



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

July 14, 2017

Prospective Vendor(s):

Subject: Solicitation Number: AHCA ITN 004–17/18 – Region 4

Title: Statewide Medicaid Manage Care Program

This solicitation is being issued by the State of Florida, Agency for Health Care Administration, hereinafter referred to as “**AHCA**” or “**Agency**”, to select a vendor to provide Statewide Medicaid Managed Care Program services. The solicitation package consists of this transmittal letter and the following attachments and exhibits:

Attachment	A	Instructions and Special Conditions
Exhibit	A-1	Questions Template
Exhibit	A-2-a	Qualification of Plan Eligibility
Exhibit	A-2-b	Provider Service Network Certification of Ownership and Controlling Interest
Exhibit	A-2-c	Additional Required Certifications and Statements
Exhibit	A-3-a	Milliman Organizational Conflict of Interest Mitigation Plan
Exhibit	A-3-b	Milliman Employee Organizational Conflict of Interest Affidavit
Exhibit	A-4	Submission Requirements and Evaluation Criteria Instructions
Exhibit	A-4-a	General Submission Requirements and Evaluation Criteria
Exhibit	A-4-a-1	SRC# 6 - General Performance Measurement Tool
Exhibit	A-4-a-2	SRC# 9 - Expanded Benefits Tool (Regional)
Exhibit	A-4-a-3	SRC# 10 - Additional Expanded Benefits Template (Regional)
Exhibit	A-4-a-4	SRC# 14 - Standard CAHPS Measurement Tool
Exhibit	A-4-b	MMA Submission Requirements and Evaluation Criteria
Exhibit	A-4-b-1	MMA SRC# 6 - Provider Network Agreements/Contracts (Regional)
Exhibit	A-4-b-2	MMA SRC# 14 - MMA Performance Measurement Tool
Exhibit	A-4-b-3	MMA SRC# 21 - Provider Network Agreements/Contracts Statewide Essential Providers
Exhibit	A-4-c	LTC Submission Requirements and Evaluation Criteria
Exhibit	A-4-c-1	LTC SRC# 4 - Provider Network Agreements/Contracts (Regional)
Exhibit	A-4-d	Specialty Submission Requirements and Evaluation Criteria
Exhibit	A-5	Summary of Respondent Commitments
Exhibit	A-6	Summary of Managed Care Savings
Exhibit	A-7	Certification of Drug-Free Workplace Program
Exhibit	A-8	Standard Contract



Attachment	B	Scope of Service - Core Provisions
Exhibit	B-1	Managed Medical Assistance (MMA) Program
Exhibit	B-2	Long-Term Care (LTC) Program
Exhibit	B-3	Specialty Plan
Attachment	C	Cost Proposal Instructions and Rate Methodology Narrative
Exhibit	C-1	Capitated Plan Cost Proposal Template
Exhibit	C-2	FFS PSN Cost Proposal Template
Exhibit	C-3	Preliminary Managed Medical Assistance (MMA) Program Rate Cell Factors
Exhibit	C-4	Managed Medical Assistance (MMA) Program Expanded Benefit Adjustment Factors
Exhibit	C-5	Managed Medical Assistance (MMA) Program IBNR Adjustment Factors
Exhibit	C-6	Managed Medical Assistance (MMA) Program Historical Capitated Plan Provider Contracting Levels During SFY 15/16 Time Period
Exhibit	C-7	Statewide Medicaid Managed Care Data Book Statewide Medicaid Managed Care Data Book Questions and
Exhibit	C-8	Answers

Your response must comply fully with the instructions that stipulate what is to be included in the response. Respondents submitting a response to this solicitation shall identify the solicitation number, date and time of opening on the envelope transmitting their response. This information is used only to put the Agency mailroom on notice that the package received is a response to an Agency solicitation and therefore should not be opened, but delivered directly to the Procurement Officer.

The designated Agency Procurement Officer for this solicitation is the undersigned. All communications from respondents shall be made in writing and directed to my attention at the address provided in **Attachment A**, Instructions and Special Conditions, **Section A.**, Overview, **Sub-Section 5.**, Procurement Officer unless otherwise instructed in this solicitation.

The term "Proposal", "Response" or "Reply" may be used interchangeably and mean the respondent's submission to this solicitation.

Section 120.57(3)(b), Florida Statutes and Section 28-110.003, Florida Administrative Code require that a Notice of Protest of the solicitation documents shall be made within seventy-two hours after the posting of the solicitation. Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

Sincerely,

Jennifer Barrett

Jennifer Barrett, Chief
Bureau of Support Services

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

Table of Contents

A.	Overview	4
1.	Solicitation Number.....	4
2.	Solicitation Type	4
3.	Solicitation Title.....	4
4.	Date of Issuance.....	4
5.	Procurement Officer.....	4
6.	Solicitation Timeline.....	4
7.	PUR 1000, General Contract Conditions	5
8.	PUR 1001, General Instructions to Respondents	5
9.	Restriction on Communications	6
10.	Respondent Questions	6
11.	Solicitation Addenda	6
12.	Public Opening of Responses.....	7
13.	Provider Comments	7
14.	Program Overview	7
15.	Program Objectives and Goals	8
16.	Definitions	8
17.	Type of Contract Contemplated.....	9
18.	Type of Plans Contemplated.....	10
19.	Term of Contract.....	10
B.	Response Preparation and Content.....	11
1.	General Instructions.....	11
2.	Mandatory Response Content	12
a.	Transmittal (Cover) Letter.....	12
b.	Required Certifications and Statements	12
c.	Milliman Organizational Conflict of Interest Mitigation Plan.....	13
d.	Original Proposal Guarantee	13
e.	Financial Information	14
f.	Submission Requirements and Evaluation Criteria	17
g.	Cost Proposal and Cost Proposal Rate Sheets	18

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

h.	Summary of Respondent Commitments	18
i.	Summary of Managed Care Savings	19
3.	Additional Response Content	19
C.	Response Submission Requirements.....	19
1.	Hardcopy and Electronic Submission Requirements	19
a.	General Provision.....	19
b.	Hardcopies of the Response	19
c.	Electronic Copy of the Response	21
2.	Confidential or Exempt Information.....	23
D.	Response Evaluation, Negotiations, and Contract Award	24
1.	Response Clarification.....	24
2.	Responsive Reply Determination.....	24
3.	Non-Scored Requirements	25
a.	Transmittal (Cover) Letter.....	25
b.	Required Certifications and Statements	25
c.	Milliman Organizational Conflict of Interest Mitigation Plan.....	25
d.	Original Proposal Guarantee	25
e.	Summary of Respondent Commitments	26
f.	Summary of Managed Care Savings	26
4.	Scored Requirements – Evaluation Criteria.....	26
a.	Financial Evaluation	26
b.	Review of Provider Comments	27
c.	Technical Response Evaluation	28
d.	Cost Proposal.....	30
e.	Ranking of Responses	30
5.	Negotiation Process.....	33
6.	Selection Criteria for Determining Best Value	35
7.	Number of Awards	35
8.	Posting of Notice of Intent to Award.....	36
9.	Contract Execution	37
E.	Contract Implementation	38
1.	Proposed Implementation Schedule	38
2.	Readiness Review	39

**ATTACHMENT A
INSTRUCTIONS AND SPECIAL CONDITIONS**

3.	Enrollment Levels	39
4.	Transition Enrollment.....	40

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ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

A. Overview

1. Solicitation Number

AHCA ITN 004-17/18 – Region 4

2. Solicitation Type

Invitation to Negotiate

3. Solicitation Title

Statewide Medicaid Managed Care Program

4. Date of Issuance

July 14, 2017

5. Procurement Officer

Jennifer Barrett
 Agency for Health Care Administration
 Building 2, Suite 203, Mail Stop 15
 2727 Mahan Drive
 Tallahassee, FL 32308-5403
 Email: solicitation.questions@ahca.myflorida.com

6. Solicitation Timeline

The projected solicitation timeline is shown below (all times are Eastern Time). The Agency for Health Care Administration (Agency) reserves the right to amend the timeline in the State's best interest. If the Agency finds it necessary to change any of the activities/dates/times listed, all interested parties will be notified by addenda to the original solicitation document posted on the Vendor Bid System (VBS) (http://myflorida.com/apps/vbs/vbs_main_menu).

ACTIVITY	DATE/TIME	LOCATION
Solicitation Issued by Agency	July 14, 2017	Electronically Posted http://myflorida.com/apps/vbs/vbs_main_menu
Deadline for Receipt of Written Questions	August 14, 2017 2:00 p.m.	solicitation.questions@ahca.myflorida.com
Anticipated Date for Agency Responses to Written Questions	September 15, 2017 2:00 p.m.	Electronically Posted http://myflorida.com/apps/vbs/vbs_main_menu

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

ACTIVITY	DATE/TIME	LOCATION
Deadline for Receipt of Responses	November 1, 2017 9:00 a.m.	Jennifer Barrett Agency for Health Care Administration Building 2, 3 rd Floor, Suite 333 Conference Room F 2727 Mahan Drive Tallahassee, FL 32308-5403
Public Opening of Responses	November 1, 2017 3:00 p.m.	Agency for Health Care Administration Building 2, 3 rd Floor, Suite 333 Conference Room F 2727 Mahan Drive Tallahassee, FL 32308-5403
Anticipated Posting of Respondent Names for Provider Comment	November 3, 2017 2:30 p.m.	Electronically Posted http://ahca.myflorida.com/medicaid/statewide_mc/ind_ex.shtml
Deadline for Receipt of Provider Comments	November 20, 2017 5:00 p.m.	Electronically Received through Agency Provider Comment Survey Tool http://ahca.myflorida.com/medicaid/statewide_mc/ind_ex.shtml
Anticipated Dates for Negotiations	January 16, 2018 through March 30, 2018	Agency for Health Care Administration 2727 Mahan Drive, Building 2 Operations Conference Room, 2nd Floor, Room 200 Tallahassee, FL 32308-5403
Anticipated Posting of Notice of Intent to Award	April 16, 2018	Electronically Posted http://myflorida.com/apps/vbs/vbs_www.main_menu

7. PUR 1000, General Contract Conditions

PUR 1000, General Contract Conditions, is incorporated by reference and is available for prospective respondents to download at:

<http://www.dms.myflorida.com/content/download/2933/11777/version/6/file/1000.pdf>

8. PUR 1001, General Instructions to Respondents

PUR 1001, General Instructions to Respondents, is incorporated by reference and is available for prospective respondents to download at:

<http://www.dms.myflorida.com/content/download/2934/11780/1001.pdf>

Unless otherwise noted, instructions in this **Attachment A** shall take precedence over the PUR 1001, General Instructions to Respondents.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

9. Restriction on Communications

Respondents to this solicitation or persons acting on their behalf may not contact, between the release of this solicitation and the end of the seventy-two (72) hour period following the Agency posting the notice of intended award, excluding Saturdays, Sundays, and State holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the Procurement Officer or as provided in this solicitation. Violation of this provision may be grounds for rejecting a response. See Section 287.057(23), Florida Statutes.

10. Respondent Questions

- a. The Agency will receive all questions pertaining to this solicitation no later than the date and time specified for written questions in **Section A., Overview, Sub-Section 6.,** Solicitation Timeline.
- b. Prospective respondents must submit all questions by email at solicitation.questions@ahca.myflorida.com, utilizing **Exhibit A-1, Questions Template.** **Exhibit A-1, Questions Template,** is a Microsoft Excel document and is available for prospective respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>

- c. The Agency will not accept questions by telephone, surface mail, hand delivery or fax.
- d. The Agency's response to questions received for all regions will be posted as an addendum to this solicitation as specified in **Section A., Overview, Sub-Section 6.,** Solicitation Timeline and may be grouped as to not repeat the same answer multiple times.
- e. The Agency reserves the right to post an addendum to this solicitation in order to address questions received after the written question submission deadline. It is the sole discretion of the Agency to consider questions received after the written questions submission deadline.

11. Solicitation Addenda

If the Agency finds it necessary to supplement, modify, or interpret any portion of this solicitation during this solicitation period, a written addendum will be posted on the VBS as addenda to this solicitation. It is the respondent's responsibility to check the VBS periodically for any information or updates to this solicitation. The Agency bears no responsibility for any resulting impacts associated with a prospective respondent's failure to obtain the information made available through the VBS.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

12. Public Opening of Responses

Responses shall be opened on the date, time and at the location indicated in **Section A.**, Overview, **Sub-Section 6.**, Solicitation Timeline. Respondents may, but are not required to, attend. The Agency will only announce the respondent(s) name at the public opening. Pursuant to Section 119.071(1)(b), Florida Statutes, no other materials will be released. Any person requiring a special accommodation because of a disability must contact the Procurement Officer at least five (5) business days prior to this solicitation opening. If you are hearing or speech impaired, contact the Agency by using the Florida Relay Service at (800) 955-8771 (TDD).

13. Provider Comments

a. Pursuant to Section 409.966(3)(a)8., Florida Statutes, the Agency will consider comments in writing by any enrolled or registered Medicaid provider relating to a respondent that has submitted a response to this solicitation in the same region in which the provider is located and rendering services.

b. The Agency will publish a list of respondents and instructions for how providers may submit comments to this solicitation within two (2) business days of the public opening at:

http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml.

c. The Agency will utilize an online survey tool for the collection of the provider comments. The online survey tool will remain open and active for a period of ten (10) business days.

d. Providers must submit comments to the Agency, through the survey tool, by the date/time indicated in **Section A.**, Overview, **Sub-Section 6.**, Solicitation Timeline and as outlined on the Agency's website.

14. Program Overview

The State of Florida has offered Medicaid services since 1970. Medicaid is funded by both the State and federal government to provide health care coverage for eligible children, seniors, disabled adults, parents of children and pregnant women. The annual budget for the program is more than \$25 billion, and makes up the largest part of the total Florida budget. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, Florida Statutes) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: Managed Medical Assistance (MMA) and Long-term Care (LTC). More than 3.2 million Floridians are enrolled in Florida's SMMC program.

ATTACHMENT A

INSTRUCTIONS AND SPECIAL CONDITIONS

15. Program Objectives and Goals

The purpose of this solicitation is to procure Contracts to provide services under the SMMC program. The Agency's overall objective is for Medicaid enrollees to receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving the best possible quality outcomes while containing costs.

The Agency intends to award Contracts to nationally accredited managed care plans that offer comprehensive, quality-driven provider networks, streamlined processes that enhance the enrollee and provider experience, expanded benefits targeted to improve outcomes for enrollees, top quality scores, and high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model.

In addition to the objectives stated above, the Agency intends to award Contracts to managed care plans that offer innovative and evidence-based approaches in meeting the following goals under the Medicaid program:

- Reduce potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services;
- Improve birth outcomes; and
- Rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of an institution.

16. Definitions

The following terms, as used in this **Attachment A**, are defined as:

- a. **Balance Sheet** – Statement of total assets, liabilities and net worth at the end of the audit period(s).
- b. **Cash Flow Statement(s)** – Statement(s) that reflect the inflow of revenue versus the outflow of expenses resulting from operating, investing, and financing activities during the audit period(s).
- c. **Contract Execution** – The date that the resulting Contract is signed by the Agency Secretary, or designee.
- d. **Long-term Care Services** – as defined in **Attachment B**, Scope of Service, Core Provisions.
- e. **Managed Medical Assistance Services** – as defined in **Attachment B**, Scope of Service, Core Provisions.
- f. **Respondent** – also referred to as Vendor/vendor refers to respondents to this solicitation.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- g. Revenue and Expense Statement(s)** – Statement(s) of profit or loss (for not-for-profits it is the excess of revenues over expenses) during the audit period(s).

17. Type of Contract Contemplated

- a.** The Contract resulting from this solicitation will be a fixed price (unit cost) Contract. The successful respondent (i.e., Managed Care Plan) shall be paid by the Agency's fiscal agent pursuant to **Attachment B**, Scope of Service - Core Provisions, **Section XI.**, Method of Payment. The Agency intends that the Contract resulting from this solicitation will be one of the following Contract types:

- 1) Capitated Managed Care Plan** — A Managed Care Plan that is licensed or certified as a fully risk-bearing entity in the State, or qualified as a provider service network pursuant to Section 409.962, Florida Statutes, that is paid a prospective per-member-per-month capitation payment for covered services provided to eligible enrollees (Section 409.968(1), Florida Statutes).

- 2) Fee-for-Service Provider Service Network (PSN)** — A Managed Care Plan qualified as a PSN pursuant to Section 409.962, Florida Statutes that is paid fee-for-service rates with a shared savings settlement (the "fee-for-service option") for covered services provided to eligible enrollees (Section 409.968(2), Florida Statutes).

- a)** A successful respondent choosing to operate as a Fee-for-Service PSN shall reimburse all providers at the fee-for-service rates established by the Agency for covered services. A Fee-for-Service PSN does not have the option to make provider incentive payments or to reimburse providers at a higher rate than the rates established by the Agency as adopted in the Florida Administrative Code (e.g., a Fee-for-Service PSN would not be able to reimburse qualified providers an enhanced rate for participation in the Managed Medical Assistance Physician Incentive Program).

- b)** A successful respondent choosing to operate as a Fee-for-Service PSN shall ensure that no health care provider with a controlling interest in the network charges a Medicaid Managed Care Plan operating in the region more than the amount paid to that provider by the PSN for the same service.

- c)** A successful respondent choosing to operate as a Fee-for-Service PSN shall only have this option for the first two (2) years of operations and must transition to a Capitated Managed Care Plan by the end of the second year of its

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

operations. The first year of operation is considered the year that the respondent was organized in accordance with its articles of incorporation, articles of organization, partnership agreement, certificate of limited partnership, or other formation documentation demonstrating the first year of operation.

- d) If a respondent has been under a Contract with the Agency to provide services under the SMMC program, the respondent shall not be eligible for the fee-for-service option and is not eligible to submit a response as a Fee-for-Service PSN. Violation of this provision **shall** result in the rejection a response.

18. Type of Plans Contemplated

The Agency intends that the Contract resulting from this solicitation will be one of the following plan types:

- a. **Comprehensive Long-term Care Plan (herein referred to as a “Comprehensive Plan”)** – A Managed Care Plan that is eligible to provide Managed Medical Assistance services and Long-term Care services to eligible recipients.
- b. **Long-term Care Plus Plan** – A Managed Care Plan that is eligible to provide Managed Medical Assistance services and Long-term Care services to eligible recipients enrolled in the Long-term Care program. This plan type is not eligible to provide services to recipients who are only eligible for MMA services.
- c. **Managed Medical Assistance (MMA) Plan** – A Managed Care Plan that is eligible to provide Managed Medical Assistance services to eligible recipients. This plan type is not eligible to provide services to recipients who are eligible for Long-term Care services.
- d. **Specialty Plan** – A Managed Care Plan that is eligible to provide Managed Medical Assistance services to eligible recipients who are defined as a specialty population in the resulting Contract.

19. Term of Contract

- a. **Contract Term** - The anticipated term of the resulting Contract shall be from the date of Contract execution through September 30, 2023.
- b. Each October 1 through September 30 within the Contract term shall be defined as a Contract Year; however, the first Contract Year (Year 1) shall be defined as the date of Contract execution through September 30, 2019.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- c. Pursuant to Section 409.967(1), Florida Statutes, the Contract may not be renewed; however, the Agency may extend the resulting Contract(s) term to cover any delays during the transition to a new plan.

B. Response Preparation and Content

1. General Instructions

- a. The instructions for this solicitation have been designed to help ensure that all responses are reviewed and evaluated in a consistent manner, as well as to minimize costs and response time.
- b. The Agency has established certain requirements with respect to responses submitted to competitive solicitations. The use of “shall”, “must”, or “will” (except to indicate futurity) in this solicitation, indicates a requirement or condition from which a material deviation may not be waived by the Agency. A deviation is material if, in the Agency’s sole discretion, the deficient response is not in substantial accord with this solicitation’s requirements, provides a significant advantage to one respondent over another, or has a potentially significant effect on the quality of the response or on the cost to the Agency. Material deviations cannot be waived. The words “should” or “may” in this solicitation indicate desirable attributes or conditions, but are permissive in nature. Deviation from, or omission of, such desirable features will not in and of itself cause rejection of a response.
- c. Respondents shall not retype and/or modify required forms and must submit required forms in the original format. Required forms are available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>.
- d. A respondent shall not, directly or indirectly, collude, consult, communicate or agree with any other respondent, as to any matter related to the response each is submitting. Additionally, a respondent shall not induce any other respondent to submit or not to submit a response.
- e. The costs related to the development and submission of a response to this solicitation is the full responsibility of the respondent and is not chargeable to the Agency.
- f. Joint ventures and legal partnerships shall be viewed as one (1) respondent. However, all parties to the joint venture/legal partnership shall submit all mandatory attachments and documentation required by this solicitation from respondents, unless otherwise stated.
- g. Pursuant to Section 287.133(2)(a), Florida Statutes, a person or affiliate who has been placed on the convicted Vendor list following a conviction for a public entity crime may not submit a Bid, Proposal, or Reply on a Contract

ATTACHMENT A

INSTRUCTIONS AND SPECIAL CONDITIONS

to provide any goods or services to a public entity; may not submit a Bid, Proposal, or Reply on a Contract with a public entity for the construction or repair of a public building or public work; may not submit Bids, Proposals, or Replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a Contract with any public entity; and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, Florida Statutes for category two for a period of thirty-six (36) months following the date of being placed on the convicted Vendor list.

2. **Mandatory Response Content**

The respondent shall include the documents listed in this Sub-Section with the submission of the Original Response. Violation of this provision may result in the rejection a response.

a. **Transmittal (Cover) Letter**

- 1) This letter serves as the document covering transmittal of the response package and must include the following information:
 - Respondent's name;
 - Respondent's address;
 - Respondent's Federal Employer Identification Number;
 - The names of the respondent's official contact person and an alternate who have the authority to bind the respondent to a Contract, along with both individuals' title, address, telephone number, email address, and official signature. These individuals shall be available for contact by telephone and e-mail and be available to attend meetings, as needed; and
 - A statement authorizing release of the redacted version of the response in the event the Agency receives a public records request.

b. **Required Certifications and Statements**

- 1) The respondent shall complete and submit **Exhibit A-2-a, Qualification of Plan Eligibility**.
 - a) Each respondent shall select one plan type for which to submit a response in a region, with the exception of respondents seeking also to submit a response as a Specialty Plan in the same region (e.g., the respondent may submit a response as a Comprehensive Plan in Region 1 and a response as a Specialty Plan in Region 1; conversely, the respondent shall not submit a response as a Long-term Care Plus Plan in Region 1 and a response as a Managed Medical Assistance Plan in Region 1).

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- b) Respondents seeking to provide long-term care services to eligible enrollees in a region shall submit a response as either a Comprehensive Plan or a Long-term Care Plus Plan.
 - c) Respondents seeking to provide services as a Specialty Plan in a region must submit a separate response for each population based upon age, medical condition, or diagnosis.
 - d) Each respondent shall certify its eligibility to provide services under the SMMC pursuant to Section 409.962(7), Florida Statutes.
 - e) A respondent choosing to submit a reply as a Provider Service Network shall complete and submit **Exhibit A-2-b**, Provider Service Network Certification of Ownership and Controlling Interest.
- 2) The respondent shall complete and submit **Exhibit A-2-c**, Additional Required Certifications and Statements.
- c. Milliman Organizational Conflict of Interest Mitigation Plan**
- 1) The Agency has determined that in order to evaluate responses and negotiate a Contract that is in the best interests of the State, it is necessary to use the services of Milliman, Inc. ("Milliman") to act as an actuary and advisor throughout all stages of the procurement process. The Agency reasonably anticipates that one or more prospective respondents may also use Milliman. The Agency has determined that all reasonably anticipated organizational conflicts of interest relating to its use of Milliman may be avoided by the mitigation plan described in **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan.
 - 2) All respondents must review and submit **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan, certifying that it has read the mitigation plan and that it will directly and indirectly fully comply with the mitigation plan through all stages of the procurement. If a respondent is using Milliman for this procurement, it must also submit **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit, completed by each identified Milliman personnel that will be assisting the respondent in the procurement.
- d. Original Proposal Guarantee**
- 1) The respondent's Original Response must be accompanied by an Original Proposal Guarantee payable to the State of Florida in the amount described in **Table 1**, Original Proposal Guarantee

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

Requirements, below, based upon the plan type selected by the respondent. The proposal guarantee is a firm commitment the respondent shall, upon the Agency's acceptance of its response, execute such contractual documents as may be required within the time specified.

Table 1 Original Proposal Guarantee Requirements	
Plan Type	Proposal Guarantee Amount
Comprehensive Plan	\$1,000,000.00
Long-term Care Plus Plan	\$1,000,000.00
Managed Medical Assistance Plan	\$1,000,000.00
Specialty Plan	\$200,000.00

- 2) The respondent must be the guarantor. If responding as a joint venture/legal partnership, at least one party of the joint venture/legal partnership shall be the guarantor.
- 3) The proposal guarantee shall be in the form of a bond, cashier's check, treasurer's check, bank draft, or certified check. The Agency will not accept a letter of credit in lieu of the Proposal Guarantee.
- 4) All proposal guarantees will be returned upon execution of the legal Contract with the successful respondent and receipt of the performance bond required under this solicitation (See **Attachment B.**, Scope of Service – Core Provisions, **Section XV.**, Special Terms and Conditions, **Item W.**, Performance Bond).
- 5) If the successful respondent fails to execute a Contract within ten (10) consecutive calendar days after a Contract has been presented to the successful respondent for signature, the proposal guarantee shall be forfeited to the State.
- 6) The proposal guarantee must not contain any provisions that shorten the time from bringing an action to a time less than that provided by the applicable Florida Statute of Limitations (see Section 95.03, Florida Statutes)

e. Financial Information

The respondent shall submit the following financial information.

- 1) **Financial Statements** – The respondent shall submit its most recent audited financial statements prepared using Statutory Accounting Principles (SAP) for the past **three (3)** years as described in **Table 2**, Financial Statement Requirements, below, based upon one of the following entity types:

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- An entity with at least three (3) years of financials
- A entity without three (3) years of its own financials
- An entity without three (3) years of its own financials and without a parent entity

Table 2 Financial Statement Requirements		
An entity with at least three (3) years of financials	An entity without three (3) years of its own financials	An entity without three (3) years of its own financials and without a parent entity
<ul style="list-style-type: none"> · The respondent's most recent audited financial statements for the past three (3) years. · The respondent's National Association of Health Insurance Commissioners' annual Health Statement for the most recent three (3) years. PSNs may submit only the first four schedules (Assets; Liabilities, Capital and Surplus; Revenue and Expenses Statement; and Cash Flow Statement). · The most recent audited financial statements for the past three (3) years of its parent entity or of individuals with five percent (5%) or more ownership interest, as applicable. 	<ul style="list-style-type: none"> · The most recent audited financial statements of its parent entity for the past three (3) years. · An organizational chart showing the relationship between the respondent and parent entity. 	<ul style="list-style-type: none"> · The most recent audited financial statements for the past three (3) years of individuals with five percent (5%) or more ownership interest in the respondent as documented through the respondent's submission of a completed CMS-1513 Disclosure of Ownership and Control Interest Statement Form.

