

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section I. Definitions and Acronyms

Section I. Definitions and Acronyms

The definitions and acronyms in **Attachment II**, Section I., Definitions and Acronyms, apply to all Managed Care Plans covering LTC services. There are no additional definitions and acronyms unique to the LTC managed care program.

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section II. General Overview

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

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ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section III. Eligibility and Enrollment

Section III. Eligibility and Enrollment

A. General Provisions

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

B. Eligibility

Medicaid recipients as defined in s. 409.979, F.S., shall receive Medicaid covered services through the SMMC program.

C. Enrollment

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

D. Disenrollment

The Managed Care Plan may recommend an enrollee for involuntary disenrollment if the enrollee wishes to remain in an ALF or AFCH that does not, and will not, comply with HCB Settings Requirements.

E. Medicaid Redetermination Assistance

1. The Managed Care Plan shall send Medicaid redetermination notices to enrollees and assist enrollees with maintaining eligibility.
2. Managed Care Plan shall develop a process for tracking eligibility for Medicaid redetermination and documenting the assistance provided by the Managed Care Plan to ensure continuous Medicaid eligibility, including both financial and clinical eligibility. If the enrollee loses Medicaid financial eligibility due to inaction or lack of follow-through with the DCF Medicaid redetermination process, the Managed Care Plan shall help the enrollee regain Medicaid financial eligibility.
3. The Managed Care Plan's assistance shall include:
 - a. Within the requirements provided below, using Medicaid recipient redetermination date information provided by the Agency to remind enrollees that their Medicaid eligibility may end soon and to reapply for Medicaid if needed;
 - b. Assisting enrollees to understand applicable Medicaid income and asset limits and, as appropriate and needed, supporting enrollees to meet verification requirements;
 - c. Assisting enrollees to understand any patient responsibility obligation they may need to meet to maintain Medicaid eligibility;
 - d. Assisting enrollees to understand the implications of their functional LOC as it relates to the eligibility criteria for the program; and

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section III. Eligibility and Enrollment

- e. If appropriate, assisting enrollees to obtain an authorized representative.
- 4. The Agency will provide Medicaid recipient redetermination date information to the Managed Care Plan.
- 5. The Managed Care Plan shall use Medicaid redetermination date information in written notices to be sent to their enrollees reminding them that their Medicaid eligibility may end soon and to reapply for Medicaid if needed. The Managed Care Plan shall adhere to the following requirements:
 - a. The Managed Care Plan shall mail a Medicaid redetermination date notice to each enrollee for whom it has received a Medicaid 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 mail the Medicaid redetermination date notice to each enrollee no more than sixty (60) days and no less than thirty (30) days before the redetermination date occurs.
- 6. The Managed Care Plan shall keep up-to-date and approved policies and procedures regarding the use, storage and securing of Medicaid redetermination date information as well as address all requirements of this subsection.

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section IV. Marketing

Section IV. Marketing

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

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ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section V. Enrollee Services

Section V. Enrollee Services

A. General Provisions

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

B. Enrollee Materials

1. New Enrollee Procedures and Materials

- a. The Managed Care Plan shall provide new enrollee materials no later than:
 - (1) Five (5) business days after the enrollee's effective date of enrollment for enrollees in the community (including ALFs and AFCHs).
 - (2) Seven (7) business days after the effective date of enrollment for those enrolled in a nursing facility.
- b. The Managed Care Plan shall develop PDO-specific procedures that shall be updated at least annually and shall obtain Agency approval prior to distributing PDO materials to enrollees, representatives, direct service workers, and case managers.
- c. The Managed Care Plan shall refer to enrollees who receive PDO services as "participants" in any PDO-specific published materials.

C. Enrollee Services

1. Toll-Free Enrollee Helpline

The Managed Care Plan shall ensure PDO-trained staff are available at the enrollee and provider call centers during the business hours specified in this Contract to assist enrollees with PDO-related matters.

2. Level of Care Redeterminations

The Managed Care Plan shall:

- a. Conduct LOC redeterminations as required by this Contract.
- b. Track LOC redeterminations to ensure enrollees are reassessed face-to-face using the Agency-required comprehensive assessment tool to ensure a new LOC determination is authorized annually. If the Agency-required comprehensive assessment tool is not submitted to the State in a timely manner and the LOC expires, the Managed Care Plan shall be responsible for ensuring that a new Agency-required certification form is completed, signed and dated by a physician. Enrollees residing and remaining in the nursing facility setting are exempt from the annual LOC redetermination requirement.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section V. Enrollee Services

- c. Ensure the appropriate staff have received the Agency-specified training for completion of the Agency-required comprehensive assessment form.
- d. For enrollees residing and remaining in the community, conduct the annual LOC redetermination, and submit the completed assessment, plan of care summary, and any required medical documentation to CARES between sixty (60) and thirty (30) days prior to the one (1) year anniversary date of the previous LOC determination.
- e. For enrollees transitioned from the nursing facility into the community within twelve (12) months of their initial LOC determination, submit the comprehensive assessment with the plan of care summary to CARES thirty (30) days prior to the date on the initial Notification of Level of Care form. The Managed Care Plan shall not transition enrollees into HCB LTC services who have not been released from the LTC wait list or who have not resided in a nursing facility for a minimum of sixty (60) consecutive days prior to transition.
- f. For enrollees that reside in a nursing facility more than twelve (12) months before transitioning into the community, complete and submit the comprehensive assessment and plan of care summary thirty (30) days prior to the anniversary date of discharge from the nursing facility.

3. Requirement for Nursing Facility Admissions and Discharges

- a. The Managed Care Plan shall ensure DCF is notified of an LTC enrollee's discharge from a nursing facility.
 - (1) The Managed Care Plan shall submit to DCF a properly completed CF-ES 2515 Form (Certification of Enrollment Status, HCBS) within ten (10) business days of the LTC enrollee's discharge from the nursing facility.
 - (2) The Managed Care Plan shall not delegate submission of the CF-ES 2515 Form (Certification of Enrollment Status, HCBS) to the nursing facility, when the LTC enrollee is discharged from a nursing facility.

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ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

Section VI. Coverage and Authorization of Services

A. Required LTC Benefits

1. General Provisions

- a. The Managed Care Plan may place appropriate limits on a service on the basis of medical necessity as follows:
 - (1) In the provision of nursing facility services, assistive care services, attendant nursing care services, hospice services, intermittent skilled nursing services, medical equipment and supplies, personal care, acute therapy services (occupational, physical, respiratory, and speech therapy services), and transportation to LTC services, the Managed Care Plan shall ensure services meet the medical necessity criteria, as defined in 59G-1.010, F.A.C.
 - (2) In the provision of all other LTC services and maintenance therapy services (occupational, physical, respiratory, and speech therapy), the Managed Care Plan shall ensure that services meet all of the following:
 - (a) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
 - (b) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;
 - (c) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

And, one of the following:

- (d) Enable the enrollee to maintain or regain functional capacity; or
- (e) Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

2. Specific LTC Services to be Provided

- a. The Managed Care Plan shall provide covered services specified in s. 409.98, F.S., in accordance with **Attachment II**, Section VI., Coverage and Authorization of Services, the approved federal waivers for the LTC program, and the following Medicaid rules and services listed on the associated fee schedules. When providing services under Section VI.A.1.a.(1), above, which exceed limits outlined in the Florida Medicaid Coverage and Limitations Handbooks, Florida Medicaid Coverage Policies, and the associated Florida Medicaid Fee Schedules, the Managed Care Plan shall comply with

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section VI. Coverage and Authorization of Services

the approved federal waivers for the LTC program and Rule 59G-4.192, F.A.C. Florida Medicaid Policies and Rule References for covered services in the LTC Program are in the Florida Medicaid Policies and Rule References for LTC Services Table, Table 1, below:

TABLE 1 FLORIDA MEDICAID POLICIES AND RULE REFERENCES FOR LTC SERVICES		
Rule No.	Policy Name	Applicable LTC Services
59G-4.025	<u>Assistive Care Services Coverage and Limitations Handbook</u>	Assistive Care Services
59G-4.070	<u>Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook</u>	Medical Equipment and Supplies
59G-4.130	<u>Home Health Services Coverage Policy</u>	Intermittent and Skilled Nursing
59G-4.140	<u>Hospice Services Coverage Policy</u>	Hospice Services
59G-1.045	<u>Medicaid Forms</u>	Nursing Facility Services
59G-4.200	<u>Nursing Facility Services Coverage Policy</u>	Nursing Facility Services
59G-4.318	<u>Occupational Therapy Services Coverage Policy</u>	Occupational Therapy Services
59G-4.160	<u>Outpatient Hospital Services Coverage Policy</u>	Physical and Respiratory Therapy Services
59G-4.320	<u>Physical Therapy Services Coverage Policy</u>	Physical Therapy Services
59G-4.322	<u>Respiratory Therapy Services Coverage Policy</u>	Respiratory Therapy Services
59G-4.215	<u>Personal Care Services Coverage Policy</u>	Personal Care Services
59G-4.261	<u>Private Duty Nursing Services Coverage Policy</u>	Private Duty Nursing Services for Enrollees Ages Eighteen (18) through Twenty (20) Years
59G-4.002	<u>Provider Reimbursement Schedules and Billing Codes</u>	Codes for LTC Covered Services
59G-4.324	<u>Speech-Language Pathology Services Coverage Policy</u>	Speech Therapy Services
59G-4.192	<u>Statewide Medicaid Managed Care Long-term Care Program Coverage Policy</u>	All LTC Covered Services
59G-4.330	<u>Transportation Services Coverage Policy</u>	Non-Emergency Transportation to LTC Covered Services

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

(1) Adult Companion Care Services

Notwithstanding Rule 59A-8.0215(2), F.A.C., the Managed Care Plan may cover adult companion care services, as specified in Rule 59G-4.192, F.A.C., in the enrollee's plan of care without the need for physician orders, as authorized by the 1915(c) Long-Term Care waiver.

(2) Personal Care Services

Notwithstanding Rule 59A-8.0215(2), F.A.C., the Managed Care Plan may cover personal care services, as specified in Rule 59-G-4.130, F.A.C., in the enrollee's plan of care without the need for physician orders, as authorized by the 1915(c) Long-Term Care waiver.

(3) Transportation Services

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

- (a) Determining service eligibility for each enrollee and what type of transportation to provide that enrollee;
 - (b) Establishing a minimum twenty-four (24) hour advance notification policy to obtain transportation services, and communicate that policy to its enrollees and transportation providers. However, advance notification policies shall comport with the timely access to medical care requirements of this Contract; and
 - (c) Complying with Agency-prescribed pick-up windows to enrollees and transportation providers.
- b. The Managed Care Plan may provide any of the following in lieu of services to enrollees when determined medically appropriate, in accordance with the requirements specified in **Attachment II**, Section VI., Coverage and Authorization of Services, after obtaining approval from the Agency:

Structured Family Caregiving - A service for plan members residing in nursing facilities who can be transitioned safely in a community setting but for whom more intensive in-home assistance/support is needed.

3. Participant Direction Option (PDO)

a. General Provisions

- (1) The Managed Care Plan is responsible for implementing and managing the PDO as defined in this Contract. The Managed Care Plan shall ensure the PDO is available to all enrollees who have one or more of the following services on their plan of care

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

and who live in their own home or family home: adult companion care, attendant nursing care, homemaker services, intermittent and skilled nursing, or personal care.

- (2) The Managed Care Plan shall operate the PDO service delivery option in a manner consistent with the PDO Manual and the PDO Participant Guidelines, and utilize PDO-specific templates, as provided by the Agency.
- (3) The Managed Care Plan shall submit a PDO report monthly as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

b. PDO Case Management

- (1) The Managed Care Plan shall assign a case manager trained extensively in the PDO within two (2) business days of an enrollee electing to participate in the PDO delivery option.
- (2) In addition to the requirements specified in **Attachment II** and this Exhibit, the Managed Care Plan shall:
 - (a) Offer PDO to the enrollee, initially and annually, upon reassessment.
 - (b) Complete the PDO Pre-Screening Tool with each enrollee and prospective representative.
 - (c) Train enrollees, initially, and as needed, on employer responsibilities such as: creating job descriptions, interviewing, hiring, training, supervising, evaluating job performance, and terminating employment of the direct service worker(s) to ensure enrollees choosing the PDO understand their roles and responsibilities.
 - (d) Ensure the enrollee reviews, signs, and dates the Participant Agreement.
 - (e) Facilitate the transition of enrollees to, and from, the PDO service delivery system.
 - (f) Ensure PDO and non-PDO services do not duplicate.
 - (g) Assist enrollees as needed with finding and hiring direct service workers.
 - (h) Assist enrollees with resolving disputes with direct service workers and/or taking employment action against direct service workers.
 - (i) Assist enrollees with developing emergency back-up plans including identifying network providers and explaining the process for accessing network providers in the event of a foreseeable or unplanned lapse in PDO services.
 - (j) Assist and train enrollees, as requested, in PDO related subjects.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

B. Expanded Benefits

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

C. Excluded Services

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

D. Coverage Provisions

1. Case Closure Standard

- a. The Managed Care Plan is responsible for notification of and coordination with service providers to assure a thorough discharge planning process and transition case management.
- b. The Managed Care Plan shall provide community referral information on available services and resources to meet the needs of enrollees who are no longer eligible for the LTC component of the SMMC program.
- c. The Managed Care Plan shall ensure the enrollee record is updated to reflect closure activity, including but not limited to:
 - (1) Reason for the closure;
 - (2) Enrollee's status at the time of the closure; and
 - (3) Referrals to community resources if the enrollee is no longer Medicaid eligible.
- d. When the enrollee's enrollment will be changed to another Managed Care Plan, the Managed Care Plan shall transfer the enrollee record from the prior twelve (12) months to the new Managed Care Plan within thirty (30) days after disenrollment.

