternative communication (AAC) systems.

- (d) The Managed Care Plan shall provide respiratory therapy services. respiratory therapy (RT) is treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. RT services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilatory support; therapeutic and diagnostic use of medical gases; respiratory rehabilitation; management of life support systems and bronchopulmonary drainage; breathing exercises and chest physiotherapy.
- (e) The Managed Care Plan shall comply with provisions of the Medicaid Therapy Services Coverage and Limitations Handbook and Medicaid Hospital Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Therapy Services Coverage and Limitations Handbook and Medicaid Hospital Services Coverage and Limitations Handbook.

(28) Transportation Services

- (a) The Managed Care Plan shall provide transportation services, including emergency transportation, for its enrollees who have no other means of transportation available to any covered service, including transportation to Medicaid State Plan services not covered by the Managed Care Plan and expanded benefits.
- (b) The Managed Care Plan shall comply with provisions of the Medicaid Transportation Services Coverage and Limitations Handbooks. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Transportation Services Coverage and Limitations Handbooks.
- (c) The Managed Care Plan is not obligated to follow the requirements of the Commission for the Transportation Disadvantaged (CTD) or the Transportation Coordinating Boards as set forth in Chapter 427, F.S., unless the Managed Care Plan has chosen to coordinate services with the CTD.
- (d) The Managed Care Plan may provide transportation services directly through its own network of transportation providers or through a provider contract relationship, which may include the Commission for the Transportation Disadvantaged. In either case, the Managed Care Plan is responsible for monitoring provision of services to its enrollees.
- (e) The Managed Care Plan shall:
 - (i) Ensure that all transportation providers comply with standards set forth in Chapter 427, F.S., and Rules 41-2 and 14-90, F.A.C. These standards include drug and alcohol testing, safety standards, driver accountability, and driver conduct;

- (ii) Ensure that all transportation providers maintain vehicles and equipment in accordance with State and federal safety standards and the manufacturers' mechanical operating and maintenance standards for any and all vehicles used for transportation of Medicaid recipients;
 - (iii) Ensure that all transportation providers comply with applicable state and federal laws, including, but not limited to, the Americans with Disabilities Act (ADA) and the Federal Transit Administration (FTA) regulations;
 - (iv) Ensure that transportation providers immediately remove from service any vehicle that does not meet the Florida Department of Highway Safety and Motor Vehicles licensing requirements, safety standards, ADA regulations, or Contract requirements and re-inspect the vehicle before it is eligible to provide transportation services for Medicaid recipients under this Contract. Vehicles shall not carry more passengers than the vehicle was designed to carry. All lift-equipped vehicles must comply with ADA regulations;
 - (v) Ensure transportation services meet the needs of its enrollees including use of multiload vehicles, public transportation, wheelchair vehicles, stretcher vehicles, private volunteer transport, over-the-road bus service, or, where applicable, commercial air carrier transport;
 - (vi) Collect and submit encounter data, as required elsewhere in this Contract;
 - (vii) Ensure a transportation network of sufficient size so that failure of any one component will not impede the ability to provide the services required in this Contract;
 - (viii) Ensure that any subcontracts for transportation services meet the subcontracting requirements detailed in Section VIII.B., Subcontracts;
 - (ix) Maintain policies and procedures, consistent with 42 CFR 438.12 to ensure there is no discrimination in serving high-risk populations or people with conditions that require costly transportation; and
 - (x) Ensure all transportation providers maintain sufficient liability insurance to meet requirements of Florida law.
- (f) The Managed Care Plan shall be responsible for the cost of transporting an enrollee from a non-participating facility or hospital to a participating facility or hospital if the reason for transport is solely for the Managed Care Plan's convenience.

- (g) The Managed Care Plan shall approve and process claims for transportation services in accordance with the requirements set forth in this Contract.
- (h) If the Managed Care Plan subcontracts for transportation services, it shall provide a copy of the model subcontract to the Agency for approval before use.
- (i) Before providing transportation services, the Managed Care Plan shall provide the Agency a copy of its policies and procedures for approval relating to the following:
 - (i) How the Managed Care Plan will determine eligibility for each enrollee and what type of transportation to provide that enrollee;
 - (ii) The Managed Care Plan's procedure for providing prior authorization to enrollees requesting transportation services;
 - (iii) How the Managed Care Plan will review transportation providers to prevent and/or identify those who falsify encounter or service reports, overstate reports or upcode service levels, or commit any form of fraud or abuse as defined in s. 409.913, F.S.;
 - (iv) How the Managed Care Plan will deal with providers who alter, falsify or destroy records before the end of the retention period; make false statements about credentials; misrepresent medical information to justify referrals; fail to provide scheduled transportation; or charge enrollees for covered services; and
 - (v) How the Managed Care Plan will provide transportation services outside its region.
- (j) The Managed Care Plan shall report within two (2) business days of the occurrence, in writing to the Agency, any transportation-related adverse or untoward incident (see s. 641.55, F.S.). The Managed Care Plan shall also report, immediately upon identification, in writing to MPI, all instances of suspected enrollee or transportation services provider fraud or abuse as defined in s. 409.913, F.S. See also Section VIII.F., Fraud and Abuse Prevention.
- (k) The Managed Care Plan shall ensure compliance with the minimum liability insurance requirement of \$200,000 per person and \$300,000 per incident for all transportation services purchased or provided for the transportation disadvantaged through the Managed Care Plan. (See s. 768.28(5), F.S.) The Managed Care Plan shall indemnify and hold harmless the local, state, and federal governments and their entities and the Agency from any liabilities arising out of or due to an accident or negligence on the part of the Managed Care Plan and/or all transportation providers under contract to the Managed Care Plan.

- (l) The Managed Care Plan shall ensure adequate seating for paratransit services for each enrollee and escort, child, or personal care attendant, and shall ensure that the vehicle meets the following requirements and does not transport more passengers than the registered passenger seating capacity in a vehicle at any time:
 - (i) Enrollee property that can be carried by the passenger and/or driver, and can be stowed safely on the vehicle, shall be transported with the passenger at no additional charge. The driver shall provide transportation of the following items, as applicable, within the capabilities of the vehicle:
 - (a) Wheelchairs;
 - (b) Child seats;
 - (c) Stretchers;
 - (d) Secured oxygen;
 - (e) Personal assistive devices; and/or
 - (f) Intravenous devices.
 - (ii) Each vehicle shall have posted inside the Managed Care Plan's toll-free telephone number for enrollee complaints.
 - (iii) The interior of all vehicles shall be free from dirt, grime, oil, trash, torn upholstery, damaged or broken seats, protruding metal or other objects or materials which could soil items placed in the vehicle or cause discomfort to enrollees.
 - (iv) The transportation provider shall provide the enrollee with boarding assistance, if necessary or requested, to the seating portion of the vehicle. Such assistance shall include, but not be limited to, opening the vehicle door, fastening the seat belt or wheelchair securing devices, storage of mobility assistive devices and closing the vehicle door. In the door-through-door paratransit service category, the driver shall open and close doors to buildings, except in situations in which assistance in opening and/or closing building doors would not be safe for passengers remaining in the vehicle. The driver shall provide assisted access in a dignified manner.
 - (v) Smoking, eating and drinking are prohibited in any vehicle, except in cases in which, as a medical necessity, the enrollee requires fluids or sustenance during transport.
 - (vi) All vehicles must be equipped with two-way communications, in good working order and audible to the driver at all times, by which to communicate with the transportation services hub or base of operations.

- (vii) All vehicles must have working air conditioners and heaters.
- (m) Vehicle transfer points shall provide shelter, security, and safety of enrollees.
- (n) The transportation provider shall maintain a passenger/trip database for each enrollee it transports.
- (o) The Managed Care Plan shall establish a minimum twenty-four (24) hour advance notification policy to obtain transportation services, and the Managed Care Plan shall communicate that policy to its enrollees and transportation providers.
- (p) The Managed Care Plan shall establish enrollee pick-up windows and communicate those timeframes to enrollees and transportation providers.
- (q) The Managed Care Plan shall submit data on transportation performance measures as defined by the Agency and as specified in the Agency's Performance Measures Specifications Manual. The Managed Care Plan shall report on those measures to the Agency as specified in Section VII, Quality and Utilization Management, Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.
- (r) The Managed Care Plan shall provide an annual attestation to the Agency by January 1 of each Contract year that it is in full compliance with the policies and procedures relating to transportation services, and that all vehicles used for transportation services have received annual safety inspections.
- (s) The Managed Care Plan shall provide an annual attestation to the Agency by January 1 of each Contract Year that all drivers providing transportation services have passed background checks and meet all qualifications specified in law and in rule.

2. Customized Benefits

- a. The Managed Care Plan may customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services.
- b. Submitted PETs must comply with instructions available from the Agency. The Agency shall evaluate the Managed Care Plan's CBP for actuarial equivalency and sufficiency of benefits before approving the CBP. Actuarial equivalency is tested by using a PET that:
 - (1) Compares the value of the level of benefits in the proposed package to the value of the contracted benefit package for the average member of the covered population;
 - (2) Ensures that the overall level of benefits is appropriate; and

- (3) Compares the proposed CBP to state-established standards. The standards are based on the covered population's historical use of Medicaid State Plan services. These standards are used to ensure that the proposed CBP is adequate to cover the needs of the vast majority of the enrollees.
- c. If, in its CBP, the Managed Care Plan limits a service to a maximum annual dollar value, the Managed Care Plan must calculate the dollar value of the service using the Medicaid fee schedule.
 - d. The CBPs may change on a Contract year basis and only if approved by the Agency in writing. The Managed Care Plan shall submit to the Agency a PET for its proposed CBP for evaluation of actuarial equivalency and sufficiency standards no later than the date established by the Agency each year.
 - e. The Managed Care Plan shall send letters of notification to enrollees regarding exhaustion of benefits for services restricted by unit amount if the amount is more restrictive than Medicaid. The Managed Care Plan shall send an exhaustion of benefits letter for any service restricted by a dollar amount. The Managed Care Plan shall implement said letters upon the written approval of the Agency. The letters of notification include the following:
 - (1) A letter notifying an enrollee when he/she has reached fifty percent (50%) of any maximum annual dollar limit established by the Managed Care Plan for a benefit;
 - (2) A follow-up letter notifying the enrollee when he/she has reached seventy-five (75%) of any maximum annual dollar limit established by the Managed Care Plan for a benefit; and
 - (3) A final letter notifying the enrollee that he/she has reached the maximum dollar limit established by the Managed Care Plan for a benefit.
 - f. The Managed Care Plan shall submit the Customized Benefit Notifications Report to the Agency in accordance with Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.