- 2) Pro Forma Financial Statements** – The respondent shall provide the following pro forma financial statements for the respondent's Florida operation, broken down by line of business. The pro forma financial statements must be prepared on an accrual basis by month for the first three (3) years (or until profitable) beginning with the first month of recipient enrollment into the plan, assuming initial enrollment in October 2018, and include: (Note: October 2018 is provided as an initial enrollment date solely for the purpose of this item.)

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- a) A statement of monthly revenue and expenses based upon the anticipated plan enrollment in the region by the last month of the third year of operation;
 - b) A monthly cash flow analysis; and
 - c) A balance sheet for each month.
- 3) **Surplus** – The respondent shall describe and provide calculations used to demonstrate how it will fund the required surplus for the particular Contract type.
- a) **Capitated Managed Care Plans:** – The required surplus must be in the form of assets allowable as admitted assets by the Office of Insurance Regulation (OIR), and restricted funds of deposits (Agency insolvency account, OIR restricted deposits), the greater of \$1.5 million, ten percent (10%) total liabilities, or two percent (2%) annualized premiums. (Section 641.225, Florida Statutes)
 - b) **Fee-For-Service PSNs:** – The required surplus must be established by the twentieth (20th) month of operations (one hundred twenty (120) calendar days prior to capitation) and must be in the form of assets allowable as admitted assets by OIR, and restricted funds of deposits (Agency insolvency account), the greater of \$1.5 million, ten percent (10%) total liabilities, or two percent (2%) annualized premiums. (Section 641.225, Florida Statutes)
- 4) **Insolvency Protection Account** – The respondent shall describe and provide calculations used to demonstrate how it will fund the Agency Insolvency Protection Account, as specified below by Contract type. The Agency will evaluate the audited financial reports of the respondent and/or parent entity to determine the respondent's ability to fund the Agency Insolvency Protection Account. If funding for the Agency Insolvency Protection Account will come from a source other than the respondent or parent entity, the respondent shall indicate the source and provide an audit, bank statement, and/or bank letter demonstrating the ability to fund this requirement.
- a) **Capitated Managed Care Plans** – five percent (5%) of the estimated monthly capitation amount that would be paid to the successful respondent by the Agency each month until a maximum total of two percent (2%) of the annualized total Contract amount is funded. The respondent shall provide a calculation of the five percent (5%) estimate and indicate the anticipated source and method of funding this requirement.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- b) **Fee-For-Service PSNs** – five percent (5%) of the estimated administrative allocation payments that would be paid to the successful respondent by the Agency each month until a maximum total of two percent (2%) of the annualized total Contract amount is funded. The respondent shall provide a calculation of the five percent (5%) estimate and indicate the anticipated source and method of funding this requirement. In the twentieth (20th) month, the successful respondent must begin funding the insolvency protection account in accordance with requirements described in **4) a)** above for Capitated Managed Care Plans.

f. **Submission Requirements and Evaluation Criteria**

- 1) Respondents shall complete and submit **Exhibit A-4, Submission Requirements and Evaluation Criteria**, as described below, based upon the respondent's plan type.
- a) **Comprehensive Plans**
- **Exhibit A-4-a**, General Submission Requirements and Evaluation Criteria
 - **Exhibit A-4-b**, MMA Submission Requirements and Evaluation Criteria
 - **Exhibit A-4-c**, LTC Submission Requirements and Evaluation Criteria
- b) **Long-term Care Plus Plan**
- **Exhibit A-4-a**, General Submission Requirements and Evaluation Criteria
 - **Exhibit A-4-c**, LTC Submission Requirements and Evaluation Criteria
- c) **Managed Medical Assistance Plans**
- **Exhibit A-4-a**, General Submission Requirements and Evaluation Criteria
 - **Exhibit A-4-b**, MMA Submission Requirements and Evaluation Criteria
- d) **Specialty Plans**
- **Exhibit A-4-a**, General Submission Requirements and Evaluation Criteria
 - **Exhibit A-4-b**, MMA Submission Requirements and Evaluation Criteria
 - **Exhibit A-4-d**, Specialty Submission Requirements and Evaluation Criteria
- 2) **Exhibit A-4**, Submission Requirements and Evaluation Criteria, including **Exhibits A-4-a, A-4-b, A-4-c and A-4-d**, as applicable,

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

shall herein collectively be referred to as **Exhibit A-4**, unless otherwise specified.

- 3) Respondents shall comply with the instructions for completing **Exhibit A-4**, which are contained therein.

g. Cost Proposal and Cost Proposal Rate Sheets

- 1) The respondent shall complete and submit **Attachment C**, Cost Proposal Instructions and Rate Methodology Narrative, including applicable exhibits. Instructions for completing the Cost Proposal are provided in **Attachment C**, Cost Proposal Instructions and Rate Methodology Narrative.
- 2) The respondent's cost proposal shall include all required rates and supporting information for all required eligibility groups based on the respondent's proposed Contract type and plan type.

a) Capitated Managed Care Plans

Reimbursement requirements that apply to Capitated Managed Care Plans are described in **Attachment B**, Scope of Service - Core Provisions, **Section XI.**, Method of Payment. Certain reimbursement-related components will be established by the Agency, rather than subject to respondent bid and negotiation. Those components are:

- Transplant kick payments;
- Rates for Managed Medical Assistance enrollees who are also enrolled in the same entity's Medicare Advantage plan; and
- Items included in **Attachment C**, Cost Proposal and Cost Proposal Rate Sheets, including applicable exhibits.

b) Fee-For-Service PSNs

Reimbursement requirements that apply to Fee-For-Service PSNs are described in **Attachment B**, Scope of Service - Core Provisions, **Section XI.**, Method of Payment.

h. Summary of Respondent Commitments

The respondent shall complete and submit **Exhibit A-5**, Summary of Respondent Commitments, as part of its response in accordance with the instructions contained therein.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

i. Summary of Managed Care Savings

The respondent shall complete and submit **Exhibit A-6**, Summary of Managed Care Savings, as part of its response in accordance with the instructions contained therein.

3. Additional Response Content

a. Regional Preference Hierarchy

A respondent that submits a response in Regions 1 and 2 shall submit its regional preference for the additional award, pursuant to Section 409.966(3)(e), Florida Statutes through submission of a completed **Exhibit A-9**, Regional Preference Hierarchy.

b. Certification of Drug-Free Workplace

The State supports and encourages initiatives to keep the workplace of Florida's suppliers and contractors drug free. Section 287.087, Florida Statutes provides that, where identical responses are received, preference shall be given to a response received from a respondent that certifies it has implemented a drug-free workplace program. If applicable, the respondent shall sign and submit **Exhibit A-7**, Certification of Drug-Free Workplace, to certify that the respondent has a drug-free workplace program.

C. Response Submission Requirements

1. Hardcopy and Electronic Submission Requirements

a. General Provision

Electronic submissions via MyFloridaMarketPlace will not be accepted for this solicitation.

b. Hardcopies of the Response

1) Original Response

The respondent shall submit **one (1)** Original Response. The Original Response shall be marked as the "Original" and contain the transmittal letter that bears the original signature of the binding authority. The box that contains the Original Response shall be marked "**Contains Original**". All forms requiring signature shall bear an original signature with the original response.

2) Duplicate Copies of the Original Response

The respondent shall submit **four (4)** duplicate copies of the Original Response.

ATTACHMENT A

INSTRUCTIONS AND SPECIAL CONDITIONS

3) Packaging and Delivery

a) Hard copy responses shall be bound individually and submitted in up to three (3), three-inch, three-ring binders or secured in a similar fashion to contain pages that turn easily for review.

b) Each component of the hard copy response shall be clearly labeled and tabbed in the order specified below:

- Transmittal Letter;
- **Exhibit A-2-a**, Qualification of Plan Eligibility;
- **Exhibit A-2-b**, Provider Service Network Certification of Ownership and Controlling Interest (if applicable);
- **Exhibit A-2-c**, Additional Required Certifications and Statements;
- **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan;
- **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit (if applicable);
- Original Proposal Guarantee;
- Financial Information – tabbed separately as follows:
 - Financial Statements
 - Pro Forma Financial Statements
 - Surplus
 - Insolvency Protection
- **Exhibit A-4-a**, General Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
- **Exhibit A-4-b**, MMA Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
- **Exhibit A-4-c**, LTC Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
- **Exhibit A-4-d**, Specialty Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
- **Exhibit A-5**, Summary of Respondent Commitments;
- **Exhibit A-6**, Summary of Managed Care Savings;
- **Exhibit A-7**, Certification of Drug-Free Workplace (if applicable);
- **Exhibit A-9**, Regional Preference Hierarchy (if applicable) and;
- **Attachment C**, Cost Proposal and Instructions, including applicable exhibits;

ATTACHMENT A

INSTRUCTIONS AND SPECIAL CONDITIONS

- c) Hard copy responses shall be double sided.
- d) Hard copy responses must be submitted in a sealed package (i.e., outer boxes must be sealed, individual binders within the box do not require individual sealing), to the Procurement Officer identified in **Section A.**, Overview, **Sub-Section 5.**, Procurement Officer, no later than the time indicated in **Section A.**, Overview, **Sub-Section 6.**, Solicitation Timeline.
- e) Hard copy responses shall be submitted via United States (U.S.) mail, courier, or hand delivery. Responses sent by fax or email will not be accepted. The Agency will not consider responses received after the date and time specified in **Section A.**, Overview, **Sub-Section 6.**, Solicitation Timeline, and any such responses will be returned to the respondent unopened.

c. **Electronic Copy of the Response**

- 1) The respondent shall submit one (1) electronic copy of the entire response on a USB flash drive.
- 2) The electronic copy of the response, including all attachments, shall be submitted as Portable Document Format (PDF) documents. The PDF documents must be searchable, allow printing and must not be password protected (unlocked).
- 3) The electronic copy of the PDF documents shall be saved on the USB flash drive, with each component listed below saved separately in individual file folders:
 - Transmittal Letter;
 - **Exhibit A-2-a**, Qualification of Plan Eligibility;
 - **Exhibit A-2-b**, Provider Service Network Certification of Ownership and Controlling Interest (if applicable);
 - **Exhibit A-2-c**, Additional Required Certifications and Statements;
 - **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan;
 - **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit (if applicable);
 - Financial Information – tabbed separately as follows:
 - Financial Statements
 - Pro Forma Financial Statements
 - Surplus
 - Insolvency Protection

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- **Exhibit A-4-a**, General Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
 - **Exhibit A-4-b**, MMA Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
 - **Exhibit A-4-c**, LTC Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
 - **Exhibit A-4-d**, Specialty Submission Requirements and Evaluation Criteria and applicable attachments/exhibits;
 - **Exhibit A-5**, Summary of Respondent Commitments;
 - **Exhibit A-6**, Summary of Managed Care Savings;
 - **Exhibit A-7**, Certification of Drug-Free Workplace (if applicable);
 - **Exhibit A-9**, Regional Preference Hierarchy (if applicable); and
 - **Attachment C**, Cost Proposal and Instructions, including applicable exhibits;
- 4) In addition to the PDF submission, the following attachments and exhibits shall be submitted in Microsoft Excel 2016, utilizing the Agency provided templates and shall be saved on the USB flash drive.
- **Exhibits A-4-a-1**, SRC# 6 - General Performance Measurement Tool;
 - **Exhibit A-4-a-3**, SRC# 10 – Additional Expanded Benefits Template (Regional);
 - **Exhibit A-4-a-4**, SRC# 14 - Standard CAHPS Measurement Tool;
 - **Exhibit A-4-b-1**, MMA SRC# 6 – Provider Network Agreements/Contracts (Regional);
 - **Exhibit A-4-b-2**, MMA SRC# 14 - MMA Performance Measurement Tool;
 - **Exhibit A-4-b-3**, MMA SRC# 21 – Provider Network Agreements/Contracts Statewide Essential Providers;
 - **Exhibit A-4-c-1**, LTC SRC# 4 - Provider Network Agreements/ Contracts (Regional);
 - **Exhibit A-5**, Summary of Respondent Commitments;
 - **Exhibit A-6**, Summary of Managed Care Savings;
 - **Exhibit C-1**, Florida SMMC ITN – Capitated Plan Cost Proposal Template – Region 4 – Respondent Name. **Note: Respondents shall use this naming convention for Exhibit C-1;** and
 - **Exhibit C-2**, Florida SMMC ITN – FFS PSN Cost Proposal Template – Region 4 – Respondent Name. **Note: Respondents shall use this naming convention for Exhibit C-2.**

ATTACHMENT A

INSTRUCTIONS AND SPECIAL CONDITIONS

5) Electronic Redacted Copies

- a) The respondent shall submit an electronic redacted copy of the response suitable for release to the public in one (1) PDF document on the USB flash drive. The electronic copy shall be saved in a separate file folder on the USB flash drive from the rest of the response. The file folder shall be identified as "Redacted Version Suitable for Public Release".
- b) The PDF document must be searchable, allow printing, and must not be password protected (unlocked).
- c) Any confidential or trade secret information covered under Section 812.081, Florida Statutes, should be redacted as described below. The redacted response shall be marked as the "redacted" copy.

2. Confidential or Exempt Information

- a. All submittals received by the date and time specified in **Section A., Overview, Sub-Section 6., Solicitation Timeline**, become the property of the State of Florida and are public records subject to the provisions of Chapter 119, Florida Statutes. The State of Florida shall have the right to use all ideas, or adaptations of the ideas, contained in any response received in relation to this solicitation. Selection or rejection of the response shall not affect this right.
- b. A respondent that asserts that any portion of the response is confidential or exempt from disclosure under Chapter 119, Florida Statutes, shall clearly mark each page of such portion as follows:
 - 1) Pages containing trade secret shall be marked "Trade secret as defined in Section 812.081, Florida Statutes" Respondents who fail to identify trade secret as directed herein acknowledge and agree that they waive any right or cause of action, civil or criminal, against the Agency, its employees, and its representatives, for the release or disclosure of trade secret information not so identified. Respondents shall not mark their entire response as trade secret. The Agency may reject a response that is so marked.
 - 2) Pages that do not contain trade secret but are otherwise exempt or confidential shall be marked "exempt" or "confidential," followed by the statutory basis for such claim. For example: "The information on this page is exempt from disclosure pursuant to Section 119.071(3)(b), Florida Statutes." Failure to identify and mark such portions as directed above shall constitute a waiver of any claimed exemption and the Agency will provide any unmarked records in response to public records requests for those records without

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

notifying the respondent. Designating material simply as “proprietary” will not necessarily protect it from disclosure under Chapter 119, Florida Statutes.

- c. All information included in the response (including, without limitation, technical and cost information) and any resulting Contract that incorporates the successful response (fully, in part, or by reference) shall be a matter of public record regardless of copyright status. Submission of a response to this solicitation that contains material for which the respondent holds a copyright shall constitute permission for the Agency to reproduce and disclose such material for the Agency’s internal use, and to make such material available for inspection pursuant to a public records request.
- d. If a public records request is submitted to the Agency for responses submitted to this solicitation, the respondent agrees that the Agency may release the redacted Response without conducting any pre-release review of the redacted Response.
- e. Unless otherwise prohibited by law, the Agency will notify the respondent if a requestor contests the respondent’s determination that information is confidential or exempt and asserts a right to the information under Chapter 119, Florida Statutes or other law. The respondent bears sole responsibility for supporting and defending its determination. If an action is brought against the Agency in any appropriate judicial forum contesting the respondent’s determination of confidentiality or the redactions made by the respondent to its response, the respondent agrees that the Agency has no duty to defend against such claims and may elect not to do so, and may elect to release an un-redacted version of the response. By submitting a response, the respondent agrees to protect, defend, hold harmless and indemnify the Agency for any and all claims arising from or relating to the respondent’s determinations of confidentiality or redaction, including the payment of any attorneys’ fees or costs assessed against the Agency.

D. Response Evaluation, Negotiations, and Contract Award

1. Response Clarification

The Agency reserves the right to seek written clarification from a respondent of any information contained in the response or to request missing items from a response. However, it is a respondent’s obligation to submit an adequately written reply for the Agency to evaluate. The Agency shall have no duty to conduct discussions or attempt to clarify ambiguities in the respondent’s reply if the respondent is not in the competitive range of respondents selected for negotiations.

2. Responsive Reply Determination

A “responsive reply” means a reply submitted by a **responsive and responsible vendor**, which conforms in all material aspects to the solicitation [Section

ATTACHMENT A

INSTRUCTIONS AND SPECIAL CONDITIONS

287.012(26), Florida Statutes]. A “responsible vendor” means a vendor who has the capacity in all respects to fully perform the Contract requirements and the integrity and reliability that will assure good faith performance [287.012(25), Florida Statutes]. The Procurement Officer may rely on any facts available to make a determination at any time prior to award as to whether a vendor is a responsible vendor. The Agency reserves the right to contact sources outside the reply to obtain information regarding past performance or other matters relevant to responsibility.

3. Non-Scored Requirements

a. Transmittal (Cover) Letter

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, a Transmittal (Cover) Letter from each required party that contains all required information as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item a.**

b. Required Certifications and Statements

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, the following, as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item b.**:

- **Exhibit A-2-a**, Qualification of Plan Eligibility;
- **Exhibit A-2-b**, Provider Service Network Certification of Ownership and Controlling Interest (if submitting a response as a PSN);
- **Exhibit A-2-c**, Additional Required Certifications and Statements

c. Milliman Organizational Conflict of Interest Mitigation Plan

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, the following, as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item c.**:

- **Exhibit A-3-a**, Milliman Organizational Conflict of Interest Mitigation Plan
- **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit

d. Original Proposal Guarantee

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, an original proposal guarantee in the appropriate amount based on the respondent’s proposed plan type, as specified in **Section B.**, Response

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item d.**

e. Summary of Respondent Commitments

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, **Exhibit A-5**, Summary of Respondent Commitments, as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item h.**

f. Summary of Managed Care Savings

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, **Exhibit A-6**, Summary of Managed Care Savings, as specified in **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item i.**

4. Scored Requirements – Evaluation Criteria

a. Financial Evaluation

- 1) A Certified Public Accountant will evaluate each respondent's financial information, as required by **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item e.** Respondents can receive a maximum score of twenty (20) points based on an analysis in **Table 3**, Financial Information Evaluation Point Scale, below:

Table 3		
Financial Information Evaluation Point Scale		
Criteria	Scale	Points
What is the likelihood that the respondent will be able to meet minimum financial requirements?	Likely	20
	Questionable	10
	Unlikely	0

- 2) Respondents determined to have insufficient financial resources to perform the Contract requirements outlined in this solicitation will be disqualified at the Agency's sole discretion.
- 3) The Agency reserves the right to evaluate and score financial information one time and apply the score to all regions for which the respondent submits a reply.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

b. Review of Provider Comments

- 1) The Agency will review the provider comments received using the following scoring method as illustrated in this example in which the respondent received a total of 24 comments.

A	Number of "Very Positive" Comments	16
B	Number of "Mostly Positive" Comments	3
C	Number of "Not Applicable" Comments	0
D	Number of "Mostly Negative" Comments	1
E	Number of "Very Negative" Comments	4
F	Total Number of Comments (A+B+C+D+E)	24
G	Raw Score $((2*A)+(1*B)+(-1*D)+(-2*E))/(F)$ <i>(Will Range from -2 to 2)</i>	1.08
H	Weight = $(F)/500 * 2.5$ 500 is the maximum number of comments that will be considered	0.12
I	Weighted Score = $(G) * (H)$ <i>(Maximum of 5.0; equals 0 for raw score ≤ 0)</i>	0.1
J	Final Score = $(I) * 25$ <i>(Maximum of 125)</i>	2.5

In this example, the respondent will receive a score of 2.5.

- 2) Below is an example of the process and the survey tool that will be utilized:

Step 1: The provider will select the region it is commenting on by clicking on link on the Agency's website that will lead the user to each regional survey.

Example:

REGION 1 – Escambia, Okaloosa, Santa Rosa and Walton Counties (HYPERLINK)

Step 2: Complete Survey. The provider will type in its name, its Medicaid provider number and assign opinions for each respondent listed in the Region.

SAMPLE:

REGION 1 – Escambia, Okaloosa, Santa Rosa and Walton Counties

Enter Medicaid Provider Name – Character Space Limitation of 300 characters

Enter Medicaid Provider Number – Character Space Limitation of 9 characters

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

Instructions: For each respondent (i.e., Managed Care Plan) listed below, the provider shall indicate if its opinion of the named respondent is very positive, mostly positive, not applicable, mostly negative or very negative for each category listed. The opinions listed below will be considered by the Agency in its decision to award Contracts under this solicitation, pursuant to Section 409.966(3)(a)8., Florida Statutes.

RESPONDENT A:					
Provider's opinion in regards to timely processing of prior authorization requests	Very Positive	Mostly Positive	Not Applicable	Mostly Negative	Very Negative
Provider's opinion in regards to timely claim(s) payment(s)	Very Positive	Mostly Positive	Not Applicable	Mostly Negative	Very Negative
Provider's opinion in regards to ease of contracting and completing the credentialing process	Very Positive	Mostly Positive	Not Applicable	Mostly Negative	Very Negative

c. Technical Response Evaluation

- 1) Responses will be independently evaluated and awarded points based on the criteria and points scale indicated in **Exhibit A-4**, Submission Requirements and Evaluation Criteria for the detailed evaluation criteria components.
- 2) Each response will be individually scored by at least three (3) evaluators, who collectively have experience and knowledge in the program areas and service requirements for which contractual services are sought by this solicitation. The Agency reserves the right to have specific Sections of the responses evaluated by less than three (3) individuals.
- 3) The scores of independent evaluators will be computed for each region's score sheet(s) to determine a total score based on the detailed evaluation criteria components indicated in **Exhibit A-4**, Submission Requirements and Evaluation Criteria and the weight factor specified in **Table 4**, Summary Score Sheet below:

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

**Table 4
Summary Score Sheet**

	General Criteria			MMA Criteria			Long-term Care Criteria			Specialty Criteria			Plan Type Totals			
	Maximum Raw Score Possible	Weight Factor	Maximum Points Available	Maximum Additional Raw Score Possible	Weight Factor	Maximum Additional Points Available	Maximum Additional Raw Score Possible	Weight Factor	Maximum Additional Points Available	Maximum Additional Raw Score Possible	Weight Factor	Maximum Additional Points Available	Comp Plan Total Points	MMA Plan Total Points	LTC Plus Plan Total Points	Specialty Plan Total Points
Provider Comments	5	25	125	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	125	125	125	125
Financial Information	20	10	200	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	200	200	200	200
Technical Response																
1. Agency Goals	330	3	990	425	1	425	275	1	275	50	1	50	1690	1415	1265	1465
2. Recipient Experience	290	3	870	85	3	255	65	2.5	162.5	40	1	40	1287.5	1125	1032.5	1165
3. Provider Experience	95	5	475	65	3	195	75	1.5	112.5	0	0	0	782.5	670	587.5	670
4. Delivery System Coordination	250	2	500	295	1	295	150	1	150	25	1.5	37.5	945	795	650	832.5
5. Respondent Background/Experience	90	3	270	0	0	0	85	1	85	20	1	20	355	270	355	290
6. Oversight and Accountability	275	1	275	0	0	0	15	7	105	0	0	0	380	275	380	275
7. Statutory Requirements	55	4	220	40	1	40	0	0	0	0	0	0	260	260	220	260
Totals:	1410		3925	910		1210	665		890	135		147.5	6025	5135	4815	5282.5

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ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

d. Cost Proposal

The Agency will review and consider the cost proposals submitted by respondents who are invited to negotiations during the negotiation phase. The Agency intends to negotiate common base rates for each region.

e. Ranking of Responses

- 1) A total score will be calculated for each response based the total maximum points available as included in **Table 4**, Summary Score Sheet, above and as described below:
 - a) Respondents bidding as a Comprehensive Plan will be ranked together based on the total maximum points of **6025**.
 - b) Respondents bidding as a Long-term Care Plus Plan will be ranked together based on the total maximum points of **4815**.
 - c) Respondents bidding as a Managed Medical Assistance plan will be ranked together based on the total maximum points of **5135**.
 - d) Respondents bidding as a Specialty Plan will be ranked based on the total maximum available points of **5282.5**.
- 2) The total point scores will be used to rank the responses by evaluator. An example is provided below to illustrate the steps in the process.

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ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

EXAMPLE:

a) Step 1

A total point score will be calculated for each response. The total point score includes Evaluator (A, B, C or D) Submission Requirement and Evaluation Criteria (SRC) score; Financial Stability score for the respondent; and the score of any sections evaluated by less than (3) evaluators for the respondent.

Below is a summary example of how the total point score is calculated (Respondent 1).

Evaluator A SRC score:	391
Financial evaluation score for Respondent 1:	10
Other Sections evaluated by less than three (3) evaluators score for Respondent 1:	45
Total Point Score for Evaluator A, Respondent 1	446
Evaluator B SRC score:	341
Financial evaluation score for Respondent 1:	10
Other Sections evaluated by less than three (3) evaluators score for Respondent 1:	45
Total Point Score for Evaluator B, Respondent 1	396
Evaluator C SRC score:	256
Financial evaluation score for Respondent 1:	10
Other Sections evaluated by less than three (3) evaluators score for Respondent 1:	45
Total Point Score for Evaluator C, Respondent 1	311
Evaluator D SRC score:	358
Financial evaluation score for Respondent 1:	10
Other Sections evaluated by less than three (3) evaluators score for Respondent 1:	45
Total Point Score for Evaluator D, Respondent 1	413

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ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

b) Step 2

The total point scores will be used to rank the responses by evaluator (Response with the highest number of points = 1, second highest = 2, etc.).

POINTS SUMMARY

Evaluator A		Evaluator B		Evaluator C		Evaluator D	
Respondent 1	446 pts.	Respondent 1	396 pts.	Respondent 1	311 pts.	Respondent 1	413 pts.
Respondent 2	425 pts.	Respondent 2	390 pts.	Respondent 2	443 pts.	Respondent 2	449 pts.
Respondent 3	397 pts.	Respondent 3	419 pts.	Respondent 3	389 pts.	Respondent 3	435 pts.
Respondent 4	410 pts.	Respondent 4	388 pts.	Respondent 4	459 pts.	Respondent 4	325 pts.

RANKING SUMMARY

Evaluator A		Evaluator B		Evaluator C		Evaluator D	
Respondent 1	1	Respondent 1	2	Respondent 1	4	Respondent 1	3
Respondent 2	2	Respondent 2	3	Respondent 2	2	Respondent 2	1
Respondent 3	4	Respondent 3	1	Respondent 3	3	Respondent 3	2
Respondent 4	3	Respondent 4	4	Respondent 4	1	Respondent 4	4

c) Step 3

An average rank will be calculated for each response for all the evaluators.