2. Service Gap Identification and Contingency Plan

- a. Service Gap Identification and Contingency Plan
 - (1) The Managed Care Plan shall develop a standardized system for verifying and documenting the delivery of services with the enrollee or enrollee's authorized representative after authorization.
 - (2) The Managed Care Plan shall ensure the case manager reviews, with the enrollee and/or enrollee's authorized representative, the Managed Care Plan's

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

process for immediately reporting any unplanned gaps in service delivery at the time of each plan of care review for each enrollee receiving HCBS.

- (3) The Managed Care Plan shall develop a form for use as a Service Gap Contingency and Back-Up Plan for enrollees receiving HCBS in their home. This form shall be reviewed and approved by the Agency prior to implementation.
- (4) The Managed Care Plan shall include information on the contingency plan about actions that the enrollee and/or enrollee's authorized representative should take to report any gaps and what resources are available to the enrollee, including on-call back-up service providers and the enrollee's informal support system, to resolve unforeseeable gaps (e.g., regular service provider illness, resignation without notice, transportation failure, etc.) within three (3) hours unless otherwise indicated by the enrollee. The informal support system shall not be considered the primary source of assistance in the event of a gap, unless this is the enrollee's/family's choice.
- (5) The following situations are not considered gaps:
 - (a) The enrollee is not available to receive the service when the service provider arrives at the enrollee's home at the scheduled time;
 - (b) The enrollee refuses the service provider when s/he arrives at the enrollee's home, unless the service provider's ability to accomplish the assigned duties is significantly impaired (e.g., drug and/or alcohol intoxication);
 - (c) The enrollee refuses services;
 - (d) The case manager is able to find an alternative service provider for the scheduled service when the regular service provider becomes unavailable;
 - (e) The enrollee and regular service provider agree in advance to reschedule all or part of a scheduled service; and/or
 - (f) The service provider refuses to go or return to an unsafe or threatening environment at the enrollee's residence.
- (6) The Managed Care Plan shall include the telephone numbers for the provider(s) and/or Managed Care Plan. The Managed Care Plan will respond promptly to calls on the contingency plan, twenty-four (24) hours per day, seven (7) days per week (24/7).
- (7) In those instances where an unforeseeable gap in in-home HCBS occurs, the Managed Care Plan shall ensure that in-home HCBS services are provided within three (3) hours of the report of the gap.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

- (8) When the Managed Care Plan is notified of a gap in services, the Managed Care Plan shall contact the enrollee or enrollee's authorized representative to acknowledge the gap.
- (9) The contingency plan shall be discussed with the enrollee or enrollee's authorized representative at least quarterly. A copy of the contingency plan shall be given to the enrollee when developed and as updated.
- (10) The Managed Care Plan shall submit a monthly summary report of all missed facility and non-facility services in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

E. Care Coordination/Case Management

1. General Provisions

- a. The Managed Care Plan shall ensure that the enrollee's authorized representative is involved in all face-to-face visits with the enrollee if the enrollee is unable to participate due to a cognitive impairment or if the authorized representative is also the enrollee's legal guardian.
- b. The Managed Care Plan shall complete and submit to DCF an initial CF-ES 2515 Form (Certification of Enrollment Status Home and Community Based Services (HCBS)) within ten (10) business days after receipt of the applicable enrollment file from the Agency or its agent. The Managed Care Plan shall retain proof of submission of the completed CF-ES 2515 Form (Certification of Enrollment Status HCBS) to DCF. The CF-ES 2515 Form (Certification of Enrollment Status HCBS) and the CF-ES 2515 Form Instructions are located at http://www.ahca.myflorida.com/Medicaid/nursing_fac/index.shtml.
- c. The Managed Care Plan shall complete and submit to DCF an initial CF-ES 2506A Form (Client Referral/Change) for a nursing facility resident within ten (10) business days after receipt of the applicable enrollment file from the Agency or its agent. The CF-ES 2506A Form (Client Referral/Change) and the CF-ES 2506A Form Instructions are located at http://www.ahca.myflorida.com/Medicaid/nursing_fac/index.shtml.

2. Case Management Program Description

The Managed Care Plan shall submit a Case Management Program Description to the Agency by June 1 of each Contract year. The Case Management Program Description shall address:

- a. How the Managed Care Plan shall implement and monitor the case management program and standards outlined in this Contract.
- b. A description of the methodology for assigning and monitoring case management caseloads and emergency preparedness plans.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

- c. A description of the Managed Care Plan's procedures for resolving conflict or disagreement in the care planning process, including guidelines for all participants.
- d. A description of how the activities performed by the Managed Care Plan's care coordination, UM, and quality management/improvement departments interface in the development of the enrollee's plan of care, including how services that are managed and authorized through sub-contracted entities are incorporated into the workflow and support a person-centered care planning approach. Interface shall include electronic and written reports and verbal communication required for coordination of care planning activities.
- e. An evaluation of the Managed Care Plan's case management program from the previous year, highlighting lessons learned and strategies for improvement.
- f. All required elements of the case management program and responsibilities of the case manager/case manager supervisor as outlined in this Contract.

3. Initial Visit

- a. The Managed Care Plan shall conduct initial visits with enrollees who need case management services in a face-to-face visit with the enrollee within five (5) business days of the enrollee's effective date of enrollment for enrollees in the community and within seven (7) business days of the effective date of enrollment for those residing in a nursing facility. If information obtained during the initial contact or during the eligibility determination indicates the enrollee has more immediate needs for services, the face-to-face visit should be completed as soon as possible.
- b. At the initial face-to-face visit, the Managed Care Plan shall:
 - (1) Confirm in writing the enrollee's receipt of the following items;
 - (a) Enrollee handbook;
 - (b) Provider Directory; and
 - (c) Managed Care Plan ID Card.
 - (2) Explain the enrollee's rights and responsibilities, including procedures for filing a grievance, appeals, and or Medicaid Fair Hearing including continuation of benefits during the fair hearing process.
 - (3) Assist enrollees who reside in their own home or family home with developing a disaster/emergency plan for their household that considers the special needs of the enrollee and assist enrollees to register with the State's Emergency Preparedness Special Needs Shelter Registry, if applicable.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

- (4) Notify an enrollee residing in an ALF or AFCH or receiving ADHC services of their right to receive waiver services in a residential or non-residential setting and to participate in his or her community, regardless of his or her living arrangement;
 - (5) Review the enrollee handbook to ensure enrollees and their authorized representatives are familiar with the contents, especially related to covered services, enrollee rights and responsibilities, the grievance and appeals process, and reporting abuse, neglect, and exploitation; and
 - (6) Finalize the plan of care, including all services and the frequency, duration, and amount that the Managed Care Plan and the enrollee agree upon during the initial face-to-face visit.
- c. If the Managed Care Plan is unable to provide case management services to an enrollee, a letter requesting that the enrollee contact the Managed Care Plan should be left at, or sent to, the enrollee's residence. If the Managed Care Plan is unable to locate/contact the enrollee within a continuous sixty (60)-day period, the Managed Care Plan shall report the enrollee to the Agency in accordance with **Attachment II**, Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.
 - d. If the Managed Care Plan fails to comply with the requirements of this section, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.

4. Comprehensive Assessment/Reassessment

The Managed Care Plan shall conduct a comprehensive assessment(s) and reassessment(s) of the enrollee utilizing Agency-required forms and the LTC supplemental assessment form.

- a. The Managed Care Plan shall conduct a comprehensive assessment of the enrollee that identifies enrollee needs across multiple domains, including current health conditions, current providers, caregiver or other supports available, transportation barriers, medications, behavioral health conditions, preferences for treatment, and the availability of caregiver support.
- b. The Managed Care Plan shall conduct an annual reassessment (no later than three hundred sixty-four (364) days or more frequently, if needed) of the enrollee to facilitate the plan of care update.
- c. Initial Assessment Requirement

The Managed Care Plan shall conduct a comprehensive assessment of the enrollee prior to the development of the initial plan of care. The Managed Care Plan shall review and utilize Agency-required forms and the LTC supplemental assessment form, as

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

defined in Rule 59G-4.193, F.A.C. when completing the initial comprehensive assessment of the enrollee.

d. Reassessment Requirement

The Managed Care Plan shall conduct an annual reassessment (no later than three hundred sixty-four (364) days or more frequently, if needed) of the enrollee to facilitate the plan of care update.

e. LTC Supplemental Assessment

The Managed Care Plan shall submit the LTC supplemental assessment form to the Agency for review prior to initial implementation and for any substantive changes thereafter.

5. Initial Plan of Care/Reviews

a. Person-Centered Care Planning Approach

(1) The Managed Care Plan shall identify the LTC service needs of enrollees in an Agency-developed plan of care template. The Managed Care Plan shall use a person-centered approach regarding the enrollee assessment and needs, taking into account not only covered services, but also other needed services and community resources, regardless of payor source, as applicable.

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

- (a) Provides necessary information and support to ensure that the enrollee directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. This includes allowing the enrollee to help make decisions about service options and identification of personal goals.
- (b) Allows the enrollee, regardless of setting, to achieve or maintain their highest level of self-sufficiency.
- (c) Allows the enrollee to invite anyone of his or her choosing (family members, authorized representatives, friends, or others) to participate.
- (d) Is timely in accordance with Section VI.E., Care Coordination/Case Management, of this Exhibit and occurs at times and locations of convenience to the enrollee.
- (e) Offers the enrollee choice regarding the services and supports the enrollee receives and from whom.
- (f) Includes a method for the enrollee to request updates to the plan of care, as needed.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

- (3) If the Managed Care Plan fails to comply with the requirements of this section, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.
- b. Plan of Care Standard
- (1) The Managed Care Plan shall develop a person-centered plan of care in accordance with Rule 59G-4.192, F.A.C. and 42 CFR 441.301(c)(2), within the timeframes specified within this Exhibit, that is based upon, at a minimum, the results of the comprehensive assessment and LTC supplemental assessment of the enrollee and that is specific to the enrollee's needs.
 - (2) Managed Care Plans shall ensure that the written plan of care:
 - (a) Reflects that the setting in which the enrollee resides is chosen by the enrollee.
 - (b) Reflects the enrollee's strengths, preferences, and self-care capabilities.
 - (c) Reflects clinical and support needs as identified through the comprehensive assessment process.
 - (d) Establishes person-centered goals and objectives, including employment (as applicable) and integrated community living goals, and desired wellness, health, functional, and quality of life outcomes for the member, and how LTC services are intended to help the member achieve these goals.
 - (e) Reflects the services and supports (paid and unpaid) that will assist the enrollee to achieve identified goals, and the providers of those services and supports, including natural supports.
 - (f) Encourages the integration of natural supports including the development of an informal volunteer network of caregivers, family, neighbors, and others to assist the enrollee or primary caregiver with services. These services will be integrated into an enrollee's plan of care when it is determined these services would improve the enrollee's capability to live safely in the home or community setting and are agreed to and approved by the enrollee or the enrollee's authorized representative.
 - (g) Reflects risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
 - (h) Identifies the individual and/or entity responsible for monitoring the plan of care.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

- (i) Prevents the provision of unnecessary or inappropriate services and supports.
 - (j) Documents any modification of the HCB setting requirements are supported by a specific assessed need.
 - (k) Identifies any existing plans of care and service providers and assesses the adequacy of existing services.
 - (l) Determines whether the enrollee has advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian.
- (3) The Managed Care Plan shall develop a plan of care template that addresses the criteria specified above and includes the minimum components specified in Rule 59G-4.192, F.A.C. The Managed Care Plan shall submit the plan of care template to the Agency for review prior to initial implementation and any substantive changes thereafter.
- (4) The enrollee or enrollee's authorized representative shall indicate whether they agree or disagree with each service authorization, and review, sign, and date the plan of care at initial development, annual review, and for any changes in services. The enrollee may request additional time to review a draft plan of care prior to signing.
- (5) The Managed Care Plan shall provide a copy of the plan of care to the enrollee or enrollee's authorized representative.
- (6) The Managed Care Plan shall provide the enrollee and their caretaker a plan of care summary, applied to a magnetic base or in a laminated form.
- (7) The Managed Care Plan shall ensure that a copy of the enrollee's plan of care is forwarded within ten (10) business days of initial development or any subsequent updates, to the enrollee's primary care provider and, if applicable, to the facility where the enrollee resides. The primary care provider shall be advised, in writing, of whom to contact with questions regarding the adequacy of the plan of care.
- (8) If the Managed Care Plan fails to comply with the requirements of this section, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.
- c. Service Planning Standard
- (1) The Managed Care Plan shall ensure that, during face-to-face care planning, the case manager has an electronic tablet or device that captures all of the elements of assessments and the entire plan of care. The tablet or device shall be

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

interoperable with the Managed Care Plan's care management and service authorization platform(s).