B. Expanded Benefits

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

C. Excluded Services

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

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D. Coverage Provisions

1. Primary Care Provider Initiatives

- a. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall establish a program to encourage enrollees to establish a relationship with their PCP.
- b. This program shall provide information to each enrollee on the importance of selecting a PCP and the procedure for selecting a PCP (see s. 409.973(4), F.S.).
- c. The Managed Care Plan shall offer each enrollee a choice of PCPs. After making a choice, each enrollee shall have a single or group PCP.
- d. The Managed Care Plan shall allow pregnant enrollees to choose Managed Care Plan obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP, as specified in Section VI, Provider Network.
- e. If the enrollee has not selected a provider for a newborn, the Managed Care Plan shall assign a pediatrician or other appropriate PCP to all pregnant enrollees for the care of their newborn babies no later than the beginning of the last trimester of gestation.
- f. The Managed Care Plan shall assign a PCP to those enrollees who did not choose a PCP at the time of managed care plan selection. The Managed Care Plan shall take into consideration the enrollee's last PCP (if the PCP is known and available in the Managed Care Plan's network), closest PCP to the enrollee's ZIP code location, keeping children/adolescents within the same family together, enrollee's age (adults versus children/adolescents), and PCP performance measures. If the language and/or cultural needs of the enrollee are known to the Managed Care Plan, the Managed Care Plan shall assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee.
- g. The Managed Care Plan shall permit enrollees to request to change PCPs at any time. If the enrollee request is not received by the Managed Care Plan's established monthly cut-off date for system processing, the PCP change will be effective the first day of the next month.
- h. The Managed Care Plan shall assign all enrollees that are reinstated after a temporary loss of eligibility to the PCP who was treating them prior to loss of eligibility, unless the enrollee specifically requests another PCP, the PCP no longer participates in the Managed Care Plan or is at capacity.
- i. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall report on the number of enrollees assigned to each participating PCP and the number of enrollees who have not had an appointment with their PCP within their first year of enrollment as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.
- j. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall report on the number of emergency room visits by enrollees who have not had at least one appointment

with their PCP as specified in the Managed Care Plan Report Guide and as referenced in Section XIV, Reporting Requirements.

2. Enrollee Screening and Education

- a. Within thirty (30) days of enrollment, the Managed Care Plan shall notify enrollees of, and ensure the availability of, a screening for all enrollees known to be pregnant or who advise the Managed Care Plan that they may be pregnant. The Managed Care Plan shall refer enrollees who are, or may be, pregnant to a provider to obtain appropriate care.
- b. The Managed Care Plan shall use the enrollee's health risk assessment and/or released medical/case records to identify enrollees who have not received CHCUP screenings in accordance with the Agency-approved periodicity schedule.
- c. The Managed Care Plan shall develop and implement an education and outreach program to increase the number of eligible enrollees receiving CHCUP screenings. This program shall include, at a minimum, the following:
 - (1) The Managed Care Plan shall have a tracking system to identify enrollees for whom a screening is due or overdue;
 - (2) The Managed Care Plan shall systematically send reminder notices to enrollees before a screening is due. The notice shall include an offer to assist with scheduling and transportation;
 - (3) If the Managed Care Plan's CHCUP screening rate is below eighty percent (80%), the Managed Care Plan shall call (which may include automated calls) all new enrollees under the age of twenty-one (21) to inform them of CHCUP services and offer to assist with scheduling and transportation;
 - (4) The Managed Care Plan shall have a process for following up with enrollees who do not get timely screenings. This shall include contacting, twice if necessary, any enrollee more than two (2) months behind in the Agency-approved periodicity screening schedule to urge those enrollees, or their legal representatives, to make an appointment with the enrollee's PCP for a screening visit and offering to assist with scheduling and transportation. The Managed Care Plan shall document all outreach education attempts. For this subsection "contact" is defined as mailing a notice to or calling an enrollee at the most recent address or telephone number available; and
 - (5) The Managed Care Plan shall provide enrollee education and outreach in community settings.
- d. The Managed Care Plan shall develop and implement an education outreach program to encourage wellness visits to prevent illness or exacerbations of chronic illness.
- e. The Managed Care Plan shall take immediate action to address any identified urgent medical needs. "Urgent medical needs" means any sudden or unforeseen situation

that requires immediate action to prevent hospitalization or nursing facility placement. Examples include hospitalization of spouse or caregiver or increased impairment of an enrollee living alone who suddenly cannot manage basic needs without immediate help, hospitalization or nursing home placement.

- (1) Pursuant to s. 409.966(3)(c)2, F.S., the Managed Care Plan may have program for recognizing patient centered medical homes (PCMHs) and providing increased compensation for recognized PCMHs, as defined by the Managed Care Plan. If the Managed Care Plan has a patient centered medical home program, it shall submit its policies and procedures for such program to the Agency, which shall include recognition standards and increased compensation protocols developed by the Managed Care Plan for the program.
- (2) The Managed Care Plan shall report to the Agency regarding providers that are recognized by the Managed Care Plan as PCMHs in accordance with Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

3. New Enrollee Procedures

- a. The Managed Care Plan shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee's enrollment to offer to schedule the enrollee's initial appointment with the PCP Pursuant to s. 409.973(4)(a), F.S., for enrollees who enroll before December 31, 2015, the appointment should be scheduled within six (6) months after enrollment in the Managed Care Plan. For enrollees who enroll after December 31, 2015, the appointment should be scheduled within thirty (30) days of enrollment. This appointment is to obtain an initial health assessment including a CHCUP screening, if applicable. For this subsection "contact" is defined as mailing a notice to or telephoning an enrollee at the most recent address or telephone number available.
- b. Within thirty (30) days of enrollment, the Managed Care Plan shall ask the enrollee to authorize release of the medical/case and behavioral health clinical records to the new PCP or other appropriate provider and shall assist by requesting those records from the enrollee's previous provider(s).
- c. The Managed Care Plan shall honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.
- d. For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, provided that the services were prearranged prior to enrollment with the Managed Care Plan:
 - (1) Prior existing orders;
 - (2) Provider appointments, e.g., dental appointments, surgeries, etc.;
 - (3) Prescriptions (including prescriptions at non-participating pharmacies); and

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

4. Telemedicine Coverage Provisions

- a. The Managed Care Plan may use telemedicine as specified in this Contract and as specified in the Medicaid State Plan for the following services:
 - (1) Behavioral Health Services;
 - (2) Dental Services; and
 - (3) Physician Services.
- b. The Managed Care Plan may utilize telemedicine for other covered services, as approved by the Agency.
- c. When providing services through telemedicine, the Managed Care Plan shall ensure:
 - (1) The equipment used meets the definition of telecommunication equipment as defined in this Contract. See hub site, spoke site and telecommunication equipment definitions in Section I, Definitions and Acronyms;
 - (2) The telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable;
 - (3) Telemedicine services are provided only to enrollees in a provider office setting;
 - (4) The Managed Care Plan's providers using telemedicine comply with HIPAA and other state and federal laws pertaining to patient privacy;
 - (5) The Managed Care Plan's telemedicine policies and procedures comply with the requirements in this Contract; and
 - (6) Provider training regarding the telemedicine requirements in this Contract.
- d. When telemedicine services are provided, the Managed Care Plan shall ensure that the enrollee's medical/case record includes documentation, as applicable.
- e. The following interactions are not Medicaid reimbursable telemedicine services:
 - (1) Telephone conversations;
 - (2) Video cell phone interactions;
 - (3) Electronic mail messages;

- (4) Facsimile transmissions;
 - (5) Telecommunication with the enrollee at a location other than the spoke site; and
 - (6) "Store and forward" visits and consultations that are transmitted after the enrollee or provider is no longer available.
- f. Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services.
 - g. Only certain providers that meet the requirements in Section VI, Provider Network, are eligible to provide services through telemedicine at the spoke and hub sites.
 - h. The Managed Care Plan shall ensure the enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter, and shall document such choice in the enrollee's medical/case record.

5. Protective Custody Coverage Provisions

- a. The Managed Care Plan shall provide a physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter or the foster care program by DCF. See 65C-29.008, F.A.C.
- b. The Managed Care Plan shall provide these required examinations without requiring prior authorization, or, if a non-participating provider is utilized by DCF, approve and process the out-of-network claim.
- c. For all CHCUP screenings for children/adolescents whose enrollment and Medicaid eligibility are undetermined at the time of entry into the care and custody of DCF, and who are later determined to be enrollees at the time the examinations took place, the Managed Care Plan shall approve and process the claims.

E. Care Coordination/Case Management

1. Behavioral Health Coverage and Coordination in Long-Term Care Settings

- a. The Managed Care Plan shall retain responsibility for provision of medically necessary behavioral health evaluation and treatment services to enrollees, regardless of setting, including in the community, a medical facility, an assisted-living facility, or a nursing facility. Provision of services in long-term care settings will require coordination with other entities including LTC Managed Care Plans and providers, Medicare plans and providers, and state-funded programs and services.
- b. In cooperation with the administration and/or treatment providers associated with the other plans, settings or agencies, the Managed Care Plan shall coordinate behavioral health services consistent with the care coordination requirements established in Section V.D.2. Specific responsibilities of the Managed Care Plan as it relates to coordinating with other entities include:

- (1) Psychiatric Evaluations and Treatment for Enrollees Applying for Nursing Facility Admission: The Managed Care Plan shall, upon request from the DCF offices, promptly arrange for and authorize psychiatric evaluations for enrollees who are applying for admission to a nursing facility pursuant to OBRA 1987, and who, on the basis of a screening conducted by Comprehensive Assessment and Review for Long-Term Care Services (CARES) workers, are thought to need behavioral health treatment. The examination shall be adequate to determine the need for “specialized treatment” under OBRA. Evaluations must be completed within five (5) business days from the time the request from the DCF office is received. Regulations have been interpreted by the state to permit any of the mental health professionals listed in s. 394.455, F.S., to make the observations preparatory to the evaluation, although a psychiatrist must sign such evaluations. The Managed Care Plan will not be responsible for resident reviews as a result of a pre-admission screening and resident review (PASRR) evaluation. If the psychiatric evaluation of an enrollee indicates covered behavioral health services are medically necessary, and the enrollee is subsequently admitted to a nursing facility, the Managed Care Plan will retain responsibility for provision of those behavioral health services to enrollee in the nursing facility.
 - (2) Assessment and Treatment of Mental Health Residents Who Reside in Assisted Living Facilities (ALFs) That Hold a Limited Mental Health License: The Managed Care Plan shall develop and implement a plan to ensure compliance with s. 394.4574, F.S., related to behavioral health services provided to residents of licensed assisted living facilities that hold a limited mental health license.
- c. The Managed Care Plan shall ensure that a cooperative agreement, as defined in s. 429.02, F.S., is developed by the ALF administrator and the Managed Care Plan’s designated care coordinator/case manager for enrollees that are residents of an ALF and qualify as a mental health resident. The Managed Care Plan must ensure that appropriate assessment services are provided to enrollees and that medically necessary behavioral health services, including psychiatric medication and access to drop-in centers and clubhouses, are available to all enrollees who meet criteria as a mental health resident and reside in this type of setting.
 - d. A community living support plan, as defined in Section I, Definitions and Acronyms, shall be developed for each enrollee who is a resident of an ALF, and it must be updated annually. The Managed Care Plan shall ensure that its designated care coordinator/case manager is responsible for ensuring that the community living support plan is implemented as written.
 - e. Upon request from an ALF, the Managed Care Plan shall provide procedures for the ALF to follow should an emergent condition arise with an enrollee that resides at the ALF (see s. 409.912(35), F.S.).