Respondent 1	$1+2+4+3=10\div 4=2.5$
Respondent 2	$2+3+2+1=8\div 4=2.0$
Respondent 3	$4+1+3+2=10\div 4=2.5$
Respondent 4	$3+4+1+4=12\div 4=3.0$

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

5. Negotiation Process

- a.** The scores from the evaluation process shall be used to determine the respondents with whom the negotiation team will negotiate. The negotiation team shall not utilize the evaluation scores in determining best value.
- b.** The Agency's negotiation team will conduct negotiation strategy sessions pursuant to Section 286.0113, Florida Statutes. Negotiation strategy includes determining best value criteria and developing award recommendation(s). During its strategy sessions, the Agency's negotiation team will develop a recommendation as to the award that will provide the best value (as defined in Section 287.012(4), Florida Statutes) to the State.
- c.** Negotiation sessions will include discussions of the scope of services to be provided by the respondent until acceptable terms and conditions are agreed upon, or it is determined that an acceptable agreement cannot be reached. The Agency will negotiate the terms and conditions determined to be the best value to the State, including, but not limited to price/cost, quality, design, and service delivery.
- d.** The actuary from Milliman will participate in discussions during the negotiation process and review and provide consultation to Agency staff on the respondents' cost proposal submissions. After negotiation sessions are concluded with respondents, Milliman will not participate in the decision-making process of determining which respondents are awarded Contracts in the region.
- e.** The Agency reserves the right at any time during the negotiation process to:
 - 1)** Negotiate concurrently or sequentially with competing respondents.
 - 2)** Schedule additional negotiation sessions with any or all responsive respondents.
 - 3)** Require any or all responsive respondents to provide additional, revised, or final written replies addressing specific topics, including modifications to the solicitation specifications, terms or conditions, or business references.
 - 4)** Require any or all responsive respondents to provide a written best and final offer or offers.
 - 5)** Require any or all responsive respondents to address services, prices, or conditions offered by any other respondents.
 - 6)** Decline to conduct further negotiations with any respondent.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- 7) Re-open negotiations with any responsive respondent.
 - 8) Take any additional, administrative steps deemed necessary in determining the final award, including additional fact-finding, evaluation or negotiations where necessary and consistent with the terms of this solicitation.
 - 9) Review and rely on relevant information contained in the responses.
 - 10) Request pricing options or models different from the initial Cost Proposal submission. This information may be used in negotiations to determine the best pricing solution to be used in the Contract.
- f. The Agency has sole discretion in deciding whether and when to take any of the foregoing actions, the scope and manner of such actions, the responsive respondent or respondents affected and whether to provide concurrent public notice of such decision.
- g. The Agency intends to invite the following number of respondents to negotiation:
- 1) Comprehensive Plans
 - The top five (5) ranking Comprehensive Plans.
 - 2) Long-term Care Plus Plans
 - The top two (2) ranking Long-term Care Plus Plans
 - 3) Managed Medical Assistance Plans
 - The top two (2) ranking Managed Medical Assistance Plans
 - 4) Specialty Managed Medical Assistance Plans
 - The top two (2) ranking Specialty Managed Medical Assistance Plans per specialty population.
- h. If there are no provider service networks included in the top ranked respondents listed above, the Agency will invite the highest ranked PSN(s) to negotiations in order to fulfill the requirements of Section 409.974(1), Florida Statutes and Section 409.981(1), Florida Statutes.
- i. In the event the Agency cannot reach agreement with a respondent who has been invited to negotiation and/or a respondent withdraws its response during the negotiation phase, the Agency reserves the right to invite the next top ranking respondent to negotiations to ensure that the Agency can enter into Contracts with the required number of plans per region as illustrated in **Table 5**, SMMC Region, below.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

6. Selection Criteria for Determining Best Value

In addition to the criteria established in Sections 409.966(3)(c), 409.974(2), and 409.981(3), Florida Statutes, the Agency’s negotiation team shall determine the best value selection criteria which include, but are not limited to:

- a. Whether a respondent proposes to operate as a Comprehensive Plan.
- b. Whether a respondent that submits a response in Regions 1 or 2 agrees to serve enrollees in both Regions 1 and 2, even if the respondent is only awarded a Contract in one of these Regions.
- c. Whether a respondent submitting a response as a Fee-for-Service PSN will agree to operate as a Capitated Managed Care Plan, starting with the Agency’s proposed regional roll-out schedule.
- d. Whether a respondent negotiates a rate acceptable to the Agency.
- e. Whether a respondent proposes and negotiates acceptable terms and conditions in the following areas:
 - Innovations and evidence-based practices that assist in achieving the Agency’s goals;
 - Expanded benefits;
 - Provider network;
 - Service authorization timeliness;
 - Value-based purchasing ;
 - Provider engagement;
 - Subcontractor oversight;
 - Enrollee engagement; and
 - Establishing program savings benchmarks.

7. Number of Awards

- a. In accordance with Sections 409.966, 409.974, and 409.981, Florida Statutes, the Agency intends to select a limited number of eligible Managed Care Plans to provide services under the SMMC program in Region 4. The Agency anticipates issuing the number of Contract awards for Region 4 as described in **Table 5**, SMMC Region, below, excluding awards to Specialty MMA Plans.

Table 5 SMMC Region	
Region	Total Anticipated Contract Awards
Region 4	5

- b. If a respondent is awarded a Contract for multiple regions, the Agency will issue one (1) Contract to include all awarded regions.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- c.** The Agency will award at least one (1) Contract to a PSN provided a PSN submits a responsive reply and negotiates a rate acceptable to the Agency. The Agency, at its sole discretion, shall make this determination.
- d.** A respondent that is awarded a Contract as a Comprehensive Plan is determined to satisfy the requirements in Section 409.974, Florida Statutes and Section 409.981, Florida Statutes and shall be considered an awardee of an MMA Contract and a LTC Contract. The Agency will issue one (1) Contract to reflect all awarded populations in all awarded regions.
- e.** In addition to the number of Contracts awarded in this region, additional Contracts may be awarded to Specialty Plans that negotiate terms and conditions determined to be the best value to the State and negotiate a rate acceptable to the Agency. The Agency, at its sole discretion, shall make this determination.
- f.** The Agency reserves the right to make adjustments to the enrollee eligibility and identification criteria proposed by a Specialty Plan prior to Contract award in order to ensure that the aggregate enrollment of all awarded Specialty Plans in a region will not exceed ten percent (10%) of the total enrollees in that region, in compliance with Section 409.974(3), Florida Statutes.
- g.** If a respondent is awarded a Contract as a Specialty Plan and another plan type, the Agency will issue one (1) Contract to include all awarded populations in all awarded regions.
- h.** The Agency shall award one (1) additional Contract in a region to each successful respondent who receives a Region 1 or 2 Contract award. The Agency shall award the additional Contract in the respondent's highest desired region of preference in which the respondent submitted a responsive reply and negotiates a rate acceptable to the Agency. If the respondent has already been awarded a Contract through the negotiation process in its top regional choice as listed in **Exhibit A-9**, Regional Preference Hierarchy, then it will be awarded its next regional choice listed on **Exhibit A-9**, Regional Preference Hierarchy, provided it meets the terms above. If a respondent is awarded a Contract to participate as a Specialty Plan in Region 1 or 2, the Agency shall award an additional Contract for the respondent to participate as that same Specialty Plan for the same Specialty Population in another region in which the respondent submitted a responsive reply, and negotiates a rate acceptable to the Agency.

8. Posting of Notice of Intent to Award

- a.** Tabulation of Results, with the recommended Contract award, will be posted and will be available for review by interested parties at the time and location specified in **Section A.**, Overview, **Sub-Section 6.**, Solicitation Timeline, and will remain posted for a period of seventy-two (72) hours, not

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

including weekends or State observed holidays. Any respondent desiring to protest the recommended Contract award must file a notice of protest to the Procurement Officer identified in **Section A. Overview, Sub-Section 5.**, Procurement Officer, and any formal protest with the Agency for Health Care Administration, Agency Clerk, 2727 Mahan Drive, Mail Stop 3, Building 3, Room 3407C, Tallahassee, Florida 32308, within the time prescribed in Section 120.57(3) Florida Statutes and Rule 28-110, Florida Administrative Code. Failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, or failure to post the bond or other security required by law, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes

- b. Pursuant to Section 409.966(4), Florida Statutes, any eligible plan that participates in this solicitation in more than one region and is selected in at least one region may not begin serving Medicaid recipients in any region for which it was selected until all administrative challenges to this solicitation to which the eligible plan is a party have been finalized. If the number of plans selected is less than the maximum amount of plans permitted in the region, the Agency may contract with other selected plans in the region not participating in the administrative challenge before resolution of the administrative challenge. For purposes of this Sub-Section, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the Agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

9. Contract Execution

- a. The Agency shall incorporate the following documents, which are included in **Exhibit A-8**, Standard Contract, in the final Contract document prepared for execution by the successful respondent:
- Standard Contract;
 - Business Associate Agreement;
 - Certification Regarding Lobbying Certification for Contracts, Grants, Loans and Cooperative Agreements;
 - Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts; and
 - Vendor Certification Regarding Scrutinized Companies Lists.
- b. The Agency will not consider modifications proposed by the respondent to the documents listed in **Exhibit A-8**, Standard Contract.
- c. This solicitation, including all its addenda, the Agency's written response to questions, and the successful respondent's response, including

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

information provided through negotiations, shall be incorporated by reference in the final Contract document.

- d. The successful respondent shall perform its contracted duties in accordance with the resulting Contract, this solicitation, including all addenda, the successful respondent's response to this solicitation, and information provided through the negotiations. In the event of conflict among resulting Contract documents, any identified inconsistency in the resulting Contract shall be resolved by giving precedence in the following order:
 - 1) The resulting Contract, including all attachments, exhibits and any subsequent amendments;
 - 2) This solicitation, including all addenda; and
 - 3) The successful respondent's response to this solicitation, including information provided through negotiations.
- e. The successful respondent shall be registered with the Florida Department of State as an entity authorized to transact business in the State of Florida by the effective date of the resulting Contract.
- f. The Agency reserves the right to amend the resulting Contract within the scope set forth in this solicitation (to include original Contract and all attachments) in order to clarify requirements or if it is determined by the Agency that modifications are necessary to better serve or provide covered services to the eligible population.
- g. The State of Florida's performance and obligation to pay under the Contract resulting from this solicitation is contingent upon an annual appropriation by the Legislature.

E. Contract Implementation

1. Proposed Implementation Schedule

- a. The Agency anticipates implementing (i.e., rolling-out) new Contracts for the SMMC program on a regional basis, between October 2018 – January 2019.
- b. The Agency will establish a regional roll-out schedule which outlines deadlines for plan readiness documentation, plan readiness deadlines, and enrollment effective dates.
- c. The Agency will provide successful respondents (herein referred to as "Managed Care Plans") with the proposed regional roll-out schedule and plan readiness review tools prior to the anticipated Contract execution date.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

The schedule may be subject to change and is provided for planning purposes only.

- d. The Agency reserves the right to roll-out Specialty Plans on a later schedule than the other plan types.
- e. The Agency reserves the right to roll-out Fee-for-Service PSNs on a later schedule than Capitated Managed Care Plans.

2. Readiness Review

- a. Prior to enrolling recipients in a Managed Care Plan in each region, the Agency will conduct a plan-specific readiness review to assess the Managed Care Plan's readiness and ability to provide services to enrollees.
- b. The scope of the plan readiness review may include any and all Contract requirements, as determined by the Agency.
- c. If a Managed Care Plan does not meet the plan readiness deadlines established by the Agency, the Agency may grant an extension for the Managed Care Plan to correct deficiencies. The Agency has no obligation to modify the proposed regional implementation schedule to accommodate the time needed for a Managed Care Plan to address deficiencies.
- d. The Agency will not enroll recipients into a Managed Care Plan until the Agency has determined that the Managed Care Plan meets all plan readiness review requirements.
- e. The Agency will require capitated PSNs to apply for and obtain a certificate of authority, per Section 641.2019, Florida Statutes, during the readiness review process.
- f. The Agency reserves the right, at its sole discretion, to terminate the Contract with the Managed Care Plan in a region if the plan fails to meet the plan readiness deadlines.

3. Enrollment Levels

- a. The Agency does not guarantee that any Managed Care Plan will receive any particular enrollment level.
- b. At any time during the Contract term, the Agency may restrict enrollment into a Specialty Plan to ensure that the aggregate enrollment of all Specialty Plans in a region will not exceed ten percent (10%) of the total enrollees of that region (Section 409.974(3), Florida Statutes).

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

4. Transition Enrollment

As part of the readiness review and at least sixty (60) days prior to the implementation (i.e., roll-out) date in a region, the Managed Care Plan will be required to demonstrate that it has an adequate network of providers to provide all covered services to enrollees.

a. Long-term Care Program Enrollees

Medicaid recipients who are eligible for both MMA services and LTC services must enroll in a Comprehensive Plan or a Long-term Care Plus Plan in the region. These recipients will only be enrolled in one (1) Managed Care Plan in the region as both plan types (i.e., Comprehensive Plan or a Long-term Care Plus Plans) provide MMA and LTC covered services for their enrollees.

b. Enrollees Who Make an Active Plan Choice

The Agency will provide Medicaid recipients with an enrollment packet in the mail informing them of the available plan options in their region. Medicaid recipients will have an opportunity to select the plan of their choice as long as he or she meets all of the eligibility criteria for the plan type.

c. Enrollees Who Do Not Make an Active Plan Choice

1) For the purposes of this Sub-Section, existing plan means a Managed Care Plan that is providing services in Region 4 under the SMMC 2014-2019 Contracts.

2) For the purposes of this Section, new plan means a Managed Care Plan that is not providing services in Region 4 under the SMMC 2014-2019 Contract, but is awarded a Contract to provide services in the region under the resulting Contract from this solicitation.

3) The Agency will assign Managed Medical Assistance enrollees who do not make an active plan choice into an existing plan if that plan was awarded a Contract to provide services in the same region under the resulting Contract from this solicitation in order to meet the criteria established in Section 409.977(2), Florida Statutes.

a) If a Long-term Care enrollee was receiving Managed Medical Assistance and Long-term Care services from two (2) different existing plans and both plans have been awarded a Contract as a Comprehensive Plan in the region, the Agency will assign the enrollee into the Comprehensive Plan that was previously providing the enrollee with Long-term Care services.

ATTACHMENT A INSTRUCTIONS AND SPECIAL CONDITIONS

- 4) For Managed Medical Assistance enrollees in existing plans that are not awarded a Contract to provide services in the same region under the resulting Contract from this solicitation, the Agency will distribute twenty percent (20%) of the total enrollees served by these plans to new plans. The Agency will assign the remaining enrollees into a Managed Care Plan based on the criteria established in Section 409.977(2), Florida Statutes.

- 5) In accordance with Section 409.977(1), Florida Statutes, the Agency will assign enrollees into a Specialty Plan in a region, if there is Specialty Plan available for which the enrollee meets all eligibility criteria (based upon age, diagnosis, and/or condition).

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EXHIBIT A-1 QUESTIONS TEMPLATE

Exhibit A-1, Questions Template is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>

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EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

RESPONDENT NAME: _____

1. IDENTIFICATION OF PLAN TYPES

I hereby certify that my company is submitting a response to AHCA ITN 004-17/18 to operate as one of the following plan types in Region 4:

Comprehensive Plan

OR

Long-Term Care Plus Plan

OR

Managed Medical Assistance Plan

OR

Specialty Plan

2. QUALIFICATION OF PLAN ELIGIBILITY

I hereby certify my company currently operates as one (1) of the following:

HMO Health Maintenance Organization and possess a current Florida Certificate of Authority and Health Care Provider Certificate in at least one (1) Florida county.

OR

PSN that possesses a Florida Third Party Administrator License or a subcontract/letter of agreement with a Florida-licensed Third Party Administrator. A copy of the Third Party Administrator license, or subcontract/letter of agreement, must be submitted with the solicitation response.

In addition, the respondent shall complete **Exhibit A-2-b**, Provider Service Network Certification of Ownership and Controlling Interest.

OR

Exclusive Provider Organization that meets the licensure requirements of Section 627.6472, Florida Statutes.

**EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY**

OR

Accountable Care Organization authorized under federal law.

Signature below indicates the respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

Respondent Name

Authorized Official Signature

Date

Authorized Official Printed Name

Authorized Official Title

Failure to submit, Exhibit A-2-a, Qualification of Plan Eligibility, signed by an authorized official may result in the rejection of response.

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EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF
OWNERSHIP AND CONTROLLING INTEREST

RESPONDENT NAME: _____

I hereby certify that the respondent submitting this reply is a Provider Service Network ("PSN") as defined in Sections 409.912(2)(b) and 409.962(14), Florida Statutes, or 409.962(9), Florida Statutes:

A PSN is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the PSN network organization. Fla. Stat. § 409.912(2)(b) (2016).

"PSN" means an entity qualified pursuant to Section 409.912(2), Florida Statutes of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies. Fla. Stat. § 409.962(14) (2016)

"Long-term care PSN" means a PSN a controlling interest of which is owned by one or more licensed nursing homes, assisted living facilities with seventeen (17) or more beds, home health agencies, community care for the elderly lead agencies, or hospices. Fla. Stat. § 409.962(9) (2016).

Please provide the following additional information.

1. The PSN's first year of operation: _____
2. The Agency considers the first year of operation to begin on the date that the vendor was organized. Please provide the articles of incorporation, articles of organization, partnership agreement, certificate of limited partnership, or other formation documentation demonstrating the first year of operation of the PSN.

EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF
OWNERSHIP AND CONTROLLING INTEREST

3. Identify (in the field below) the health care provider or group of affiliated health care providers (or licensed nursing homes, assisted living facilities with seventeen (17) or more beds, home health agencies, community care for the elderly lead agencies, or hospices) that have a controlling interest in the governing body of the PSN and the basis for such controlling interest.

4. To the extent that such health care provider or group of affiliated health care providers identified above is not the ultimate owner, then identify (in the field below) such owners and the affiliates of such health care provider or group of affiliated health care providers and their ultimate owners, indicating the percentage of such ownership. Please see the Affiliation Criterion to Determine Controlling Interest for Purposes of the SMMC solicitation below.

5. Provide a detailed explanation (in the field below), with references to documentation and other information required by this section, that demonstrates how the vendor qualifies under the statutes and requirements of this solicitation to provide services as a PSN or LTC PSN providing services as a Managed Care Plan.

6. The individual that signed the Transmittal Letter or a person authorized in the Transmittal Letter to sign on behalf of the respondent as required by **Attachment A**, Instructions and Special Conditions, **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item a.**, Transmittal (Cover) Letter, shall sign the responses to these requests for additional information above.

Affiliation Criteria to Determine Controlling Interest for Purposes of the SMMC Solicitation

7. For purposes of responding to the above, use the following General Principles of Affiliation to determine whether a controlling interest exists.
 - a. Concerns and entities are affiliates of each other when one controls or has the power to control the other, or a third party or parties controls or has the power to control both. It does not matter whether control is exercised, so long as the power to control exists.

EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF OWNERSHIP AND CONTROLLING INTEREST

- b. The Agency considers factors such as ownership, management, previous relationships with or ties to another concern, and contractual relationships, in determining whether affiliation exists.
 - c. Control may be affirmative or negative. Negative control includes, but is not limited to, instances where a minority shareholder has the ability, under the concern's charter, by-laws, or shareholder's agreement, to prevent a quorum or otherwise block action by the board of directors or shareholders.
 - d. Affiliation may be found where an individual, concern, or entity exercises control indirectly through a third party.
 - e. In determining whether affiliation exists, the Agency will consider the totality of the circumstances, and may find affiliation even though no single factor is sufficient to constitute affiliation.
8. Affiliation based on stock ownership.
- a. A person (including any individual, concern or other entity) that owns, or has the power to control, fifty percent (50%) or more of a concern's voting stock, or a block of voting stock which is large compared to other outstanding blocks of voting stock, controls or has the power to control the concern.
 - b. If two or more persons (including any individual, concern or other entity) each owns, controls, or has the power to control less than fifty percent (50%) of a concern's voting stock, and such minority holdings are equal or approximately equal in size, and the aggregate of these minority holdings is large as compared with any other stock holding, the Agency presumes that each such person controls or has the power to control the concern whose size is at issue. This presumption may be rebutted by a showing that such control or power to control does not in fact exist.
 - c. If a concern's voting stock is widely held and no single block of stock is large as compared with all other stock holdings, the concern's Board of Directors and CEO or President will be deemed to have the power to control the concern in the absence of evidence to the contrary.
9. Affiliation arising under stock options, convertible securities, and agreements to merge.

EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF
OWNERSHIP AND CONTROLLING INTEREST

- a. The Agency considers stock options, convertible securities, and agreements to merge (including agreements in principle) to have a present effect on the power to control a concern. The Agency treats such options, convertible securities, and agreements as though the rights granted have been exercised.
 - b. Agreements to open or continue negotiations towards the possibility of a merger or a sale of stock at some later date are not considered “agreements in principle” and are thus not given present effect.
 - c. Options, convertible securities, and agreements that are subject to conditions precedent which are incapable of fulfillment, speculative, conjectural, or unenforceable under State or federal law, or where the probability of the transaction (or exercise of the rights) occurring is shown to be extremely remote, are not given present effect.
 - d. An individual, concern or other entity that controls one or more other concerns cannot use options, convertible securities, or agreements to appear to terminate such control before actually doing so. The Agency will not give present effect to individuals', concerns' or other entities' ability to divest all or part of their ownership interest in order to avoid a finding of affiliation.
- 10.** Affiliation based on common management. Affiliation arises where one or more officers, directors, managing members, or partners who control the board of directors and/or management of one concern also control the board of directors or management of one or more other concerns.
- 11.** Affiliation based on identity of interest. Affiliation may arise among two or more persons with an identity of interest. Individuals or firms that have identical or substantially identical business or economic interests (such as family members, individuals or firms with common investments, or firms that are economically dependent through contractual or other relationships) may be treated as one party with such interests aggregated. An individual or firm may rebut that determination with evidence showing that the interests deemed to be one are in fact separate.
- a. Firms owned or controlled by married couples, parties to a civil union, parents, children, and siblings are presumed to be affiliated with each other if they conduct business with each other, such as subcontracts or joint ventures or share or provide loans, resources, equipment, locations or employees with one another. This presumption may be overcome by showing a clear line of fracture between the concerns.

EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF
OWNERSHIP AND CONTROLLING INTEREST

Other types of familial relationships are not grounds for affiliation on family relationships.

- b.** The Agency may presume an identity of interest based upon economic dependence if the concern in question derived seventy percent (70%) or more of its receipts from another concern over the previous three (3) fiscal years. This presumption may be rebutted by a showing that despite the contractual relations with another concern, the concern at issue is not solely dependent on that other concern, such as where the concern has been in business for a short amount of time and has only been able to secure a limited number of contracts.
- 12.** Affiliation based on newly organized concern. Affiliation may arise where former officers, directors, principal stockholders, managing members, or key employees of one concern organize a new concern in the same or related industry or field of operation, and serve as the new concern's officers, directors, principal stockholders, managing members, or key employees, and the one concern is furnishing or will furnish the new concern with contracts, financial or technical assistance, indemnification on bid or performance bonds, and/or other facilities, whether for a fee or otherwise. A concern may rebut such an affiliation determination by demonstrating a clear line of fracture between the two concerns. A "key employee" is an employee who, because of his/her position in the concern, has a critical influence in or substantive control over the operations or management of the concern.

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**EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF
OWNERSHIP AND CONTROLLING INTEREST**

Signature below indicates the respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

Respondent Name

Authorized Official Signature

Date

Authorized Official Printed Name

Authorized Official Title

Failure to submit, Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest, signed by an authorized official may result in the rejection of response.

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EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

RESPONDENT NAME: _____

1. ACCEPTANCE OF SOLICITATION REQUIREMENTS

I hereby certify that I understand and agree that my organization has read all requirements and Agency specifications provided in this solicitation, accepts said requirements, and that this response is made in accordance with the provisions of such requirements and specifications. By my written signature below, I guarantee and certify that all items included in this response shall meet or exceed any and all such requirements and Agency specifications. I further agree, if awarded a Contract resulting from this solicitation, to deliver services that meet or exceed the requirements and specifications provided in this solicitation.

AND

2. ACCEPTANCE OF CONTRACT TERMS AND CONDITIONS

I hereby certify that should my organization be awarded a Contract resulting from this solicitation, it will comply with all terms and conditions as specified in this solicitation and in the Agency Standard Contract (**Exhibit A-8, including Attachments II - V**).

AND

3. STATEMENT OF NO-INVOLVEMENT

I hereby certify that neither my organization nor any person with an interest in the organization had any prior involvement in performing a feasibility study of the implementation of the subject Contract, in drafting of this solicitation or in developing the subject program.

AND

4. PROHIBITION OF GRATUITIES

I hereby certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from such my organization's response or subsequent Contract in violation of the provisions of Chapter 112, Florida Statutes. I understand that any Contract issued as a result of this solicitation may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

AND

5. NON-COLLUSION CERTIFICATION

I hereby certify that all persons, companies, or parties interested in the response as principals are named therein, that the response is made without collusion with any other person, persons, organization, or parties submitting a response; that it is in all respects made in good faith; and as the signer of the response, I have full authority to legally bind the prospective respondent to the provisions of this solicitation.

AND

6. PERFORMANCE OF SERVICES

I hereby certify my organization shall ensure all services, provided directly or indirectly under the Contract resulting from this solicitation, will be performed within the borders of the United States and its territories and protectorates.

AND

7. ORGANIZATIONAL CONFLICT OF INTEREST CERTIFICATION

The standards on organizational conflicts of interest in Title 48, Code of Federal Regulations, Subpart 9.5 – Organizational and Consultant Conflicts of Interest and Section 287.057(17), Florida Statutes, apply to this solicitation. A respondent with an actual or potential organizational conflict of interest shall disclose the conflict. If the respondent believes the conflict of interest can be mitigated, neutralized or avoided, the respondent shall submit a Conflict of Interest Mitigation Plan with its response, that shall, at a minimum:

- a)** Identify any relationship, financial interest or other activity which may create an actual or potential organizational conflict of interest.
- b)** Describe the actions the respondent intends to take to mitigate, neutralize, or avoid the identified organizational conflicts of interest.
- c)** Identify the official within the respondent's organization responsible for making conflict of interest determinations.

The Conflict of Interest Mitigation Plan will be evaluated as acceptable or not acceptable. The Agency reserves the right to request additional information from the respondent or other sources, as deemed necessary, to determine whether or not the plan adequately neutralizes, mitigates, or avoids the identified conflicts.

Pursuant to the aforementioned requirements, I hereby certify that, to the best of my knowledge, my organization (including its subcontractors, subsidiaries and partners):

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

Please check the applicable paragraph below. Do not check more than one of the paragraphs below.

- Has no existing relationship, financial interest or other activity which creates any actual or potential organizational conflicts of interest relating to the award of a Contract resulting from this solicitation.

- Has included information in its response to this solicitation detailing the existence of actual or potential organizational conflicts of interest and has provided a "Conflict of Interest Mitigation Plan", as outlined above.

AND

8. RESPONDENT ATTESTATION FOR EXHIBIT A-4

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria, including **Exhibits A-4-a, A-4-b, A-4-c and A-4-d**, including all exhibits/attachments, as applicable.

I understand the Agency may not consider supplemental response narrative for evaluation which is not contained within the Response Sections contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria.

AND

9. RESPONDENT ATTESTATION FOR ATTACHMENT C, COST PROPOSAL INSTRUCTIONS AND RATE METHODOLOGY NARRATIVE

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Attachment C, Cost Proposal Instructions and Rate Methodology Narrative**, including all applicable exhibits.