- (2) The Managed Care Plan shall ensure the case manager:
 - (a) Documents the entire care planning process in the enrollee record.
 - (b) Provides the enrollee with information about the available providers when service needs are identified so that the enrollee can make an informed choice of providers.
 - (c) Coordinates the services with appropriate providers upon the enrollee's or enrollee authorized representative's agreement to the plan of care.
 - (d) Identifies the enrollee's PCP and specialists involved in the enrollee's treatment and obtains the required authorizations for release of information in order to coordinate and communicate with the primary care provider and other treatment providers.
 - (e) Informs the enrollee's PCP and other treatment providers that the enrollee should be encouraged to adopt healthy habits and maintain his or her personal independence.
 - (f) Informs the enrollee or the enrollee's authorized representative when a PCP must prescribe an HCBS service.
 - (g) Assists the enrollee in acquiring documentation needed for requested services, including a physician's order for those services requiring a physician's order.
 - (h) Coordinates the effort to obtain a PCP or to change the PCP if the enrollee does not have a PCP or wishes to change PCP.
 - (i) Verifies that medically necessary services are available in the enrollee's community. If a service is not currently available, the case manager shall substitute a combination of other services in order to meet the enrollee's needs until such time as the desired service becomes available. The enrollee may need a temporary alternative placement if services cannot be provided to safely meet the enrollee's needs.
 - (j) Monitors the services and placement of each enrollee assigned to their caseload in order to assess the continued suitability of the services and placement in meeting the enrollee's needs as well as the quality of the care delivered by the enrollee's service providers.
- (3) The Managed Care Plan shall not require an enrollee to enter an alternative residential placement/setting because it is more cost-effective than living in his/her home.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

- (4) The Managed Care Plan shall submit a summary report of the physical location/residence of all enrollees as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.
- (5) If the Managed Care Plan fails to comply with the requirements of this section, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.

6. Monthly Contact Requirements

- a. The Managed Care Plan shall maintain, at a minimum, monthly telephone contact with enrollees receiving care coordination/case management, or the enrollee's authorized representative, to verify satisfaction with and receipt of services.
- b. For an enrollee who has requested a voluntary suspension of authorized services, the Managed Care Plan shall obtain verbal or written consent prior to enacting a suspension of an LTC service (except for private duty nursing services), using the Agency-required form. The Managed Care Plan may obtain verbal consent from the enrollee prior to enacting the suspension of service, but the Managed Care Plan shall follow up to obtain the enrollee's signature on the form at the next face-to-face visit.

7. Ongoing Contact Requirements

- a. The case manager shall meet face-to-face at least every ninety (90) days with the enrollee and/or the enrollee's authorized representative, in order to:
 - (1) Review the enrollee's plan of care and, if necessary, update the enrollee's plan of care. The Managed Care Plan shall review the plan of care in a face-to-face visit more frequently than once every ninety (90) days if the enrollee experiences a significant change.
 - (2) Discuss the frequency, duration, and amount of authorized services, and the authorized providers for each service. If the enrollee or the authorized representative reports any issues or the case manager discovers any issues during the face-to-face visit, the case manager shall document the actions taken to resolve the issues as quickly as possible.
 - (3) Assess needs, including any changes to the enrollee's informal support system.
 - (4) Discuss the enrollee's perception of his/her progress toward established goals.
 - (5) Identify any barriers to the achievement of the enrollee's goals.
 - (6) Develop new goals as needed.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

- (7) Document the enrollee's current functional, medical, behavioral and social strengths.
- b. The Managed Care Plan shall have an annual face-to-face visit with the enrollee to:
 - (1) Complete the annual reassessment.
 - (2) Determine the enrollee's functional status, satisfaction with services, and changes in service needs.
 - (3) Develop a new plan of care.
- c. The Managed Care Plan shall conduct a face-to-face visit with the enrollee within five (5) business days following an enrollee's change of placement type (e.g., from a community-based setting to an institutional setting, from the enrollee's own home to an ALF, or from an institutional setting to a community-based setting) or following a significant change in an enrollee's condition. This review shall be conducted to ensure that appropriate services are in place and that the enrollee agrees with the plan of care as authorized.
- d. For enrollees ages eighteen (18) through twenty (20) years and receiving private duty nursing services or nursing facility services, the Managed Care Plan shall conduct the MDT review requirement as described in the applicable Coverage Policies. The Managed Care Plan shall:
 - (1) Conduct the MDT meeting concurrent with the initial plan of care development;
 - (2) Conduct the MDT meeting every six (6) months concurrent with the plan of care review; and
 - (3) Document the MDT meetings and recommendations in the enrollee record.
- e. If the Managed Care Plan is unable to contact an enrollee to schedule an ongoing visit, a letter shall be sent to the enrollee or enrollee's authorized representative requesting contact within ten (10) business days from the date of the letter. If no response is received by the designated date, the Managed Care Plan shall report such inability to locate enrollees to the Agency, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide indicating loss of contact.

8. Freedom of Choice

The Managed Care Plan shall ensure the enrollee or their authorized representative reviews, signs, and dates the Agency-approved Freedom of Choice Certification Form on the following schedule:

- a. Within seven (7) business days of the effective date of enrollment, as provided by the Agency.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

b. Upon a change in the enrollee's living arrangement.

9. Pre-Admission Screening and Resident Review

There are no additional provisions related to PASRR unique to the LTC program.

10. Transition of Care

There are no additional provisions related to transition of care unique to the LTC program.

11. Disease Management Program

In addition to the requirements specified in **Attachment II**, the Managed Care Plan shall include disease management programs for:

Dementia and Alzheimer's issues.

F. Quality Enhancements

1. The Managed Care Plan shall offer QEs to enrollees as specified below:

- a. Safety concerns in the home and fall prevention; and
- b. End of life issues, including information on advanced directives.

2. The Managed Care Plan shall implement and maintain a formal Caregiver Training Program. The Caregiver Training Program shall address the financial, emotional, and physical elements of caregiving, as well as outline the resources available to caregivers in crisis.

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

G. Authorization of Services

1. Service Authorizations

- a. The Managed Care Plan shall ensure service authorizations are consistent with the services documented on enrollee's plan of care, including the amount, frequency, and duration necessary to support the enrollee adequately and safely in the setting of his or her choice.
- b. The Managed Care Plan shall send authorizations to all applicable providers for the agreed upon services, including amount, frequency, and duration, within twenty-four (24) hours of the initial face-to-face visit.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

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

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

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

- d. The Managed Care Plan shall not deny covered services based on an incomplete plan of care.
- e. The Managed Care Plan shall authorize ongoing services within the timeframes specified in the enrollee’s plan of care.
- f. The Managed Care Plan shall process service authorization requests for respite services requested on an emergent basis within the expedited timeframes specified in **Attachment II**, Section VI.G., Authorization of Services.
- g. The Managed Care Plan may determine the duration for which services shall be authorized, except as follows:
 - (1) Maintenance therapies, as defined in Rule 59G-4.192, F.A.C., shall be authorized for no less six (6) months on the enrollee’s plan of care. The authorization must be supported by the results from the comprehensive assessment or objective LTC evidence-based criteria.
 - (2) All other covered services that are authorized for a duration of less than six (6) months must be for the treatment of an acute illness or a condition that will be resolved within six (6) months. The authorization decision must be supported by the PCP’s prescription of the service for a shorter duration or, in the case of services that do not require a PCP’s prescription, the authorization decision must be supported by objective evidence-based criteria.
 - (3) The authorization time period shall be consistent with the end date of the services as specified in the plan of care.
- h. The Managed Care Plan shall not deny authorization for a service solely because a caregiver is at work or is unable to participate in the enrollee’s care because of their own medical, physical, or cognitive impairments.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VI. Coverage and Authorization of Services

- i. The Managed Care Plan shall not deny medically necessary services required for the enrollee to remain safely in the community because of cost.
- j. If the case manager and PCP or attending physician do not agree regarding the need for a change in LOC, placement, or physician's orders for medical services, the case manager shall refer the case to the Managed Care Plan's Medical Director for review. The Medical Director shall be responsible for reviewing the case, discussing it with the PCP and/or attending physician, if necessary, and making a determination in order to resolve the issue.
- k. In addition to the requirements specified in **Attachment II**, the Managed Care Plan shall ensure a notice of adverse benefit determination is provided to enrollees receiving LTC services in each instance during a course of treatment where the Managed Care Plan authorizes fewer units or days subsequent to the initial authorization for the service.

2. Utilization Management Program Description

The Managed Care Plan shall supplement the Utilization Management Program Description required in **Attachment II**, Section VI.G., Coverage and Authorization of Services, to include distinct procedures related to the authorization of LTC services, including but not limited to:

- a. Protocols for ensuring that entities reviewing service authorization requests for LTC services have access to enrollees' plan of care and information obtained from the comprehensive assessment;
- b. Protocols for evaluating service authorization requests utilizing objective LTC evidence-based criteria;
- c. A description of the responsibilities and scope of authority of case managers in authorizing LTC services and in submitting service authorization requests (when applicable);
- d. A description of the process for authorizing and implementing services based on an incomplete plan of care;
- e. Procedures for ensuring service authorization decisions are consistent with the goals documented on the plan of care;
- f. Protocols for ensuring that there are no gaps in service authorization for enrollees requiring ongoing services;
- g. Issuing service authorizations to enrollees requesting transportation services.

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section VI. Coverage and Authorization of Services

3. Service Authorization System

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

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section VII. Grievance and Appeal System

Section VII. Grievance and Appeal System

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

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ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VIII. Provider Services

Section VIII. Provider Services

A. Network Adequacy Standards

1. Network Capacity and Geographic Access Standards

- a. Pursuant to s. 409.982(4), F.S., and 409.98(1)-(19), F.S., Managed Care Plans must maintain a region wide network of providers in sufficient numbers to meet the access standards for LTC services for all plan enrollees. At a minimum, Managed Care Plans shall contract with the providers specified in the LTC Minimum Network Adequacy Requirements Table, Table 2. Managed Care Plans shall ensure regional provider ratios and provider-specific geographic access standards for enrollees in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the Table 2.
- b. In accordance with s. 409.982(1), F.S., the Managed Care Plan shall, in good faith, offer a provider agreement to all of the following providers in the region who are determined to meet all quality standards established by the Agency:
 - (1) Nursing facilities; and
 - (2) Hospices.

After the first twelve (12) months of the Contract period, the Managed Care Plan may limit the providers in its network, based on credentials, quality, and price in accordance with Section VIII.C., Provider Credentialing and Contracting.

- c. The Managed Care Plan shall ensure that providers of PDO services meet the minimum provider qualifications in the PDO Provider Qualifications Table, Table 3, and all training and background screening requirements.
- d. The Managed Care Plan shall permit enrollees to choose from among all Managed Care Plan network residential facilities with a Medicaid-designated bed available. The Managed Care Plan shall inform the enrollee of any residential facilities that have specific cultural or religious affiliations. In the event the enrollee does not make a choice, the Managed Care Plan shall place the enrollee with a participating facility-based provider with a Medicaid-designated bed available within the closest geographical proximity to the enrollee's current residence. All Managed Care Plan enrollee placements into participating or non-participating residential facilities shall be appropriate to the enrollees' needs.

B. Network Management

1. General Provisions

The Managed Care Plan shall ensure HCBS are available to enrollees with LTC benefits on a seven (7) day a week basis, and for extended hours, as dictated by enrollee needs.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VIII. Provider Services

2. Annual Network Development Plan

There are no additional annual network development plan provisions unique to the LTC managed care program.

3. Regional Network Changes

In addition to the requirements of **Attachment II**, Section VI.B., Expanded Benefits, the Managed Care Plan shall notify the Agency within seven (7) business days of the loss of a nursing facility, adult day health care center, AFCH, or ALF in a region where another participating nursing facility, adult day health care center, AFCH, or ALF of equal service ability is not available to ensure compliance with the geographic access standards specified in this Exhibit.

4. Facility-based Services Provider Network Changes

The Managed Care Plan shall notify the Agency one hundred twenty (120) days prior to the effective date of termination or exclusion of facility-based services providers.

C. Provider Credentialing and Contracting

1. General Provisions

There are no additional general provisions for provider credentialing and contracting unique to the LTC managed care program.