2. Enhanced Care Coordination for Enrollees under Age 21 Receiving Skilled Nursing facility or Private Duty Nursing Services

- a. The Managed Care Plan shall implement enhanced care coordination processes for medically complex and medically fragile enrollees under the age of 21 who are receiving services in a skilled nursing facility or are receiving private duty nursing services in their family home or other community based setting.
- b. The Managed Care Plan shall maintain written protocols for the care coordination of medically complex and medically fragile enrollees, as described in sub-item a., above, which shall include:
 - (1) The Managed Care Plan shall assign a care coordinator to all enrollees meeting the criteria described in sub-item a., above. The Managed Care Plan shall maintain documentation of an enrollee or their parent or legal guardian's rejection of care coordination services.
 - (2) The Managed Care Plan shall utilize care coordinators who possess the following qualifications:
 - (a) State of Florida licensed registered nurse with at least two (2) years of pediatric experience;
 - (b) State of Florida licensed practical nurse with four (4) years of pediatric experience; or
 - (c) Master's degree in social work with at least one (1) year of related professional experience.
 - (3) The Managed Care Plan shall ensure that care coordinator caseloads do not exceed a ratio of forty (40) enrollees to one care coordinator for enrollees receiving private duty nursing services in their family home or other community based setting and no more than a ratio of fifteen (15) enrollees to one (1) care coordinator for enrollees who are receiving services in a skilled nursing facility.
 - (4) The Managed Care Plan shall ensure that the care coordinator maintains monthly (or more frequently, if needed) contact with the enrollee and the enrollee's parent or legal guardian. The contact shall be face-to-face or telephonic. The Managed Care Plan shall maintain documentation in the enrollee's record of any contacts made, including whether such attempts were successful in reaching the enrollee or the parent or legal guardian.
 - (5) The Managed Care Plan shall convene a multidisciplinary team (MDT) every six (6) months to provide a comprehensive review of the services and supports that the enrollee needs and to authorize any Medicaid reimbursable services that are prescribed for the enrollee (e.g., private duty nursing, therapy services, etc.). The MDT shall meet more frequently, if needed, based on any changes in the enrollee's medical condition. The MDT meeting shall include at a minimum:

the enrollee's care coordinator, the enrollee (if able), the enrollee's parent or legal guardian, and other health care professionals involved in that enrollee's care. The MDT shall also develop a person centered individualized service plan that reflects the services and supports that the enrollee needs.

- (6) The Managed Care Plan shall convene an MDT meeting one year prior to an enrollee turning the age of twenty-one (21) to discuss the services and supports that the enrollee will need after turning twenty-one (21). If the services are not covered by Medicaid, the Managed Care Plan shall inform the enrollee or their representative of any community programs or home and community based waiver options that may be able to meet the needs and make the necessary referrals, as needed.
- c. The Managed Care Plan shall maintain written protocols that address the transition/discharge planning process for medically complex and medically fragile enrollees who are receiving services in a skilled nursing facility. The Managed Care Plan shall:
- (1) Ensure that transition planning begins upon admission to a skilled nursing facility. In those cases where the enrollee has been residing a skilled nursing facility prior to enrollment in the Managed Care Plan, the Managed Care Plan shall begin the transition planning process upon enrollment in the Managed Care Plan.
 - (2) Convene an MDT meeting focused specifically on transition planning to proactively consider placement alternatives and offer such opportunities to the enrollee and his or her parent or legal guardian. This transition planning meeting shall occur every three (3) months until the enrollee is transitioned home or to another community based setting.
 - (3) Develop a final written transition plan within thirty (30) days prior to discharge that includes all of the services and supports that the enrollee needs to successfully reside in the community.
 - (4) Maintain contact with the enrollee and his or her parent or legal guardian at least two (2) times a month during the first six (6) months after discharge from the skilled nursing facility. If agreed to by the parent or legal guardian, at least one of these contacts must be face-to-face. After this six (6) month transition period, the Managed Care Plan shall continue to maintain monthly contact with the enrollee and his or her parent or legal guardian.

3. Healthy Behaviors Program

- a. Pursuant to s. 409.973(3), F.S., the Managed Care Plan shall establish and maintain programs to encourage and reward healthy behaviors. At a minimum, the Managed Care Plan must establish a medically approved smoking cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse recovery program. The Managed Care Plan must identify enrollees

- who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participation in these programs.
- b. The Managed Care Plan shall receive written approval of its healthy behavior program from the Agency before implementing the program. The Managed Care Plan's program shall include a detailed description of the program, including the goals of the program, how targeted enrollees will be identified, the interventions, rewards for or incentives to participate, research to support the effectiveness of the program, and evidence that the program is medically approved or directed, as applicable. Programs administered by the Managed Care Plan must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG). The Managed Care Plan is encouraged to seek an advisory opinion from OIG once the specifics of its Healthy Behaviors programs are determined.
 - c. The Managed Care Plan shall make all programs, including incentives and rewards available to all enrollees and shall not use incentives or rewards to direct individuals to select a particular provider.
 - d. The Managed Care Plan may inform enrollees, once they are enrolled, about its healthy behavior programs, including incentives and rewards.
 - e. The Managed Care Plan shall not include the provision of gambling, alcohol, tobacco or drugs (except for over-the-counter drugs) in any of its incentives or rewards and shall state on the incentive or reward that it may not be used for such purposes.
 - f. Incentives or rewards may have some health- or child development-related function (e.g., clothing, food, books, safety devices, infant care items, subscriptions to publications that include health-related subjects, membership in clubs advocating educational advancement and healthy lifestyles, etc.). Incentive or reward dollar values shall be in proportion to the importance of the healthy behavior being encouraged or rewarded (e.g., a tee-shirt for attending one (1) smoking cessation class, but a gift card for completion of a series of classes).
 - g. Incentives and rewards shall be limited to a value of twenty dollars (\$20), except in the case of incentives or rewards for the completion of a series of services, health education classes or other educational activities, in which case the incentive or reward shall be limited to a value of fifty dollars (\$50). The Agency will allow a special exception to the dollar value relating to infant car seats, strollers, and cloth baby carriers/ slings.
 - h. The Managed Care Plan shall not include in the dollar limits on incentives or rewards any money spent on the transportation of enrollees to services or child care provided during the delivery of services.
 - i. Healthy Behavior incentives/rewards are non-transferable from one managed care plan to another.
 - j. As part of its smoking cessation program, the Managed Care Plan shall provide participating PCPs with the Quick Reference Guide to assist in identifying tobacco

users and supporting and delivering effective smoking cessation interventions. (The Managed Care Plan can obtain copies of the guide by contacting the DHHS, Agency for Health Care Research & Quality (AHR) Publications Clearinghouse at (800) 358-9295 or P.O. Box 8547, Silver Spring, MD 20907.)

- k. As part of its medically approved alcohol or substance abuse recovery program, the Managed Care Plan shall offer annual alcohol or substance abuse screening training to its providers. The Managed Care Plan shall have all PCPs screen enrollees for signs of alcohol or substance abuse as part of prevention evaluation at the following times:
 - (1) Initial contact with a new enrollee;
 - (2) Routine physical examinations;
 - (3) Initial prenatal contact;
 - (4) When the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services; and
 - (5) When documentation of emergency room visits suggests the need.
- l. The Managed Care Plan shall report on its healthy behavior programs in accordance with Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. This shall include submitting data related to each healthy behavior program, caseloads (new and ongoing) for each healthy behavior program, and the amount and type of rewards/incentives provided for each healthy behavior program.

4. Additional Care Coordination / Case Management Requirements

- a. The Managed Care Plan shall be responsible for the management and continuity of medical and behavioral health care for all enrollees.
- b. The Managed Care Plan shall maintain written care coordination/case management and continuity of care protocols that include the following minimum functions:
 - (1) Appropriate referral and scheduling assistance for enrollees needing specialty health care or transportation services, including those identified through CHCUP screenings;
 - (2) Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting (to include referral to WIC and Healthy Start) with assistance, as needed, by the Medicaid Area Office;
 - (3) Care coordination/case management follow-up services for children/adolescents whom the Managed Care Plan identifies through blood screenings as having abnormal levels of lead;

- (4) A mechanism for direct access to specialists for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs;
 - (5) An outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant;
 - (6) Documentation of referral services in enrollee medical/case records, including reports resulting from the referral;
 - (7) Documentation of emergency care encounters in enrollee medical/case records with appropriate medically indicated follow-up;
 - (8) Coordination of hospital/institutional discharge planning that includes post-discharge care, including residential services, day treatment programs, outpatient appointments, skilled short-term rehabilitation, and skilled nursing facility care, as appropriate;
 - (9) Sharing with other Managed Care Plans serving the enrollee the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated; and
 - (10) Ensuring that in the process of coordinating care/case management, 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.
- c. The Managed Care Plan shall maintain written protocols for identifying, assessing and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:
- (1) Identifying eligible enrollees and stratifying enrollees by severity and risk level including developing an algorithm to identify and stratify eligible enrollees;
 - (2) Developing different types of interventions and specifying minimum touch frequency for each severity and/or risk level;
 - (3) Determining maximum caseloads for each case manager and support staff and managing and monitoring caseloads;
 - (4) Specifying experience and educational requirements for case managers and case management support staff;
 - (5) Providing training and continuing education for case management staff;
 - (6) Using evidence based guidelines;

- (7) Conducting comprehensive assessments that identify enrollee needs across multiple domains, including current health conditions, current providers, caregiver or other supports available, transportation barriers, medications, behavioral health conditions, and preferences for treatment;
- (8) Developing treatment plans that incorporate the health risk issues identified during the assessment and incorporate the treatment preferences of the enrollee. The treatment plan shall contain goals that are outcomes based and measurable and include the interventions and services to be provided to obtain goals. Interventions should include community service linkage, improving support services and lifestyle management as appropriate based on the enrollee's identified issues. Treatment plans shall be updated at least every six (6) months when there are significant changes in enrollee's condition;
- (9) Identifying enrollees with co-morbid mental health and substance abuse disorders, including a depression screening, and addressing those disorders;
- (10) Identifying enrollees with co-morbid medical conditions and addressing the co-morbid medical conditions;
- (11) Interfacing with the enrollee's PCP and/or specialists;
- (12) Assessing enrollees for literacy levels and other hearing, vision or cognitive functions that may impact an enrollee's ability to participate in his/her care and implementing interventions to address the limitations;
- (13) Assessing enrollees for community, environmental or other supportive services needs and referring enrollees to get needed assistance;
- (14) Facilitating enrollee preferences for treatment, including cultural preferences, and enrollee participation in treatment planning;
- (15) Using best practices to increase enrollee engagement;
- (16) Documentation of emergency care encounters in enrollee medical/case records with appropriate medically indicated follow-up;
- (17) Coordination of hospital/institutional discharge planning that includes post-discharge care, including residential services, day treatment programs, outpatient appointments, skilled short-term rehabilitation, and skilled nursing facility care, as appropriate;
- (18) Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services for enrollees who have justice system involvement;
- (19) Sharing with other managed care plans serving the enrollee the results of its identification and assessment of any enrollee with special health care needs so that those activities need not be duplicated; and