AND

10. RESPONDENT ATTESTATION REGARDING SCRUTINIZED COMPANIES LIST

I hereby certify that my company is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes. Pursuant to Section 287.135(5), Florida Statutes, the respondent agrees the Agency may immediately terminate the resulting Contract for cause if the respondent is found to have submitted a false certification or if the respondent is

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the resulting Contract.

AND

11. NAMES OF OPERATION

I hereby certify the following is a list of all names under which my organization has operated during the past five (5) years (since July 14, 2012).

AND

12. BUSINESS RELATIONSHIP

The respondent shall disclose any business relationship (as defined in Section 409.966(3)(e), Florida Statutes) with any other eligible Managed Care Plan that is a potential respondent to this solicitation. Such disclosure shall include identifying information for each Managed Care Plan, the nature of the business relationship, the current service area of each Managed Care Plan (by line of business), and the signature of the authorized representative for each Managed Care Plan.

The respondent must disclose any business relationship(s) in the space provided below:

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

AND

13. COMPLETE MEDICAID PROVIDER ENROLLMENT PACKAGE SUBMISSION

- I hereby certify my organization, if awarded a Contract, shall provide the Agency with an accurate and complete Medicaid Provider Enrollment Application, including all ownership and principal fingerprint cards and processing fees, within thirty (30) days after the Contract award is complete.

AND

14. REQUIRED PLAN READINESS DOCUMENTATION

- I hereby certify my organization, if awarded a Contract, shall submit to the Agency all required Plan Readiness documentation within established timeframes as required in **Attachment A**, Instructions and Special Conditions, **Section E.**, Contract Implementation.
- I hereby certify my organization, if a prepaid PSN that is awarded a Contract, shall submit within thirty (30) days, the application for a Health Care Provider Certificate and for a Certificate of Authority, as provided for in Section 641.2019, Florida Statutes.

AND

15. CERTIFICATION REGARDING TERMINATED CONTRACTS

I hereby certify that my organization (including its subsidiaries and affiliates) has not unilaterally or willfully terminated any previous contract prior to the end of the contract with a State or the Federal government and has not had a contract terminated by a State or the Federal government for cause, prior to the end of the contract, within the past five (5) years (since July 14, 2012), other than those listed on **Page 7** of this Exhibit.

AND

16. LIST OF TERMINATED CONTRACTS

List the terminated contracts in chronological order and provide a brief description (half-page or less) of the reason(s) for the termination. Additional pages may be submitted; however, no more than five (5) additional pages should be submitted in total.

The Agency is not responsible for confirming the accuracy of the information provided.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

The Agency reserves the right within its sole discretion, to determine the respondent to be an non-responsible vendor based on any or all of the listed contracts and therefore may reject the respondent's reply.

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EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS

Respondent Name: _____

Client's Name: _____

Term of Terminated Contract: _____

Description of Services: _____

Brief Summary of Reason(s) for Contract Termination: _____

Respondent Name: _____

Client's Name: _____

Term of Terminated Contract: _____

Description of Services: _____

Brief Summary of Reason(s) for Contract Termination: _____

**EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**

Signature below indicates the respondent's full acknowledgement of; understanding of; and agreement with all of the certifications and statements identified above in Items 1 through 16 as written and without caveat.

Respondent Name

Authorized Official Signature

Date

Authorized Official Printed Name

Authorized Official Title

Failure to submit, Exhibit A-2-c, Additional Required Certifications and Statements, signed by an authorized official may result in the rejection of response.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

RESPONDENT NAME: _____

The Agency for Health Care Administration (“Agency” or “AHCA”) “must avoid, neutralize, or mitigate significant potential organizational conflicts of interest (OCI) before a Contract is awarded. If the Agency elects to mitigate the significant potential organizational conflict or conflicts of interest, an adequate mitigation plan, including organizational, physical, and electronic barriers, shall be developed. [Section 287.057(17)(a)(1), Florida Statutes]

The Agency has determined that in order to evaluate proposals and negotiate a Contract that is in the best interests of the State, it is necessary to use the services of Milliman, Inc. (“Milliman”) to act as an actuary and advisor throughout all stages of the “Statewide Medicaid Managed Care Program” competitive solicitation. The Agency reasonably anticipates one or more prospective respondents may also use Milliman. The Agency has determined that all reasonably anticipated OCIs relating to Milliman may be mitigated by the following mitigation plan, which has been agreed to by Milliman:

I. Milliman

- a.** All Milliman personnel who will perform services under the “Statewide Medicaid Managed Care Program” competitive solicitation shall be part of a separate internal Milliman working group (the “Milliman AHCA Group”) with its own internal electronic and hard folders.
- b.** All documents or communications received or generated by the Milliman AHCA Group that relate in any way to this solicitation shall be placed only in this Group’s separate files.
- c.** Each member of the Milliman AHCA Group shall submit **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit indicating they will provide actuarial services to the Agency.
- d.** No Milliman personnel, other than the Milliman AHCA Group personnel shall have access to the Milliman AHCA’s Groups files.
- e.** The above-listed personnel shall not discuss any information relating to the SMMC ITN Services with any other Milliman personnel.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

II. Respondents

- a. Any actual or prospective respondent who is using Milliman for this procurement must disclose this fact in its initial reply to the solicitation. Specifically, a respondent wishing to use Milliman must:
 - i. Identify itself and its intent to use Milliman;
 - ii. Identify the specific Milliman personnel that will be assisting the respondent in the procurement;
 - iii. Submit **Exhibit A-3-b, Milliman Employee Organizational Conflict of Interest Affidavit** forms, completed by each identified Milliman personnel.
- b. All replies submitted in response to this solicitation must include the completed declaration in **Section IV.** of this Exhibit, signed by the authorized official who signed the reply on behalf of the respondent.
- c. Any actual or prospective respondent who learns there is a reasonable basis to believe there has or may have been a violation of the Milliman OCI Mitigation Plan shall, within seventy-two (72) hours, notify the Agency of the facts and circumstances of the possible violation.

III. Protests

- a. **Actual or prospective respondents are advised they have a burden to diligently investigate and challenge potential OCIs relating to Milliman.**
- b. All challenges to the Milliman OCI Mitigation Plan must be timely filed as a challenge to the specifications of this solicitation. Similarly, challenges to amendments to the Milliman OCI Mitigation Plan must be timely filed as specifications challenges.
- c. All challenges to Milliman-related information provided by actual or prospective respondents and posted by the Agency must be timely filed as specifications challenges.
- d. **All protests filed after a Notice of Intent to Award has been posted which allege a Milliman-related OCI shall be limited to alleged violations of the Milliman OCI Mitigation Plan.**

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**EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN**

IV. Declaration

Declaration of _____
Authorized Official Printed Name

Pursuant to Section 92.525, Florida Statutes, _____
Authorized Official Printed Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.
2. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that _____
Respondent Name

will directly and indirectly fully comply with the Milliman Organizational Conflict of Interest Mitigation Plan through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this _____ day of _____ 2017.

Authorized Official Signature

Authorized Official Printed Name

Failure to submit, Exhibit A-3-a, Milliman Organizational Conflict of Interest Mitigation Plan, certified by an authorized official may result in the rejection of response.

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**EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT**

Declaration of _____
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, _____
Milliman Employee Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.
2. I am an employee of Milliman at Milliman's business office located in _____ and have been assigned to provide actuarial services to _____
Respondent Name
3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this _____ day of _____ 2017.

Signature

Printed Name

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EXHIBIT A-4 SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA INSTRUCTIONS

Instructions to respondents for the completion of Exhibit A-4 (including Exhibits A-4-a, A-4-b, A-4-c and A-4-d):

All respondents to this solicitation shall utilize **Exhibit A-4** for submission of its response as specified in **Attachment A.**, Instructions and Special Conditions, **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item f.**, Submission Requirements and Evaluation Criteria. Respondents shall adhere to the instructions below for each Submission Requirement Component (SRC).

Respondents shall not include website links, embedded links and/or cross references between SRCs.

Each SRC contains form fields. Population of the form fields with text will allow the form field to expand and cross pages. There is no character limit. All SRCs, marked as "(Statewide)" must be identical for each region in which the respondent submits a reply. For timeliness of response evaluation, the Agency will evaluate each "(Statewide)" SRC once and transfer the score to each applicable region's evaluation score sheet(s). The SRCs marked as "(Regional)" will be specific and only apply to the region identified in the solicitation and the evaluation score will not be transferred to any other region.

Attachments are acceptable for any SRC but must be referenced in the form field for the respective SRC and located behind each respective SRC response. Respondents shall name and label attachments to refer to respective SRCs by SRC identifier number.

Agency evaluators will be instructed to evaluate the responses based on the narrative contained in the SRC form fields and the associated attachment(s), if applicable.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below unless otherwise identified in each SRC contained within **Exhibit A-4**.

STANDARD EVALUATION CRITERIA SCALE	
Point Score	Evaluation
0	The component was not addressed.
1	The component contained significant deficiencies.
2	The component is below average.
3	The component is average.
4	The component is above average.
5	The component is excellent.

The SRCs in **Exhibit A-4** may not be retyped and/or modified and must be submitted in the original format.

Exhibit A-4 is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

RESPONDENT NAME: _____

A. RESPONDENT BACKGROUND / EXPERIENCE

SRC# 1 – Managed Care Experience (Statewide):

The respondent, including respondent's parent, affiliate(s) and subsidiary(ies), shall provide a list of all current and/or recent (within five (5) years of the issue date of this solicitation (since July 14, 2012) contracts for managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support).

The respondent shall provide the following information for each identified contract:

- a. The Medicaid population served (such as TANF, ABD, dual eligible);
- b. The name and address of the client;
- c. The name of the contract;
- d. The specific start and end dates of the contract;
- e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
- f. The use of administrative and/or delegated subcontractor(s) and their scope of work;
- g. The annual contract amount (payment to the respondent) and annual claims payment amount;
- h. The scheduled and actual completion dates for contract implementation;
- i. The barriers encountered that hindered implementation (if applicable) and the resolutions;
- j. Accomplishments and achievements;
- k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
- l. Whether the contract was capitated, FFS or other payment method.

In addition, the respondent shall describe its experience in delivering managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support), to Medicaid populations similar to the target population (such as TANF, ABD, dual eligible) identified in this solicitation.

For this SRC, the respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program.

Response:

Evaluation Criteria:

- 1. The extent of the respondent's experience with providing integrated medical and behavioral health services.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

2. The extent of the respondent's subcontractors' experience in coordinating or providing services to Medicaid recipients.
3. The extent to which the barriers to implementation experienced by the respondent have clear resolutions outlined.
4. The extent to which the respondent has listed accomplishments and achievements that are relevant to this solicitation.
5. The extent to which the respondent's Medicaid populations served are similar to the populations served by the SMMC program.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 2 – Florida Experience (Regional):

The respondent shall provide documentation of the extent to which it has experience operating as a Florida Medicaid health plan in the region in which it plans to provide services or in any other region in the State of Florida. If applicable, the respondent shall provide the Agency Contract number and the regions of operation to show it has experience providing managed care services and/or LTC services in Florida. The respondent shall provide documentation of any Medicare Advantage Plan contracts for counties in the State of Florida.

Response:

Evaluation Criteria:

For the Managed Care Plan that is proposing to provide services under this solicitation, whether the respondent has:

- An existing SMMC Contract in that region;
- An existing SMMC Contract in another region in the State of Florida; or
- A Medicare Advantage Plan contract in that region.

Score: This section is worth a maximum of 30 raw points as outlined below.

1. 20 points if the respondent already has an SMMC Contract in the region that it plans to provide services (MMA, LTC and/or Specialty).
2. 10 points if the respondent has an SMMC Contract in other regions in the State.
3. 5 additional points will be awarded if the respondent has a comprehensive (MMA & LTC) SMMC Contract in the region that it plans to provide Medicaid services.
4. 5 additional points will be awarded if the plan has a Medicare Advantage Plan in the region that it plans to provide services.
5. 0 points will be awarded if the plan does not have an SMMC Contract in Florida or a Medicare Advantage Plan contract in the region.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 3 – Statutorily Required Florida Presence (Statewide):

The respondent shall provide information regarding whether each operational function, as defined in Section 409.966(3)(c)3, Florida Statutes, will be based in the State of Florida, and the extent to which operational functions will be conducted by staff in-house or through contracted arrangements, located in the State of Florida. This includes:

- a. Specifying the location of where the respondent's corporate headquarters will be located (as defined by Section 409.966(3)(c)3, Florida Statutes);
- b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and
- c. Identifying the number of full-time staff, by operational function (as defined in Section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Evaluation Criteria:

1. Whether the respondent's corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).
2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida.

Score: This section is worth a maximum of 15 raw points. Each of the above components is worth a maximum of 5 points each as described below. 5 additional points will be awarded if respondent meets Items 1(a) and 2(a) below.

For Item 1:

- (a) 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
- (b) 0 points if no relevant corporate headquarters in Florida.

For Item 2:

- (a) 5 points if all functions will be performed in Florida;

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

- (b)** 4 points for 6-7 functions to be performed in Florida;
- (c)** 3 points for 4-5 functions to be performed in Florida;
- (d)** 2 points for 2-3 functions to be performed in Florida;
- (e)** 1 point for 1 function to be performed in Florida;
- (f)** 0 points for no functions to be performed in Florida;
- (g)** 0 points if only community outreach, medical director and State administrative functions will be performed in Florida.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 4 – Contract Performance (Statewide):

The respondent shall state whether, in the past five (5) years (since July 14, 2012), it has voluntarily terminated all or part of a managed care contract under which it provided health care services as the insurer; has had such a contract partially or fully terminated before the contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address and telephone number of the client/other party. If the Contract was terminated based on the respondent's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries.

Response:

Evaluation Criteria:

1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.
2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.
3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).
4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each as described below.

For Item 1:

- (a) 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction and no service area withdrawals;
- (b) 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

For Item 2:

- (a) 5 points for no involuntary terminations;
- (b) 0 points for any involuntary termination based on performance.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

For Item 3:

- (a) 5 points for no contract terminations related to patient care;
- (b) 0 points if termination related to patient care.

For Item 4:

- (a) 5 points for no contract terminations related to provider network management, claims processing or solvency concerns;
- (b) 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

B. Agency Goals

SRC# 5 – Disease Management (DM) Program (Statewide):

The respondent shall describe its proposed approach to implementation of specific disease management programs and how they will be used to advance the Agency's goals as stated in **Attachment A**, Instructions and Special Conditions, **Section A.**, Overview, **Sub-Section 15.**, Program Objectives and Goals, of this solicitation. The respondent's description shall include:

- a. A description of each proposed disease management program;
- b. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;
- c. A description of the evidence-based guidelines utilized in the approach;
- d. A description of how disease management programs are integrated with case management/care coordination programs; and
- e. A description of performance metrics used to evaluate the efficacy of the disease management program, including cost-savings, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics.

Response:

Evaluation Criteria:

1. The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions:
 - (a) Cancer (Section 409.966, Florida Statutes);
 - (b) Diabetes (Section 409.966, Florida Statutes);
 - (c) Asthma;
 - (d) Hypertension;
 - (e) Mental health; and
 - (f) Substance abuse.
2. The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals.
3. The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

4. The adequacy of the respondent's description of how its disease management programs will be integrated into case management/care coordination programs.
5. The extent to which the respondent's disease management programs include the following components:
 - (a) Symptom management;
 - (b) Medication support;
 - (c) Emotional support;
 - (d) Behavior change; and
 - (e) Communication with providers, including the PCP/specialists.
6. The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

Score: This section is worth a maximum of 75 raw points with each component being worth a maximum of 5 points each.

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EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

SRC# 6 – HEDIS Measures (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include, in table format, the target population (TANF, ABD, dual eligible), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-a-1**, General Performance Measurement Tool to provide results for the following HEDIS measures:

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Response:

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.
2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 160 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 150 points as described below:

Exhibit A-4-a-1, General Performance Measurement Tool, provides for seventy-two (72) opportunities for a respondent to report prior experience in meeting quality standards (twelve (12) measure rates, three (3) states each, two (2) years each).

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

For each of the measure rates, a total of 10 points is available per state reported (for a total of 360 points available). The respondent will be awarded 2 points if their reported plan rate exceeded the national Medicaid mean and 2 points if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 2 points for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 150 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 360 points, the final score will be 150 points (100%). If a respondent receives 324 (90%) of the available 360 points, the final score will be 135 points (90%). If a respondent receives 36 (10%) of the available 360 points, the final score will be 15 points (10%).

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 7 – HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

Response:

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.
2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

SRC# 8 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Robert, a 50-year-old man, was diagnosed with chronic obstructive pulmonary disease (COPD) five (5) years ago. His symptoms have been worsening recently, and he has presented at the emergency department three (3) times during the past thirty (30) days. Robert previously smoked twenty-five (25) cigarettes per day for thirty (30) years, but cut down to ten (10) cigarettes per day after his first COPD exacerbation two (2) years ago. He has attempted to quit smoking on several occasions without any success. Robert is prescribed several regular medications for his COPD, as well as for hypertension and hypercholesterolemia. He is pre-diabetic and obese with a BMI of 35. His last appointment with his specialist was ten (10) months ago. Robert has difficulty taking his medications regularly, as he is sometimes unable to get his prescriptions in his rural community and he lacks transportation. After his last visit to the emergency department, Robert was prescribed oxygen treatments and a new medication; however, he has not filled these orders. Robert lives with his 15-year old son and is a single parent. Robert and his son have been on Medicaid for the last four (4) years since he lost his job. Robert has been a member of the plan since December 2016.

The respondent shall describe its approach to coordinating care for an enrollee with Robert's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

- b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
 - c. Application of the respondent's case management risk stratification protocol;
 - d. Identification of service needs (covered and non-covered) and a description for service referral processes;
 - e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
 - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
 - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
 - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
 - i. Identification of strategies that promote enrollee self-management and treatment adherence;
 - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
 - k. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
 3. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
 4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
 5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provides evidence of strategies utilized that resulted in improved health outcomes.
 6. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
 7. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

C. RECIPIENT EXPERIENCE

SRC# 9 – Expanded Benefits (Regional):

Based upon the expanded benefits listed in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent shall identify the benefits it proposes to offer its enrollees by eligible population (TANF, ABD, dual eligible, and LTC populations). **Exhibit A-4-a-2**, Expanded Benefits Tool outlines specific expanded benefits, including category, procedure code descriptions and procedure codes. When electing to offer expanded benefits included in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in **Exhibit A-4-a-2**.

Response: The respondent shall select the following expanded benefits it will offer, as listed in **Exhibit A-4-a-2**, Expanded Benefits Tool (Respondent shall check all that apply):

- Dental benefits for adults
- Over-the-counter benefits
- Occupational Therapy benefits for adults
- Physical Therapy benefits for adults
- Hearing benefit for adults
- Vision benefit for adults
- Prenatal benefit
- Respiratory Therapy benefit for adults
- Speech Therapy benefit for adults
- Additional Primary Care services benefit
- Newborn Circumcision benefit

Evaluation Criteria:

Score: This section is worth a maximum of 190 raw points as outlined below.

- | | | |
|------------|---|--------|
| (a) | Election of the Dental benefit for adults: | 50 pts |
| (b) | Election of the Over-the-counter benefit: | 25 pts |
| (c) | Election of the Occupational Therapy benefits for adults: | 20 pts |
| (d) | Election of the Physical Therapy benefit for adults: | 20 pts |
| (e) | Election of the Prenatal benefit: | 20 pts |
| (f) | Election of the Hearing benefit for adults: | 10 pts |
| (g) | Election of the Vision benefit for adults: | 10 pts |
| (h) | Election of the Respiratory Therapy benefit for adults: | 10 pts |
| (i) | Election of the Speech Therapy benefit for adults: | 10 pts |
| (j) | Election of the Additional Primary Care services benefit: | 10 pts |
| (k) | Election of the Newborn Circumcision benefit: | 5 pts |

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 10 – Additional Expanded Benefits (Regional)

The respondent shall identify each additional expanded benefit that it proposes to offer its enrollees by eligible population (TANF, ABD, dual eligible, and LTC populations). For the purposes of this SRC, the respondent must not select expanded benefits that are included in **Exhibit A-4-a-2**, Expanded Benefits Tool described in SRC# 9. The respondent shall include the name of the benefit, procedure code descriptions, procedure codes and any limitations (frequency/duration, etc.).

The respondent shall submit documentation that includes the calculations used to determine the per-member-per-month (PMPM) cost and the data source used for the calculations (e.g. previous SMMC experience, commercial experience). The submitted PMPM cost must be developed on a “total member” basis, rather than a “per user” or “per benefit eligible” basis (e.g., if the benefit is for adults only, do not submit the expected monthly cost per adult but rather the expected cost per member; or, if the benefit is for the household, its expected monthly cost must be converted to the expected cost per member) and should exclude administrative costs. The respondent shall submit **Exhibit A-4-a-3**, Additional Expanded Benefits Template (Regional).

Response:

Evaluation Criteria:

- a. The extent to which the respondent identifies the expanded benefits it will provide and the information included in **Exhibit A-4-a-3**, Additional Expanded Benefits Template (Regional).

Score: This section is worth a maximum of 5 raw points with the above component being worth a maximum of 5 points.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 11 – Online Provider Directory (Statewide):

The respondent shall describe the provider search function for the online provider directory, including submission of:

- a. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether or not the online provider directory is mobile friendly.
- b. Screen shots for each mouse click required from the start of the respondent's home page to actual search results for a provider, using durable medical equipment providers and zip code as the search elements.
- c. A list of performance indicators the respondent will include for each provider type listed in its provider directory.
- d. A description of the respondent's process for verification of provider information in the online provider directory, including delegated subcontractor provider information, and the method(s) the respondent uses to ensure the weekly network file submission to the Agency is accurate.

Response:

Evaluation Criteria:

1. The extent of the respondent's search functions for the respondent's online directory and ease of access for enrollees' navigation of the online provider directory, including whether or not the online directory is mobile friendly.
2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5).
3. The extent and relevance of the performance indicators available in the respondent's provider directory for each provider type listed.
4. The extent of the respondent's efforts to ensure information in the respondent's online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.
5. The extent to which the respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency's information.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 12 – Enrollee Grievance and Appeal System (Statewide):

The respondent shall provide a flowchart and written description of how the respondent will execute its enrollee grievance and appeal system, including identifying, tracking and analysis of enrollee complaints, grievances, appeals and Medicaid fair hearing data. The respondent shall include in the description detail regarding how data resulting from the grievance and appeal system are used to improve the operational performance of the respondent.

Response:

Evaluation Criteria:

1. The extent to which the respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages.
2. The extent to which the respondent's timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements.
3. The extent to which the respondent's complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.
4. The extent to which the respondent's complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.
5. The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent's established complaint, grievance and appeal process.
6. The extent to which the respondent's grievance and appeal system data resulted in operational improvements of the respondent.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 13 – Social Media (Statewide):

The respondent shall describe its approach for engaging enrollees by using innovative communication methods and technologically advanced resources, including, but not limited to the use of social media, texting and smartphone application platforms.

Response:

Evaluation Criteria:

1. The extent to which the respondent described how these technology investments will be used to improve health literacy and promote improved health outcomes.
2. The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population.
3. The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline).
4. The extent to which the respondent is able to provide routine performance data to support enrollee usage trends.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

SRC# 14 – CAHPS Results (Statewide):

The Respondent (including respondents' parent, affiliate(s), or subsidiary(ies)) shall include in table format, the target population (TANF, ABD, dual eligible) and the respondent's results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid Contracts (as measured by number of enrollees). If the Respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent's largest Contracts. If the Respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported. Respondents shall provide the data requested in **Exhibit A-4-a-4**, Standard CAHPS Measurement Tool, to provide results for the following CAHPS items/composites:

- a. Health Plan Rating;
- b. Health Care Rating;
- c. Getting Needed Care (composite);
- d. Getting Care Quickly (composite); and
- e. Getting Help for Customer Service (composite).

Response:

Evaluation Criteria:

1. The extent to which the respondent exceeded the national Medicaid mean for each CAHPS survey item/component reported.

Score: This section is worth a maximum of 20 raw points as described below.

Exhibit A-4-a-4, Standard CAHPS Measurement Tool, provides for thirty (30) opportunities for a respondent to report prior experience in providing desirable experiences with health care (five (5) measures, three (3) states each, adult population for each, and child population for each). For each of the five (5) measures, a total of six (6) points are available.

The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean, for each available state, for adults and for children, respectively. An aggregate score will be calculated and respondents will receive a final score of 0 through 20 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 30 points, the final score will be 20 points (100%). If a respondent receives 27 (90%) of the available 30 points, the final score will be 18 points (90%). If a respondent receives 3 (10%) of the available 30 points, the final score will be 2 points (10%).

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

D. PROVIDER EXPERIENCE

SRC# 15 – Provider Engagement Model (Statewide):

The respondent shall describe in detail its provider engagement model. The respondent shall include the following elements in its description, at a minimum:

- a. The respondent's staff that play a role in provider engagement;
- b. The presence of local provider field representatives and their role;
- c. The mechanism to track interactions with providers (electronic, physical and telephonic);
- d. How the respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;
- e. The metrics used to measure the overall satisfaction of network providers with the respondent; and
- f. The approach and frequency of provider training on respondent and Agency requirements.

Response:

Evaluation Criteria:

- 1. The extent to which plan leadership are involved in provider engagement.
- 2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.
- 3. The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas.
- 4. The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs.
- 5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.
- 6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

SRC# 16 – Dispute Resolution (Statewide):

The respondent shall describe in detail its provider dispute resolution process.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Evaluation Criteria:

1. The extent to which the respondent's process identifies claims related dispute trends and initiates process improvement activities/system enhancements.
2. The extent to which the respondent's process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes resolved within required timeframes.
3. The extent to which the respondent's process incorporates timely response to Agency requests related to complaint resolution in accordance with the scope of services.
4. The extent to which the respondent integrates all complaints, regardless of the complaint referral source (e.g., Agency, third party).
5. The extent to which the respondent's resolution process includes the respondent's participation in the Agency's claims dispute resolution program authorized in Section 408.7057, Florida Statutes, as well as includes the following:
 - (a) Responding to requests for information from the State contracted independent dispute resolution organization;
 - (b) A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and
 - (c) Prompt payment of final orders issued by the Agency related to claims arbitration case determinations.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 17 – Claims Processing and Payment Process (Statewide):

In a manner suitable for the provider community, the respondent shall submit key components of its claims processing and payment process, addressing both paper and electronic claims submissions for both participating and non-participating providers.

The response shall include detailed information on the metrics to be employed by the vendor to track timeliness and accuracy of claims adjudication and payment for claims submitted by participating providers and how these metrics will be used by line level and management staff to improve processes and provide for rapid cycle improvement.