2. Credentialing and Recredentialing

a. The Managed Care Plan shall verify provider credentialing and recredentialing criteria as directed by the Agency to ensure that ALFs, AFCHs, and ADHC providers meet HCB Settings Requirements. The Managed Care Plan shall verify facility compliance through an on-site review, using the Agency-prescribed HCB Settings Assessment and Remediation Tools, prior to offering the provider as an enrollee choice.

b. When recredentialing a participating nursing facility provider, the Managed Care Plan shall review the facility's performance using the following measures as provided on the federal CMS Nursing Home Compare website at: <http://www.medicare.gov/nursinghomecompare/>. The Managed Care Plan, based on information from the CMS Nursing Home Compare website, determines that the nursing facility has:

(1) Met this performance measure when the nursing facility has an:

i. Overall rating of two (2) or more stars; or

ii. Overall rating of one (1) star, plus a rating of two (2) or more stars in the Quality Measures category within the Long-Stay Residents section; or

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VIII. Provider Services

- iii. Overall rating of one (1) star, plus a rating of one (1) star in the Quality Measures category within the Long-Stay Residents section, plus (under the Quality Measures category within the Long-Stay Residents section) the percentage of residents who receive an antipsychotic medication is the same as or less than Florida's statewide average; and
- (2) Not met this performance measure when the nursing facility has an overall rating of one (1) star, plus a rating of one (1) star in the Quality Measures category within the Long-Stay residents section, plus (under the Quality Measures category within the Long-Stay Residents section) the percentage of residents who receive an antipsychotic medication in the facility is greater than Florida's statewide average. If the nursing facility has not met this performance measure, the Managed Care Plan may exclude the facility from its network.
- c. The Managed Care Plan's credentialing and recredentialing process shall include ensuring that all LTC providers are appropriately qualified, as specified in Rule 59G-4.192, F.A.C. and below in Table 3 – PDO Provider Qualifications. Network adequacy requirements for LTC are listed in Table 2 - LTC Minimum Network Adequacy Requirements Table below.
 - d. The Managed Care Plan shall provide reports demonstrating provider network qualifications as specified in **Attachment II**, Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.
 - e. Participant Direction Option.

For the purposes of this Section, "enrollee" means the enrollee or their representative.

- (1) Enrollees may hire any individual who satisfies the minimum qualifications set forth in Section VIII., Provider Services, including but not limited to neighbors, family members, or friends. The Managed Care Plan shall not restrict an enrollees' choice of direct service worker(s) or require them to choose providers in the Managed Care Plan's provider network.
- (2) The enrollee shall have employer authority. An enrollee may delegate their employer authority to a representative. The representative can neither be paid for services as a representative, nor be a direct service worker.
- (3) The Managed Care Plan shall inform enrollees, upon choosing the PDO, of the rate of payment for the PDO services. If the rate of payment changes for any PDO service, the Managed Care Plan shall provide a written notice to the applicable enrollees and direct service workers, at least thirty (30) days prior to the change.
- (4) The Managed Care Plan shall ensure enrollees update their Participant/Direct Service Worker Agreement indicating any changes in rate of payment.

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section VIII. Provider Services

- (5) The Managed Care Plan shall provide instructions to the enrollee regarding the submission of timesheets.
- (6) The Managed Care Plan shall ensure the Participant/Direct Service Worker Agreement includes, at a minimum, include the following:
 - (a) Service(s) to be provided;
 - (b) Hourly rate;
 - (c) Direct service worker work schedule;
 - (d) Relationship of the direct service worker to the enrollee;
 - (e) Job description and duties;
 - (f) Agreement statement; and
 - (g) Dated signatures of the case manager, enrollee, and direct service worker.
- (7) The Managed Care Plan shall pay for Level II background screening for at least one representative (if applicable) per enrollee and at least one direct service worker for each service, per enrollee, per Contract year. The Managed Care Plan shall receive the results of the background screening and make a determination of clearance, adhering to all requirements in Chapters 435 and 408.809, F.S.
- (8) The Managed Care Plan shall monitor utilization of services based on payroll and an enrollee's approved plan of care. The Managed Care Plan shall report its performance on these standards to the Agency as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

3. Minority Recruitment and Retention Plan

There are no additional minority recruitment and retention plan provisions unique to the LTC managed care program.

4. Prohibition Against Discriminatory Practices

There are no additional prohibitions against discriminatory practices unique to the LTC managed care program.

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section VIII. Provider Services

TABLE 2		
LTC MINIMUM NETWORK ADEQUACY REQUIREMENTS TABLE*		
Long-Term Care Plan Benefit	Minimum Network Adequacy Requirements Urban Counties	Minimum Network Adequacy Requirements Rural Counties
Adult Companion	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Adult Day Care (Adult Day Health Care)	At least two (2) providers serving each county of the region AND at least one (1) provider within thirty (30) minutes' travel time.	At least two (2) providers serving each county of the region AND at least one (1) provider within sixty (60) minutes' travel time.
Assisted Living Facility Services	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.
Assistive Care Services	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.
Attendant Nursing Care	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Behavior Management	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Caregiver Training	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Case Management	Each case manager's caseload may not exceed caseload ratios as described in Section V.E.5.b. of this Exhibit.	Each case manager's caseload may not exceed caseload ratios as described in Section V.E.5.b. of this Exhibit.
Home Accessibility Adaptation	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section VIII. Provider Services

TABLE 2		
LTC MINIMUM NETWORK ADEQUACY REQUIREMENTS TABLE*		
Long-Term Care Plan Benefit	Minimum Network Adequacy Requirements Urban Counties	Minimum Network Adequacy Requirements Rural Counties
Home Delivered Meals	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Homemaker	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Hospice	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Intermittent and Skilled Nursing	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Medication Administration	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Medication Management	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Medical Equipment & Supplies	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Nutritional Assessment and Risk Reduction	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Nursing Facility Care	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.
Personal Care	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Personal Emergency Response System	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Respite Care	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section VIII. Provider Services

TABLE 2		
LTC MINIMUM NETWORK ADEQUACY REQUIREMENTS TABLE*		
Long-Term Care Plan Benefit	Minimum Network Adequacy Requirements Urban Counties	Minimum Network Adequacy Requirements Rural Counties
Transportation	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Occupational Therapy	At least two (2) providers serving each county of the region AND at least (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within sixty (60) minutes travel time.
Physical Therapy	At least two (2) providers serving each county of the region AND at least (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within sixty (60) minutes travel time.
Respiratory Therapy	At least two (2) providers serving each county of the region AND at least one (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least one (1) provider within sixty (60) minutes travel time.
Speech Therapy	At least two (2) providers serving each county of the region AND at least one (1) provider within thirty (30) minutes travel time.	At least two (2) providers serving each county of the region AND at least one (1) provider within sixty (60) minutes travel time.

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

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section VIII. Provider Services

TABLE 3 PDO PROVIDER QUALIFICATIONS		
LTC Program Benefit	Qualified Service Provider Types	Minimum Provider Qualifications
Adult Companion	Individual	None *
Attendant Nursing Care	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Homemaker	Individual	None *
Intermittent/ Skilled Nursing	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Personal Care	Individual	None*

Individuals of the enrollee's choosing may provide PDO services so long as they meet the minimum provider qualifications as above and are age eighteen (18) years and older. PDO providers are also required to sign and date a Participant/Direct Service Worker Agreement and obtain a satisfactory Level II background screening.

5. Provider Agreement Requirements

- a. The Managed Care Plan shall include the following provisions in its provider agreements:
 - (1) Require that each provider develop and maintain policies and procedures for back-up plans in the event of absent employees, and that each provider maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees;
 - (2) Require that ALFs and AFCHs conform to the HCB Settings Requirements. The Managed Care Plan shall include the following statement verbatim in its provider agreements with ALF and AFCH providers:

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VIII. Provider Services

(Insert ALF/AFCH identifier) will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

Enrollees residing in (insert ALF/AFCH identifier) shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

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

Ability to have:

- *Unrestricted visitation; and*
- *Snacks as desired.*

Ability to:

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

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

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

- (4) For ADHC providers, that they shall conform to the HCB Settings Requirements. The Managed Care Plan shall include the following statement verbatim in its provider agreements with ADHC providers:

(Insert ADHC provider identifier) will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VIII. Provider Services

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

Choice of:

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

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

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

6. Network Performance Management

There are no additional network performance management provisions unique to the LTC managed care program.

7. Provider Termination and Continuity of Care

There are no additional provider termination and continuity of care provisions unique to the LTC managed care program.

D. Provider Services

1. Provisions for Providers Subject to HCB Settings Requirements

- a. As directed by the Agency, the Managed Care Plan shall monitor provider compliance with provider agreement requirements and take corrective action as necessary if the

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section VIII. Provider Services

Managed Care Plan or the Agency concludes an ALF, AFCH, or ADHC provider does not meet the HCB Settings Requirements.

- (1) Upon discovery of non-compliance with the HCB Settings Requirements by an ALF, AFCH, or ADHC provider, the Managed Care Plan shall require the provider to remediate all areas of non-compliance within ten (10) business days of discovery. The Managed Care Plan must submit documentation of the remediation to the Agency in a format and timeframe specified by the Agency.
- (2) As directed by the Agency, the Managed Care Plan shall not place, continue to place, and/or provide reimbursement for enrollees residing in an ALF or AFCH, or receiving services from an ADHC provider that does not meet the HCB Settings Requirements and/or does not have a provider agreement as specified in Section VIII.C.5.a.(2)., of this Exhibit.
- (3) As directed by the Agency, the Managed Care Plan must terminate providers that are non-compliant with HCB Settings Requirements.

2. Provider Handbook and Bulletin Requirements

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

- a. The role of case managers; and
- b. Requirements for HCBS providers regarding critical incident reporting and management.

3. Provider Education and Training

There are no additional provider education and training provisions unique to the LTC managed care program.

4. Toll-Free Provider Help Line

There are no additional toll-free provider help line provisions unique to the LTC managed care program.

5. Provider Complaint System

There are no additional provider complaint system provisions unique to the LTC managed care program.

E. Claims and Provider Payment

During the 2019 Novel Coronavirus Public Health Emergency, the Managed Care Plan shall make monthly retainer payments, in a manner prescribed by the Agency, to adult day care centers licensed pursuant to rule 59A-16, F.A.C.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

Section IX. Quality

A. Quality Improvement

1. General Provisions

- a. The Managed Care Plan shall appoint a staff member with five (5) or more years of experience and/or training in working with elders and/or individuals with disabilities to the QI program committee.
- b. The Managed Care Plan shall establish and maintain an enrollee advisory committee to consider issues for LTC enrollees, and obtain periodic feedback from LTC enrollees on satisfaction with care, problem identification, and suggestions for improving the service delivery system. (42 CFR 438.110(a))
 - (1) The advisory committee shall meet at least twice annually.
 - (2) The Managed Care Plan shall submit to the Agency by October 1st of each year documentation in the form of advisory committee meeting agendas, meeting minutes, and any other documentation that demonstrates the Managed Care Plan's response to concerns raised by advisory committee participants.

2. Accreditation

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

3. Quality Improvement Program

There are no additional quality improvement program provisions unique to the LTC managed care program.

4. Quality Improvement Program Committee

There are no additional quality improvement program committee provisions unique to the LTC managed care program.

5. Quality Improvement Plan

In addition to the requirement specified in **Attachment II**, Section IX.5., the Managed Care Plan's QI plan must include mechanisms to assess the quality and appropriateness of care furnished to enrollees. (42 CFR 438.330(b)(5)(i))

6. EQRO Coordination Requirements

There are no additional EQRO coordination requirements unique to the LTC managed care program.

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section IX. Quality

B. Performance Measures (PMs)

1. General Provisions

The Agency, at its sole discretion, may add and/or change required performance measures based on State and federal quality initiatives. These measures may include, but are not limited to, Medicare measures related to nursing facility care and home-based care.

2. Required Performance Measures

a. Agency-Prescribed Performance Measures

- (1) The Managed Care Plan shall collect and report the following performance measures in the Centers for Medicare and Medicaid Services and Mathematica Managed Long-Term Services and Supports (LTSS) Measures Table, Table 4, below, certified via qualified auditor, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. The Measures for Medicaid Managed Long-Term Services and Supports Plans Technical Specifications and Resource Manual is available online at: https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf.

TABLE 4 CENTERS FOR MEDICARE AND MEDICAID SERVICES AND MATHEMATICA MANAGED LONG-TERM SERVICES AND SUPPORTS (LTSS) MEASURES	
1.	LTSS Comprehensive Assessment and Update: the percentage of LTC plan enrollees who have documentation of a comprehensive assessment within the appropriate time frame (within ninety (90) days of enrollment or annually).
2.	LTSS Comprehensive Care Plan and Update: the percentage of LTSS enrollees who have documentation of a comprehensive LTSS care plan within the appropriate time frame (within one hundred twenty (120) days of enrollment or annually).
3.	LTSS Shared Care Plan with Primary Care Practitioner: the percentage of LTSS plan enrollees with a care plan for whom all or part of the care plan was transmitted to key LTSS providers and the primary care provider within thirty (30) days of development or update.
4.	LTSS Reassessment and Care Plan Update after Inpatient Discharge: the percentage of discharges from inpatient facilities in the measurement year for LTSS Plan enrollees resulting in a reassessment and care plan update within thirty (30) days of discharge.
5.	Screening, Risk Assessment, and Plan of Care to Prevent Future Falls: this is a clinical process measure that assesses fall prevention in LTSS enrolled older and disabled adults. The measure has three rates:

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section IX. Quality

	<ul style="list-style-type: none"> • Screening for Future Fall Risk: percentage of LTSS enrollees age eighteen (18) years and older and disabled who were screened for future fall risk at least once within twelve (12) months. • Falls Risk Assessment: percentage of LTSS enrollees age eighteen (18) years and older and disabled with a history of falls who had a risk assessment for falls completed within twelve (12) months. • Plan of Care for Falls: percentage of LTSS enrollees age eighteen (18) years and older and disabled with a history of falls who had a plan of care for falls documented within twelve (12) months.
6.	LTSS Admission to an Institution from the Community: the number of LTSS enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community that result in a short-term (less than one hundred one (101) days) or long-term stay (greater than or equal to 101 days) during the measurement year per one thousand (1,000) enrollee months. Two rates are reported: short-term stay and long-term stay.
7.	Successful Transition after Short-Term Institutional Stay among LTSS enrollees: the percentage of LTSS enrollee institutional admissions that result in successful discharge to the community (community residence for thirty (30) or more days) within one hundred (100) days of admission.
8.	Successful Transition after Long-Term Institutional Stay among LTSS enrollees: the percentage of LTSS enrollees who are long-term residents (one hundred one (101) days or more) of institutions who are successfully discharge to the community (community residence for thirty (30) or more days).