- (20) Ensuring that in the process of coordinating care/case management, 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. Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate behavioral health professionals (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, the Managed Care Plan shall have a mechanism in place to allow enrollees to directly access a behavioral health care specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.
- e. The Managed Care Plan shall maintain written protocols for discharge planning through the evaluation of an enrollee's medical care needs, mental health service needs, and substance use service needs and coordination of appropriate care after discharge from one level of care to another. The Managed Care Plan shall:
- (1) Monitor all enrollee discharge plans from behavioral health inpatient admissions to ensure that they incorporate the enrollee's needs for continuity in existing behavioral health therapeutic relationships;
 - (2) Ensure enrollees' family members, guardians, outpatient individual practitioners and other identified supports are given the opportunity to participate in enrollee treatment to the maximum extent practicable and appropriate, including behavioral health treatment team meetings and discharge plan development. For adult enrollees, family members and other identified supports may be involved in the development of the discharge plan only if the enrollee consents to their involvement;
 - (3) Designate care coordination/case management staff who are responsible for identifying and providing care coordination/case management to enrollees who remain in the hospital for non-clinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk enrollees and enrollees with multiple agency involvement);
 - (4) Develop and implement a plan that monitors and ensures that clinically indicated behavioral health services are offered and available to enrollees within seven (7) days of discharge from an inpatient setting;
 - (5) Ensure that a behavioral health program clinician provides medication management to enrollees requiring medication monitoring within seven (7) days of discharge from a behavioral health program inpatient setting. The Managed Care Plan shall ensure that the behavioral health program clinician is duly qualified and licensed to provide medication management; and
 - (6) Upon the admission of an enrollee, the Managed Care Plan shall make its best efforts to ensure the enrollee's smooth transition to the next service or to the community and shall require that behavioral health care providers:

- (a) Assign a mental health case manager to oversee the care given to the enrollee;
 - (b) Develop an individualized discharge plan, in collaboration with the enrollee where appropriate, for the next service or program or the enrollee's discharge, anticipating the enrollee's movement along a continuum of services; and
 - (c) Document all significant efforts related to these activities, including the enrollee's active participation in discharge planning.
- f. The Managed Care Plan and its QI plan shall demonstrate specific interventions in its behavioral health care coordination/case management to better manage behavioral health services and promote positive enrollee outcomes. The Managed Care Plan's written policies and procedures shall address components of effective behavioral health care coordination/case management including, but not limited to: anticipation, identification, monitoring, measurement, evaluation of enrollee's behavioral health needs, and effective action to promote quality of care; participation in the DCF planning process outlined in s. 394.75, F.S.; and the provision of enhanced care coordination and management for high-risk populations. Such populations shall include, at a minimum, enrollees that meet any of the following conditions:
- (1) Have resided in a state mental health facility for at least six (6) of the past thirty-six (36) months;
 - (2) Reside in the community and have had two (2) or more admissions to a state mental health facility in the past thirty-six (36) months;
 - (3) Reside in the community and have had three (3) or more admissions to a crisis stabilization unit, short-term treatment facility, inpatient psychiatric unit, or any combination of these facilities within the past twelve (12) months;
 - (4) Have been diagnosed with a behavioral health disorder in conjunction with a complex medical condition and have been prescribed numerous prescription medications; or
 - (5) Have been identified as exceeding the Managed Care Plan's prescription limits as permitted under Section V, Covered Services.

If an enrollee makes a request for behavioral health services to the Managed Care Plan, the Managed Care Plan shall provide the enrollee with the name (or names) of qualified behavioral health care providers, and if requested, assist the enrollee with making an appointment with the provider that is within the required access times indicated in Section VI, Provider Network.

The Managed Care Plan shall be responsible for the management and continuity of medical and behavioral health care for all enrollees.

- g. The Managed Care Plan shall ensure that appropriate resources are available to address the treatment of complex conditions that reflect both behavioral health and physical health involvement. The following conditions must be addressed:
- (1) Mental health disorders due to or involving a general medical condition; and
 - (2) Eating disorders.

The Managed Care Plan shall develop a plan of care that includes all appropriate collateral providers necessary to address the complex medical issues involved. Clinical care criteria shall address modalities of treatment that are effective for each diagnosis. The Managed Care Plan's provider network must include appropriate treatment resources necessary for effective treatment of each diagnosis within the required access time periods.

F. Quality Enhancements

The Managed Care Plan shall offer quality enhancements (QE) to enrollees as specified below:

1. Children's Programs

- a. The Managed Care Plan shall provide regular general wellness programs targeted specifically toward enrollees from birth to age of five (5), or the Managed Care Plan shall make a good faith effort to involve enrollees in existing community children's programs.
- b. Children's programs shall promote increased use of prevention and early intervention services for at-risk enrollees. The Managed Care Plan shall approve claims for services recommended by the Early Intervention Program when they are covered services and medically necessary.
- c. The Managed Care Plan shall offer its providers annual training that promote proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.

2. Domestic Violence

The Managed Care Plan shall ensure that PCPs screen enrollees for signs of domestic violence and shall offer referral services to applicable domestic violence prevention community agencies.

3. Pregnancy Prevention

The Managed Care Plan shall conduct regularly scheduled pregnancy prevention programs, or shall make a good faith effort to involve enrollees in existing community pregnancy prevention programs, such as the Abstinence Education Program. The programs shall be targeted towards teen enrollees, but shall be open to all enrollees, regardless of age, gender, pregnancy status or parental consent.

4. Prenatal/Postpartum Pregnancy Programs

The Managed Care Plan shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Managed Care Plan's prenatal and postpartum programs. The Managed Care Plan shall coordinate its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services.

5. Behavioral Health Programs

The Managed Care Plan shall provide outreach to homeless and other populations of enrollees at risk of justice system involvement, as well as those enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity shall be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system.

6. Other Programs and Services

The Managed Care Plan is encouraged to actively collaborate with community agencies and organizations, including CHDs, local Early Intervention Programs and local school districts in offering these services.

Section VI. Provider Network

A. Network Adequacy Standards

1. Network Capacity and Geographic Access Standards

Pursuant to s. 409.967(2)(c)(1), Managed Care Plans must maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. At a minimum, Managed Care Plans shall contract with the providers specified in the MMA Provider Network Standards Table (table) below. Managed Care Plans shall ensure regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the table.

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**Managed Medical Assistance
Provider Network Standards Table**

	Urban County		Rural County		Regional Provider Ratios
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Providers per Recipient
Primary Care Providers	30	20	30	20	1:1,500 enrollees
Specialists					
Adolescent Medicine	100	75	110	90	1:31,200 enrollees
Allergy	80	60	90	75	1:20,000 enrollees
Anesthesiology	n/a	n/a	n/a	n/a	1:1,500 enrollees
Cardiology	50	35	75	60	1:3,700 enrollees
Cardiology (PEDS)	100	75	110	90	1:16,667 enrollees
Cardiovascular Surgery	100	75	110	90	1:10,000 enrollees
Chiropractic	80	60	90	75	1:10,000 enrollees
Dermatology	60	45	75	60	1:7,900 enrollees
Endocrinology	100	75	110	90	1:25,000 enrollees
Endocrinology (PEDS)	100	75	110	90	1:20,000 enrollees
Gastroenterology	60	45	75	60	1:8,333 enrollees
General Dentist	50	35	75	60	1:1,500 enrollees
General Surgery	50	35	75	60	1:3,500 enrollees
Infectious Diseases	100	75	110	90	1:6,250 enrollees
Midwife	100	75	110	90	1:33,400 enrollees
Nephrology	80	60	90	75	1:11,100 enrollees
Nephrology (PEDS)	100	75	110	90	1:39,600 enrollees
Neurology	60	45	75	60	1:8,300 enrollees
Neurology (PEDS)	100	75	110	90	1:22,800 enrollees
Neurosurgery	100	75	110	90	1:10,000 enrollees
Obstetrics/Gynecology	50	35	75	60	1:1,500 enrollees
Oncology	80	60	90	75	1:5,200 enrollees
Ophthalmology	50	35	75	60	1:4,100 enrollees
Optometry	50	35	75	60	1:1,700 enrollees

**Managed Medical Assistance
Provider Network Standards Table**

	Urban County		Rural County		Regional Provider Ratios
	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	
Required Providers					Providers per Recipient
Oral Surgery	100	75	110	90	1:20,600 enrollees
Orthodontist	100	75	110	90	1:38,500 enrollees
Orthopaedic Surgery	50	35	75	60	1:5,000 enrollees
Otolaryngology	80	60	90	75	1:3,500 enrollees
Pathology	n/a	n/a	n/a	n/a	1:3,700 enrollees
Pediatrics	50	35	75	60	1:1,500 enrollees
Pharmacy	30	20	60	45	1:2,500 enrollees
24-hour Pharmacy	60	45	60	45	n/a
Podiatry	60	45	75	60	1:5,200
Pulmonology	60	45	75	60	1:7,600 enrollees
Rheumatology	100	75	110	90	1:14,400 enrollees
Therapist (Occupational)	50	35	75	60	1:1,500 enrollees
Therapist (Speech)	50	35	75	60	1:1,500 enrollees
Therapist (Physical)	50	35	75	60	1:1,500 enrollees
Therapist (Respiratory)	100	75	110	90	1:8,600 enrollees
Urology	60	45	75	60	1:10,000 enrollees
Facility/ Group/ Organization					
Hospitals (acute care)	30	20	30	20	1 bed: 275 enrollees
Hospital or Facility with Birth/Delivery Services	30	20	30	20	2: County
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	n/a	n/a	n/a	n/a	2: County
Adult Family Care Home	n/a	n/a	n/a	n/a	2: County
ALF	n/a	n/a	n/a	n/a	2: County
Birthing Center	n/a	n/a	n/a	n/a	1: County
Hospice	n/a	n/a	n/a	n/a	2: County

Managed Medical Assistance Provider Network Standards Table					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Providers per Recipient
DME/HME	n/a	n/a	n/a	n/a	As required in s. 409.975(1)(d), F.S.
Behavioral Health					
Board Certified or Board Eligible Adult Psychiatrists	30	20	60	45	1:1,500 enrollees
Board Certified or Board Eligible Child Psychiatrists	30	20	60	45	1:7,100 enrollees
Licensed Practitioners of the Healing Arts	30	20	60	45	1:1,500 enrollees
Licensed Community Substance Abuse Treatment Centers	30	20	60	45	2: county
Inpatient Substance Abuse Detoxification Units	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees

2. Primary Care Providers

- a. The Managed Care Plan shall enter into provider contracts with at least one (1) FTE PCP per one-thousand five-hundred (1,500) enrollees. The Managed Care Plan may increase the ratio by seven-hundred fifty (750) enrollees for each FTE advanced

registered nurse practitioner (ARNP) or physician's assistant (PA) affiliated with a PCP. The Managed Care plan shall have at least one (1) FTE PCP in each of the following four (4) specialty areas within the geographic access standards indicated above:

- (1) Family Practice;
- (2) General Practice;
- (3) Pediatrics; and
- (4) Internal Medicine.

b. The Managed Care Plan shall ensure the following:

- (1) The PCP provides, or arranges for coverage of services, consultation or approval for referrals twenty-four hours per day, seven days per week (24/7) by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage shall consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number;
- (2) The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage; and
- (3) Pregnant enrollees are allowed to choose Managed Care Plan obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

3. Primary Dental Providers

a. The Managed Care Plan shall enter into provider contracts with a sufficient number of Primary Dental Providers (PDPs) providing dental services to ensure adequate accessibility for enrollees of all ages. The Managed Care Plan shall ensure that PDPs provide services in accordance with this Contract and the Medicaid Dental Services Coverage and Limitations Handbooks.

b. The Managed Care Plan shall provide the following:

- (1) At least one (1) FTE PDP per service area including, but not limited to, the following broad specialty areas:
 - (a) General dentist; and
 - (b) Pediatric dentist.
- (2) At least one (1) FTE PDP per 1,500 enrollees. The Managed Care Plan may increase the ratio by 500 enrollees for each FTE licensed dental hygienist

affiliated with a PDP providing dental services. However, this increase is limited to two (2) FTE licensed dental hygienists per FTE dentist.