The response shall also include a detailed description of how the respondent will make data and metrics regarding claims and payment available to the Agency and will ensure that network providers have access to real-time and trend data regarding claims processing and payment by the respondent and all applicable proposed subcontractors.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Evaluation Criteria:

1. The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.
2. The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process.
3. The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.
4. The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data.
5. The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

6. The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

E. DELIVERY SYSTEM COORDINATION

SRC# 18 – Utilization Management (Statewide):

The respondent shall describe the following related to its utilization management (UM) approach:

- a. A description of the process used to determine whether a service should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid benefit.
- b. A description of how the respondent will ensure consistent application of the review criteria for authorization decisions.
- c. A description of how the respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.
- d. A description of the approach used to determine whether a service will be needed short-term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the respondent's service authorization approach (if any exists) based on the length of time that the service will be needed.
- e. To the extent that a service is needed long-term, a description of the strategies that the respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.
- f. A description and example of how the respondent will detect, monitor and evaluate under-utilization, over-utilization and inappropriate utilization as well as processes to identify and address opportunities for improvement.

Response:

Evaluation Criteria:

1. The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.
2. The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.
3. The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for plan staff and network providers).

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

4. The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced.
5. The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization).
6. The adequacy of the respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long-term (ongoing maintenance services/therapies).
7. The adequacy of the respondent's approach at ensuring continuity of care, particularly as it relates to special needs populations.
8. The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 19 – Utilization Management – Ease of Use (Statewide):

The respondent shall describe the following related to its utilization management systems:

- a. A description of how the respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;
- b. A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, subcontractors and the respondent (to the extent any UM functions are delegated);
- c. A description of the respondent's experience meeting timeliness standards for service authorization requests;
- d. A description of the approach that the respondent will use to educate enrollees and providers about the process for seeking authorization; and
- e. A detailed workflow of how "special service" requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the plan to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbooks/coverage policy or the associated fee schedule.

Response:

Evaluation Criteria:

1. The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.
2. The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.
3. The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests.
4. The adequacy of the respondent's education and training plan providers on the service authorization processes.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

5. The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).
6. The extent to which the workflow describing the respondent's process for handling "special service" requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

SRC# 20 – Care Coordination (Statewide):

The respondent shall describe its approach for identifying, assessing, and implementing interventions for enrollees that present with the following:

- Complex medical and/or behavioral health needs;
- High service utilization;
- Intensive health care needs; and
- Consistently accessing services at the highest level of care.

The respondent's approach shall include:

- a. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;
- b. A description of minimum contact frequencies and contact type for each severity and/or risk level;
- c. A description of the maximum caseloads for each case manager (ratio requirements) and support staff;
- d. A description of evidence-based guidelines utilized in the care coordination approach, including interventions deployed to improve enrollee engagement and improve treatment adherence; and
- e. A description of performance metrics used to evaluate the efficacy of the care coordination, including cost-savings, reduction in the use of higher cost services, etc.

Response:

Evaluation Criteria:

1. The extent to which the respondent's algorithm and risk stratification approach is well-defined and incorporates data elements other than diagnosis.
2. The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.
3. The extent to which the respondent's approach includes the use of predictive modeling.
4. The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

5. The extent to which the respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.
6. The adequacy of the respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.
7. The efficacy of the respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 21 – Coordination of Benefits (Statewide):

The respondent shall describe the strategies utilized in care coordination with other plans and insurers (e.g., Medicare) to provide necessary services for its enrollees when the third party payer is the primary insurer. The respondent shall include information on its approach in the following circumstances:

- a. Florida Medicaid does not cover the service, but it is available through the third party payer;
- b. Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid;
- c. The third party carrier benefit limit is exhausted and the service is now a Medicaid expense. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid; and
- d. The service is not covered by the third party but is available through Florida Medicaid.

Response:

Evaluation Criteria:

- 1. The adequacy of the respondent's approach when:
 - (a) Florida Medicaid does not cover the service, but it is available through the third party payer.
 - (b) Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.
 - (c) The third party carrier benefit limit is exhausted and the service is now a Medicaid expense.
 - (d) The service is not covered by the third party but is available through Florida Medicaid.
- 2. The extent to which the respondent's approach includes:
 - (a) Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials).
 - (b) Processes used to identify non-covered services by the primary insurer for individual enrollees.
 - (c) Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

3. The extent to which respondent's description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 22 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Statewide):

The respondent shall describe its approach to education and monitoring of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, including:

- a. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.
- b. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan (case management, utilization management, provider relations, etc.) as well as subcontractors.
- c. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the plan and with subcontractors.
- d. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the respondent's approach towards coverage of the EPSDT benefit.

Response:

Evaluation Criteria:

- 1. The adequacy of the respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.
- 2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.
- 3. The adequacy of the respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.
- 4. The adequacy of the respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors.
- 5. The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 23 – Behavioral Health/Primary Care Integration (Statewide):

The respondent shall describe its proposed approach in promoting integrated behavioral health and primary care models, including:

- a. Identification of integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness.
- b. Identification of opportunities for improvement across the respondent's system of care (e.g., care management, provider network, utilization management, enrollee services) with the goal of advancing to more integrated care models.
- c. Description of strategies the respondent will deploy to overcome the barriers/gaps identified to increase its capacity for providing integrated care models, including use of alternative payment models/financing strategies.

Response:

Evaluation Criteria:

- 1. The extent with which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care.
- 2. The extent to which the respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. The respondent must also describe the data sources.
- 3. The extent to which the respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the respondent will implement across its systems to increase capacity for providing integrated care.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 24 – Transportation (Statewide):

The respondent shall describe its experience and approach for coverage of non-emergency transportation services by providing the following:

- a. A description of the software capabilities utilized to facilitate ease in scheduling and tracking of enrollee pickup adherence;
- b. Strategies for determining the most appropriate mode of transportation; and
- c. Providing data on the following performance metrics for calendar year 2016:
 - (1) Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
 - (2) Percentage of missed trip requests (failed to pick up the enrollee);
 - (3) Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
 - (4) Percentage of urgent care requests fulfilled within three (3) hours of the request; and
 - (5) Number of transportation related complaints and grievances per 1,000 enrollees.
- d. A description of how the respondent uses the performance metric data above to identify areas in need of improvement and implements successful strategies that improve the provision of service.

Response:

Evaluation Criteria:

- 1. The adequacy of the respondent's software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence;
- 2. The extent to which the respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee's individual needs.
- 3. The extent to which the respondent's approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.
- 4. The adequacy of the respondent's performance related to:
 - (a) Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
 - (b) Percentage of missed trip requests;
 - (c) Percentage of hospital discharge requests fulfilled within three (3) hours of the request;

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

- (d) Percentage of urgent care requests fulfilled within three (3) hours of the request;
and
 - (e) Number of transportation related complaints and grievances per 1,000 enrollees.
5. The extent to which the respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 25 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Deshea is 25 years old. She was auto-assigned to your plan and enrolled effective January 1, 2019. Deshea's enrollment information did not include a telephone number and listed a local area homeless shelter as her last place of residence. She left the shelter on December 27, 2018, and the shelter does not know her current whereabouts.

The respondent shall describe the process it will use to attempt to contact Deshea by March 29, 2019.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - (a) Identification of strategies for identifying new enrollees; and
 - (b) Description of the sources of data/information that will be utilized to identify enrollees with special health care needs or circumstances.
2. The extent to which the respondent describes its process for contacting enrollees, including the data sources.
3. A description of how network providers and community partners will be engaged in the identification process.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

F. OVERSIGHT AND ACCOUNTABILITY

SRC# 26 – Subcontractor Oversight (Statewide):

The respondent shall list any proposed subcontractors to which it will delegate the management of: provision of covered services, utilization management, provider networks or paying providers. The respondent shall describe how it will oversee and monitor the performance of subcontractors in general, as well as any specific oversight planned for certain subcontractors, including any corresponding service level agreements. The respondent shall include in its response the schedule and type of monitoring and how findings are reported, remediated, and used for process improvements.

Response:

Evaluation Criteria:

1. The extent to which the respondent provides a list of subcontractors it proposes to use under the SMMC Program for the delegation of work as described above.
2. The adequacy of the respondent's oversight structure, including the extent of executive level staff participation.
3. The extent to which the respondent uses and monitors for service level agreements consistent with the SMMC Program Scope of Services.
4. The adequacy of the respondent's approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.
5. The adequacy of the respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.
6. The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 27 – Subcontractor Oversight (Statewide):

The respondent shall submit a sample contingency plan it would enact in the event a subcontractor to which the plan has delegated authority to manage utilization and pay providers on behalf of the plan, files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Response:

Evaluation Criteria:

1. The extent to which the respondent has outlined the data sources it would use to trigger the respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.
2. The extent to which the respondent outlines a communications strategy in the contingency plan.
3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.
4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 28 – System Modification Protocol (Statewide):

The respondent shall describe, in detail the following change control IT processes:

- a. How the respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems,
- b. How the respondent will accommodate Agency-directed IT modifications; and
- c. How the respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

For each of the descriptions, the respondent shall also include the expected timeframes for making modifications, the prioritization process employed, the communication processes used for planned or unplanned changes, as well as status updates provided to employees, Agency staff, and providers. The descriptions shall also address testing procedures, production control procedures, and any applicable claims/encounter reprocessing for historical or retroactive system changes.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's IT processes addressing internal modifications for its core systems and subcontractor's systems.
2. The extent to which the respondent's IT processes documented for implementing Agency-directed modifications is less than ninety (90) days.
3. The adequacy of the respondent's processes documented for handling production IT system issues.
4. The adequacy of the respondent's communication process used when system issues/updates are identified and resolved by the respondent and/or its subcontractors throughout the change control process.
5. The adequacy of the respondent's approach to system internal testing to ensure the respondent's and/or subcontractors' system changes/updates are accurate.
6. The adequacy of the respondent's approach to integration testing to ensure the respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

7. The adequacy of the respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 29 – Encounter Data Submission (Statewide):

- a. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.
- b. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.
- c. The respondent shall demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.
- d. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.
- e. The respondent shall include documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.
- f. The respondent shall submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

Response:

Evaluation Criteria:

- 1. The adequacy of the respondent's process to ensure accurate, timely, and complete encounter data.
- 2. Demonstrated knowledge of the combination of key fields needed to identify services.
- 3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.
- 4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.
- 5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

6. The completeness of the respondent's flowcharts describing its encounter data submission process.
7. The adequacy of the respondent's mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.
8. The adequacy of the respondent's encounter data submission historical compliance ratings.
9. The adequacy of the respondent's ability to implement timely corrective actions to compliance ratings, if indicated.
10. The adequacy of the tools and methodologies used to determine compliance.
11. The adequacy of the respondent's process for converting paper claims to electronic encounter data.
12. The adequacy of the respondent's approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.
13. The adequacy of the tool to ensure that all encounters are submitted.

Score: This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 30 – Encounter Submission for Sub-Capitated, Subcontracted, Non-Pay and Atypical (Statewide):

The respondent shall describe how it will work with providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to ensure the accuracy, timeliness and completeness of encounter data.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.
2. The adequacy of the respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.
3. The adequacy of the respondent's approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the respondent's approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.
4. The adequacy of the respondent's approach to educating and supporting providers who submit paper claims.
5. The adequacy of the respondent's approach to encouraging providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.
6. The adequacy of the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.
7. The adequacy of the respondent's approach to work with providers to comply with correct coding.
8. The adequacy of the respondent's approach to ensure that all encounters are included in submissions.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 31 – Fraud and Abuse/Compliance Office (Statewide):

The respondent shall describe its compliance program including the compliance officer's level of authority and reporting relationships. The respondent shall describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. The respondent shall include a résumé or curriculum vitae for the compliance officer. The respondent shall also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

Response:

Evaluation Criteria:

1. The extent to which the respondent's compliance program complies with all State and federal requirements.
2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program.
3. The extent to which there are sufficient staff to implement the compliance program.
4. The extent to which the respondent's compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

**SRC# 32 – Fraud and Abuse Special Investigations Unit (SIU)
(Statewide):**

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, including verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

Response:

Evaluation Criteria:

1. The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.
2. The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.
3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.
4. The extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

SRC# 33 – Disaster Recovery Requirements (Statewide):

The respondent shall demonstrate its capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section X.D.4.h**.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.
2. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract.
3. The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract.
4. The adequacy of the respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract.
5. The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.
6. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date.
7. The adequacy of the respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.
8. The adequacy of the respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times.
9. The adequacy of the respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

G. STATUTORY REQUIREMENTS

SRC# 34 – Statutory Community Partnerships (Regional):

The respondent shall describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees, including:

- a. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.
- b. Partnerships with local community organizations focused on addressing the following social determinants of health:
 - (1) Access to Food;
 - (2) Employment;
 - (3) Housing Stability;
 - (4) Education; and
 - (5) Exposure to Crime/Violence.
- c. Participation in both grass-roots and grass-tops provider initiatives.

Response:

Evaluation Criteria:

- 1. The extent to which the respondent provides details on how their local community partnerships, activities and initiatives support the local system of care.
- 2. The extent to which the respondent has senior executive leadership staff who will be assigned to the resulting Contract who also participate on local health and human service related boards, councils, and commissions.
- 3. The extent to which the respondent has partnerships with local agencies that focus on addressing social determinants of health.
- 4. The extent to which the respondent jointly develops and incorporates change from grassroots and grass-tops provider initiatives.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 35 – Organization Commitment to Quality (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall describe its organizational commitment to quality improvement, including active involvement by the respondent's medical and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

Response:

Evaluation Criteria:

1. The extent to which the respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.
2. The adequacy of the respondent's approach to incorporating quality improvement activities into the culture and operations of the organization.
3. The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.
4. The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.
5. The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.
6. The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable events or improving birth outcomes.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

SRC# 36 – Health Plan Accreditation (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall specify its current accreditation status by a nationally recognized accrediting body. This shall include the name of the accrediting body, the most recent date of certification, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (i.e., provisional, conditional, etc.). The respondent shall attach documentation that supports this information.

Response:

Evaluation Criteria:

1. Evidence that the respondent has:
 - (a) Full health plan accreditation by a nationally recognized accrediting body; e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); or
 - (b) Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or
 - (c) No health plan accreditation or denied accreditation.

Score: This section is worth a maximum of 5 raw points as outlined below:

- (a) 5 points for full health plan accreditation.
- (b) 3 points for partial/conditional health plan accreditation.
- (c) 0 points if health plan accreditation denied or no accreditation.

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EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/HEDIS 2017 performance measure data for the selected HEDIS measures for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

If the respondent does not have HEDIS results for at least (3) three Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The performance measures that respondents are required to report on can be found on the Performance Measure Group A tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year.

EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL

RESPONDENT NAME:

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Group A						
	State #1:	Florida	State #2:	Hawaii	State #3:	Georgia
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Adherence to Antipsychotic Medications for Individuals with Schizophrenia						
Antidepressant Medication Management - Acute Phase						
Comprehensive Diabetes Care - HbA1c Control (<8%)						
Controlling High Blood Pressure						
Follow-Up After Hospitalization for Mental Illness - 7 day						
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation - Total						
Medication Management for People with Asthma - 75% Compliance - Total						
Children and Adolescents' Access to Primary Care Practitioners - 12-24 months						
Children and Adolescents' Access to Primary Care Practitioners - 25 months - 6 years						

EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL

Group A						
	State #1:	Florida	State #2:	Hawaii	State #3:	Georgia
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Children and Adolescents' Access to Primary Care Practitioners - 7-11 years						
Children and Adolescents' Access to Primary Care Practitioners - 12-19 years						
Adults' Access to Preventive/Ambulatory Health Services - Total						

Total Points	0
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**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Adult Dental Services	Diagnostic	PERIODIC ORAL EVALUATION	D0120	21	N/A	Not covered	2 per year
Adult Dental Services	Diagnostic	SCREENING OF A PATIENT	D0190	21	N/A	Not covered	2 per year
Adult Dental Services	Diagnostic	ASSESSMENT OF A PATIENT	D0191	21	N/A	Not covered	2 per year
Adult Dental Services	Diagnostic	EXTRAORAL FIRST FILM	D0250	21	N/A	Not covered	1 per 36 months
Adult Dental Services	Diagnostic	EXTRAORAL POSTERIOR RADIOGRAPH	D0251	21	N/A	Not covered	1 per 36 months
Adult Dental Services	Diagnostic	DENTAL BITEWING SINGLE IMAGE	D0270	21	N/A	Not covered	1 per year
Adult Dental Services	Diagnostic	DENTAL BITEWINGS TWO IMAGES	D0272	21	N/A	Not covered	1 per year
Adult Dental Services	Diagnostic	BITEWINGS FOUR IMAGES	D0274	21	N/A	Not covered	1 per year
Adult Dental Services	Preventive	DENTAL PROPHYLAXIS ADULT	D1110	21	N/A	Not covered	2 per year

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Adult Dental Services	Preventive	TOPICAL FLUORIDE VARNISH	D1206	21	N/A	Not covered	2 per year
Adult Dental Services	Preventive	TOPICAL APP FLUORID EX VRNSH	D1208	21	N/A	Not covered	2 per year
Adult Dental Services	Preventive	ORAL HYGIENE INSTRUCTION	D1330	21	N/A	Not covered	2 per year
Adult Dental Services	Preventive	DENTAL SEALANT PER TOOTH	D1351	21	N/A	Not covered	1 per tooth per 3 years
Adult Dental Services	Preventive	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION	D1354	21	N/A	Not covered	2 per tooth per 6 months
Adult Dental Services	Restorative	AMALGAM ONE SURFACE PERMANEN	D2140	21	N/A	Not covered	
Adult Dental Services	Restorative	AMALGAM TWO SURFACES PERMANE	D2150	21	N/A	Not covered	
Adult Dental Services	Restorative	AMALGAM THREE SURFACES PERMA	D2160	21	N/A	Not covered	
Adult Dental Services	Restorative	AMALGAM 4 OR > SURFACES PERM	D2161	21	N/A	Not covered	

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Adult Dental Services	Restorative	RESIN ONE SURFACE-ANTERIOR	D2330	21	N/A	Not covered	Limitation should be once per [tooth + surface] per 3 years
Adult Dental Services	Restorative	RESIN TWO SURFACES-ANTERIOR	D2331	21	N/A	Not covered	
Adult Dental Services	Restorative	RESIN THREE SURFACES-ANTERIO	D2332	21	N/A	Not covered	
Adult Dental Services	Restorative	RESIN 4/> SURF OR W INCIS AN	D2335	21	N/A	Not covered	
Adult Dental Services	Restorative	ANT RESIN-BASED CMPST CROWN	D2390	21	N/A	Not covered	
Adult Dental Services	Restorative	POST 1 SRFC RESINBASED CMPST	D2391	21	N/A	Not covered	
Adult Dental Services	Restorative	POST 2 SRFC RESINBASED CMPST	D2392	21	N/A	Not covered	
Adult Dental Services	Restorative	POST 3 SRFC RESINBASED CMPST	D2393	21	N/A	Not covered	
Adult Dental Services	Restorative	PROTECTIVE RESTORATION	D2940	21	N/A	Not covered	1 per tooth per day

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Adult Dental Services	Periodontics	PERIODONTAL SCALING & ROOT	D4341	21	N/A	Not covered	4 units every 24 months
Adult Dental Services	Periodontics	PERIODONTAL SCALING 1-3TEETH	D4342	21	N/A	Not covered	4 units every 24 months
Adult Dental Services	Periodontics	SCALING IN PRESC OF MODERATE OR SEVERE INFLAMATION - FULL MOUNTH AFTER ORAL EVALUATION	D4346	21	N/A	Not covered	2 per year
Adult Dental Services	Periodontics	FULL MOUTH DEBRIDEMENT	D4355	21	N/A	Not covered	1 per year
Adult Dental Services	Oral and Maxillofacial Surgery	EXTRACTION CORONAL REMNANTS	D7111	21	N/A	Not covered	1 per tooth per lifetime
Adult Dental Services	Oral and Maxillofacial Surgery	TOOTH REIMPLANTATION	D7270	21	N/A	Not covered	1 per tooth per day
Adult Dental Services	Adjunctive General Services	TX DENTAL PAIN MINOR PROC	D9110	21	N/A	Not covered	None
Adult Dental Services	Adjunctive General Services	DENTAL CONSULTATION	D9310	21	N/A	Not covered	1 per year
Adult Dental Services	Adjunctive General Services	BEHAVIOR MANAGEMENT	D9920	21	N/A	Not covered	3 per year

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Product Description	Min Age	Max Age	Current Florida Medicaid Coverage	Expanded Benefit Coverage (Units)
Over the counter benefit	Cough,cold and allergy medications Vitamins and supplements Ophthalmic/Otic preparations Pain relievers Gastrointestinal products First aid care Hygiene products Insect repellent (deet and non-deet) Oral hygiene products Skin care	0 0 0 0 0 0 0 0 0 0	999 999 999 999 999 999 999 999 999 999	Coverage of products must exceed allowable units as described in the pharmacy coverage policy for OTC benefits.	The managed care plan must provide over the counter benefits in the following categories up to \$25 per member per month.

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adult)	Expanded Benefit Coverage (Units)
Therapy	Occupational Therapy Services	OCCUPATIONAL THERAPY EVALUATION MODERATE COMPLEXITY	97166	21	N/A	Not Covered	1 per year
Therapy	Occupational Therapy Services	OCCUPATIONAL THERAPY RE-EVALUATION	97168	21	N/A	Not Covered	1 per year
Therapy	Occupational Therapy Services	OCCUPATIONAL THERAPY TREATMENT VISIT	97530	21	N/A	Not Covered	up to 7 therapy treatment units per week

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adult)	Expanded Benefit Coverage (Units)
Therapy	Physical Therapy	PHYSICAL THERAPY EVALUATION, MODERATE COMPLEXITY	97162	21	N/A	Not covered in an office setting, but may be covered within the \$1500 outpatient hospital services limit, if medically necessary.	1 per year
Therapy	Physical Therapy	PHYSICAL THERAPY RE-EVALUATION	97164	21	N/A	Not covered in an office setting, but may be covered within the \$1500 outpatient hospital services limit, if medically necessary.	1 per year
Therapy	Physical Therapy	PHYSICAL THERAPY TREATMENT VISIT	97110	21	N/A	Not covered in an office setting, but may be covered within the \$1500 outpatient hospital services limit, if medically necessary.	up to 7 therapy treatment units per week

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Coverage (child bearing age)	Expanded Benefit Coverage (Units)
Expanded Prenatal/Perinatal Visits	N/A	HOSPITAL GRADE BREAST PUMP	E0604 (RO - rental only)	10	59	Max of three months (rental, PA is required)	Max of one per year (rental, PA is required)
Expanded Prenatal/Perinatal Visits	N/A	BREAST PUMP	E0603 (RO - rental only)	10	59	1 per every 5 years (PA required)	1 per 2 years (rental, no PA required)
Expanded Prenatal/Perinatal Visits	N/A	ANTEPARTUM MANAGEMENT	H1000	10	59	10 visits for low-risk pregnancies and 14 visits for high-risk pregnancies	14 visits for low-risk pregnancies and 18 visits for high-risk pregnancies
Expanded Prenatal/Perinatal Visits	N/A	POSTPARTUM CARE	59430	10	59	2 visits within 90 days following delivery	3 visits within 90 days following delivery

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Expanded Hearing Service	N/A	ASSESSMENT FOR HEARING AID	V5010	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	HEARING AID FITTING/CHECKING	V5011	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	HEARING AID MONAURAL IN EAR	V5050	21	N/A	1 per every 3 years	1 per year
Expanded Hearing Service	N/A	BEHIND EAR HEARING AID	V5060	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	HEARING AID DISPENSING FEE	V5090	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	IN EAR BINAURAL HEARING AID	V5130	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	BEHIND EAR BINAUR HEARING AI	V5140	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	DISPENSING FEE BINAURAL	V5160	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	BEHIND EAR CROS HEARING AID	V5180	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	CROS HEARING AID DISPENS FEE	V5200	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	BEHIND EAR BICROS HEARING AI	V5220	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	DISPENSING FEE BICROS	V5240	21	N/A	1 per every 3 years	1 per every 2 years
Expanded Hearing Service	N/A	HEARING EVALUATION	92557	21	N/A	1 per every 3 years	1 per every 2 years

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Expanded Vision Services	Equipment	Contact lens, PMMA, spherical, per lens	V2500	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, PMMA, toric or prism ballast, per lens	V2501	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, gas permeable, toric, prism ballast, per lens	V2511	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, gas permeable, extended wear, per lens	V2513	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, hydrophilic, spherical, per lens	V2520	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, hydrophilic, toric, or prism ballast, per lens	V2521	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, hydrophilic, extended wear, per lens	V2523	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Contact lens, other type	V2599	21	N/A	Not covered	6 months supply with prescription
Expanded Vision Services	Equipment	Frames	V2020 V2025	21	N/A	1 per every 2 years	1 per year

**EXHIBIT A-4-a-2
 SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Expanded Vision Services	Equipment	Eye Exam	99173	21	N/A	Visual exam services when there is a reported vision problem, illness, disease, or injury but services cannot be performed exclusively to screen visual acuity.	1 per year

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Coverage (Adults)	Expanded Benefit Coverage (Units)
Therapy	Respiratory Therapy	INITIAL EVALUATION/RE-EVALUATION	S5180 (Modifier HA)	21	N/A	Not covered in an office setting, but may be covered within the \$1500 outpatient hospital services limit, if medically necessary.	1 per year
Therapy	Respiratory Therapy	RESPIRATORY THERAPY VISIT	G0238	21	N/A	Not covered in an office setting, but may be covered within the \$1500 outpatient hospital services limit, if medically necessary.	1 per day

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Therapy	Speech-Language Pathology Services	EVALUATION/RE-EVALUATION	92521-92524	21	N/A	Not Covered	1 per year
Therapy	Speech-Language Pathology Services	EVALUATION OF ORAL & PHARYNGEAL SWALLOWING FUNCTION	92610	21	N/A	Not Covered	1 per year
Therapy	Speech-Language Pathology Services	SPEECH THERAPY VISIT	92507	21	N/A	Not Covered	up to 7 therapy treatment units per week
Therapy	Speech-Language Pathology Services	AAC INITIAL EVALUATION	92597	21	N/A	1 per every five years	1 per year
Therapy	Speech-Language Pathology Services	AAC RE-EVALUATION	92597 (GN Modifier)	21	N/A	Not Covered	1 per year
Therapy	Speech-Language Pathology Services	AAC FITTING, ADJUSTMENT, & TRAINING VISIT	92609	21	N/A	Not Covered	Up to four 30-minute AAC fitting, adjustment, and training sessions/year

**EXHIBIT A-4-a-2
SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Sub-category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99211	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99212	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99213	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99214	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	OFFICE/OUTPATIENT VISIT EST	99215	21	N/A	Limited to 2 visits/month for primary care visits	Unlimited
Primary Care Visits for Adults	N/A	NURSING FAC CARE SUBSEQ	99307	21	N/A	Covered once per month, per provider	Unlimited
Primary Care Visits for Adults	N/A	NURSING FAC CARE SUBSEQ	99308	21	N/A	Covered once per month, per provider	Unlimited
Primary Care Visits for Adults	N/A	NURSING FAC CARE SUBSEQ	99309	21	N/A	Covered once per month, per provider	Unlimited
Primary Care Visits for Adults	N/A	NURSING FAC CARE SUBSEQ	99310	21	N/A	Covered once per month, per provider	Unlimited
Primary Care Visits for Adults	N/A	PREV VISIT EST AGE 18-39	99395	21	39	Once per recipient, per provider, per revolving year	Unlimited
Primary Care Visits for Adults	N/A	PREV VISIT EST AGE 40-64	99396	40	64	Once per recipient, per provider, per revolving year	Unlimited
Primary Care Visits for Adults	N/A	PER PM REEVAL EST PAT 65+ YR	99397	65	N/A	Once per recipient, per provider, per revolving year	Unlimited

**EXHIBIT A-4-a-2
 SRC# 9 - EXPANDED BENEFITS TOOL (REGIONAL)**

Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (children)	Expanded Benefit Coverage (Units)
Newborn Circumcision	CIRCUMCISION NEONATE	54160	0	28 days	1/lifetime if medically necessary	1 per lifetime

Exhibit A-4-a-3
SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit

EXHIBIT A-4-a-4
SRC#14 - STANDARD CAHPS MEASUREMENT TOOL

INSTRUCTIONS:

Respondents should provide results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid contracts (as measured by number of enrollees).