(2) A Managed Care Plan operating under the 2014-2018 contract and continuing under the 2018-2023 contract must submit LTSS performance measure results (representing services received in calendar year 2018) to the Agency by November 1, 2019 for the following four (4) measures, using the performance measures report template:

- LTSS Comprehensive Assessment and Update;
- LTSS Comprehensive Care Plan and Update;
- LTSS Shared Care Plan with Primary Care Practitioner; and
- LTSS Reassessment Care Plan Update after Inpatient Discharge.

(3) All Managed Care Plans operating under the 2018-2023 contract must submit LTSS performance measure results (representing services received in calendar year 2019) to the Agency by July 1, 2020 and annually thereafter for the eight

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

- (8) performance measures listed in the Centers for Medicare and Medicaid Services and Mathematica Managed Long-Term Services and Supports (LTSS) Measures Table, using the performance measures report template.
- (4) The Managed Care Plan shall report the following four (4) HEDIS measures to both the Agency and the NCQA via the Interactive Data Submission System (IDSS) beginning with the July 1, 2020 submission:
- LTSS Comprehensive Assessment and Update;
 - LTSS Comprehensive Care Plan and Update;
 - LTSS Shared Care Plan with Primary Care Practitioner; and
 - LTSS Reassessment/Care Plan Update after Inpatient Discharge.
- (5) The Managed Care Plan shall comply with the minimum performance standards established by the Agency for the Agency-Prescribed Performance Measures specified above. The Managed Care Plan shall achieve at least a two percent (2%) improvement each year of the Contract until the Managed Care Plan achieves the performance standards established by the Agency.
- (6) If the Managed Care Plan fails to comply with the requirements of this section, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages, as determined by the Agency.
- (7) Due to year 2018 being a transition year across contracts, the Agency will collect and may report performance measures publicly. The Agency shall label such performance measures as “transition year” measures. The Agency shall not assess liquidated damages or sanctions where LTC performance measure results do not meet the targets, but will assess liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting.
- (8) Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2020, covering the measurement period of calendar year 2019 all performance measure-related liquidated damages and sanctions will be in effect.

b. 1915(c) Long-term Care Waiver Performance Measures

The Managed Care Plan shall report the following performance measures in the Waiver Home and Community-Based Services Performance Measures Table, Table 5, below, to the Agency in a manner prescribed by the Agency.

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section IX. Quality

TABLE 5 WAIVER HOME AND COMMUNITY-BASED SERVICES PERFORMANCE MEASURES	
Evaluation/Reevaluation of Level of Care	
1.	Percentage of new applicants receiving an LOC evaluation prior to enrollment.
2.	Percentage of new enrollees having a current LOC based on the State-approved assessment tool.
Qualified Providers	
3.	Percentage of licensed service providers, by type, within the LTC provider network that meets provider qualifications prior to delivering services.
4.	Percentage of licensed service providers, by type, within LTC's provider network that meets service provider qualifications continuously.
5.	Percentage of LTC plans continuously qualified on an annual basis.
6.	Percent of non-licensed/non-certified service providers, by type, within the LTC provider network, satisfying waiver service provider qualifications prior to providing services.
7.	Percent of non-licensed/non-certified service providers, by type, within the LTC network, satisfying waiver service provider qualifications continuously.
8.	Percentage of subcontractors with staff mandated to report abuse, neglect, and exploitation, verified by LTC plan that staff had received appropriate training.
9.	Percentage of LTC plan case managers satisfying abuse, neglect, exploitation, Alzheimer's disease, and dementia training requirements.
Participant-Centered Planning and Service Delivery	
10.	Percentage of recipients with plans of care that meet all assessed needs and risks.
11.	Percentage of recipients with care plans that documents personal goal setting and community integration goal setting.
12.	Percentage of recipients' care plans that are distributed within ten (10) business days of development to primary care physician.
13.	Percentage of enrollees' care plans where enrollees' participation is verified by signatures.
14.	Percentage of recipients whose care plans are updated when needs change.
15.	Number of recipients' care plans updated at least annually.
16.	Percentage of recipients' care plans reviewed on a face-to face basis at least every three months and updated as appropriate.
17.	Percentage of recipient services delivered according to the care plan as to service type, amount, frequency, duration and scope.
18.	Percentage of new recipients with Agency-approved Freedom of Choice Certification forms indicating choice of setting in their case records.
19.	Percentage of new recipients with forms indicating their choice between waiver services and institutional care in their case records.

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section IX. Quality

20.	Percentage of all new recipients with signatures on the care plan indicating a choice of services and service providers.
Health and Welfare	
21.	Percentage of recipients who received telephone contact at least monthly to assess their health status, satisfaction with services and any additional needs.
22.	Percentage of health, safety and welfare issues reported to the Agency in adverse incident reports within twenty-four (24) hours of the incident.
23.	Percentage of recipients with substantiated reports of abuse, neglect or exploitation that had appropriate follow-up by LTC plan.
24.	Percentage of recipients with reports of the use of prohibited restraints, whose investigations started within twenty-four (24) hours of being reported to Adult Protective (APS).
25.	Percent of health status and service concerns that were addressed by the Managed Care Plan.

3. Quality Assessment and Performance Improvement Program

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

4. Publication of Performance Measures

There are no additional publication of performance measures provisions unique to the LTC managed care program.

C. Performance Improvement Projects (PIPs)

1. General Provisions

There are no additional general provisions for PIPs unique to the LTC managed care program.

2. PIP Proposals

- a. The Managed Care Plan shall include its LTC population in three (3) PIPs:
 - (1) One (1) of the PIPs shall focus on reducing potentially preventable events, including hospital admissions, readmissions, and emergency department visits;
 - (2) One (1) of the PIPs shall be an administrative PIP focusing on the administration of the transportation benefit, specifically focusing on improving the rate of trips resulting in the enrollee arriving to their scheduled appointment on time; and

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

- (3) One (1) PIP shall be a choice of PIP in one of two topic areas: behavioral health or integrating primary care and behavioral health.

- b. The first two (2) PIPs listed above shall be collaborative PIP coordinated by the Agency and the EQRO. The EQRO will put together a proposed methodology for the collaborative PIP, which will be sent to the Managed Care Plans for review. Once the proposed methodology has 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 methodology.

3. Annual PIP Submission

There are no additional annual PIP submission provisions unique to the LTC managed care program.

4. EQRO Validation

There are no additional EQRO validation provisions unique to the LTC managed care program.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

- a. The Managed Care Plan shall conduct an annual CAHPS survey for a time period specified by the Agency, using the HCBS CAHPS Survey 1.0, available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html>.

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

- c. The Managed Care Plan shall adhere to the following Survey Administration Guidelines:
 - (1) The Managed Care Plan shall contract with an Agency-approved survey vendor certified by the National Committee for Quality Assurance (NCQA) to administer the HCBS CAHPS Survey.

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

 - (3) The Managed Care Plan shall include in the survey sample only those enrollees who have been enrolled in the Managed Care Plan covering LTC benefits and

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

receiving home and community-based services for at least three (3) consecutive months.

- (4) The minimum sample size is 2,000, with a target of 411 completed surveys. The Managed Care Plan shall have its sample validated by an NCQA-certified HEDIS Auditor.
- (5) To increase response rates in order to meet the target number of completed surveys, the Managed Care Plan may oversample, send a pre-notification letter and/or postcard to enrollees to let them know they may be called to participate in the survey, and/or increase the number of call attempts made to enrollees on different days and at different times.
- (6) The Managed Care Plan covering LTC benefits shall submit to the Agency:
 - (a) An Excel file of the survey results (including the responses to each survey item for each respondent);
 - (b) An Excel file of the tabulated response rates for the plan for each survey item; and
 - (c) An attestation completed by the Managed Care Plan's survey vendor in accordance with the requirements in Chapter 2 of the SMMC Managed Care Plan Report Guide.
- d. The Managed Care Plan shall report the 2019 HCBS CAHPS survey results to the Agency by November 1, 2019. In subsequent years, the Managed Care Plan covering LTC benefits shall submit HCBS CAHPS survey results to the Agency by September 1 of each year.
- e. The Managed Care Plan shall use the results of the annual HCBS CAHPS survey to develop and implement plan-wide activities designed to improve member satisfaction. The Managed Care Plan shall submit the Member Satisfaction Improvement Report on a quarterly basis on activities pertaining to improving member satisfaction resulting from the annual enrollee satisfaction survey, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

2. Provider Satisfaction Survey

There are no additional provider satisfaction survey provisions unique to the LTC managed care program.

E. Enrollee Record Requirements

1. General Provisions

There are no additional general provisions for enrollee record requirements unique to the LTC managed care program.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

2. Enrollee Record Review Strategy

There are no additional enrollee record review strategy provisions unique to the LTC managed care program.

3. Standards for Enrollee Records

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

- (1) Enrollee demographic data including emergency contact information, guardian contact data, if applicable, permission forms and copies of assessments, evaluations, and medical and medication information;
- (2) Legal data such as guardianship papers, court orders and release forms;
- (3) Copies of eligibility documentations, including LOC determinations by CARES;
- (4) Identification of the enrollee's PCP;
- (5) Information from quarterly face-to-face visit that addresses at least the following:
 - a. The enrollee's current medical/functional/behavioral health status, including strengths and needs;
 - b. Identification of family/informal support system or community resources and their availability to assist the enrollee, including barriers to assistance;
 - c. The enrollee's ability to participate in the review and/or who case manager discusses service needs and goals with if the enrollee was unable to participate, and
 - d. An assessment of the enrollee's environment, including fall risk screening, and/or other special needs;
 - e. Environmental and/or other special needs (e.g., safety risks, sanitation, need for physical adaptations, general condition of the home, amount of space, adequacy of sleeping area, access to the bathroom, temperature, availability of food, etc.).
- (6) Needs assessments;
- (7) Plan of care;

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

- (8) Documentation of enrollee's responses to HCB Settings Requirements queries;
- (9) Documentation of interaction and contacts (including telephone contacts and enrollee-specific correspondence) with enrollee, family of enrollees, PCP, service providers, or other individuals related to provision of services;
- (10) Documentation of issues relevant to the enrollee remaining in the community with supports and services consistent with his or her capacities and abilities. This includes monitoring achievement of goals and objectives as set forth in the plan of care;
- (11) Residential agreements between the facility(ies) and the enrollee;
- (12) Problems with service providers, with a planned course of action noted;
- (13) Record of service authorizations;
- (14) Documentation that the enrollee has received and signed, if applicable, all required plan and program information (including copies of the enrollee handbook, provider directory, etc.);
- (15) Documentation of the discussion with the enrollee on the procedures for filing complaints and grievances;
- (16) Documentation of the choice of PDO, initially, annually, and upon reassessment;
- (17) Documentation of the signed Participant Agreement for PDO (if applicable);
- (18) Notices of Adverse Benefit Determination sent to the enrollee regarding denial, termination, reduction or suspension of services;
- (19) Proof of submission to DCF of the completed CF-ES 2506A Form (Client Referral/Change) and CF-ES 2515 Form (Certification of Enrollment Status HCBS);
- (20) Other documentation as required by the Managed Care Plan;
- (21) Copy of the contingency plan and other documentation that indicates the enrollee/authorized representative has been advised regarding how to report unplanned gaps in authorized service delivery;
- (22) Copy of the disaster/emergency plan for the enrollee's household that considers the special needs of the enrollee; and
- (23) Documentation of choice between institutional and HCBS services.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

- c. The Managed Care Plan's enrollee record information shall be maintained by the Managed Care Plan in compliance with State regulations for record retention. Written and electronically retrievable documentation of all evaluations and re-evaluations shall be maintained as required in 42 CFR 441.303(c)(3). The Managed Care Plan shall specify in policy where records of evaluation and re-evaluations of LOC are maintained and exchanged with the CARES Program.

4. Standards for Provider-Specific Enrollee Records

There are no additional standards for provider-specific enrollee records unique to the LTC managed care program.

F. Provider-Specific Performance Monitoring

1. General Provision

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

2. Peer Review

There are no additional peer review provisions unique to the LTC managed care program.