- c. The Managed Care Plan shall ensure that PDP services and referrals to participating specialists are available on a timely basis, as follows:
 - (1) Urgent Care — within one (1) day;
 - (2) Routine Sick Patient Care — within one (1) week;
 - (3) Well Care Visit — within one (1) month; and
 - (4) Follow-up dental services — within one (1) month after assessment.

4. Specialists and Other Providers

- a. The Managed Care Plan shall enter into provider contracts with a sufficient number of specialists to ensure adequate accessibility for enrollees of all ages. The Managed Care Plan shall ensure the following:
 - (1) At least one (1) of the network infectious disease specialists have expertise in HIV/AIDS and its treatment and care;
 - (2) Female enrollees have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist; and
 - (3) In accordance with s. 641.31, F.S., low-risk enrollees have access to certified nurse midwife services or licensed midwife services, licensed in accordance with Chapter 467, F.S.
- b. For pediatric specialists not listed the Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at a location or via a PCP within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code. Alternatively, for pediatric specialists not listed in the Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.
- c. The Managed Care Plan shall ensure the availability of providers in the following dental specialty areas, as appropriate for both adults and pediatric enrollees, on at least a referral basis. The Managed Care Plan shall use participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (for example a pediatric endodontist). Specialties below marked with an asterisk (*) require the Managed Care Plan to assure the availability of both adult and pediatric participating providers.

- (1) Endodontics;
 - (2) Oral and maxillofacial surgery*;
 - (3) Orthodontics;
 - (4) Periodontics; and
 - (5) Prosthodontics*.
- d. The Managed Care Plan shall determine when exceptional referrals to non-participating specialty-qualified providers are needed to address any unique dental needs of an enrollee (for example, when an enrollee's dental condition requires the placement of a maxillofacial prosthesis for the correction of an anatomical deficiency). Financial arrangements for the provision of such services shall be agreed to prior to the provision of services. The Managed Care Plan shall develop and maintain policies and procedures for such referrals.

5. Public Health Providers

- a. The Managed Care Plan shall make a good faith effort to execute memoranda of agreement with the local County Health Departments (CHDs) to provide services which may include, but are not limited to, family planning services, services for the treatment of sexually transmitted diseases, other public health related diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and services related to Healthy Start prenatal and post-natal screenings. The Managed Care Plan shall provide documentation of its good faith effort upon the Agency's request.
- b. The Managed Care Plan shall pay, without prior authorization, at the contracted rate or the Medicaid fee-for-service rate, all valid claims initiated by any CHD for office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis. The Managed Care Plan shall reimburse the CHD when the CHD notifies the Managed Care Plan and provides the Managed Care Plan with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.
- c. The Managed Care Plan shall authorize all claims from a CHD, a migrant health center funded under Section 329 of the Public Health Services Act or a community health center funded under Section 330 of the Public Health Services Act, without prior authorization for the services listed below. Such providers shall attempt to contact the Managed Care Plan before providing health care services to enrollees and shall provide the Managed Care Plan with the results of the office visit, including test results. The Managed Care Plan shall not deny claims for services delivered by these providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred sixty-five (365) days, and shall be reimbursed by the Managed Care Plan at the rate negotiated between the Managed Care Plan and the public provider or the applicable Medicaid fee-for-service rate. The Medicaid FFS rate is the standard Medicaid fee schedule

rate or the CHD cost-based rate as specified by the County Health Department Clinic Services Coverage and Limitations Handbook for applicable rates.

- (1) The diagnosis and treatment of sexually transmitted diseases and other reportable infectious diseases, such as tuberculosis and HIV;
 - (2) The provision of immunizations;
 - (3) Family planning services and related pharmaceuticals;
 - (4) School health services listed in a, b and c above, and for services rendered on an urgent basis by such providers; and
 - (5) In the event that a vaccine-preventable disease emergency is declared, the Managed Care Plan shall authorize claims from the CHD for the cost of the administration of vaccines.
- d. Other clinic-based services provided by a CHD, migrant health center or community health center, including well-child care, dental care, and sick care services not associated with reportable infectious diseases, require prior authorization from the Managed Care Plan in order to receive reimbursement. If prior authorization is provided, the Managed Care Plan shall reimburse at the entity's cost-based reimbursement rate. If prior authorization for prescription drugs is given and the drugs are provided, the Managed Care Plan shall reimburse the entity at Medicaid's standard pharmacy rate.
- e. The Managed Care Plan shall make a good faith effort to execute a contract with a Rural Health Clinic (RHC).
- f. The Managed Care Plan shall reimburse FQHCs and RHCs at rates comparable to those rates paid for similar services in the FQHC's or RHC's community.
- g. The Managed Care Plan shall report quarterly to the Agency as part of its quarterly financial reports (as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide), the payment rates and the payment amounts made to FQHCs and RHCs for contractual services provided by these entities.
- h. The Managed Care Plan shall make a good faith effort to execute memoranda of agreement with school districts participating in the certified match program regarding the coordinated provision of school-based services pursuant to ss. 1011.70, 409.9071, F.S. and 409.908(21), F.S.

6. Facilities and Ancillary Providers

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

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

- b. Network facilities are licensed, as required by law and rule, accessible to the handicapped, in compliance with federal Americans with Disabilities Act guidelines, and have adequate space, supplies, good sanitation, and fire, safety, and disaster preparedness and recovery procedures in operation;
- c. Care for medically high-risk perinatal enrollees is provided in a facility with a NICU sufficient to meet the appropriate level of need for the enrollee;
- d. Pursuant to s. 409.967(2)(c)1, F.S., the Managed Care Plan may use mail-order pharmacies; however mail-order pharmacies shall not count towards the Managed Care Plan's pharmacy network access standards; and
- e. In accordance with s. 409. 975(1)(d), F.S., a provider contract is offered to each licensed home medical equipment and supplies provider and to each Medicaid enrolled durable medical equipment (DME) provider in the region, as specified by the Agency, that meets quality and fraud prevention and detection standards established by the Managed Care Plan and that agrees to accept the lowest price previously negotiated between the Managed Care Plan and another such provider.
- f. The Managed Care Plan's provider network includes:
 - (1) Independent laboratories to conduct medically necessary clinical laboratory procedures in freestanding facilities;
 - (2) Freestanding dialysis centers to conduct medically necessary hemodialysis and peritoneal dialysis performed in the center and related injectable medications, including Erythropoietin (Epogen or EPO) administered in the freestanding dialysis center;
 - (3) Portable x-ray providers to provide diagnostic x-ray services at the residence of an enrollee who is unable to travel to a physician's office or an outpatient hospital's radiology facility;
 - (4) Ambulatory surgical centers to provide scheduled, elective, medically necessary surgical care to patients who do not require hospitalization; and
 - (5) Audiologists to provide medically necessary hearing related services.

7. Essential Providers

- a. Pursuant to s. 409.975(1)(b), F.S., certain providers are statewide resources and essential providers for all managed care plans in all regions. The Managed Care Plan shall include these essential providers in its network, even if the provider is located outside of the region served by the Managed Care Plan.
- b. Statewide essential providers include:
 - (1) Faculty plans of Florida medical schools, which include University of Florida College of Medicine, University of Miami School of Medicine, University of South Florida College of Medicine, University of Central Florida College of Medicine, Nova Southeastern University College of Osteopathic Medicine,

Florida State University College of Medicine, and Florida International University College of Medicine;

- (2) Regional perinatal intensive care centers (RPICCs) as defined in s. 383.16(2), F.S., including All Children's Hospital, Arnold Palmer Hospital, Bayfront Medical Center, Broward General Medical Center, Jackson Memorial Hospital, Lee Memorial Hospital at HealthPark, Memorial Regional Hospital, Sacred Heart Hospital, Shands – Jacksonville, Shands Teaching Hospital, St. Mary's Hospital and Tampa General Hospital;
 - (3) Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28), F.S., including All Children's Hospital, Miami Children's Hospital, Nemours; and Shriners Hospitals for Children; and
 - (4) Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.
- c. If the Managed Care Plan has not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment, the Managed Care Plan must continue to negotiate in good faith.
- (1) The Managed Care Plan shall make payments to physicians on the faculty of non-participating Florida medical schools at the applicable Medicaid rate.
 - (2) The Managed Care Plan shall make payments for services rendered by a regional perinatal intensive care center at the applicable Medicaid rate as of the first day of this Contract.
 - (3) The Managed Care Plan shall make payments to a non-participating specialty children's hospital equal to the highest rate established by contract between that provider and any other Medicaid managed care plan.
- d. Pursuant to s. 409.975(1)(c), F.S., after twelve (12) months of active participation in the Managed Care Plan's network, the Managed Care Plan may exclude any essential provider from the network for failure to meet quality or performance criteria.
- e. Pursuant to s. 409.975(1)(a), F.S., the Managed Care Plan must include all providers in the region that are classified by the Agency as essential Medicaid providers, unless the Agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers.
- f. The Agency may determine that the following providers are essential Medicaid providers:
- (1) Federally qualified health centers;
 - (2) Statutory teaching hospitals as defined in s. 408.07(45), F.S.;

- (3) Hospitals that are trauma centers as defined in s. 395.4001(14), F.S.; and
- (4) Hospitals located at least twenty-five (25) miles from any other hospital with similar services.