If the respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent's largest Contracts. If the respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported.

The CAHPS items/composites that the respondent is required to report on are located in the CAHPS Results tab.

Use the drop-down box to select the state for which you are reporting and enter the CAHPS results (to the hundredths place, or XX.XX) for that state's Medicaid population for the 2017 survey.

EXHIBIT A-4-a-4
SRC#14 - STANDARD CAHPS MEASUREMENT TOOL

RESPONDENT NAME:

	State #1:	Florida	State #2:	Hawaii	State #3:	Delaware
CAHPS Item/Composite	2017 Adult	2017 Child	2017 Adult	2017 Child	2017 Adult	2017 Child
Rating of Health Plan (the percentage of respondents rating their plan an 8, 9, or 10 out of 10)						
Rating of Health Care (the percentage of respondents rating their health care an 8, 9, or 10 out of 10)						
Getting Needed Care Composite (the percentage of respondents reporting it is usually or always easy to get needed care)						
Getting Care Quickly Composite (the percentage of respondents reporting it is usually or always easy to get care quickly)						
Getting Help from Customer Service Composite (the percentage of respondents reporting it is usually or always easy to get help needed from customer service)						

Total Points	0
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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

RESPONDENT NAME: _____

A. RESPONDENT BACKGROUND/EXPERIENCE

No SRCs in this Category for MMA.

B. AGENCY GOALS

MMA SRC# 1 – Potentially Preventable Events (Regional):

The respondent shall describe its organizational commitment to quality improvement as it relates to reducing potentially preventable events. More specifically, the respondent shall describe its overall approach and specific strategies that will be used to ensure a reduction in potentially preventable hospital admissions and readmissions, a reduction in the use of the emergency department for non-emergent/urgent visits, and a reduction in the use of unnecessary ancillary services during hospitalization and outpatient visits. The respondent's approach shall also include:

- A description of the respondent's assessment (using available data sources) of hospital utilization rates and the potential for improvement;
- A description of performance benchmarks for each area of focus;
- A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings; and
- A description of evidence-based interventions and strategies that will be used to target super-utilizers, particularly related to pain management and behavioral health conditions.

Response:

Evaluation Criteria:

1. The extent to which the respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health).
2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers.
3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

4. The extent to which the respondent plans to include the use of the Agency's Event Notification System as a means to extract relevant data from hospitals.
5. The adequacy of the respondent's description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.
6. The extent to which the respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid patients).
7. The extent to which the respondent proposed local performance benchmarks for:
 - (a) Reducing potentially preventable hospital admissions and readmissions;
 - (b) Reducing use of the emergency department for non-emergent/urgent visits; and
 - (c) Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

MMA SRC# 2 – Birth Outcomes (Statewide):

The respondent shall describe its organizational commitment to quality improvement as it relates to pregnancy and birth outcomes. More specifically, the respondent shall describe its overall approach, and specific strategies, that will be used to address prematurity prevention, improve perinatal outcomes, and reduce unintended pregnancies, including:

- A description of performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries;
- A description of incentives that will be implemented for providers and enrollees aimed at improving birth outcomes; and
- A description of strategies to decrease unintended pregnancies (e.g., increase in the use of long acting reversible contraceptives).

Response:

Evaluation Criteria:

1. The extent to which the respondent identified opportunities for improvement in achieving the benchmarks and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care.
2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify high-risk pregnancies (including enrollees with co-occurring behavioral health conditions).
3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for pregnant enrollees that are determined to be high-risk.
4. The adequacy of the respondent's description of specific evidenced-based programs and interventions that will be used to decrease the number of unintended pregnancies and the associated indicators or measures that will be used to determine their effectiveness.
5. The extent to which the respondent describes financial and non-financial provider and enrollee incentives for evidence-based practices that will contribute to hitting the benchmarks.
6. The adequacy of the respondent's proposed performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries.
7. The extent to which the respondent describes its experience implementing successful strategies that resulted in a reduction in non-medically indicated cesarean sections and early elective deliveries. In order to receive all points for this component, the respondent must include outcome data on specific performance metrics.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 3 – Patient Centered Medical Homes (Regional):

The respondent shall describe its experience with patient centered medical homes (PCMHs) including the respondent's efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvement in quality measures. Specifically, the respondent shall describe programs and initiatives utilizing PCMHs to promote the Agency's goals.

Response:

Evaluation Criteria:

1. The extent to which the respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:
 - (a) Enhanced access;
 - (b) Coordinated and/or integrated care; and
 - (c) Achievement of improved quality outcomes.
2. The extent to which the respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH for their PCP.
3. The extent to which the respondent's description of recognizing PCMHs addresses methodologies and processes to improve prenatal care and birth outcomes for enrollees assigned to a PCMH as their PCP.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

MMA SRC# 4 – Telemedicine (Regional):

The respondent shall describe its overall approach to utilizing telemedicine services to promote the Agency’s goals, in particular as it relates to enhanced access to the following providers within the plan’s network:

- a. Primary Care;
- b. Licensed mental health clinicians;
- c. Psychiatrists;
- d. Cardiologists;
- e. Pulmonologists;
- f. Endocrinologists; and
- g. Internists.

The respondent shall describe any limitations placed on telemedicine services within its network and the percentage of providers with the network that are authorized to provide telemedicine services for the specialty types referenced above and those actually providing telemedicine.

Response:

Evaluation Criteria:

1. The extent to which the respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the Agency’s goals.
2. The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.
3. The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:
 - (a) The percentage of providers authorized to provide telemedicine services for the provider types referenced; and
 - (b) The percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

MMA SRC# 5 – Provider Network Development (Statewide):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to primary and specialty care services, necessary to promote the Agency's goals, including:

- a. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);
- b. Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;
- c. Strategies (including a description of data sources utilized) for measuring timely access to appointments with the following provider types:
 - (1) Cardiologists (pediatric and adult);
 - (2) Pulmonologists (pediatric and adult);
 - (3) Endocrinologists (adult);
 - (4) Internists (adult);
 - (5) Psychiatrists (pediatric and adult);
 - (6) Obstetricians/Gynecologists (adult); and
 - (7) Licensed mental health clinicians (pediatric and adult).
- d. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider's success in making progress towards the Agency goals.

Response:

Evaluation Criteria:

- 1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.
- 2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.
- 3. The adequacy of the respondent's approach for measuring timely access for the specified provider types and the extent to which the respondent's approach includes clear methodology for determining the following:
 - (a) Average wait time for an urgent appointment; and
 - (b) Average wait time for a routine appointment.
- 4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent.
6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the Agency goals are transparent to providers, including the frequency with which providers will be able to access their progress.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

5 additional points will be awarded to respondents who demonstrate that providers shall have real-time access to their progress in achieving quality and/or performance metrics.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 6 – Provider Network Agreements/Contracts (Regional):

The Agency has identified some of the key network service provider types that will be critical in order for the respondent to promote the Agency’s goals.

The respondent shall demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting **Exhibit A-4-b-1**, Provider Network Agreements/Contracts (Regional):

Response:

Evaluation Criteria:

For each service provider type the respondent may receive up to 20 points as described below. Points for each service provider type will be awarded as outlined in the table below:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	5
25.1%- 50%	10
50.1%- 75%	15
75.1% or greater	20

Score: This section is worth a maximum of 240 raw points based on the above point scale.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide):

The Agency has designed the MMA Physician Incentive Program with the expectation that Managed Care Plans should be able to increase compensation for physicians, using funds achieved through savings from effective care management, as specified by Section 409.967(2)(a), Florida Statutes. The respondent shall describe its plan for ensuring physician compensation rates are equal to or exceed Medicare rates for MMA covered services. Specifically, the response shall include detailed descriptions of quality initiatives the respondent intends to implement or maintain that produce savings by promoting the Agency's goals, as well as other areas where the respondent has evidence that a potential for savings and increased quality exists.

Response:

Evaluation Criteria:

1. The extent to which the respondent's proposal to improve quality can be tied to redirecting costs to pay higher physician rates.
2. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.
3. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by improving prenatal care and birth outcomes.
4. The extent to which the respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

C. RECIPIENT EXPERIENCE

MMA SRC# 8 – Primary Care Providers (PCP) Assignment (Statewide):

The respondent shall describe its overall process of assigning enrollees to primary care providers (PCPs), including its assignment algorithm. The response shall include the quality and/or performance metrics used to determine high quality PCPs, and the timeframes associated with processing an enrollee's request to change PCPs.

Response:

Evaluation Criteria:

1. The extent to which the respondent's description includes how quality and/or performance metrics are defined and utilized in the assignment process.
2. The extent to which the respondent's algorithm includes assignment of enrollees to high quality PCPs.
3. The extent to which the respondent can process requests for PCP changes within three (3) business days.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 9 – PCP Timely Access Standards (Statewide):

The respondent shall describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards. The respondent shall also describe the process and methodology it uses for determining whether a PCP has the capacity to accept new patients.

Response:

Evaluation Criteria:

1. The extent to which the respondent's process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services, **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards.
2. The extent to which the respondent's monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.
3. The extent to which the respondent's process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 10 – Transitions of Care (Statewide):

The respondent shall describe how it will address the transition of care between service settings, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home. Identify specific methodologies for ensuring that transition planning ensures appropriate primary care and behavioral health follow up, where appropriate. Provide an example of an effective transition plan.

Response:

Evaluation Criteria:

1. The extent to which the respondent's process and example address the following transition of care requirements:
 - (a) Assessment criteria for making sure the enrollee can be served safely in the community;
 - (b) Collaboration with providers' (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;
 - (c) Referral and scheduling assistance;
 - (d) Coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred; and
 - (e) Processes to prevent unnecessary hospital or nursing facility readmissions.
2. The extent to which the respondent's process and example ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 11 – Provider Network – Network Development Plan (Regional):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to the following services:

- Physical therapy (pediatric);
- Speech-language pathology services (pediatric);
- Occupational therapy (pediatric);
- Private duty nursing services (pediatric);
- Intermittent skilled nursing (pediatric and adult);
- Early intervention services;
- Compounding pharmacies; and
- Specialized therapeutic foster care.

The respondent's approach shall include at a minimum:

- a. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);
- b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;
- c. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received; and
- d. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region-specific identified gaps and future needs projection.
2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.
3. The extent to which the respondent's plan includes strategies for measuring the time in-between when services are authorized and when they are received.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

4. The extent to which the respondent's update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.).
5. The extent to which the respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

D. PROVIDER EXPERIENCE

MMA SRC# 12 – Provider Credentialing (Statewide):

The respondent shall describe its proposed process to credential and recredential providers (including subcontractors' processes, if applicable), including credentialing timeframes, internal continuous quality improvement initiatives for recredentialing, transparency for providers on their application status and the steps the respondent or its subcontractors will take to ensure the respondent and the Agency have accurate provider demographic information in-between credentialing cycles.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's description of its credentialing and recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor.
2. The extent to which the respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days.
3. The adequacy of the respondent's approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process.
4. The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its recredentialing process.
5. The extent to which the respondent and its subcontractors incorporate the Agency's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes.
6. The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan in-between credentialing cycles.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

MMA SRC# 13 – Value Based Purchasing (Regional):

- a. The respondent shall describe the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated by primary care, specialty care and hospital-based care.
- b. The respondent shall describe the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five (5) Contract years, delineated by primary care, specialty care and hospital-based care.
- c. The respondent shall include specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by primary care, specialty care and hospital-based care.
- d. The respondent shall describe specific VBP arrangements it intends to implement and/or maintain in an effort to promote the Agency's goals, delineated by primary care, specialty care and hospital-based care.

Response:

Evaluation Criteria:

1. The extent to which the respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.
2. The extent to which the respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five (5) Contract years, including a rationale for the intended percentages.
3. The extent to which the respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum.
4. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.
5. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for improvement of birth outcomes.
6. The extent to which the respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.
7. The extent to which the respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

E. DELIVERY SYSTEM COORDINATION

MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. Include in table format, the target population (TANF, ABD, dual eligibles), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-b-2**, MMA Performance Measurement Tool to provide results for the following HEDIS measures:

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.
2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 70 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 60 points as described below:

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

Exhibit A-4-b-2, MMA Performance Measurement Tool, provides for forty-eight (48) opportunities for a respondent to report prior experience in meeting quality standards (eight (8) measure rates, three (3) states each, two (2) years each).

For each of the eight (8) measure rates, a total of 5 points is available per state reported (for a total of 120 points available). The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean and 1 point if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 1 point for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 60 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 120 points, the final score will be 60 points (100%). If a respondent receives 108 (90%) of the available 120 points, the final score will be 54 points (90%). If a respondent receives 12 (10%) of the available 120 points, the final score will be 6 points (10%).

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 15 – Failure to Meet HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (\geq 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.
2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 16 – HEDIS (Data Sources) (Statewide):

The respondent shall describe:

- a. The extent to which it has used the following standard supplemental data sources for its HEDIS and other performance measures:
 - Laboratory result files;
 - Immunization data in State or county registries;
 - Transactional data from behavioral healthcare vendors; and
 - Current or historic State transactional files in a standard electronic format.
- b. The extent to which it has used supplemental data from electronic health record vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.
- c. The extent to which it has experience reporting HEDIS measures collected using Electronic Clinical Data Systems.

Response:

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare vendors; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures.
2. The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.
3. The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS).

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 17 – Coordination of Carved Out Services (Statewide):

The respondent shall describe its approach to coordinating services that are not covered by the respondent, but are covered by Florida Medicaid either through the FFS delivery system (e.g., behavior analysis services, prescribed pediatric extended care) or through a prepaid dental plan.

Response:

Evaluation Criteria:

1. The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services.
2. The adequacy of the respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems.
3. The extent to which the respondent's description includes a process for ensuring respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

MMA SRC# 18 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Jose is a 15-year old male. He is diagnosed with bipolar disorder and is currently hospitalized under the Baker Act; this is his third psychiatric admission under the Baker Act in the past year. Up until six (6) months ago, Jose lived with his mother and two younger siblings, but he moved in with his father after his behavior declined and his mother was unable to protect herself and his siblings from Jose's angry outbursts and verbal and physical aggression. His father is physically disabled from a work injury, and he is concerned about managing Jose upon release, as Jose's behavior at home and school has significantly declined. At school, Jose is currently failing and has a notable number of absences and office referrals for altercations. Jose was diagnosed two months ago, during his second psychiatric admission, with bipolar disorder. Jose has been prescribed a low dose of Seroquel daily, but he does not take it consistently because of the side effects. He experiences drowsiness, dry mouth, and nausea. In his current admission, his laboratory testing results showed evidence of thyroid dysfunction. The hospital social worker assisted the family in completing and submitting a referral for Statewide Inpatient Psychiatric Program (SIPP) services, but the SIPP provider informed the social worker that authorization was denied. Jose's father has called the plan's enrollee help line for assistance with completing an expedited appeal. Jose was involved in outpatient therapy for the past six weeks. There have not been any adjustments to his medications to date. Jose has been enrolled in Medicaid since he was 5-years old. He has been enrolled in his health plan since July 2014.

The respondent shall describe its approach to coordinating care for an enrollee with Jose's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
 - b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
 - c. Application of the respondent's case management risk stratification protocol;
 - d. Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
 - e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
 - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
 - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
 - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
 - i. Identification of strategies that promote enrollee self-management and treatment adherence;
 - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
 - k. Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

MMA SRC# 19 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Jane is a 57-year old female with Type II diabetes mellitus and hypertension. Jane is compliant with her treatment plan, which consists of the following prescribed drugs: Insulin and Lisinopril. She is also compliant with her follow-up appointments with her specialists. She lives alone, but receives support from her eldest daughter who lives nearby. Jane thought she timed her follow-up visit with her endocrinologist adequately to allow sufficient time to receive a new prescription for all drugs; however, Jane realizes she only has enough insulin to last through the doses for tomorrow. Her appointment with Dr. Seem, her endocrinologist, is in two weeks. Jane calls her doctor's office who informs her that they have no availability to see her today or tomorrow and Dr. Seem will not write a new prescription without examining Jane since it has been four months since her last appointment. Jane decides to call her health plan's member hotline for assistance.

The respondent shall describe the approach for handling Jane's call and how the respondent would help Jane obtain her medication.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - (a) Training for call center staff that illustrates the ability to triage cases of this nature, including the internal escalation process available to call center staff.
 - (b) Description of the interventions and strategies that would assist Jane in avoiding a visit to urgent care or the emergency department to receive a new prescription.
 - (c) Evidence of the integration between and among all relevant departments, including subcontractors if applicable, to facilitate a seamless resolution.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

MMA SRC# 20 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Emma is four-years old. She currently lives in a pediatric nursing facility. At the age of two she was admitted to PICU following a respiratory arrest during an acute illness. A further complication of her condition led to her requiring a tracheostomy to support her breathing. Following an acute exacerbation of her condition, she is now unable to breathe without the support of her ventilator when she is tired, asleep, or unwell. She is fully ventilated overnight. Her difficulties are compounded by complex seizures. Emma's doctor says Emma needs to have nurses or health care assistants with her at all times to monitor her ventilation. Emma's most recent developmental screening indicates the presence of an intellectual disability. Emma's condition has stabilized, but her mother is concerned about agreeing to bring her home permanently. Her mother is the sole income for their home, which includes three older siblings and Emma's maternal grandmother. Emma's grandmother is retired, and her ability to help the family is limited by severe rheumatoid arthritis.

To be discharged to her home, Emma's physician has ordered a custom wheelchair that must be individually fabricated and assembled. Her physician also ordered an electronic tablet to provide cognition exercises for Emma. The tablet has a cognition exercise application that reduces the likelihood for any seizure activity that may occur with other similar tablets. Florida Medicaid does not cover the tablet nor the wheelchair, which includes a part that will make it easier for Emma to hold the tablet. Her mother is unable to bear the costs for these special service items. Further orders for Emma's transition to home care are:

- *Continuous pulse oximetry monitoring.*
- *Apnea monitor when she is not on the ventilator.*
- *A backup generator for the ventilator if the power goes out in the home.*

Emma is a new enrollee. Prior to her enrollment, all services were provided through the Medicaid FFS delivery system.

The respondent shall describe its approach to coordinating care for an enrollee with Emma's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
 - b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
 - c. Application of the respondent's case management risk stratification protocol;
 - d. Identification of service needs (covered and non-covered) and a description for service referral processes that the respondent has in place;
 - e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
 - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
 - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
 - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
 - i. Identification of strategies that promote enrollee self-management and treatment adherence;
 - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
 - k. Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondents' workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoid unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

F. OVERSIGHT AND ACCOUNTABILITY

No SRCs in this Category for MMA.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

G. STATUTORY REQUIREMENTS

MMA SRC #21 – Provider Network Agreements/Contracts Statewide Essential Providers (Statewide)

The respondent shall submit **Exhibit A-4-b-3**, Provider Network Agreements/Contracts Statewide Essential Providers, to demonstrate its progress with executing agreements or contracts with Statewide Essential Providers by submitting **Exhibit A-4-b-3**:

Response:

Evaluation Criteria:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	10
25.1%- 50%	20
50.1%- 75%	30
75.1% or greater	40

Score: This section is worth a maximum of 40 raw points based on the above point scale.

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**EXHIBIT A-4-b-1
MMA SRC# 6 – PROVIDER NETWORK AGREEMENTS/CONTRACTS
(REGIONAL)**

Exhibit A-4-b-1, MMA SRC# 6 – Provider Network Agreements/Contracts (Regional) is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>.

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EXHIBIT A-4-b-2
SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/ HEDIS 2017 performance measure data for the selected HEDIS measures for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The performance measures that respondents are required to report on can be found on the Performance Measure Group B tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year.

EXHIBIT A-4-b-2
MMA SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL

RESPONDENT NAME:

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Group B						
	State #1:	Florida	State #2:	Idaho	State #3:	Alaska
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Adolescent Well-Care Visits						
Childhood Immunization Status - Combination 3						
Frequency of Ongoing Prenatal Care - \geq 81% of expected visits						
Immunizations for Adolescents - Combination 1						
Timeliness of Prenatal Care						
Well-Child Visits in the First 15 Months of Life - 6 or more visits						
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life						

Total Points	0
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EXHIBIT A-4-b-3
MMA SRC# 21 – PROVIDER NETWORK AGREEMENTS/CONTRACTS
STATEWIDE ESSENTIAL PROVIDERS

Exhibit A-4-b-3, MMA SRC# 21 – Provider Network Agreements/Contracts Statewide Essential Providers is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>

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**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

RESPONDENT NAME:

A. RESPONDENT BACKGROUND / EXPERIENCE

LTC SRC# 1 – Participant Direction of Services (Statewide):

The respondent shall describe its experience with participant direction of services (also referred to as self-directed or consumer-directed) by specifying the model(s) of participant direction used in the states in which the respondent currently operates and previously operated (e.g., agency with choice or fiscal employer agent). The respondent shall include a flowchart depicting how services are authorized and delivered through the participant direction programs referenced in the response. The description shall include:

- Whether the model(s) includes the use of employer authority, budget authority, or both;
- The target population (ABD, DD, general aging population, etc.);
- The number of participants in each participant direction program;
- The services provided through its participant direction programs;
- The monitoring approach used to prevent and detect waste and abuse, specifically over-utilization of services;
- The lessons learned from implementing participant direction programs; and
- The innovations it has deployed to enhance the delivery of services through the participant direction program.

Response:

Evaluation Criteria:

1. The extent to which the respondent's description includes experience with managing a participant direction of service delivery model.
2. The extent to which the respondent's flowchart provides a description that addresses the following components:
 - (a) Care planning;
 - (b) Service authorization;
 - (c) Involvement of the Fiscal Employer Agent;
 - (d) Electronic Visit Verification;
 - (e) Claims processing;
 - (f) Claims payment; and
 - (g) Encounter data submission.
3. The extent to which lessons learned have been utilized to improve the respondent's participant direction of service delivery model.

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

4. The extent to which the described experience demonstrates past innovations or planned innovations in participant direction of services (e.g., mobile telephone applications, implementation of electronic access/training to complete required forms, and electronic visit verification).
5. The extent to which the respondent's monitoring approach ensures that fraud, waste and abuse is monitored and prevented, including over utilization of services.

Score: This section is worth a maximum of 55 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

LTC SRC# 2 – Performance Measures (Statewide):

- a. The respondent shall describe its experience in measuring performance and achieving quality standards with populations similar to the target population for the long-term care (LTC) component of the SMMC program. Describe experience with and performance on measures of the following elements of LTC:
- (1) Comprehensive LTC assessment and update (the percentage of LTC plan enrollees who have documentation of a comprehensive assessment within the appropriate time frame);
 - (2) Comprehensive LTC Care Plan (the percentage of LTC enrollees who have documentation of a Comprehensive LTC Care Plan within the appropriate time frame);
 - (3) Shared Care Plan (the percentage of LTC plan enrollees with a care plan for whom all or part of the care plan was transmitted to key LTC providers and the primary care provider within the appropriate time frame);
 - (4) Re-Assessment and Care Plan Update after Discharge (the percentage of discharges from inpatient facilities in the measurement year for LTC plan enrollees resulting in a re-assessment and care plan update within 30 days of discharge);
 - (5) Admission to an Institution from the Community among LTC enrollees (the percentage of LTC 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 or long-term stay during the measurement year);
 - (6) Successful Transition after Short-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollee institutional admissions that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission); and
 - (7) Successful Transition after Long-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollees who are long-term residents (101 days or more) of institutions who are successfully discharged to the community (community residence for 30 or more days)).
- b. The respondent shall describe any instances of failure to meet Contract-required quality standards for these types of measures, actions taken to improve performance, and how improvement was measured. (See Section 409.966(3)(a)2., Florida Statutes)
- c. The respondent shall describe its experience with and performance on other LTC performance measures, any instances of failure to meet Contract-required quality standards for these measures, actions taken to improve performance, and how improvement was measured.
- d. The respondent shall describe the data sources used for collecting and reporting LTC performance measures.
- e. The respondent shall describe how the respondent has obtained data needed to track measures related to care plan updates after hospital admissions and discharges, and emergency department visits.

**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

Response:

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for measures related to the elements of LTC identified as number a.(1) through a.(7).
2. The extent of experience (e.g., number of Contracts, enrollees, or years) in achieving quality standards with similar target populations for other LTC performance measures.
3. The extent to which the described experience demonstrates the ability to effectively measure quality improvement.
4. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way.
5. The extent to which the respondent met all quality measures or successfully remediated all failures.
6. The extent to which the respondent has used multiple data sources and has obtained data needed to collect and report on LTC performance measures, including those that require information related to care plan updates after hospital admissions and discharges, and emergency department visits.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

B. AGENCY GOALS

LTC SRC# 3 – Transitions of Care (Statewide):

The respondent shall describe how it will address transition and discharge planning for an enrollee going from a hospital or nursing facility rehabilitation setting and returning to a community setting. The respondent should identify specific strategies for ensuring that transition and discharge planning incorporates assessment of appropriate supports in the home, provision of supplies and home care/nursing services. The respondent shall include an example of an effective transition plan with appropriate timeframes for each step of the process.

Response:

Evaluation Criteria:

1. The extent to which the respondent's process and example address the following components of transition and discharge planning:
 - (a) Assessment criteria for ensuring the enrollee can be served safely in the community;
 - (b) Collaboration with providers' discharge planning staff (e.g., hospitals, institutional settings, assisted living facilities, ancillary providers);
 - (c) Referral and scheduling assistance;
 - (d) Coordination with home and community-based providers, including DME and home health providers as appropriate to meet the enrollee's needs; and
 - (e) Processes to prevent unnecessary hospital or nursing facility readmissions.
2. The extent to which the respondent's process and example ensure the protection of the enrollee's privacy consistent with confidentiality requirements.
3. The extent to which the respondent's example provides appropriate timeframes for each step of the transition and discharge planning process.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

LTC SRC# 4 – Provider Network Agreements/Contracts (Regional):

The Agency has identified some of the key network provider types that will be critical in order for the respondent to promote the Agency’s goals.

The respondent shall demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting **Exhibit A-4-c-1**, Provider Network Agreements/Contracts (Regional):

Response:

Evaluation Criteria:

For each service type the respondent may receive up to 20 points as described below. There are 12 service types available in a region.