3. Monitoring Activities

- a. The Managed Care Plan shall develop an organized quality assurance and quality improvement program to enhance delivery of services, including, but not be limited to conducting quarterly enrollee record audits and quarterly reviews of the consistency of enrollee assessments/service authorizations (inter-rater reliability). The Managed Care Plan shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Managed Care Plan has taken to resolve identified issues. The Managed Care Plan shall submit this information to the Agency on a quarterly basis, thirty (30) days after the close of each quarter.
- b. The Managed Care Plan shall implement a system of internal monitoring of the case management program, using, at a minimum, the Case File Audit Report and the results of its monitoring, including case file audits, reviews of the consistency of enrollee assessments and service authorizations, and the development and implementation of continuous improvement strategies to address identified deficiencies.
 - (1) The Managed Care Plan shall submit its Case File Audit Report template to the Agency for review and approval prior to implementation and revision.
 - (2) In addition to monitoring the case manager's compliance with the requirements of this Exhibit, the Managed Care Plan shall target the monitoring of person-centered planning and practices with its Case File Audit Report.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

- (3) The Managed Care Plan shall conduct the Case File Audit Report on a quarterly basis, at a minimum, with a statistically significant sample of the LTC enrollee population.
 - (4) The Managed Care Plan shall document its monitoring findings and make such findings available to the Agency upon request.
- c. The Managed Care Plan shall have data collection and analysis capabilities that enable the tracking of enrollee service utilization, cost, and demographic information and maintain documentation of the need for all services provided to enrollees.
- d. The Managed Care Plan shall provide reports demonstrating case management monitoring and evaluation as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. These reports shall include results for the following performance measures including but not limited to:
- (1) Number and percentage of LOC-related redeterminations within three hundred thirty-five (335) days of previous LOC determination;
 - (2) Number and percentage of complete and accurate LOC forms for annual re-evaluations sent to CARES within thirty (30) days of LOC due date;
 - (3) Number and percentage of staff meeting mandated abuse, neglect and exploitation training requirements;
 - (4) Number and percentage of enrollee plans of care being distributed within ten (10) business days of development, or as updated, to the enrollee's PCP;
 - (5) Number and percentage of plans of care/summaries where enrollee participation is verified by signatures;
 - (6) Number and percentage of enrollee plans of care reviewed for changing needs on a face-to-face basis at least every three (3) months and updated as appropriate;
 - (7) Number and percentage of plan of care services delivered according to the plan of care as to service type, scope, amount and frequency;
 - (8) Number and percentage of enrollees with plans of care addressing all identified care needs;
 - (9) Number and percentage of critical incidents reported within twenty-four (24) hours to the appropriate agency;
 - (10) Number and percentage of enrollee records that include evidence that advance directives were discussed with the enrollee;
 - (11) Number and percentage of enrollees requesting a Fair Hearing and outcomes;

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section IX. Quality

- (12) Number and percentage of enrollees whose record contains a plan of care that includes a completed LTC supplemental assessment as defined in Rule 59G-4.192, F.A.C., including the availability of family/informal support systems and the amount of assistance the existing support systems are able to provide to the enrollee; and
- (13) Number and percentage of enrollees whose record contains a plan of care that includes LTC service authorizations for time periods that are shorter than the end date of the plan of care.

G. Other Quality Management Requirements

1. Abuse/Neglect and Critical Incident Reporting Standard

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

- a. The Managed Care Plan shall ensure suspected cases of abuse, neglect and/or exploitation are reported to the Florida Abuse Hotline (1-800-96A-BUSE) (s. 415.1034, F.S.). If the investigation requires the enrollee to move from his/her current location(s), the Managed Care Plan shall assist the investigator in finding a safe living environment or another participating provider of the enrollee's choice.
- b. The Managed Care Plan shall serve the enrollees designated as "high" risk within seventy-two (72) hours of referral to the Managed Care Plan from the Florida Adult Protective Services Unit or designee. The Managed Care Plan shall provide Adult Protective Services a primary and back-up contact person, including a telephone number, for "high" risk referrals. The Managed Care Plan's contacts shall return calls from Adult Protective Services within twenty-four (24) hours of initial contact.
- c. Documentation related to the suspected abuse, neglect, or exploitation, including the reporting of such, must be kept in a confidential file, separate from the enrollee record. This documentation will consist of only the necessary elements for the treatment of and service delivery to a vulnerable adult. The Managed Care Plan shall make the file available to the Agency upon request.
- d. The Managed Care Plan shall report critical incidents to the Agency within twenty-four (24) hours of the incident. The Managed Care Plan shall not require nursing facilities or ALFs to report critical incidents or provide incident reports to the Managed Care Plan. Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law, including but not limited to ss. 400.147 and 429.23, F.S., and Chapters 39 and 415, F.S.
- e. The Managed Care Plan shall report critical incidents to the Agency as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section IX. Quality

2. Agency Monitoring

There are no additional Agency monitoring provisions unique to the LTC managed care program.

H. Continuity of Care in Enrollment

The Managed Care Plan shall provide continuation of LTC services in accordance with **Attachment II**, Section IX.G. Additional Quality Management Requirements, until the enrollee receives a comprehensive assessment, a plan of care is developed, and services are arranged and authorized as required to address the LTC needs of the enrollee.

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ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section X. Administration and Management

Section X. Administration and Management

A. General Provisions

There are no additional general provisions for administration and management unique to the LTC managed care program.

B. Organizational Governance and Staffing

1. The Managed Care Plan shall have at least two (2) staff that are certified in person-centered planning and practices, by an institute or agency that has been approved by the Agency.

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

2. Additional requirements related to case management staffing are specified in Section VI.E., Care Coordination/Case Management.

3. Case Management Staff Qualifications and Experience

- a. Case managers shall meet one of the following qualifications:

- (1) Case Managers with the following qualifications shall also have a minimum of two (2) years of relevant experience:

- (a) Bachelor's degree in social work, sociology, psychology, gerontology, or a related social services field;
- (b) Registered nurse, licensed to practice in the State;
- (c) Bachelor's degree in a field other than social science; or

- (2) Case Managers with a master's degree in social work, sociology, psychology, gerontology, or a related social services field may substitute experience obtained through a practicum, internship, or clinical rotation on an equivalent basis for up to one (1) year of the experience requirements.

- (a) Case Managers with the following qualifications shall also have a minimum of four (4) years of relevant experience: Licensed Practical Nurse, licensed to practice in the State.

4. Case Managers without the aforementioned qualifications may substitute professional human service experience on a year-for-year basis for the educational requirement. Case Managers without a bachelor's degree shall have a minimum of six (6) years of relevant experience.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section X. Administration and Management

- b. All Case Managers are required to obtain a successful Level II criminal history screening and/or background investigation.
- c. All Case Managers shall have at least four (4) hours of in-service training annually in the identification of abuse, neglect, and exploitation.
- d. The Managed Care Plan shall designate a staff person(s) as the expert(s) on housing, education, behavioral health, and employment issues and resources within the Managed Care Plan's Contract region(s). This individual shall be available to assist case managers with up-to-date information designed to aid enrollees in making informed decisions about their independent living options.

5. Case Management Supervision

- a. Supervision of case managers

A supervisor-to-case-manager ratio shall be established that is conducive to a sound support structure for case managers. Supervisors shall have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers.

- b. Case management supervisor qualifications

- (1) Successful completion of a Level II criminal history and/or background investigation; and
- (2) Master's degree in a human service, social science or health field and has a minimum of two (2) years' experience in case management, at least one (1) year of which shall be related to the elderly and disabled populations; or
- (3) Bachelor's degree in a human service, social science, or health field with a minimum of five (5) years' experience in case management, at least one (1) year of which shall be related to the elderly and disabled populations; or
- (4) Professional human service, social science or health related experience may be substituted on a year-for-year basis for the educational requirement, (i.e., a high school diploma or equivalent and nine (9) years of experience in a human service, social science or health field, five (5) years of which shall be related to case management, at least one (1) year of which shall be related to elders and individuals with disabilities).

6. Training

- a. The Managed Care Plan shall provide case managers with adequate orientation and ongoing training on subjects relevant to the population served. The Managed Care Plan shall maintain documentation of training dates and staff attendance, as well as copies of materials used. The Managed Care Plan shall ensure that there is a training

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section X. Administration and Management

plan in place to provide uniform training to all case managers. This plan should include formal training classes as well as practicum observation and instruction for newly hired case managers.

- b. The Managed Care Plan shall submit the training plan and any resources, PowerPoints, handouts, or notes to the Agency's SFTP site specified in Policy Transmittal 2019-22, hereby incorporated by reference, no later than January 15th of each year.
- c. The Managed Care Plan shall provide orientation and training to newly hired case managers, in a minimum of the following areas:
 - (1) The role of the case manager in utilizing person-centered planning and practices in the delivery LTC case management services, including allowing the enrollee to direct the care planning to the maximum extent possible;
 - (2) The role of the case manager in advocating on behalf of the enrollee;
 - (3) Enrollee rights and responsibilities;
 - (4) Enrollee safety, including fall prevention, and infection control;
 - (5) Participant Direction Option (overview);
 - (6) Case management responsibilities as outlined in this Exhibit;
 - (7) Case management procedures specific to the Managed Care Plan;
 - (8) The LTC component of SMMC and the continuum of LTC services, including available service settings and service restrictions/limitations;
 - (9) The Managed Care Plan's provider network by location, service type, and capacity;
 - (10) Information on local resources for housing, education, and employment services/program that could help enrollees gain greater self-sufficiency in these areas;
 - (11) Responsibilities related to monitoring for and reporting of regulatory issues and quality of care concerns, including but not limited to suspected abuse/neglect and/or exploitation and critical incidents (Chapters 39 and 415, F.S.);
 - (12) Information on Alzheimer's disease and related disorders, and continuing education and training, including risk factors, signs and symptoms, treatment options, and new developments in the field;

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section X. Administration and Management

- (13) General medical information, such as symptoms, medications, and treatments for diagnostic categories common to the LTC population serviced by the Managed Care Plan;
 - (14) Behavioral health information, including identification of the enrollee's behavioral health needs and how to refer the enrollee to behavioral health services; and
 - (15) Reassessment processes.
- d. The Managed Care Plan shall provide all case managers with an annual review of orientation topics listed above, as well as regular ongoing training on topics relevant to the population(s) served. The following are examples of topics that could be covered:
- (1) In-service training on issues affecting the aged and disabled population;
 - (2) Abuse, neglect, and exploitation training;
 - (3) Policy updates and new procedures;
 - (4) Refresher training for areas found deficient through the Managed Care Plan;
 - (5) Interviewing skills;
 - (6) Assessment/observation skills;
 - (7) Cultural competency;
 - (8) Enrollee rights;
 - (9) Participant Direction Option (extensive);
 - (10) Critical incident reporting;
 - (11) Medical/behavioral health issues; and/or
 - (12) Medication awareness (including identifying barriers to compliance and side effects).
- e. Training Requirements
- (1) The Managed Care Plan shall ensure all applicable staff receives basic training on the PDO service delivery option.
 - (2) The Managed Care Plan shall ensure extensive training of an adequate number of case managers in the PDO, as described in the Participant Direction Option Manual. The Managed Care Plan shall maintain records of employee training in the employee's file.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section X. Administration and Management

- f. The Managed Care Plan shall ensure all case management staff hold current CPR certification.
- g. The Managed Care Plan shall train all affected staff, prior to implementation, on the use of redetermination date information and submit documentation of such training to the Agency for review within five (5) business days after the Agency's direction for training.
- h. The Managed Care Plan shall submit reports to the Agency on case manager training as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.

7. Caseload Requirements

- a. The Managed Care Plan shall have an adequate number of qualified and trained case managers to meet the needs of enrollees.
- b. Caseload Ratio Requirements:
 - (1) The Managed Care Plan shall ensure that case manager caseloads do not exceed:
 - (a) A ratio of sixty (60) enrollees to one (1) case manager for enrollees that reside in the community, except as follows: no more than a ratio of forty (40) enrollees to one (1) case manager for enrollees under age twenty-one (21) years receiving private duty nursing services in their family home or other community-based setting.
 - (b) No more than a ratio of one hundred (100) enrollees to one (1) case manager for enrollees age twenty-one (21) years and older that reside in a nursing facility.
 - (c) No more than a ratio of fifteen (15) enrollees to one (1) case manager for enrollees under age twenty-one (21) years who reside in a skilled nursing facility.
- c. The Managed Care Plan may implement a mixed caseload of enrollees.
 - (1) Where the case manager's caseload consists of enrollees who reside in the community and enrollees who reside in nursing facilities (mixed caseload), and if none of the enrollees who reside in a nursing facility are under the age of twenty-one (21) years, the Managed Care Plan shall ensure that the ratio does not exceed sixty (60) enrollees to one (1) case manager, except as follows: no more than a ratio of forty (40) enrollees to one (1) case manager for enrollees under age twenty-one (21) years receiving private duty nursing services in their family home or other community-based setting.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section X. Administration and Management

- (2) If the mixed caseload includes any enrollees residing in nursing facilities who are under the age of twenty-one (21) years, the Managed Care Plan shall ensure that the ratio does not exceed fifteen (15) enrollees to one (1) case manager.
 - (3) The Managed Care Plan may submit a request to the Agency to implement a mixed caseload of enrollees. The Managed Care Plan shall receive authorization from the Agency prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established by the Managed Care Plan and do not require authorization. The Managed Care Plan shall submit any caseload exception requests to the Agency. The Agency may, at any time, revoke the Managed Care Plan's authorization to exceed caseload ratios.
- d. The Managed Care Plan shall have written protocols to ensure assignment of a case manager immediately upon enrollment of newly enrolled enrollees. The case manager assigned to special subpopulations (e.g., individuals with AIDS, dementia, behavioral health issues, or traumatic brain injury) shall have experience or training in case management techniques for such populations.
 - e. The Managed Care Plan shall ensure that case managers are not assigned duties unrelated to enrollee-specific case management for more than fifteen percent (15%) of their time if they carry a full caseload.
8. The Managed Care Plan shall report to the Agency monthly on its case manager caseloads as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

C. Subcontracts

1. Fiscal/Employer Agent
 - a. The Managed Care Plan shall be the F/EA for PDO enrollees or may sub-contract this function. Should any of the F/EA duties be sub-contracted, the Managed Care Plan shall provide enrollees with at least thirty (30) days' notice informing them that the Managed Care Plan shall utilize a subcontractor to perform certain F/EA duties.
 - b. The Managed Care Plan or its subcontractor shall perform all F/EA responsibilities as specified in the Participant Direction Option Manual, as provided by the Agency.