8. Timely Access Standards

- a. The Managed Care Plan must assure that PCP services and referrals to specialists for medical and behavioral health services are available on a timely basis, as follows:
 - (1) Urgent Care — within one (1) day of the request;
 - (2) Sick Care — within one (1) week of the request; and
 - (3) Well Care Visit — within one (1) month of the request.
- b. Annually the Managed Care Plan shall review a statistically valid sample of PCP and specialist offices' average appointment wait times to ensure services are in compliance with this subsection, and report the results to the Agency as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. (See 42 CFR 438.206(c)(1)(iv),(v) and (vi).)

9. Network Adequacy Measures

- a. The Managed Care Plan shall collect regional data on the following measures in order to evaluate the Managed Care Plan's provider network and to ensure that covered services are reasonably accessible.
- b. The Managed Care Plan shall comply with the regional standards for each measure as specified in the Provider Network Adequacy Standards Table below.
- c. The Managed Care Plan shall submit the results of the network adequacy standards specified in the table below to the Agency quarterly as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.
- d. The Agency reserves the right to require Managed Care Plans to collect data and report results on additional network adequacy standards.

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Provider Network Adequacy Measures Table												
Measure	Standard	Region										
		1	2	3	4	5	6	7	8	9	10	11
The Managed Care Plan agrees that at least ___ percent of required participating primary care providers (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit II-A), by region, are accepting new Medicaid enrollees.		90	85	90	85	85	90	85	90	85	85	85
The Managed Care Plan agrees that at least ___ percent of required participating specialist providers, (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit II-A), by region, are accepting new Medicaid enrollees.		90	90	85	90	90	90	90	90	90	90	90
The Managed Care Plan agrees that at least ___ percent of required participating primary care providers (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit II-A), by region, offer after hours appointment availability to Medicaid enrollees.		30	40	35	40	35	35	40	30	40	40	40
The Managed Care Plan agrees that no more than ___ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in Subsection VII. H., Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.		5	5	8	5	3	5	5	5	5	10	8
The Managed Care Plan agrees that no more than ___ percent of enrollee specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in Subsection VII. H., Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.		8	10	10	10	8	8	8	8	10	10	8

10. Electronic Health Record Measures

- a. The Managed Care Plan shall collect regional data on the regional standards specified in the Electronic Health records Standards Table below in order to evaluate the Managed Care Plan’s provider’s EHR capabilities.
- b. The Managed Care Plan shall comply with the regional standards specified in the Electronic Health Record Standards Table below.
- c. The Managed Care Plan shall submit the results of the electronic health record standards specified below to the Agency quarterly as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.

- d. The Agency reserves the right to require Managed Care Plans to collect data and report results on additional network adequacy standards.

Electronic Health Records Standards Table												
Measure	Standard	Region										
		1	2	3	4	5	6	7	8	9	10	11
By the end of the second Contract year, the Managed Care Plan agrees at least ___ percent of eligible professionals and hospitals, as defined under the HITECH Act, are: (1) Using certified electronic health records in a meaningful manner; (2) Using certified electronic health exchange of health information to improve quality of health care; and, (3) Using certified electronic health record technology to submit clinical quality measures and other such measures selected by the Secretary of DHHS under the HITECH Act.		55	55	60	65	50	60	60	50	60	50	45
By the end of the second Contract year, the Managed Care Plan agrees at least ___ percent of enrollees are assigned to primary care providers meeting meaningful use requirements defined above.		65	65	65	75	70	75	70	70	70	70	70

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B. Network Development and Management Plan

1. Regional Network Changes

- a. The Managed Care Plan shall notify the Agency within seven (7) business days of any significant changes to its regional provider network. A significant change is defined as follows:
 - (1) Any change that would cause more than five percent (5%) of enrollees in the region to change the location where services are received or rendered; or
 - (2) For MMA Managed Care Plans, a decrease in the total number of PCPs by more than five percent (5%).

C. Provider Credentialing and Contracting

1. Credentialing and Recredentialing

- a. Managed Care Plan credentialing and recredentialing processes must include verification of the following additional requirements for physicians and must ensure compliance with 42 CFR 438.214.
 - (1) Good standing of privileges at the hospital designated as the primary admitting facility by the physician or if the physician does not have admitting privileges, good standing of privileges at the hospital by another provider with whom the physician has entered into an arrangement for hospital coverage.
 - (2) Valid Drug Enforcement Administration (DEA) certificates, where applicable.
 - (3) Attestation that the total active patient load (all populations, including but not limited to, Medicaid FFS; Children's Medical Services Network; SMMC plans; Medicare; KidCare and commercial coverage) is no more than three-thousand (3,000) patients per PCP. An active patient is one that is seen by the provider a minimum of three (3) times per year.
 - (4) A good standing report on a site visit survey. For each PCP, documentation in the Managed Care Plan's credentialing files regarding the site survey shall include the following:
 - (a) Evidence that the Managed Care Plan has evaluated the provider's facilities using the Managed Care Plan's organizational standards;
 - (b) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place;
 - (c) Evidence that the Managed Care Plan has evaluated the provider's medical/case record keeping practices at each site to ensure conformity with the Managed Care Plan's organizational standards; and

- (d) Evidence that the Managed Care Plan has determined that the following documents are posted in the provider's waiting room/reception area: the Agency's statewide consumer call center telephone number, including hours of operation, and a copy of the summary of Florida's Patient's Bill of Rights and Responsibilities, in accordance with s. 381.026, F.S. The provider must have a complete copy of the Florida Patient's Bill of Rights and Responsibilities, available upon request by an enrollee, at each of the provider's offices.
- (5) Attestation to the correctness/completeness of the provider's application.
- (6) Statement regarding any history of loss or limitation of privileges or disciplinary activity as described in s. 456.039, F.S.
- (7) A statement from each provider applicant regarding the following:
 - (a) Any physical or behavioral health problems that may affect the provider's ability to provide health care;
 - (b) Any history of chemical dependency/substance abuse;
 - (c) Any history of loss of license and/or felony convictions; and
 - (d) The provider is eligible to become a Medicaid provider.
- (8) Current curriculum vitae, which includes at least five (5) years of work history.
- (9) Proof of the provider's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training, if applicable.
- (10) Evidence of specialty board certification, if applicable.
- b. The Managed Care Plan shall recredential its providers at least every three (3) years using information from ongoing provider monitoring.
- c. Hospital ancillary providers are not required to be independently credentialed if those providers serve Managed Care Plan enrollees only through the hospital.

2. Provider Contract Requirements

- a. The Managed Care Plan shall include the following additional provisions in its MMA provider contracts:
 - (1) If there is a Managed Care Plan physician incentive plan, include a statement that the Managed Care Plan shall make no specific payment directly or indirectly under a physician incentive plan to a provider as an inducement to reduce or limit, medically necessary services to an enrollee, and that incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care;

- (2) Require providers to meet timely access standards pursuant to this Contract;
- (3) Require that all providers agreeing to participate in the network as PCPs fully accept and agree to responsibilities and duties associated with the PCP designation;
- (4) Contain no provision that prohibits the provider from providing inpatient services in a participating hospital to an enrollee if such services are determined to be medically necessary and covered services under this Contract;
- (5) For hospital contracts, include rates that are in accordance with s. 409.975(6), F.S.;
- (6) For hospital contracts, include a clause that states whether the Managed Care Plan or the hospital will complete the DCF Excel spreadsheet for unborn activation and include Provider-Preventable Conditions (PPC) reporting requirements as specified in Section V, Covered Services;
- (7) If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount, less any applicable copayments; and
- (8) If the provider has been approved by the Managed Care Plan to provide services through telemedicine, specify that the provider is required to have protocols to prevent fraud and abuse. The provider must implement telemedicine fraud and abuse protocols that address:
 - (a) Authentication and authorization of users;
 - (b) Authentication of the origin of the information;
 - (c) The prevention of unauthorized access to the system or information;
 - (d) System security, including the integrity of information that is collected, program integrity and system integrity; and
 - (e) Maintenance of documentation about system and information usage.

D. Provider Services

1. Additional Provider Handbook Requirements

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

- a. Child Health Check-Up program services and standards;
- b. PCP responsibilities;

- c. Information on the Managed Care Plan’s Healthy Behaviors programs;
- d. If Managed Care Plan allows the use of telemedicine, telemedicine requirements for providers; and
- e. If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount, less any applicable copayments.

E. Medical/Case Record Requirements

1. Standards for Medical/Case Records

- a. All records shall contain documentation to include the following items for services provided through telemedicine:
 - (1) A brief explanation of the use of telemedicine in each progress note;
 - (2) Documentation of telemedicine equipment used for the particular covered services provided;
 - (3) A signed statement from the enrollee or the enrollee’s representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided; and
 - (4) For telepsychiatry, the results of the assessment, findings and practitioner(s) plan for next steps.

Section VII. Quality and Utilization Management

A. Quality Improvement

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

B. Performance Measures (PMs)

The Managed Care Plan shall collect and report the following performance measures, certified via qualified auditor.

HEDIS	
1	Adolescent Well Care Visits - (AWC)
2	Adults' Access to Preventive/Ambulatory Health Services - (AAP)
3	Annual Dental Visits - (ADV)

HEDIS	
4	Antidepressant Medication Management - (AMM)
5	BMI Assessment – (ABA)
6	Breast Cancer Screening – (BCS)
7	Cervical Cancer Screening – (CCS)
8	Childhood Immunization Status – (CIS) – Combo 2 and 3
9	Comprehensive Diabetes Care – (CDC) <ul style="list-style-type: none"> · Hemoglobin A1c (HbA1c) testing · HbA1c poor control · HbA1c control (<8%) · Eye exam (retinal) performed · LDL-C screening · LDL-C control (<100 mg/dL) · Medical attention for nephropathy
10	Controlling High Blood Pressure – (CBP)
11	Follow-up Care for Children Prescribed ADHD Medication – (ADD)
12	Immunizations for Adolescents – (IMA)
13	Chlamydia Screening for Women – (CHL)
14	Prenatal and Postpartum Care – (PPC)
15	Use of Appropriate Medications for People With Asthma – (ASM)
167	Well-Child Visits in the First 15 Months of Life – (W15)
17	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34)
18	Children and Adolescents' Access to Primary Care - (CAP)
19	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
20	Ambulatory Care - (AMB)
21	Lead Screening in Children – (LSC)
22	Annual Monitoring for Patients on Persistent Medications (MPM)

HEDIS	
23	Plan All-Cause Readmissions (PCR)
Agency-Defined	
1	Mental Health Readmission Rate – (RER)
2	Transportation Timeliness (TRT)
3	Transportation Availability (TRA)
HEDIS & Agency-Defined	
1	Follow-Up after Hospitalization for Mental Illness – (FHM)
2	Prenatal Care Frequency (PCF)
Health Resources and Services Administration – HIV/AIDS Bureau	
1	CD4 Cell Count (CD4)
2	Viral Load Monitoring (VLM)
3	Antiretroviral Therapy (ART)
4	Viral Load Suppression (VLS)
CHIPRA Child Core Set/Child Health Check-Up Report (CMS-416)	
1	Preventive Dental Services (PDENT)
2	Dental Treatment Services (TDENT)
3	Sealants (SEA)
CMS Adult Medicaid Core Set/Joint Commission	
1	Antenatal Steroids (ANT)
CAHPS Health Plan Survey	
1	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)

The first Performance Measure Report is due to the Agency no later than July 1, 2015, covering the measurement period of calendar year 2014. Measures should be collected based on the technical specifications for the measure, across the Statewide Medicaid Managed Care (SMMC) contract and the previous Health Plan contract, as applicable. For example, if someone has been in XYZ Managed Care Plan for six months under the SMMC contract and for six months under the previous managed care/health plan contract, the enrollee would meet the 12 months of continuous enrollment required for many performance measures. Due to calendar year 2014 being a transition year across contracts, performance measures will be collected and may be reported publicly by the Agency, but will be labeled as “transition year” measures and will not be subject to liquidated damages and sanctions related to where performance measure results fall relative to the National Medicaid Means and Percentiles (as published by the National

Committee for Quality Assurance). Liquidated damages and sanctions due to incomplete and/or inaccurate reporting will be in effect.

Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2016, covering the measurement period of calendar year 2015, all performance measure-related liquidated damages and sanctions will be in effect.

C. Performance Improvement Projects

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

1. One (1) of the PIPs shall combine a focus on improving prenatal care and well-child visits in the first fifteen (15) months;
2. One (1) of the PIPs shall focus on preventive dental care for children;
3. One (1) of the PIPs shall be an administrative PIP focusing on a topic prior approved by the Agency; and
4. One (1) PIP shall be a choice of PIP in one of the following topic areas: population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that have been identified as in need of improvement; integrating primary care and behavioral health; and reducing preventable readmissions.
5. The PIPs identified in 1. and 2. above will be collaborative PIPs coordinated by the External Quality Review Organization (EQRO). The EQRO will put together proposed methodologies for the collaborative PIPs, which will be sent to the managed care plans for review. Once the proposed methodologies for the collaborative PIPs have been sent to the managed care plans, the Managed Care Plan has two (2) weeks to submit feedback to the Agency and the EQRO on the methodologies.
6. By April 15, 2014, the Managed Care Plan shall submit to the Agency, in writing:
 - a. The Managed Care Plan's proposed administrative PIP topic and its indicator(s);
 - b. The Managed Care Plan's proposed PIP topic and its indicator(s) from one of the following topic areas: population health issues within a specific geographic area that have been identified as in need of improvement; integrating primary care and behavioral health; and reducing preventable readmissions; and
 - c. A brief summary of the baseline data that the Managed Care Plan will use for each indicator for each of the proposed PIPs.
7. The Managed Care Plan shall submit to the Agency in writing, a proposal for each planned PIP by August 1, 2014. The proposal must meet the requirements provided in **Attachment II**, Core Contract Provisions, Section VII, Quality Improvement, sub-item C.2.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

- a. The Managed Care Plan shall conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for a time period specified by the Agency, using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey - Medicaid Survey 5.0.
- b. In addition to the core survey, the Managed Care Plan shall include items MH1 through MH4 (related to Behavioral Health) and H.17 through H.20 (related to medical assistance with smoking and tobacco use cessation) from the CAHPS Health Plan Survey – Supplemental Items for the Adult Questionnaires.
- c. The Managed Care Plan shall submit to the Agency, in writing within ninety (90) calendar days of initial contract execution, a proposal for survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a CAHPS survey vendor; sampling methodology; administration protocol; analysis plan; and reporting description.
- d. The Managed Care Plans shall report CAHPS survey results to the Agency with an action plan to address the results of the CAHPS survey by July 1 of each Contract year. (See Section XIV, Reporting Requirements.)
- e. 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 identified in the annual CAHPS survey.
- f. The Managed Care Plan shall use the results of the annual CAHPS survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities conducted by the Managed Care Plan pertaining to improving member satisfaction resulting from the annual member satisfaction survey must be reported to the Agency on a quarterly basis.

E. Provider-Specific Performance Monitoring

1. Medical/Case Record Review

- a. The Managed Care Plan shall conduct medical/case record reviews of all PCP sites that serve ten (10) or more enrollees. Practice sites include individual offices, clinics, multi-provider practices and facilities at least once every three (3) years.
 - (1) 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.

F. Other Quality Management Requirements

MMA Managed Care Plans and Comprehensive LTC Managed Care Plans shall develop a reporting and management system for critical and adverse incidents that occur in all service delivery settings applicable to enrollees with MMA benefits only.

G. Utilization Management

There are no additional utilization management contract provisions unique to the MMA managed care program.

H. Continuity of Care in Enrollment

There are no additional continuity of care in enrollment contract provisions unique to the MMA managed care program.

Section VIII. Administration and Management

A. Organizational Governance and Staffing

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

B. Subcontracts

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

C. Information Management and Systems

There are no additional information management and systems provisions unique to the MMA managed care program.

D. Claims and Provider Payment

There are no additional claims and provider payment provisions unique to the MMA managed care program.

E. Encounter Data Requirements

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

F. Fraud and Abuse Prevention

There are no additional fraud and abuse prevention provisions unique to the MMA managed care program.

Section IX. Method of Payment

A. Fixed Price Unit Contract

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

B. Payment Provisions

1. The Agency shall pay the Managed Care Plan one kick payment for each heart, liver and lung transplant covered for enrollees who are not also eligible for Medicare.
2. The Agency shall make kick payments for heart, liver and lung transplants in the amounts specified in the resulting Contract.
3. To receive a kick payment for a heart, liver and/or lung transplant, the Managed Care Plan must adhere to the specific requirements listed in subsection 4. below and adhere to the following requirements:
 - a. The Managed Care Plan must have provided the covered transplant while the recipient was enrolled in the Managed Care Plan; and
 - b. The Managed Care Plan shall submit any required documentation to the Agency upon its request in order to receive the transplant kick payment.
4. In addition to subsection 3. above, to receive a kick payment for covered transplants provided to an enrollee without Medicare, the Managed Care Plan shall comply with the following requirements:
 - a. For each transplant provided, the Managed Care Plan shall submit an accurate and complete CMS-1500 claim form (CMS-1500) to the fiscal agent within the required Medicaid FFS claims submittal timeframes;
 - b. The Managed Care Plan shall list itself as both the pay-to and the treating provider on the CMS-1500; and
 - c. The Managed Care Plan shall use the following table: Kick Payment Rates for Covered Transplant Services, Effective Date: May 1, 2014, that includes transplant procedure codes relative to the type of transplant performed when completing Field 24 D on the CMS-1500.

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**KICK PAYMENT RATES FOR COVERED TRANSPLANT SERVICES;
NOT FOR USE UNLESS APPROVED BY CMS.
EFFECTIVE DATE: May 1, 2014**

CPT Code	Transplant CPT Code Description	Children/Adolescents or Adult	All Areas
32851	Lung single, without bypass	Children/Adolescents	\$320,800.00
32851	Lung single, without bypass	Adult	\$238,000.00
32852	Lung single, with bypass	Children/Adolescents	\$320,800.00
32852	Lung single, with bypass	Adult	\$238,000.00
32853	Lung double, without bypass	Children/Adolescents	\$320,800.00
32853	Lung double, without bypass	Adult	\$238,000.00
32854	Lung double, with bypass	Children/Adolescents	\$320,800.00
32854	Lung double, with bypass	Adult	\$238,000.00
33945	Heart transplant with or without recipient cardiectomy	All Age Groups	\$162,000.00
47135	Liver, allotransplantation, orthotopic, partial or whole from cadaver or living donor	All Age Groups	\$122,600.00
47136	Liver, heterotopic, partial or whole from cadaver or living donor any age	All Age Groups	\$122,600.00

- The Agency shall make kick payments to the Managed Care Plan for Sovaldi or Sovaldi/Olysio therapy for treatment of Hepatitis C in the amounts indicated in the Kick Payment Rates for Covered Hepatitis C Treatment Services table below, Effective Date: May 1, 2014.

**KICK PAYMENT RATES FOR COVERED HEPATITIS C TREATMENT SERVICES;
NOT FOR USE UNLESS APPROVED BY CMS.
EFFECTIVE DATE: May 1, 2014**

Prior Authorization Period	All Regions
4-Week	\$34,972.00
8-Week	\$69,943.00
12-Week	\$104,915.00

- Payment is triggered if a member in a capitated plan is authorized for hepatitis C treatment that includes Olysio or Sovaldi.
- The kick payment is the same amount by authorization duration regardless of the type of treatment that is included.
- Each additional payment is triggered when the member is authorized and continues the treatment.

- a. To receive a kick payment for Sovaldi or Sovaldi/Olysio therapy for treatment of Hepatitis C, the Managed Care Plan shall follow the prior authorization (PA) criteria specified by the Agency.
- b. The Managed Care Plan may request kick payment(s) for any authorized Sovaldi or Sovaldi/Olysio therapies dated May 1, 2014, and later.
- c. The Managed Care Plan records documenting each PA are subject to review by the Agency upon request.

6. Health Insurance Providers Fee

a. 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:

- (1) 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.
- (2) 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.
- (3) 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.
- (4) 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.

b. Health Insurance Providers Fee Methodology

- (1) 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.

- (2) 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	

- c. An actuarially sound approach will be developed to calculate the amount of federal and state income tax related to the Health Insurance Providers Fee.
7. Upon receipt of acceptable quarterly reports of utilization and encounter data for physicians eligible for the ACA primary care physician payment increase, the Agency shall pay the Managed Care Plan a supplemental payment for eligible services provided between January 1, 2013 and December 31, 2014. This payment will be based on the Agency's approved Managed Care Plan payment methodology from CMS.
- a. The Agency shall notify the Managed Care Plan of the supplemental payment being made.
- b. Such payment shall be made through the Medicaid fiscal agent. The Managed Care Plan shall address errors found regarding such reports in accordance with Section XIII.F.

8. The Managed Care Plan shall submit enrollees identified with an HIV/AIDS diagnosis to the Agency in a report format and transmittal method approved by the Agency and as specified in the Agency's Managed Care Plan Report Guide. See Attachment II, Section XIV, Reporting Requirements, of this Contract.

Section X. Financial Requirements

A. Insolvency Protection

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

B. Surplus

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

C. Interest

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

D. Third Party Resources

There are no additional third party resources provisions unique to the MMA managed care program.

E. Assignment

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

F. Financial Reporting

1. Medical Loss Ratio

- a. The Managed Care Plan shall maintain an annual (January 1 – December 31) medical loss ratio (MLR) of a minimum of eighty-five percent (85%) for the first full year of MMA program operation, beginning January 1, 2015.
- b. The Agency will calculate the MLR in a manner consistent with 45 CFR Part 158 and s. 409.9122(21)(b) and (c), F.S. To demonstrate ongoing compliance, the Managed Care Plan shall complete and submit appropriate financial reports, as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. The Agency will provide additional guidance to Comprehensive LTC managed care plans within the Managed Care Plan Report Guide, as appropriate, to ensure that the Managed Care Plan adheres to all relevant Federal requirements .
- c. The federal Centers for Medicare & Medicaid Services, will determine the corrective action for non-compliance with this requirement.