Percentage of agreements/contracts for each service type	Points
0.0%	0
1.0% - 25%	5
25.1%- 50%	10
50.1%- 75%	15
75.1% or greater	20

Score: This section is worth a maximum of 240 raw points based on the above point scale.

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**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

C. RECIPIENT EXPERIENCE

LTC SRC# 5 – Transition from Nursing Facility to Community (Statewide):

The respondent shall describe its experience with transitioning individuals from institutional to community settings and strategies to ensure individuals maintain successful community placement including:

- a. Experience and strategies pertaining to deploying transitional care teams and using evidence-based practices with support from other clinical resources and community-based organizations.
- b. Experience and strategies pertaining to individuals who reside in an institutional setting for rehabilitation, or have otherwise resided in a facility for less than one year.
- c. Experience and strategies pertaining to individuals who have resided in an institutional setting for more than one year.

Response:

Evaluation Criteria:

- 1. The extent to which the respondent identifies how it will coordinate care with all individuals and/or entities necessary.
- 2. The extent to which the respondent assesses potential caregiver willingness and availability in supporting the transition.
- 3. The extent to which the respondent's description addresses transitioning enrollees with special circumstances or medical conditions (e.g., complex needs); enrollees with ongoing needs; and enrollees who at the time of their transition have existing prior authorization or approval for ancillary services.
- 4. The extent to which the respondent demonstrates through data its success rate at transitioning individuals from institutional to community settings.
- 5. The extent to which the respondent demonstrates through data its success rate at maintaining individuals who have transitioned from an institutional placement to community placements.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

LTC SRC# 6 – Care Planning (Statewide):

The respondent shall provide a flowchart depicting how it will use the information contained in the State of Florida approved assessment (Florida Department of Elder Affairs 701B Comprehensive Assessment), the respondent's supplemental assessment (if applicable), and any additional information collected in its utilization and case management processes for LTC services, in order to properly complete the initial care planning process for a recipient in a facility-based setting and in a community-based setting.

Response:

Evaluation Criteria:

1. The extent to which the flowchart outlines specific data components it will use from the State of Florida approved assessment in the development of the plan of care for enrollees.
2. The extent to which the flowchart outlines specific data components it will use from the respondent's supplemental assessment, and/or any additional informational sources, in the development of the plan of care for enrollees.
3. The extent to which the flowchart incorporates specific data components it will use to ensure a person-centered approach is achieved in the care planning process, including documenting personal goals.
4. The extent to which the respondent uses the caregiver assessment to determine the availability of family/informal support systems, and the amount of assistance the existing support systems are able to provide the enrollee, in making authorization decisions.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

LTC SRC# 7 – Freedom of Choice & Residential Settings (Statewide):

The respondent shall describe how it will address the enrollee's preference in residential settings (i.e., home, adult family care home, assisted living, or nursing facility). The respondent shall describe the safeguards it will have in place during the implementation of the re-procurement of the SMMC program to ensure enrollees do not have to move out of their current residence, by residential setting.

Response:

Evaluation Criteria:

1. The extent to which the respondent's description addresses the process it will use to ensure enrollees are educated about their choice in residential setting, including freedom of choice.
2. The extent to which the respondent describes initial or ongoing case manager training to confirm enrollee preference in residential setting.
3. The extent to which the respondent's description addresses how all residential settings are considered for enrollee placement.
4. The extent to which the respondent's description includes safeguards the respondent has in place to ensure enrollees will not have to move out of their current residence, by residential setting.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

D. PROVIDER EXPERIENCE

**LTC SRC# 8 Home and Community-Based Services (HCBS)
Performance and Credentialing (Statewide):**

The respondent shall describe how its staff will create, collect, report and use internal provider performance measures and/or criteria for home and community-based, residential, and participant direction provider types. The respondent shall include how the performance measures will improve network quality and be utilized in recredentialing activities, and if/how the respondent will use the internally-developed performance measures to limit its provider networks pursuant to Section 409.982(1)(c), Florida Statutes.

Response:

Evaluation Criteria:

1. The extent to which the respondent's description includes a plan to create, collect, report and use provider performance measures.
2. The extent to which the respondent describes how performance measures are reported and trended for each participating provider type and incorporates utilization data, quality of care concerns, performance measure scoring, and provider and enrollee satisfaction in recredentialing activities.
3. The extent to which the respondent's description includes a plan to communicate the performance measure results to providers, including any provider incentives or alternative payment methodology opportunities available.
4. The extent to which the respondent's description includes the establishment of data-based targets to determine the completion of provider corrective action plans and utilization of these targets pursuant to Section 409.982(1), Florida Statutes, including the ability for providers to be notified of performance issues prior to termination.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

LTC SRC# 9 – Claims Submission and Payment (Statewide):

The respondent shall describe how it will educate and train LTC providers about claims submission and payment processes.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Evaluation Criteria:

1. The extent to which the respondent describes the initial and ongoing training targeted to LTC providers, including the type, location, and frequency of training.
2. The extent to which the respondent's initial and ongoing training addresses characteristics unique to facility-based vs. community-based providers' claims submission and payment (e.g., rate changes, patient responsibility, Medicare coordination and crossover).
3. The extent to which the respondent will provide ongoing education and training, including problem resolution, responding to provider requests for training and how the respondent will evaluate the effectiveness of its education and training activities, including provider satisfaction.
4. The extent to which the respondent ensures training materials and tools are transparent and easily accessible.
5. The extent to which the training materials provided to LTC providers include information on how to access the Agency's third party claims dispute resolution contract (Maximus).
6. The extent to which the respondent will provide training to providers on medical necessity criteria, as defined in the Contract pursuant to 42 Code of Federal Regulations 447.45 and in 59G-1.010(166), Florida Administrative Code.
7. The adequacy of the respondent's notification process when system issues are identified/resolved by the respondent and/or its subcontractor(s), including notification to all impacted parties of estimated time for resolution, and updates and notification to providers prior to launching system changes that may impact billing and payment.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

LTC SRC# 10 – Claims Submission and Payment (Statewide):

The respondent shall describe how it will ensure that electronically-submitted nursing facility and hospice claims processes will enable claims payment within ten (10) business days after receipt of clean claims. (See Section 409.982 (5), Florida Statutes) The respondent shall provide the specific data metrics it will use to ensure compliance with this provision.

Response:

Evaluation Criteria:

1. The extent to which the respondent describes the systems that will be used to measure timeliness of claims payment.
2. The extent to which the respondent's data metrics demonstrate an ability to comply with Section 409.982(5), Florida Statutes.
3. The extent to which the respondent describes how it will work with providers when the timeliness standards are not met.
4. The extent to which the respondent ensures that billing systems platform changes will be limited.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

E. DELIVERY SYSTEM COORDINATION

LTC SRC# 11 – Case Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Alisha is a 35-year old single mother who suffered from a major car accident when she was 27 years old, which resulted in incomplete paraplegia. Until she received Medicaid coverage, Alisha was unable to afford the recommended level of physical and occupational therapy treatments that would have assisted her in maintaining maximum mobility in her upper extremities. As such, Alisha requires assistance with almost all self-care tasks. Alisha has suffered from clinical depression since her accident. She is cognitively intact and since starting individual therapy sessions with a licensed mental health clinician, she has started to express a desire to be more engaged in her community. Alisha has a primary care physician (who specializes in internal medicine) and is also seen by a neurologist. Alisha's physician has ordered ongoing maintenance physical therapy; she also receives personal care services and durable medical equipment. Alisha gave birth to a son, Noah, one year before the accident. Alisha's mother assists with Noah's care as often as she can, but her mother recently accepted a job in a different city, which will mean Alisha will have less supports (both for herself and Noah). Alisha and Noah currently live with her mother. Because her mother is moving, Alisha has been looking for a new place to live, but she is having trouble finding a home that is functional for her needs. Since Alisha is experiencing changes in her support system and living situation, she requests assistance from her case manager.

The respondent shall describe its approach to coordinating care for an enrollee with Alisha's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. Comprehensive Assessment;
- b. Caregiver Assessment;
- c. Person Centered Care Planning;
- d. Transition Planning;
- e. Disease Management;
- f. Utilization Management/Service Authorization; and
- g. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

- (a) Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
 - (b) Application of the respondent's case management risk stratification protocol, including a rationale for the decision;
 - (c) Application of a person centered care planning approach;
 - (d) Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
 - (e) Description of the interventions and strategies that would be used to facilitate community integration and transition planning;
 - (f) Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services;
 - (g) Description of the assessment of provider capacity to meet the specific needs of enrollees;
 - (h) Identification of strategies that promote self-management and compliance with the plan of care;
 - (i) Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
 - (j) Application of strategies to integrate information across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
 3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
 4. The extent to which the respondent demonstrates experience providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
 5. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
 6. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows.

Score: This section is worth a maximum of 75 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

LTC SRC# 12 – Case Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Mr. and Mrs. Smith are a husband and wife, both in their early 70s. They have an adult daughter who lives in State. The Smiths are both enrolled in Medicaid managed care and are dual-eligible for Medicaid and Medicare. The Smiths are enrolled in Medicare FFS. Mr. Smith is enrolled in a Managed Medical Assistance plan, while Mrs. Smith is newly enrolled in your LTC Plus Plan or Comprehensive Plan. Mrs. Smith has moderate to severe dementia that is progressing. She is able to walk with the aid of a walker and she can feed herself. However, she needs assistance with bathing and dressing, and she needs supervision due to wandering. Mrs. Smith was admitted to the hospital three months ago for pneumonia but was discharged to a nursing facility, as her husband was unable to care for her on his own anymore. Mrs. Smith would like to move home. Mr. Smith would like for her to move home, but he is concerned that he cannot meet all of her needs on his own. Mr. Smith has a single, below-the-knee amputation, but is otherwise healthy. Their small home is cluttered, and they have many pets. Mr. Smith says he is overwhelmed because she needs more care than he can provide by himself.

The respondent shall describe its approach to coordinating care for an enrollee with Mrs. Smith's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. Comprehensive Assessment;
- b. Caregiver Assessment;
- c. Person Centered Care Planning;
- d. Transition Planning;
- e. Disease Management;
- f. Utilization Management/Service Authorization; and
- g. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - (a) Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
 - (b) Application of the respondent's case management risk stratification protocol, including a rationale for the decision;
 - (c) Application of a person centered care planning approach;

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

- (d) Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
 - (e) Description of the interventions and strategies that would be used to facilitate community integration and transition planning;
 - (f) Application of coordination protocols utilized with other insurers, (when applicable) primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services;
 - (g) Description of the assessment of provider capacity to meet the specific needs of enrollees;
 - (h) Identification of strategies that promote self-management and compliance with the plan of care;
 - (i) Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
 - (j) Application of strategies to integrate information across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondents workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
 3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
 4. The extent to which the respondent demonstrates experience providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
 5. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
 6. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows.

Score: This section is worth a maximum of 75 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

F. OVERSIGHT AND ACCOUNTABILITY

LTC SRC# 13 – Management Experience and Retention (Statewide):

The respondent shall describe its approach to the hiring and promoting retention, throughout the Contract term, of executive managers (e.g., CEO, COO, CFO, CMO, vice presidents, senior managers) who have expertise and experience in serving elders and adults with disabilities who require LTC, and document such expertise and experience. The respondent shall describe the relevant experience of their current management team. [See Section 409.981(3)(a), Florida Statutes]

Response:

Evaluation Criteria:

1. The extent to which executive managers have expertise and experience in implementing innovative care delivery systems serving elders and adults with disabilities who require LTC.
2. The extent to which executive managers have expertise and experience for their respective positions.
3. The degree to which the respondent provides evidence, data, or metrics to demonstrate the effectiveness of its approaches to staff retention, including staff tenure, by contract, for the respondent's two (2) most recent contracts.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c-1
LTC SRC# 4 – PROVIDER NETWORK AGREEMENTS/CONTRACTS
(REGIONAL)**

Exhibit A-4-c-1, LTC SRC# 4 – Provider Network Agreements/Contracts (Regional) is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>.

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**EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

RESPONDENT NAME: _____

A. RESPONDENT BACKGROUND/EXPERIENCE

SPECIALTY SRC#1 – Specialty Experience (Statewide):

The respondent, including respondent's parent, affiliate(s) or subsidiary(ies), shall provide a list of all current and/or recent (within five (5) years of the issue date of this solicitation [since July 14, 2012]) contracts for managed care for the proposed specialty population. If the respondent does not have experience with the provision of managed care to the proposed specialty population, the respondent shall not submit a response to this SRC. The respondent shall provide the following information for each identified contract:

- a. The specialty population served;
- b. The name and address of the client;
- c. The name of the Contract;
- d. The specific start and end dates of the Contract;
- e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
- f. The use of administrative and/or delegated subcontractor(s), their scope of work;
- g. The annual contract amount (payment to the respondent) and annual claims payment amount;
- h. The scheduled and actual completion dates for contract implementation;
- i. The barriers encountered that hindered implementation (if applicable) and the resolutions;
- j. Accomplishments and achievements;
- k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
- l. Whether the contract was capitated, fee-for-service or other payment method.

For this SRC the respondent shall not include subcontractor experience.

Response:

Evaluation Criteria:

- 1. The extent the Medicaid population served by the managed care contracts is similar to the specialty population proposed.
- 2. The number and size of managed care contracts active in the last five (5) years.
- 3. The extent to which managed care contracts, or other contracts, active in the last five (5) years, provided relevant experience.
- 4. The extent to which listed accomplishments and achievements are significant and relevant to the specialty population proposed.

EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

B. AGENCY GOALS

Specialty SRC#2 - Care Coordination and/or Case Management (Statewide):

The respondent shall propose care coordination and/or case management activities to meet the unique needs of the specialty population being proposed for this solicitation, including specific disease management interventions or special condition management relevant to the specialty population. The respondent (including respondents' parent, affiliate(s) or subsidiary(ies)) shall describe its experience in providing care coordination/case management for populations similar to the specialty population being proposed, including experience with disease management or other special condition management. The respondent shall describe proposed interventions, evidence-based risk assessment tools, self-management practices, practice guidelines, etc., relevant to the specialty population proposed. The respondent shall identify specific staff qualifications, training and/or experience for case management personnel related to the specialty population proposed. The respondent shall describe any other care coordination/case management activities the respondent proposes to meet the needs of the specialty population proposed.

Response:

Evaluation Criteria:

1. The extent of experience (e.g., number of contracts, enrollees or years) in providing care coordination/case management to similar target populations, including disease or special condition management.
2. The extent to which the described experience demonstrates the ability to effectively provide care coordination/case management to the population proposed.
3. The extent to which the care coordination/case management activities proposed are relevant to the specialty population proposed.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 10 points each as described below:

- (a) 10 points if the component is excellent;
- (b) 8 points if the component is above average;
- (c) 6 points if the component is average;
- (d) 4 points if the component is below average;
- (e) 2 points if the component contained significant deficiencies;
- (f) 0 points if the component was not addressed.

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

Specialty SRC#3 – Quality Measures (Statewide):

The respondent shall propose quality management activities to address the needs of the specialty population(s) being proposed for this solicitation, including specific quality measures relevant to the specialty population(s). The respondent (including respondents' parent, affiliate(s) or subsidiary(ies)) shall describe its experience in quality management for population(s) similar to the specialty population(s) being proposed for this solicitation. Include experience with standardized measures, such as HEDIS and Contract-required measures, relevant to the specialty population(s) proposed. Identify specific quality measures relevant to the specialty population(s) the respondent proposes to collect and report to the Agency. Describe any other quality management activities the respondent proposes to improve performance. Describe any instances of failure to meet HEDIS or Contract-required quality standards and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract required standards were met, but improvement was desirable.

Response:

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, including HEDIS or Contract required measures.
2. The extent to which the quality measures proposed are relevant to the specialty population(s) being proposed for this solicitation.
3. The extent to which the quality management activities proposed demonstrate the ability to improve quality for the population(s) proposed in a meaningful way.
4. The extent to which the respondent met quality measure targets, successfully remediated all failures or achieved improvement to overall performance.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

C. RECIPIENT EXPERIENCE

Specialty SRC#4 Eligibility and Enrollment (Statewide):

The respondent shall propose detailed and specific criteria (age, medical condition and/or diagnoses) for the specialty population proposed in response to this solicitation. The respondent shall include proposed methods for identifying the specialty population proposed, including any data sources/system, specific medical codes for procedures (e.g. Current Procedural Technology (CPT), Healthcare Common Procedure Coding System (HCPC), International Classification of Diseases (ICD-10)) or diagnoses (e.g. ICD-10, Diagnosis Related Groups (DRG), American College of Gastroenterology (ACG)) associated with the population, clinical assessment and/or referral protocols required. The respondent shall identify the estimated number of recipients meeting the criteria for the specialty population proposed, along with the source or methodology for such an estimate.

Response:

Evaluation Criteria:

1. The extent to which the proposed criterion produces a clearly defined and readily identifiable target population.
2. The extent to which the proposed criterion results in a specialty population that does not exceed ten percent (10%) of the total population of MMA eligible recipients.

Score: This section is worth a maximum of 40 raw points as indicated below.

For Item 1:

- (a) 20 points if the proposed criterion produces a clear target population that is data driven and not dependent on assessment or referral;
- (b) 10 points if the proposed criterion produces a clear target population that is in any way dependent on assessment or referral;
- (c) 0 points if the proposed criterion does not produce a clear target population that can readily be identified.

For Item 2:

- (a) 20 points if the estimated size of the specialty population does not exceed ten percent (10%) of the estimated total population of MMA recipients;
- (b) 0 points if the estimated size of the specialty population exceeds ten percent (10%) of the estimated total population of MMA recipients.

**EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

D. PROVIDER EXPERIENCE

No SRCs in this Category for Specialty.

**EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

E. DELIVERY SYSTEM COORDINATION

Specialty SRC#5 - PROVIDER NETWORK (Regional):

The respondent shall propose provider network standards that meet the needs of the specialty population(s) being proposed for this solicitation, including specific provider access ratios that exceed MMA standards for provider types relevant to the specialty population(s). The respondent (including respondents' parent, affiliate(s) or subsidiary(ies)) shall describe its experience in managing provider networks for population(s) similar to the specialty population(s) being proposed for this solicitation, including experience with provider contracting and performance measurement relevant to the specialty population(s) proposed. Identify specific requirements for provider contracts, credentialing, provider handbooks, etc., the respondent proposes for network providers serving the specialty population(s) proposed. Describe any additional provider services the respondent proposes to make available to the provider network serving the specialty population(s).

Response:

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) managing a provider network serving the proposed population(s).
2. The extent to which the described experience demonstrates the ability to manage a provider network relevant to the specialty population(s) proposed.
3. The extent to which the provider capacity ratios proposed ensure the adequacy of a provider network relevant to the specialty population(s) proposed.
4. The extent to which the provider requirements proposed are relevant to the provider network serving the specialty population(s) proposed.
5. The extent to which the additional provider services proposed are relevant to the provider network serving the specialty population(s) proposed.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

F. OVERSIGHT AND ACCOUNTABILITY

No SRCs in this Category for Specialty.

G. STATUTORY REQUIREMENTS

No SRCs in this Category for Specialty.

**EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS**

PURPOSE: The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to capture commitments made by the respondent in response to this solicitation.

INSTRUCTIONS: The respondent shall identify each commitment made/proposed in the solicitation. Commitments include, but are not limited to: innovations that assist in achieving the Agency goals, improvements in service delivery coordination and quality outcomes for enrollees, improving the enrollee experience, commitments made in the respondent's provider engagement approach which result in an improved provider experience, and commitments reducing overall costs to the Medicaid program. The respondent shall identify the solicitation section/sub-section (Attachment X, Exhibit Y, Subsection Z), as applicable where the commitment can be found.

Category	Commitment (Brief Summary/Description)	Solicitation Section Reference
<u>Example:</u> Agency Goals	<u>(Respondent to complete)</u>	Exhibit A-4-a, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)

Respondent Name

Authorized Official Signature

Date

Authorized Official Printed Name

Authorized Official Title

**EXHIBIT A-6
SUMMARY OF MANAGED CARE SAVINGS**

PURPOSE: The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to identify managed care savings included by the respondent in response to this solicitation.

THE AGENCY RESERVES THE RIGHT TO INCLUDE ANY OR ALL MANAGED CARE SAVINGS LISTED HEREIN, OR AS NEGOTIATED, AS PART OF THE RESULTING CONTRACT.

INSTRUCTIONS: THE RESPONDENT SHALL IDENTIFY EACH MANAGED CARE SAVINGS PROPOSED IN ITS RESPONSE TO THIS SOLICITATION AND IDENTIFY BOTH THE SOLICITATION SECTION(S)/SUBSECTION(S)/ITEM(S), AND THE SECTION/COLUMN OF THE COST PROPOSAL TEMPLATE (ATTACHMENT C) IN WHICH THE MANAGED CARE SAVINGS IS PROPOSED. (SEE EXAMPLE BELOW) ADDITIONAL PAGES MAY BE INCLUDED AS NEEDED.

Managed Care Savings Activity (Brief Summary/Description)	Solicitation Section Reference	Cost Proposal Template (Attachment C) Reference
Hospital Readmissions	<i>Example: Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 1 Potentially Preventable Events (Regional)</i>	<i>Example: Cost Proposal Template (Attachment C), Managed Care Savings Adjustments, #1</i>

Respondent Name

Authorized Official Signature **Date**

Authorized Official Printed Name

Authorized Official Title

EXHIBIT A-7 CERTIFICATION OF DRUG-FREE WORKPLACE PROGRAM

In the event of Identical or Tie Bids/Proposals: Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free work place program shall be given preference in the award process. Established procedures for processing tied awards will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

- 1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.
- 2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.
- 3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).
- 4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.
- 5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by, any employee who is so convicted.
- 6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

Respondent Name

Authorized Official Signature

Date

Authorized Official Printed Name

Authorized Official Title

**EXHIBIT A-8
STANDARD CONTRACT**

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

All respondents should review the proposed contract language contained below. In responding to this solicitation, a respondent has agreed to accept the terms and conditions of the Contract contained in this Exhibit. Note: If the resulting Contract is funded with Federal funds, additional terms and conditions may be included at the time of contract award based on the specific Federal requirements.

THIS CONTRACT is entered into between the State of Florida, **AGENCY FOR HEALTH CARE ADMINISTRATION**, hereinafter referred to as the "**Agency**", whose address is 2727 Mahan Drive, Tallahassee, Florida 32308, and **VENDOR NAME** hereinafter referred to as the "**Vendor**", whose address is **VENDOR ADDRESS**, a (type of entity), to provide **service description**.

Table of Contents

I.	THE VENDOR HEREBY AGREES:	3
A.	General Provisions	3
B.	Florida Department of State	3
C.	MyFloridaMarketPlace.....	3
D.	Federal Laws and Regulations	3
E.	Prohibition of Gratuities	4
F.	Audits/Monitoring	4
G.	Inspection of Records and Work Performed.....	5
H.	Accounting	5
I.	Public Records Requests	6
J.	Communications	7
K.	Background Screening.....	7
L.	Monitoring	8
M.	Indemnification	9
N.	Insurance	10
O.	Assignments and Subcontracts.....	11
P.	Subcontracting	11
Q.	Return of Funds	12
R.	Purchasing	12
S.	Procurement of Products or Materials with Recycled Content	13
T.	Civil Rights Requirements/Vendor Assurance.....	13
U.	Equal Employment Opportunity (EEO) Compliance.....	14

**EXHIBIT A-8
STANDARD CONTRACT**

V.	Discrimination.....	14
W.	Requirements of Section 287.058, Florida Statutes	14
X.	Sponsorship	17
Y.	Final Invoice	17
Z.	Use Of Funds For Lobbying Prohibited	18
AA.	Public Entity Crime	18
BB.	Health Insurance Portability and Accountability Act.....	18
CC.	Confidentiality of Information.....	18
DD.	Employment	19
EE.	Work Authorization Program	19
FF.	Scrutinized Companies Lists	20
II.	THE AGENCY HEREBY AGREES:	20
A.	Contract Amount	20
B.	Contract Payment	20
III.	THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE:	20
A.	Termination	20
B.	Contract Managers.....	21
C.	Renegotiation or Modification.....	21
D.	Name, Mailing and Street Address of Payee.....	22
E.	All Terms and Conditions	22

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**EXHIBIT A-8
STANDARD CONTRACT**

I. THE VENDOR HEREBY AGREES:

A. General Provisions

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

B. Florida Department of State

To be registered with the Florida Department of State as an entity authorized to transact business in the State of Florida by the effective date of this Contract.

C. MyFloridaMarketPlace

1. Each Vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in Section 287.012, Florida Statutes (F.S.), shall register in MyFloridaMarketPlace, in compliance with Rule 60A-1.030, Florida Administrative Code (F.A.C.), unless exempt under Rule 60A-1.030(3), F.A.C.
2. This Contract has been exempted by the Florida Department of Management Services from paying the transaction fee per Rule 60A-1.032(2)(a and b), F.A.C.

D. Federal Laws and Regulations

1. This Contract contains Federal funds, therefore, the Vendor shall comply with all applicable Federal requirements pertaining to procurement, including but not limited to Chapter 2 of the Code of Federal Regulations (CFR) and any other final or interim rules.
2. This Contract contains Federal funding in excess of **\$100,000.00**, therefore, the Vendor must, upon Contract execution, complete the Certification Regarding Lobbying Form, **Attachment III**. If a Disclosure of Lobbying Activities Form, Standard Form LLL, is required, it may be obtained from the Agency's Contract Manager. All disclosure forms as required by the Certification Regarding Lobbying Form must be completed and returned to the Agency's Procurement Office.
3. Pursuant to 2 CFR 376, the Vendor must, upon Contract execution, complete the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts Form, **Attachment IV**.

**EXHIBIT A-8
STANDARD CONTRACT**

E. Prohibition of Gratuities

To certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from this Contract in violation of the provisions of Chapter 112, F.S. This Contract may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

F. Audits/Monitoring

1. The Agency may conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency may conduct a review of a sample of analyses performed by the Vendor to verify the quality of the Vendor's analyses. Reasonable notice shall be provided for reviews conducted at the Vendor's place of business.
2. Reviews may include, but shall not be limited to, reviews of procedures, computer systems, recipient records, accounting records, and internal quality control reviews. The Vendor shall work with any reviewing entity selected by the Agency.
3. During this Contract period, these records shall be available at the Vendor's office at all reasonable times. After this Contract period and for ten (10) years following, the records shall be available at the Vendor's chosen location subject to the approval of the Agency. If the records need to be sent to the Agency, the Vendor shall bear the expense of delivery. Prior approval of the disposition of the Vendor and subcontractor records must be requested and approved by the Agency. This obligation survives termination of this Contract.
4. The Vendor shall comply with all applicable Federal requirements pertaining to procurement, including but not limited to Chapter 2 of the CFR and any other final or interim rules with respect to audit requirements of Federal contracts administered through State and local public agencies.
5. The Vendor shall maintain and file with the Agency such progress, fiscal and inventory reports as specified in **Attachment I**, Scope of Services, and other reports as the Agency may require within the period of this Contract. In addition, access to relevant computer data and applications which generated such reports should be made available upon request.
6. The Vendor shall ensure that all related party transactions are disclosed to the Agency Contract Manager.
7. The Vendor shall provide a financial and compliance audit to the Agency as specified in Attachment **Number, Name** and to ensure that all related party transactions are disclosed to the Agency Contract Manager. Additional audit requirements are specified in **Attachment I**, Scope of Services, **Section Number, Name**.
8. The Vendor shall include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments.