D. Information Management and Systems

The Managed Care Plan shall transmit plan of care data to the Agency in a format prescribed by the Agency and at the request of the Agency.

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

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section X. Administration and Management

E. Claims and Provider Payment

1. For Medicaid only enrollees residing in a nursing facility and receiving hospice services, the Managed Care Plan shall pay the hospice provider the per diem rate set by the Agency for hospice services.
2. The Managed Care Plan shall report to the Agency monthly on all suspended or denied claims submitted by nursing facility providers as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

F. Encounter Data Requirements

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

G. Fraud and Abuse Prevention

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

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ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section XI. Method of Payment

Section XI. Method of Payment

A. General Provisions

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

B. Fixed Price Unit Contract

There are no additional fixed price unit Contract provisions unique to the LTC managed care program.

C. Payment Provisions

1. Capitation Rates

- a. The Agency will prospectively adjust the base capitation rates included in the Contract to reflect the Managed Care Plan's enrolled risk.
- b. The Agency will develop a pre-enrollment benchmark case mix for each region based on analysis of the most recent twelve (12) months of historical data that allows for three (3) months of claims run out. The enrollment distribution will be calculated using population segmentation logic consistent with that used in rate development. Recipients whose last care setting prior to the start of the capitation rate period was nursing facility will be classified as Non-HCBS. Recipients who become program-eligible after the start of the capitation rate period will be classified as Non-HCBS based on program codes that indicate ICP eligibility. Enrollees not meeting the Non-HCBS classification criteria will be classified as HCBS. For rate purposes, for both the transitioned and new enrollees, the recipient's initial classification will remain valid through the duration of the capitation rate period.
- c. Month One (1): In each region, the Agency will pay the Managed Care Plan a blended capitation rate that reflects the regional pre-enrollment benchmark case mix, adjusted for the Agency-required transition percentage, which shall be included in the Contract. The Agency will later perform a reconciliation based on month one (1) actual enrollment and case mix for each plan.
- d. Subsequent months: For the second month and each subsequent month of the Contract payment period, the Agency will develop a blended capitation rate for the Managed Care Plan, adjusted for the new enrollments and disenrollments that occurred in the previous month, and adjusted for the Agency-required transition percentage.
- e. To the extent that the Managed Care Plan achieves a utilization mix, wherein at least sixty-five percent (65%) of its enrollees are receiving home and community-based services and at least thirty-five percent (35%) are receiving services in an institutional setting, the Managed Care Plan shall accept an incentive adjustment in capitation rates in order to increase the number of enrollees receiving services in the community instead of in an institutional setting. The incentive adjustment shall continue in

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section XI. Method of Payment

subsequent contract periods, at a rate of one (1) percentage point per year as compared to the utilization mix at the end of the immediately preceding rate-setting period, until no more than twenty-five percent (25%) of the Managed Care Plan's enrollees are receiving services in an institutional setting.

2. Rate Adjustments and Reconciliations

- a. Pursuant to ss. 409.983(6) and 409.983(7), F.S., the Agency will reconcile the Managed Care Plan's payments to nursing facilities, including patient responsibility and hospices as follows:
- b. Actual nursing facility payments shall be reconciled by the Agency to ensure actual claim payments are, at a minimum, the same as Medicaid FFS claim payments. Any Managed Care Plan provider payments to nursing facilities in excess of FFS claim payment will not be reimbursed by the Agency or in any way increase per member per month payment to the Managed Care Plan in any current or future capitation rate setting period. The Managed Care Plan accepts and assumes all risks of excess payments as a cost of doing business and cannot seek additional Medicaid payments for such business decisions. Any inadvertent payments made by the Agency to a Managed Care Plan in excess of the FFS amount shall be overpayments and shall be recouped.
- c. The nursing facility rate reconciliation process required by 409.983(6), F.S., is as follows:
 - (1) The Agency will set facility-specific payment rates based on the rate methodology outlined in the most recent version of the Florida Title XIX LTC Reimbursement Plan. The Managed Care Plan shall pay nursing facilities an amount no less than the nursing facility specific payment rates set by the Agency and published on the Agency website. The Managed Care Plan shall use the published facility-specific rates as a minimum payment level for all payments.
 - (2) Participating nursing facilities shall maintain their active Medicaid enrollment and submit required cost reports to the Agency.
 - (3) For changes in nursing facility payment rates, the following process shall be used:
 - (a) The Agency will annually reconcile between the nursing facility payment rates used in the capitation rates and the actual published payment rates. This Managed Care Plan-specific reconciliation will be performed using the Managed Care Plan's own utilization, as reflected through encounter data that covers the capitation rate period dates of services with at least four (4) months of claims run out.
 - (b) The Managed Care Plan shall review and provide written comments or a letter of concurrence to the Agency within forty-five (45) days after receipt

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section XI. Method of Payment

of the reconciliation results. This reconciliation is considered final if the Managed Care Plan concurs with the result.

- (c) Comments and errors identified are limited to the published rates reviewed and related Managed Care Plan nursing facility and hospice payments, methodology and/or calculations.
 - (d) If the Managed Care Plan or the Agency comments that such an error has occurred, a new forty-five (45) day review period shall start on the date the Managed Care Plan receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive. The Managed Care Plan may dispute the Agency's decision as per **Attachment II**, Section XV., Special Terms and Conditions, if it does not concur with the results.
 - (e) If the Managed Care Plan does not provide comments within the forty-five (45) day period, no further opportunity for review consideration will be provided.
- (4) For retroactive changes in nursing facility payment rates, the following process shall be used:
- (a) The Managed Care Plan shall settle directly with the nursing facility that was overpaid based on the rate adjustment. The Managed Care Plan shall collect from the nursing facility the difference between the published rate and the previous rate for paid claims for the appropriate rate period.
 - (b) The Managed Care Plan shall settle directly with the nursing facility that was underpaid based on the rate adjustment. The Managed Care Plan shall pay the nursing facility the difference between the published rate and the previous rate for paid claims for the appropriate rate period. The Managed Care Plan shall make these payments to the provider within sixty (60) days of the adjusted rates being published on the Agency's website.
- (5) The Agency will set hospice LOC and room and board rates based upon the rate development methodology detailed in 42 CFR Part 418 for per diem rates and Chapter 409.906 (14), F.S., and 59G-4.140, F.A.C., for room and board rates. The Managed Care Plan shall pay hospices an amount no less than the hospice payment rates set by the Agency and published on the Agency website no later than October 1 of each year for per diem rates and January 1 and July 1 of each year for room and board rates for nursing facility residents. The Managed Care Plan shall use the published hospice rates as a minimum payment level for all future payments.
- (a) Participating hospices shall maintain their active Medicaid enrollment and submit room and board cost logs to the Agency.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section XI. Method of Payment

- (b) For changes in hospice per diem and room and board payment rates that apply prospectively, the following process shall be used:
 - i. The Agency shall annually reconcile between the hospice per diem and room and board payment rates used in the capitation rates paid and the actual published payment rates. The Agency shall perform this hospice-specific reconciliation using the Managed Care Plan's own utilization, as reflected through encounter data that covers the capitation rate period dates of services with at least four (4) months of claims run out.
 - ii. The Managed Care Plan shall review and provide written comments or a letter of concurrence to the Agency within forty-five (45) days after receipt of the reconciliation results. This reconciliation is considered final if the Managed Care Plan concurs with the result.
 - iii. Comments and errors identified are limited to the published rates reviewed and related Managed Care Plan hospice payments, and methodology, and/or calculations.
 - iv. If the Managed Care Plan or the Agency comments that such an error has occurred, a new forty-five (45) day review period shall start on the date the Managed Care Plan receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive. The Managed Care Plan may dispute the Agency's decision as per **Attachment II**, Section XV., Special Terms and Conditions, if it does not concur with the results.
 - v. If the Managed Care Plan does not provide comments within the forty-five (45) day period, no further opportunity for review consideration will be provided.

- (6) Patient Responsibility Reconciliation.
 - (a) The Managed Care Plan shall utilize patient responsibility as calculated by the Department of Children and Families (DCF) for each enrollee, in compliance with 42 CFR 435.622 and 435.725.
 - (b) Reconciliation Process
 - i. The Agency will pay a blended capitation rate to the Managed Care Plan net of the expected patient responsibility set by the Agency.
 - ii. The Agency will annually reconcile between the expected patient responsibility deducted from the capitation rates and the actual patient responsibility calculated by the DCF.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section XI. Method of Payment

- iii. If the actual patient responsibility is greater than the expected patient responsibility, the Managed Care Plan shall pay the Agency the difference between the actual patient responsibility and the expected patient responsibility.
- iv. If the actual patient responsibility is less than the expected patient responsibility, the Agency shall pay the Managed Care Plan the difference between the expected patient responsibility and the actual patient responsibility.
- v. The following process shall be used to finalize the reconciliation results:
 - a. The Managed Care Plan shall review and provide written comments or a letter of concurrence to the Agency within forty-five (45) days after receipt of the reconciliation results. This letter of concurrence is considered final and binding if the Managed Care Plan concurs with the result. If the Managed Care Plan does not provide comments within the forty-five (45) day period, no further opportunity for review consideration will be provided.
 - b. If the Managed Care Plan or the Agency comments that an error has occurred, the Agency will consider the comments and send a final determination of the reconciliation results. A new forty-five (45) day review period shall start on the date the Managed Care Plan receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive. The Managed Care Plan may dispute the Agency's decision as per **Attachment II**, Section XV., Special Terms and Conditions, if it does not concur with the results.
- (c) Nursing Facility, Hospice and Patient Responsibility Collection Reconciliation Schedule. The Agency will announce the reconciliation schedule after the close of each capitation rate period. The Managed Care Plan shall respond to any Agency requests for additional information concerning the reconciliation within fifteen (15) days of notification.
- (d) Actual hospice payments shall be reconciled by the Agency to ensure actual claim payments are, at a minimum, the same as Medicaid FFS claim payments. Any Managed Care Plan provider payments to hospices in excess of FFS claim payment will not be reimbursed by the Agency or in any way increase per member per month payment to the Managed Care Plan in any current or future capitation rate setting period. The Managed Care Plan accepts and assumes all risks of excess payments as a cost of doing business and cannot seek additional Medicaid payments for such business decisions. Any inadvertent payments made by the Agency to a

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XI. Method of Payment

Managed Care Plan in excess of the FFS amount shall be overpayments and shall be recouped.

3. Errors

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

4. Enrollee Payment Liability Protection

There are no additional enrollee payment liability protection provisions unique to the LTC managed care program.

5. Achieved Savings Rebate

In order to be eligible to retain up to an additional one percent (1%) of revenue in the first year, a Managed Care Plan shall exceed the specified threshold for each and all performance measures as listed in the Performance Measure Thresholds Table, Table 6, below:

TABLE 6: PERFORMANCE MEASURE THRESHOLDS	
Measure	Threshold
Centers for Medicare & Medicaid Services and Mathematica Managed Long-Term Services and Supports (MLTSS) Measures	
LTSS Comprehensive Assessment and Update	Ninety-five percent (95%)
LTSS Comprehensive Care Plan and Update	Ninety-five percent (95%)
LTSS Shared Care Plan with Primary Care Practitioner	Ninety-five percent (95%)
LTSS Re-Assessment and Care Plan Update after Inpatient Discharge	Ninety-five (95%)

6. Community High Risk Pool (CHRP)

(a) The Community High Risk Pool (CHRP) for the SMMC LTC program recognizes the disproportionate enrollment of high cost HCBS recipients. The CHRP operates as a revenue neutral redistribution of plan reimbursement associated with community enrollees. The risk pool is funded through a small withhold amount applied to the pre-transition adjusted HCBS enrollment for the LTC contractor. Encounter data submissions are required in accordance with **Attachment II**, Section X., Administration and Management. The Agency shall analyze the LTC encounter data submitted by the Managed Care Plan.