G. Inspection and Audit of Financial Records

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

Section XI. Sanctions

A. Contract Violations and Non-Compliance

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

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

There are no PMAP and/or CAP contract provisions unique to the MMA managed care program.

C. Performance Measure Sanctions

1. The Agency may sanction the Managed Care Plan for failure to achieve minimum scores on HEDIS performance measures after the first year of poor performance. The Agency may impose monetary sanctions as described below in the event that the plan's performance is not consistent with the Agency's expected minimum standards, as specified in this subsection.
2. The Agency shall assign performance measures a point value that correlates to the National Committee for Quality Assurance HEDIS National Means and Percentiles for Medicaid plans. The scores will be assigned according to the table below. Individual performance measures will be grouped and the scores averaged within each group.

PM Ranking	Score
>= 90th percentile	6
75th – 89th percentile	5
60th – 74th percentile	4
50th – 59th percentile	3
25th-49th percentile	2
10th – 24th percentile	1
< 10th percentile	0

3. The Agency may require the Managed Care Plan to complete a Performance Measure Action Plan (PMAP) after the first year of poor performance.
4. The Managed Care Plan may receive a monetary sanction of up to \$10,000 for each performance measure group where the group score is below three (3). Performance measure groups are as follows:
 - a. Mental Health and Substance Abuse
 - (1) Antidepressant Medication Management
 - (2) Follow-up Care for Children Prescribed ADHD Medication
 - (3) Follow-up after Hospitalization for Mental Illness (7 day)

- (4) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- b. Well-Child
 - (1) Adolescent Well Care Visits
 - (2) Childhood Immunization Status – Combo 3
 - (3) Immunizations for Adolescents
 - (4) Well-Child Visits in the First 15 Months of Life (6 or more)
 - (5) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
 - (6) Lead Screening in Children
- c. Other Preventive Care
 - (1) Adults' Access to Preventive/Ambulatory Health Services
 - (2) Annual Dental Visits
 - (3) BMI Assessment
 - (4) Breast Cancer Screening
 - (5) Cervical Cancer Screening
 - (6) Children and Adolescents' Access to Primary Care
 - (7) Chlamydia Screening for Women
- d. Prenatal/Perinatal
 - (1) Prenatal and Postpartum Care (includes two (2) measures)
 - (2) Prenatal Care Frequency
- e. Diabetes – Comprehensive Diabetes Care measure components
 - (1) HbA1c Testing
 - (2) HbA1c Control (< 8%)

- (3) Eye Exam
 - (4) LDL-C Screening
 - (5) LDL-C Control
 - (6) Medical Attention for Nephropathy
- f. Other Chronic and Acute Care
- (1) Controlling High Blood Pressure
 - (2) Pharyngitis – Appropriate Testing related to Antibiotic Dispensing
 - (3) Use of Appropriate Medications for People with Asthma
 - (4) Annual Monitoring for Patients on Persistent Medications

The Agency may amend the performance measure groups with sixty (60) days' advance notice.

D. Other Sanctions

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

E. Notice of Sanctions

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

F. Dispute of Sanctions

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

Section XII. Special Terms and Conditions

The Special Terms and Conditions in Section XII, Special Terms and Conditions apply to all MMA Managed Care Plans and Comprehensive LTC Managed Care Plans unless specifically noted otherwise in this Exhibit.

Section XIII. Liquidated Damages

A. Damages

Additional damages issues and amounts unique to the MMA managed care program are specified below.

B. Issues and Amounts

If the Managed Care Plan fails to perform any of the services set forth in the Contract, the Agency may assess liquidated damages for each occurrence listed in the MMA Issues and Amounts Table below.

Liquidated Damages Issues and Amounts		
#	MMA PROGRAM ISSUES	DAMAGES
1.	Failure to obtain and/or maintain managed behavioral health organization (MBHO) national accreditation as described in the Contract.	\$500 per day for every calendar day beyond the day accreditation status must be in place.
2.	Failure to comply with the medical/case records documentation requirements pursuant to the Contract.	\$500 per enrollee file (medical/case) that does not include all of the required elements.
3.	Failure to have a face-to-face contact between the case manager and/or behavioral health provider, if applicable, and each enrollee as described in the Contract.	\$5,000 for each occurrence.
4.	Failure to comply with the federal and/or state CHCUP eighty percent (80%) screening rate and/or federal eighty percent (80%) CHCUP participation rate requirements described the Contract.	\$50,000 per occurrence in addition to \$10,000 for each percentage point less than the target.

Liquidated Damages Issues and Amounts		
#	MMA PROGRAM ISSUES	DAMAGES
5.	Failure to comply with the preventive dental services rate requirement of at least twenty-eight percent (28%), described in the Contract.	\$50,000 per occurrence in addition to \$10,000 for each percentage point less than the target.
6.	Failure to accurately report utilization and encounter data for physicians that are eligible for the ACA primary care physician fee increase as described in the Contract.	\$5,000 per occurrence.
7.	Failure to timely report utilization and encounter data for physicians that are eligible for the ACA primary care physician fee increase as described in the Contract.	\$1,000 per day.
8.	The Managed Care Plan receives a score of lower than three (3) on the mental health and substance abuse performance measure group, as described in the Contract.	\$10,000 for the performance measure group.
9.	The Managed Care Plan receives a score of lower than three (3) on the well-child performance measure group, as described in the Contract.	\$10,000 for the performance measure group.
10.	The Managed Care Plan receives a score of lower than three (3) on the other preventive care performance measure group, as described in the Contract.	\$10,000 for the performance measure group.
11.	The Managed Care Plan receives a score of lower than three (3) on the prenatal-postpartum performance measure group, as described in the Contract.	\$10,000 for the performance measure group.

Liquidated Damages Issues and Amounts		
#	MMA PROGRAM ISSUES	DAMAGES
12.	The Managed Care Plan receives a score lower than three (3) on the diabetes performance measure group, as described the Contract.	\$10,000 for the performance measure group.
13.	The Managed Care Plan receives a score of lower than three (3) on the chronic care performance measure group, as described in the Contract.	\$10,000 for the performance measure group.
14.	<p>The Managed Care Plan receives a score of zero (0) on one or more of the following individual measures:</p> <p>(1) Follow-Up after Hospitalization for Mental Illness (7 day)</p> <p>(2) Antidepressant Medication Management</p> <p>(3) Follow-Up Care for Children Prescribed ADHD Medication</p> <p>(4) Use of Appropriate Medications for People with Asthma</p> <p>(5) Controlling High Blood Pressure</p> <p>(6) Comprehensive Diabetes Care (excluding the blood pressure submeasures)</p>	\$500 for each enrollee of the denominator not present in the numerator. If no improvement in subsequent years, \$1,000 for each enrollee of the denominator not present in the numerator.

B. Performance Measure Liquidated Damages

1. The Agency may impose liquidated damages for performance measures as described below in the event that the Managed Care Plan fails to perform at the level of the Agency’s expected minimum standards, as specified in sub-item 2 of this item.
2. The Agency shall compare the Managed Care Plan’s performance measure rates to the National Committee for Quality Assurance (NCQA) HEDIS National Means and

Percentiles for Medicaid plans. For each measure where the Managed Care Plan's rate falls below the 50th percentile, the Managed Care Plan may receive liquidated damages. Liquidated damages will be calculated based on the number of members enrolled in the Managed Care Plan.

3. Liquidated damages will be assessed at the following rates by percentile under which the Managed Care Plan's rate falls for each measure. The 40th percentile rate will be calculated as a midpoint between the 25th and 50th percentile rates that are published by NCQA.

PM Ranking	Amount per member
40 th – 49 th percentile	\$1.25
25 th – 39 th percentile	\$2.00
10 th – 24 th percentile	\$2.75
< 10 th percentile	\$3.50

4. The Agency may assess liquidated damages for each of the following measures:
 - a. Antidepressant Medication Management (acute);
 - b. Follow-up Care for Children Prescribed ADHD Medication (initiation);
 - c. Follow-up after Hospitalization for Mental Illness (7 day);
 - d. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (initiation – total);
 - e. Adolescent Well Care Visits;
 - f. Childhood Immunization Status – Combo 3;
 - g. Immunizations for Adolescents;
 - h. Well-Child Visits in the First 15 Months of Life (6 or more);
 - i. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
 - j. Lead Screening in Children;
 - k. Adults' Access to Preventive/Ambulatory Health Services (total);
 - l. Annual Dental Visits (total);
 - m. BMI Assessment;
 - n. Breast Cancer Screening;
 - o. Cervical Cancer Screening;
 - p. Children and Adolescents' Access to Primary Care (includes 4 age group rates);

- q. Chlamydia Screening for Women (total);
 - r. Prenatal and Postpartum Care (includes two (2) measures);
 - s. Prenatal Care Frequency;
 - t. Comprehensive Diabetes Care - HbA1c Testing;
 - u. Comprehensive Diabetes Care - HbA1c Control (< 8%);
 - v. Comprehensive Diabetes Care - Eye Exam;
 - w. Comprehensive Diabetes Care - LDL-C Screening;
 - x. Comprehensive Diabetes Care - LDL-C Control;
 - y. Comprehensive Diabetes Care - Medical Attention for Nephropathy;
 - z. Controlling High Blood Pressure;
 - aa. Pharyngitis – Appropriate Testing related to Antibiotic Dispensing;
 - bb. Use of Appropriate Medications for People with Asthma (total); and
 - cc. Annual Monitoring for Patients on Persistent Medications (total)
5. The Agency may amend the performance measure listing with sixty (60) days' advance notice.

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Section XIV. Reporting Requirements

A. Required Reports

The Managed Care Plan shall comply with all reporting requirements set forth in this Contract, including reports specific to MMA managed care plans as specified in the Summary of Reporting Requirements Table below and the Managed Care Plan Report Guide.

Summary of Reporting Requirements		
Report Name	Plan Type	Frequency
CHCUP (CMS-416) and FL 80% Screening	All MMA Plans	Annually
Affordable Care Act (ACA) Physician Fee Increase Quarterly Report each quarter of 2014)	All MMA Plans	Quarterly
Hernandez Settlement Ombudsman Log	All MMA Plans	Quarterly
Hernandez Settlement Agreement Survey	All MMA Plans	Annually
PCP Appointment Report	All MMA Plans	Annually
ER Visits for Enrollees without PCP appointment	All MMA Plans	Monthly
Customized Benefit Notification	All MMA Plans	Monthly
Patient Centered Medical Home (PCMH) Providers	All MMA Plans	Quarterly
Healthy Behaviors	All MMA Plans	Quarterly
Timely Access/PCP Wait Times Report	All MMA Plans	Annually
Supplemental HIV/AIDS Report	All MMA Plans	Monthly
Additional Network Adequacy Standards	All MMA Plans	Monthly
Electronic Health Records Standards	All MMA Plans	Quarterly