(1) Only HCBS will be used to evaluate the SMMC LTC risk pool for an enrolled recipient.

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section XI. Method of Payment

- (2) Costs associated with nursing facility services and hospice services are explicitly excluded from the distribution of the risk pool.
- (b) The Agency will establish a withhold per-member-per-month (PMPM) on a quarterly basis.
- (1) The withhold PMPM will use only State plan or waiver approved services and exclude nursing facility and hospice services.
 - (2) The CHRP will be established by SMMC LTC region.
 - (3) The Agency may adjust the PMPM withhold value on a quarterly basis as necessary.
 - (4) The Agency shall communicate the terms of the CHRP including the threshold and coinsurance amount each quarter.
 - (5) The established CHRP withhold will be applied to the pre-transition HCBS enrollment on a monthly basis.
- (c) The Agency will distribute the funds in the CHRP in proportion to each Managed Care Plan's reported or Agency adjusted expenditures in excess of the CHRP threshold average PMPM for HCBS recipients for the quarterly period.
- (1) The Agency will utilize encounter data submitted by the Managed Care Plan and the enrollment maintained by the Agency to evaluate Managed Care Plan expenditures for the purpose of distributing the CHRP funds. Encounter data shall be submitted in accordance with **Attachment II**, Section X., Administration and Management.
 - (2) The Agency shall aggregate the qualified service expenditures from the encounter data by Managed Care Plan for the quarter based on incurred date reported on the encounter data for HCBS recipients who were eligible on the date of service. The Agency, at its discretion, may reprice encounter data based on what the Agency would have paid for the same services under FFS.
 - (3) CHRP distributions will occur every three (3) months using the following schedule:
 - i. May Disbursement – Claims incurred September – November, paid and submitted through February;
 - ii. August Disbursement – Claims incurred December – February, paid and submitted through May;
 - iii. November Disbursement – Claims incurred March – May, paid and submitted through August; and

ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section XI. Method of Payment

- iv. February Disbursement – Claims incurred June – August, paid and submitted through November.
- (4) At the end of each twelve (12) month period, in the event the eligible expenditures for the CHRP are less than the total amount withheld, the Agency shall refund the balance of the withheld amount less any disbursement for eligible expenditures to the Managed Care Plans participating in the region.
- (5) At the end of each twelve (12) month period, in the event the Managed Care Plan(s) in a region do not have any HCBS recipients whose expenditures meet the threshold, the Agency shall refund the withheld amounts to the Managed Care Plans participating in the region.
- (6) At the end of each twelve (12) month period, the Agency will close the funds, eliminating any carry over balances, and return any unused portion of each regional fund to the Managed Care Plans operating in that region on a per member basis. The Agency, at its discretion, may distribute any unused portion of the funds from the pool before the end of the twelve (12) month period.
- (d) The Agency may adjust prior CHRP distributions if the encounter data used for the original CHRP distribution has changed through adjustments submitted in the encounter data that may include but are not limited to voided and replaced encounters submitted by the Managed Care Plans or a recipients retro-active disenrollment from the SMMC LTC program. Twelve (12) months after the end of the quarter, the Agency will make no further post-payment adjustments.
- (e) The Agency retains the right to update the withhold percentage on a quarterly basis, if needed. Inclusion of this information in the LTC data book does not imply the continued due of CHRP, and it does not imply that the methodology of CHRP will stay the same if it continues.

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ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM

Section XII. Financial Requirements

Section XII. Financial Requirements

A. Insolvency Protection

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

B. Surplus

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

C. Interest

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

D. Third Party Resources

1. Covered Third Party Collections

There are no additional covered third party collections provisions unique to the LTC managed care program.

2. Optional Third Party Recovery Services

There are no additional optional third party recovery services provisions unique to the LTC managed care program.

E. Assignment

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

F. Financial Reporting

There are no additional financial reporting provisions unique to the LTC managed care program.

G. Inspection and Audit of Financial Records

The Managed Care Plan shall maintain books, records, documents, and other evidence of PDO-related expenditures using generally accepted accounting principles (GAAP).

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XIII. Sanctions

Section XIII. Sanctions

A. Contract Violations and Non-Compliance

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

B. Corrective Action Plans (CAP)

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

C. Performance Measure Sanctions

1. The Agency may sanction the Managed Care Plan for failure to achieve minimum performance scores on performance measures specified by the Agency after the first year of poor performance. The Agency shall apply the rates according to the Performance Measure Sanction Table – Effective 10/1/2018 – 9/30/2023, Table 7, below.

TABLE 7 PERFORMANCE MEASURE SANCTION TABLE – EFFECTIVE 10/1/2018 – 9/30/2023	
Centers for Medicare and Medicaid Services and Mathematica Long-Term Services and Supports (LTC) measures	Rate and applicable sanction
LTSS Comprehensive Assessment and Update	Rate < eighty-five percent (85%), ten thousand dollar (\$10,000.00) monetary sanction
LTSS Comprehensive Care Plan and Update	Rate < eighty-five percent (85%), ten thousand dollar (\$10,000.00) monetary sanction
LTSS Shared Care Plan with Primary Care Practitioner	Rate < eighty-five percent (85%), ten thousand dollar (\$10,000.00) monetary sanction
LTSS Reassessment and Care Plan Update after Inpatient Discharge	Rate < eighty-five percent (85%), ten thousand dollars (\$10,000.00) monetary sanction

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

D. Other Sanctions

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

E. Notice of Sanctions

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

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XIII. Sanctions

F. Dispute of Sanctions

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

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XIV. Liquidated Damages

Section XIV. Liquidated Damages

A. Damages

Additional damages issues and amounts unique to the LTC 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 LTC Liquidated Damages Issues and Amounts Table, Table 8, below.

TABLE 8 LTC LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	LTC Program Issue	Damages
1	Failure to comply with the enrollee records documentation requirements pursuant to the Contract	One thousand dollars (\$1,000.00) per occurrence
2	Failure to comply with the timeframes for developing and approving a plan of care for transitioning or initiating HCBS services as described in the Contract	Five hundred dollars (\$500.00) per day, per occurrence
3	Failure to have a face-to-face contact between the Managed Care Plan case manager and each enrollee at least every ninety (90) days or following a significant change as described in the Contract	Five thousand dollars (\$5,000.00) for each occurrence
4	Failure to complete in a timely manner minimum care coordination contacts required for persons transitioned from a nursing facility to a community placement as described in the Contract	Five hundred dollars (\$500.00) per day, per occurrence
5	Failure to meet the performance standards established by the Agency regarding missed visits for personal care, attendant nursing care, homemaker, or home-delivered meals for enrollees (referred to herein as "specified HCBS") pursuant to the Contract	Five hundred dollars (\$500.00) per occurrence

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XIV. Liquidated Damages

TABLE 8 LTC LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	LTC Program Issue	Damages
6	Failure to develop a person-centered plan of care as described in the Contract for an enrollee that includes all of the required elements, and which has been reviewed with and signed and dated by the enrollee or enrollee's authorized representative, unless the enrollee or enrollee's authorized representative refuses to sign, which shall be documented in writing	Five hundred dollars (\$500.00) per deficient plan of care. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the caseload and staffing requirements specified in the Contract
7	Failure to implement and maintain a formal Caregiver Training Program as described in this Contract	Five hundred dollars (\$500.00) per day
8	Failure to meet any timeframe regarding care coordination for enrollees as described in the Contract	Two hundred and fifty dollars (\$250.00) per day, per occurrence
9	Failure to follow-up within seven (7) days of initial plan of care development to ensure that in-home HCBS services are in place as described in the Contract	Five hundred dollars (\$500.00) for each enrollee falling below the eighty-five percent (85%) threshold for whom the Managed Care Plan failed to follow-up within seven (7) days
10	Failure to provide a copy of the plan of care to each enrollee's PCP and facility-based provider in the timeframes as described in the Contract	Five hundred dollars (\$500.00) per day
11	Failure to report enrollees that do not receive any LTC services listed in the approved plan of care for a continuous sixty (60)-day period, as described in the Contract	For each enrollee, an amount equal to the capitation rate for the month in which the enrollee did not receive Long-Term Care services
12	Failure to send authorizations to all applicable providers for the agreed upon services within twenty-four (24) hours of the initial face-to-face visit as described in the Contract	One hundred dollars (\$100.00) for each occurrence
13	Failure to comply with obligations and time frames in the delivery of annual face-to-face LOC redeterminations as described in the Contract	One thousand dollars (\$1,000.00) per occurrence
14	Failure to ensure that for each enrollee all necessary paperwork is submitted to DCF within the timeframes included in the Contract	One hundred dollars (\$100.00) assessed for each enrollee who temporarily loses eligibility (for less than sixty (60) days) pursuant to a redetermination

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XIV. Liquidated Damages

TABLE 8 LTC LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	LTC Program Issue	Damages
15	Failure to follow-up within twenty-four (24) hours of initial contact by the Florida Adult Protective Services Unit for “high risk” referrals pursuant to Section VII.F.1.b. of this Exhibit	Five thousand dollars (\$5,000.00) per occurrence
16	Failure to serve enrollees who have been designated as “high risk” within seventy-two (72) hours after being referred to the Managed Care Plan from the Florida Adult Protective Services Unit or designee, as mandated by Florida Statutes	Five thousand dollars (\$5,000.00) per occurrence
17	Failure to report suspected cases of abuse, neglect, and/or exploitation of elders and individuals with disabilities to the Florida Abuse Hotline (1-800-96A-BUSE) (s. 415.1034, F.S.)	Five thousand dollars (\$5,000.00) per occurrence
18	Performance Measure: Comprehensive LTC Assessment and Update	Failure to achieve a rate of eighty-five percent (85%) or higher for this measure will result in liquidated damages of one hundred dollars (\$100.00) per each case in the denominator not present in the numerator for the measure up to the eighty-five (85%) rate
19	Performance Measure: Comprehensive LTC Care Plan	Failure to achieve a rate of eighty-five percent (85%) or higher for this measure will result in liquidated damages of \$100.00 per each case in the denominator not present in the numerator for the measure up to the eighty-five (85%) rate
20	Performance Measure: Shared Care Plan	Failure to achieve a rate of eighty-five (85%) or higher for this measure will result in liquidated damages of one hundred dollars (\$100.00) per each case in the denominator not present in the numerator for the measure up to the eighty-five (85%) rate

**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XIV. Liquidated Damages

TABLE 8 LTC LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	LTC Program Issue	Damages
21	Performance Measure: Reassessment and Care Plan Update after Discharge	Failure to achieve a rate of eighty-five (85%) or higher for this measure will result in liquidated damages of one hundred dollars (\$100.00) per each case in the denominator not present in the numerator for the measure up to the eighty-five (85%) rate

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XV. Special Terms and Conditions

Section XV. Special Terms and Conditions

A. Conflict of Interest

1. The Managed Care Plan shall not contract with the same entity to provide case management services/functions and any other LTC covered services for an enrollee unless the Managed Care Plan demonstrates all of the following:
 - a. The entity is the only willing and qualified entity to provide case management services in a geographic area;
 - b. The entity is a provider of LTC services, without which the Managed Care Plan is unable to meet minimum Provider Network Standards for the service; and
 - c. The Managed Care Plan shall utilize an independent entity, qualified by training and experience, to process and resolve conflicts between the enrollee and the case management provider.
2. Prior to implementing a Contract under the above conditions, the Managed Care Plan shall submit to the Agency procedures that demonstrate the conflict of interest protections that are place for enrollees receiving case management services from a provider of other HCBS services, including separation of case management responsibilities from provider functions, and the process that enrollees may use to file a complaint through the Managed Care Plan's alternative dispute resolution process.

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**ATTACHMENT II
EXHIBIT II-B - UPDATE: FEBRUARY 1, 2022
LONG-TERM CARE (LTC) PROGRAM**

Section XVI. Reporting Requirements

Section XVI. Reporting Requirements

A. Managed Care Plan Reporting Requirements

1. Required Reports

The Managed Care Plan shall comply with all reporting requirements set forth in this Contract, including reports specific to Managed Care Plans covering LTC services as specified in the Summary of Reporting Requirements Table, Table 9, below, and the Managed Care Plan Report Guide.

TABLE 9 SUMMARY OF REPORTING REQUIREMENTS		
Report Name	Program Type	Frequency
Case Manager and Provider Training Report	LTC Program	Annually
Case Manager Caseload Report	LTC Program	Monthly
Case Management File Audit Report	LTC Program	Quarterly
Critical Incident Report Individual	LTC Program	Immediately upon occurrence and no later than within twenty-four (24) hours after detection or notification
Denial, Reduction, Termination or Suspension of Services Report	LTC Program	Monthly
Enrollee Roster and Facility Residence Report	LTC Program	Monthly
Missed Services Report	LTC Program	Monthly
Participant Direction (PDO) Roster Report	LTC Program	Monthly
Provider Network and Qualifications Report	LTC Program	Quarterly
Unable to Provide Case Management Report	LTC Program	Monthly

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