**EXHIBIT A-8
STANDARD CONTRACT**

G. Inspection of Records and Work Performed

1. The Agency and its authorized representatives shall, at all reasonable times, have the right to enter the successful Vendor's premises, or other places where duties under this Contract are performed. All inspections and evaluations shall be performed in such a manner as not to unduly delay work. Persons duly authorized by the Agency and federal auditors, pursuant to 45 CFR, Part 74 and/or 45 CFR, Part 92, shall have full access to and the right to examine any of said records and documents.
2. The Vendor shall retain all financial records, medical records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of ten (10) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of ten (10) years, the records shall be retained until resolution of the audit findings.
4. Refusal by the Vendor to allow access to all records, documents, papers, letters, other materials or on-site activities related to this Contract performance shall constitute a breach of this Contract.
5. The right of the Agency and its authorized representatives to perform inspections shall continue for as long as the Vendor is required to maintain records.
6. The Vendor shall be responsible for all storage fees associated with all records maintained under this Contract. The Vendor is also responsible for the destruction of all records that meet the retention schedule noted above.
7. Failure to retain all records as required may result in cancellation of this Contract. The Agency shall give the Vendor advance notice of cancellation pursuant to this provision and shall pay the Vendor only those amounts that are earned prior to the date of cancellation in accordance with the terms and conditions of this Contract. Performance by the Agency of any of its obligations under this Contract shall be subject to the successful Vendor's compliance with this provision.
8. In accordance with Section 20.055, F.S., the Vendor and its subcontractors shall cooperate with the Office of the Inspector General in any investigation, audit, inspection, review or hearing; and shall grant access to any records, data or other information the Office of the Inspector General deems necessary to carry out its official duties.
9. The rights of access in this Section must not be limited to the required retention period but shall last as long as the records are retained.

H. Accounting

1. To maintain an accounting system and employ accounting procedures and practices that conform to generally accepted accounting principles and standards. All charges applicable to this Contract shall be readily ascertainable from such records.

**EXHIBIT A-8
STANDARD CONTRACT**

2. To submit annual financial audits (or parent organization's annual financial audits with organizational chart) to the Agency within thirty (30) calendar days of receipt.

I. Public Records Requests

1. To comply with Section 119.0701, F.S., if applicable, and all other applicable parts of the Florida Public Records Act.
2. To keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Contract.
3. To provide the public with access to public records on the same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in Section 119.07, F.S., or as otherwise provided by law.
4. To upon request from the appropriate Agency custodian of public records, provide the Agency with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost in Section 119.07, F.S., or as otherwise provided by law.
5. To ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of this Contract term and following completion of this Contract if the Vendor does not transfer the records to the Agency.
6. To not collect an individual's social security number unless the Vendor has stated in writing the purpose for its collection. The Vendor collecting an individual's social security number shall provide a copy of the written statement to the Agency and otherwise comply with applicable portions of Section 119.071(5), F.S.
7. To meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Vendor upon termination of this Contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the information technology systems of the Agency.
8. If the Vendor does not comply with a public records request, the Agency shall enforce Contract provisions in accordance with this Contract.
9. **IF THE VENDOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE VENDOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE AGENCY CUSTODIAN OF PUBLIC RECORDS FOR THIS CONTRACT. THE AGENCY CUSTODIAN OF PUBLIC**

**EXHIBIT A-8
STANDARD CONTRACT**

**RECORDS FOR THIS CONTRACT IS THE CONTRACT
MANAGER.**

J. Communications

1. Notwithstanding any term or condition of this Contract to the contrary, the Vendor bears sole responsibility for ensuring that its performance of this Contract fully complies with all State and Federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including but not limited to the Florida Security of Communications Act, Section 934.01, et seq., F.S.; and the Electronic Communications Privacy Act, 18 U.S.C. Section 2510 et seq. (hereafter, collectively, "Communication Privacy Laws").
2. Prior to intercepting, recording or monitoring any communications which are subject to Communication Privacy Laws, the Vendor must:
 - a. Submit a plan which specifies in detail the manner in which the Vendor will ensure that such actions are in full compliance with Communication Privacy Laws (the "Privacy Compliance Plan"); and
 - b. Obtain written approval, signed and notarized by the Agency Contract Manager, approving the Privacy Compliance Plan.
3. No modifications to an approved Privacy Compliance Plan may be implemented by the Vendor unless an amended Privacy Compliance Plan is submitted to the Agency, and written approval of the amended Privacy Compliance Plan is signed and notarized by the Agency Contract Manager. Agency approval of the Vendor's Privacy Compliance Plan in no way constitutes a representation by the Agency that the Privacy Compliance Plan is in full compliance with applicable Communication Privacy Laws, or otherwise shifts or diminishes the Vendor's sole burden to ensure full compliance with applicable Communication Privacy Laws in all aspects of the Vendor's performance of this Contract. Violation of this term may result in sanctions to include termination of this Contract and/or liquidated damages.
4. The Vendor agrees that it is the custodian of any and all recordings for purposes of the Public Records Act, Chapter 119, F.S., and is solely responsible for responding to any public records requests for recordings. This responsibility includes gathering, redaction, duplication and provision of the recordings as well as defense of any actions for enforcement brought pursuant to Section 119.11, F.S.

K. Background Screening

1. To ensure that all Vendor employees including managing employees that have direct access to personally identifiable information (PII), protected health information (PHI), or financial information have a County, State, and Federal criminal background screening comparable to a level 2 background screening as described in Section 435.04, F.S., completed with results prior to employment.

**EXHIBIT A-8
STANDARD CONTRACT**

2. Per Section 435.04(1)(a), F.S., level 2 screening standards include, but need not be limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement, and national criminal history records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.
3. If the Vendor employee or managing employee was employed prior to the execution of this Contract, the Vendor shall ensure that the County, State, and Federal criminal background screening comparable to a level 2 background screening is completed with results prior to the employee accessing any PII, PHI, or financial information.
4. Any Vendor employee or managing employee with background results that are unacceptable to the State as described in Section 435.04, F.S., or related to the criminal use of PII as described in Section 817, F.S., or has been subject to criminal penalties for the misuse of PHI under 42 U.S.C. 1320d-5, or has been subject to criminal penalties for the offenses described in Section 812.0195, F.S., Section 815, F.S., Section 815.04, F.S., or Section 815.06, F.S., shall be denied employment or be immediately dismissed from performing services under this Contract by the Vendor unless an exemption is granted.
5. Direct access is defined as having, or expected to have, duties that involve access to PII, PHI, or financial information by any means including, but not limited to, network shared drives, email, telephone, mail, computer systems, and electronic or printed reports.
6. To ensure that all Vendor employees including managing employees that have direct access to any PII, PHI or financial information have a County, State, and Federal criminal background screening comparable to a level 2 background screening completed with results every five (5) years.
7. To develop and submit policies and procedures related to this criminal background screening requirement to the Agency for review and approval within thirty (30) calendar days of this Contract execution. The Vendor's policies and procedures shall include a procedure to grant an exemption from disqualification for disqualifying offenses revealed by the background screening, as described in Section 435.07, F.S.
8. To keep a record of all background screening records to be available for Agency review upon request.
9. Failure to comply with background screening requirements shall subject the Vendor to liquidated damages as described **Attachment I**, Scope of Services.

L. Monitoring

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

**EXHIBIT A-8
STANDARD CONTRACT**

3. To ensure that each of its employees or subcontractors who performs activities related to the services associated with this Contract will report to the Agency any health care facility that is the subject of these services that may have violated the law. To report concerns pertaining to a health care facility, the Vendor employee or subcontractor may contact the Agency Complaint Hotline by calling 1-888-419-3456 or by completing the online complaint form found at <https://apps.ahca.myflorida.com/hcfc>.
4. To ensure that each of its employees or subcontractors who performs activities related to the services associated with this Contract, will report to the Agency areas of concern relative to the operation of any entity covered by this Contract. To report concerns, the Vendor employee or subcontractor may contact the Agency Complaint Hotline by calling 1-877-254-1055 or by completing the online complaint form found at https://apps.ahca.myflorida.com/smmc_cirts/.
5. Reports which represent individuals receiving services are at risk for, or have suffered serious harm, impairment, or death shall be reported to the Agency immediately and no later than twenty four (24) clock hours after the observation is made. Reports that reflect noncompliance that does not rise to the level of concern noted above shall be reported to the Agency within ten (10) calendar days of the observation.

M. Indemnification

The Vendor agrees to indemnify, defend, and hold harmless the Agency, as provided in this Clause.

1. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the “Duty to Indemnify and Defend”), extend to any completed, actual, pending or threatened action, suit, claim or proceeding, whether civil, criminal, administrative or investigative (including any action by or in the right of the Vendor), and whether formal or informal, in which the Agency is, was or becomes involved and which in any way arises from, relates to or concerns the Vendor’s acts or omissions related to this Contract (inclusive of all attachments, etc.) (collectively “Proceeding”).
 - a. Duty to Indemnify. The Vendor agrees to hold harmless and indemnify the Agency to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages and costs of whatsoever name and description, including attorneys’ fees, arising from or relating to any Proceeding.
 - b. Duty to Defend. With respect to any Proceeding, the Vendor agrees to fully defend the Agency and shall timely reimburse all of the Agency’s legal fees and costs; provided, however, that the amount of such payment for attorneys’ fees and costs is reasonable pursuant to rule 4–1.5, Rules Regulating The Florida Bar. The Agency retains the exclusive right to select, retain and direct its defense through defense counsel funded by the Vendor pursuant to the Duty to Indemnify and Defend the Agency.

**EXHIBIT A-8
STANDARD CONTRACT**

2. Expense Advance. The presumptive right to indemnification of damages shall include the right to have the Vendor pay the Agency's expenses in any Proceeding as such expenses are incurred and in advance of the final disposition of such Proceeding.
3. Enforcement Action. In the event that any claim for indemnity, whether an Expense Advance or otherwise, is made hereunder and is not paid in full within sixty (60) calendar days after written notice of such claim is delivered to the Vendor, the Agency may, but need not, at any time thereafter, bring suit against the Vendor to recover the unpaid amount of the claim (hereinafter "Enforcement Action"). In the event the Agency brings an Enforcement Action, the Vendor shall pay all of the Agency's attorneys' fees and expenses incurred in bringing and pursuing the Enforcement Action.
4. Contribution. In any Proceeding in which the Vendor is held to be jointly liable with the Agency for payment of any claim of any kind (whether for damages, attorneys' fees, costs or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Vendor shall contribute toward satisfaction of the claim whatever portion is or would be payable by the Agency in addition to that portion which is or would be payable by the Vendor, including payment of damages, attorneys' fees and costs, without recourse against the Agency. No provision of this part or of any other section of this Contract (inclusive of all attachments, etc.), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the State or the Agency's immunity to suit or limitations on liability; (ii) obligate the State or the Agency to indemnify the Vendor for the Vendor's own negligence or otherwise assume any liability for the Vendor's own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

N. Insurance

1. To the extent required by law, the Vendor shall be self-insured against, or shall secure and maintain during the life of this Contract, Worker's Compensation Insurance for all its employees connected with the work of this Contract and, in case any work is subcontracted, the Vendor shall require the subcontractor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under this Contract are covered by the Vendor's self-insurance program. Such self-insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the Vendor under this Contract and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the Vendor shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Agency, for the protection of its employees not otherwise protected.
2. The Vendor shall secure and maintain Commercial General Liability insurance including bodily injury, property damage, personal and advertising injury and products and completed operations. This insurance will provide coverage for all claims that may arise from the services and/or operations completed under this Contract, whether such services and/or operations are by the Vendor or anyone directly, or indirectly employed by it. Such insurance shall include a Hold Harmless Agreement in favor of the State of Florida and also include the State of Florida as an Additional Named Insured for the entire length of this Contract

**EXHIBIT A-8
STANDARD CONTRACT**

and hold the State of Florida harmless from subrogation. The Vendor shall set the limits of liability necessary to provide reasonable financial protections to the Vendor and the State of Florida under this Contract.

3. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Vendor's current insurance policy(ies) shall contain a provision that the insurance will not be canceled for any reason except after thirty (30) calendar days written notice. The Vendor shall provide thirty (30) calendar days written notice of cancellation to the Agency's Contract Manager.
4. The Vendor shall submit insurance certificates evidencing such insurance coverage prior to execution of this Contract.

O. Assignments and Subcontracts

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

P. Subcontracting

1. To not subcontract, assign, or transfer any work identified under this Contract, without prior written consent of the Agency.
2. All subcontracts must comply with applicable State and/or Federal law.
3. The Agency encourages Vendors to partner with subcontractors who can provide best value and the best in class solutions. However, the Vendor is responsible for all work performed under this Contract. No subcontract that the Vendor enters into with respect to performance under this Contract shall in any way relieve the Vendor of any responsibility for performance of its duties. The Vendor shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract. If the Agency determines, at any time, that a subcontract is not in compliance with a Contract requirement, the Vendor shall promptly revise the subcontract to bring it into compliance. In addition, the Vendor may be subject to sanctions and/or liquidated damages pursuant to this Contract and Section 409.912(6), F.S. (related to sanctions).
4. All payments to subcontractors will be made by the Vendor.
5. To be responsible for monitoring the subcontractor's performance. The results of the monitoring shall be provided to the Agency's Contract Manager, fourteen (14) business days after the end of each month or as specified by the Agency. If the subcontractor's performance does not meet the Agency's performance standard according to the Agency's monitoring report or the Vendor's monitoring report, an improvement plan must be submitted to the Vendor and the Agency within fourteen (14) business days of the deficient report.
6. The State supports and encourages supplier diversity and the participation of

**EXHIBIT A-8
STANDARD CONTRACT**

small and minority business enterprises in State contracting, both as Vendors and subcontractors. The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this Contract enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of Florida. Vendors can contact the Office of Supplier Diversity at (850) 487-0915 or online at <http://osd.dms.state.fl.us/> for information on minority Vendors who may be considered for subcontracting opportunities.

7. A minority owned business is defined as any business enterprise owned and operated by the following ethnic groups: African American (Certified Minority Code H or Non-Certified Minority Code N); Hispanic American (Certified Minority Code I or Non-Certified Minority Code O); Asian American (Certified Minority Code J or Non-Certified Minority Code P); Native American (Certified Minority Code K or Non-Certified Minority Code Q); or American Woman (Certified Minority Code M or Non-Certified Minority Code R).

Q. Return of Funds

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

R. Purchasing

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

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

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

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

2. RESPECT of Florida

It is expressly understood and agreed that any articles that are the subject of, or required to carry out, this Contract shall be purchased from a nonprofit agency for the blind or for the severely handicapped that is qualified pursuant to Chapter

**EXHIBIT A-8
STANDARD CONTRACT**

413, F.S., in the same manner and under the same procedures set forth in Section 413.036(1) and (2), F.S.; and, for purposes of this Contract the person, firm, or other business entity carrying out the provisions of this Contract shall be deemed to be substituted for this Agency insofar as dealings with such qualified nonprofit agency are concerned.

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

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

S. Procurement of Products or Materials with Recycled Content

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

T. Civil Rights Requirements/Vendor Assurance

The Vendor assures that it will comply with:

1. Title VI of the Civil Rights Act of 1964, as amended, 42 United States Code (U.S.C.) 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin.
2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.
3. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.
4. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.
5. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.
6. The Americans with Disabilities Act of 1990, Public Law (P.L.) 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.
7. Chapter 409, F.S.
8. Rule 62-730.160, F.A.C. pertaining to standards applicable to generators of hazardous waste.
9. All applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 United States Code (U.S.C.) 7401 et seq.

**EXHIBIT A-8
STANDARD CONTRACT**

10. The Medicare-Medicaid Fraud and Abuse Act of 1978.
11. Other Federal omnibus budget reconciliation acts.
12. The Balanced Budget Act of 1997.
13. All regulations, guidelines, and standards as are now or may be lawfully adopted under the above statutes.

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

U. Equal Employment Opportunity (EEO) Compliance

To not discriminate in its employment practices with respect to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap.

V. Discrimination

Pursuant to Section 287.134(2)(a), F.S., an entity or affiliate who has been placed on the discriminatory vendor list may not submit a Bid, Proposal, or Reply on a contract to provide any goods or services to a public entity; may not submit a Bid, Proposal, or Reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit Bids, Proposals, or Replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity. The Florida Department of Management Services is responsible for maintaining the discriminatory vendor list. Questions regarding the discriminatory vendor list may be directed to the Florida Department of Management Services, Office of Supplier Diversity at (850) 487-0915.

W. Requirements of Section 287.058, Florida Statutes

1. To submit bills for fees or other compensation for services or expenses in detail sufficient for a proper pre-audit and post-audit thereof.
2. Where applicable, to submit bills for any travel expenses in accordance with Section 112.061, F.S. The Agency may establish rates lower than the maximum provided in Section 112.061, F.S.
3. To provide units of deliverables, including reports, findings, and drafts, in writing and/or in an electronic format agreeable to both Parties, as specified in **Attachment I**, Scope of Services, to be received and accepted by the Contract Manager prior to payment.
4. To comply with the criteria and final date, as specified herein, by which such

**EXHIBIT A-8
STANDARD CONTRACT**

criteria must be met for completion of this Contract.

5. This Contract shall begin upon execution by both Parties or **BEGIN DATE**, (whichever is later) and end on **END DATE**, inclusive.
6. In accordance with Section 287.057(13), F.S., this Contract may be renewed for a period that may not exceed three (3) years or the term of the original Contract, whichever period is longer. Renewal of this Contract shall be in writing and subject to the same terms and conditions set forth in the initial Contract. A renewal Contract may not include any compensation for costs associated with the renewal. Renewals are contingent upon satisfactory performance evaluations by the Agency, are subject to the availability of funds, and optional to the Agency.
7. If this Contract is renewed, it is the Agency's policy to reduce the overall payment amount by the Agency to the Vendor by at least five percent (5%) during the period of this Contract renewal, unless it would affect the level and quality of services.
8. The Vendor agrees that the Agency may unilaterally cancel this Contract for refusal by the Vendor to allow public access to all documents, papers, letters, or other material made or received by the Vendor in conjunction with this Contract, unless the records are exempt from Section 24(a) of Article I of the State Constitution and the Florida Public Records Act, Chapter 119, F.S.
9. To comply with Patents, Royalties, Copyrights, Right to Data, and Works for Hire/Software requirements as follows:
 - a. The Vendor, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Vendor. The Vendor has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Vendor or is based solely and exclusively upon the Agency's alteration of the article.
 - b. The Agency will provide prompt written notification of a claim of copyright or patent infringement and shall afford the Vendor full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Vendor may, at its option and expense procure for the Agency the right to continue the use of, replace or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Vendor and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).
 - c. If the Vendor brings to the performance of this Contract a pre-existing patent, patent-pending and/or copyright, at the time of Contract execution, the Vendor shall retain all rights and entitlements to that pre-existing patent, patent-pending and/or copyright, unless this Contract provides otherwise.

**EXHIBIT A-8
STANDARD CONTRACT**

- d.** If the Vendor uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services under this Contract, the Vendor shall disclose, in writing, all intellectual properties relevant to the performance of this Contract which the Vendor knows, or should know, could give rise to a patent or copyright. The Vendor shall retain all rights and entitlements to any pre-existing intellectual property which is so disclosed. Failure to disclose will indicate that no such property exists. The Agency will then have the right to all patents and copyrights which arise as a result of performance under this Contract as provided in this Sub-Section.
- e.** If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Contract, or in any way connected herewith, the Vendor shall refer the discovery or invention to the Agency for a determination whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the Vendor in such a manner as to preserve and protect the legal rights of the Agency.
- f.** Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation and works of any similar nature, the Agency has the right to use, duplicate and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to Section 286.021, F.S., no person, firm, corporation, including parties to this Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.
- g.** The Agency will have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Vendor under this Contract.
- h.** All rights and title to works for hire under this Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this Contract.
- i.** The computer programs, data, materials and other information furnished by the Agency to the Vendor hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Vendor. The services and products listed in this Contract shall become the property of the Agency upon the Vendor's

**EXHIBIT A-8
STANDARD CONTRACT**

performance and delivery thereof. The Vendor hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Vendor hereunder, together with the products delivered and services performed by the Vendor hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, F.S., and that the Vendor shall not disclose, publish or use same for any purpose other than the purposes provided in this Contract; however, upon the Vendor first demonstrating to the Agency's satisfaction that such information, in part or in whole, (1) was already known to the Vendor prior to its receipt from the Agency; (2) became known to the Vendor from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the Vendor shall be free to use and disclose same without restriction. Upon completion of the Vendor's performance or otherwise cancellation or termination of this Contract, the Vendor shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the Vendor's possession.

- j. The Vendor warrants that all materials produced hereunder shall be of original development by the Vendor and shall be specifically developed for the fulfillment of this Contract and shall not knowingly infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the Vendor shall indemnify and hold the Agency harmless from and against any loss, cost, liability or expense arising out of any breach or claimed breach of this warranty.
- k. The terms and conditions specified in this Sub-Section shall also apply to any subcontract made under this Contract. The Vendor shall be responsible for informing the subcontractor of the provisions of this Sub-Section and obtaining disclosures.

- 10. The financial consequences that the Agency must apply if the Vendor fails to perform in accordance with this Contract are outlined in **Attachment I**, Scope of Services.

X. Sponsorship

Pursuant to Section 286.25, F.S., all non-governmental Vendors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the Vendor shall include the Statement: "Sponsored by (name of Vendor) and the State of Florida, Agency for Health Care Administration." If the sponsorship reference is in written material, the words, "State of Florida, Agency for Health Care Administration" shall appear in the same size letters or type as the name of the organization.

Y. Final Invoice

The Vendor must submit the final invoice for payment to the Agency no more than **NUMBER** calendar days after this Contract ends or is terminated. If the Vendor fails to do so, all right to payment is forfeited and the Agency will not honor any requests submitted after the aforesaid time period. Any payment due under the terms of this Contract may be withheld until all reports due from the Vendor and necessary

**EXHIBIT A-8
STANDARD CONTRACT**

adjustments thereto have been approved by the Agency.

Z. Use Of Funds For Lobbying Prohibited

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

AA. Public Entity Crime

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

BB. Health Insurance Portability and Accountability Act

1. To comply with the Department of Health and Human Services Privacy Regulations in the CFR, Title 45, Sections 160 and 164, regarding disclosure of protected health information as specified in **Attachment II**, Business Associate Agreement.
2. The Vendor must ensure it meets all Federal regulations regarding required standard electronic transactions and standards for privacy and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 and associated regulations.
3. The Vendor shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or Federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with Federal Information Processing Standards (FIPS), and/or the National Institute of Standards and Technology (NIST) publications regarding cryptographic standards.

CC. Confidentiality of Information

1. The Vendor shall not use or disclose any confidential information, including social security numbers that may be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Medicaid recipient or services under this Contract for any purpose not in conformity with State and Federal laws, except upon written consent of the recipient, or his/her guardian.
2. All personally identifiable information, including Medicaid information, obtained by the Vendor shall be treated as privileged and confidential information and shall be used only as authorized for purposes directly related to the administration of this Contract. The Vendor must have a process that specifies

**EXHIBIT A-8
STANDARD CONTRACT**

that patient-specific information remains confidential, is used solely for the purposes of data analysis or other Vendor responsibilities under this Contract, and is exchanged only for the purpose of conducting a review or other duties outlined in this Contract.

3. Any patient-specific information received by the Vendor can be shared only with those agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Vendor is retained by the Agency. The Vendor must have in place written confidentiality policies and procedures to ensure confidentiality and to comply with all Federal and State laws (including the HIPAA and HITECH Acts) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).
4. The Vendor's subcontracts must explicitly state expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the Vendor. If provider-specific data are released to the public, the Vendor shall have policies and procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, F.S., are met.
5. The Vendor and its subcontractors shall comply with the requirements of Section 501.171, F.S. and shall, in addition to the reporting requirements therein, report to the Agency any breach of personal information.
6. Any releases of information to the media, the public, or other entities require prior approval from the Agency.

DD. Employment

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

EE. Work Authorization Program

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

**EXHIBIT A-8
STANDARD CONTRACT**

FF. Scrutinized Companies Lists

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

II. THE AGENCY HEREBY AGREES:

A. Contract Amount

To pay for contracted services according to the conditions of **Attachment I**, Scope of Services, in an amount not to exceed **\$AMOUNT**, subject to the availability of funds. The State of Florida's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature.

B. Contract Payment

Section 215.422, F.S., provides that agencies have five (5) business days to inspect and approve goods and services, unless bid specifications, Contract or Purchase Order specifies otherwise. With the exception of payments to health care providers for hospital, medical, or other health care services, if payment is not available within forty (40) calendar days, measured from the latter of the date the invoice is received or the goods or services are received, inspected and approved, a separate interest penalty set by the Comptroller pursuant to Section 55.03, F.S., will be due and payable in addition to the invoice amount. To obtain the applicable interest rate, please contact the Agency's Fiscal Section at (850) 412-3858, or utilize the Department of Financial Services website at www.myfloridacfo.com/aadir/interest.htm. Payments to health care providers for hospital, medical or other health care services, shall be made not more than thirty five (35) calendar days from the date eligibility for payment is determined, and the daily interest rate is .0003333%. Invoices returned to a vendor due to preparation errors will result in a payment delay. Invoice payment requirements do not start until a properly completed invoice is provided to the Agency. A Vendor Ombudsman, whose duties include acting as an advocate for vendors who may be experiencing problems in obtaining timely payment(s) from a State agency, may be contacted at (850) 413-5516 or by calling the State Office of Financial Regulation Consumer Helpline, 1-877-693-5236.

III. THE VENDOR AND AGENCY HEREBY MUTUALLY AGREE:

A. Termination

1. Termination at Will

This Contract may be terminated by the Agency upon no less than thirty (30) calendar days written notice, without cause, unless a lesser time is mutually agreed upon by both Parties. Said notice shall be delivered by certified mail,

**EXHIBIT A-8
STANDARD CONTRACT**

return receipt requested, or in person with proof of delivery.

2. Termination Due To Lack of Funds

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

3. Termination for Breach

- a. Unless the Vendor's breach is waived by the Agency in writing, the Agency may, by written notice to the Vendor, terminate this Contract upon no less than twenty four (24) clock hours' written notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. If applicable, the Agency may employ the default provisions in Rule 60A-1.006(3), F.A.C.
- b. Waiver of breach of any provisions of this Contract shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms of this Contract. The provisions herein do not limit the Agency's right to remedies at law or to damages.

B. Contract Managers

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

Name
Agency for Health Care Administration
Address
City, State Zip Code
Phone Number

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

Name
Address
City, State Zip Code
Phone Number

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

C. Renegotiation or Modification

1. Modifications of provisions of this Contract shall only be valid when they have been reduced to writing and duly signed during the term of this Contract. The Parties agree to renegotiate this Contract if Federal and/or State revisions of any applicable laws, or regulations make changes in this Contract necessary.

**EXHIBIT A-8
STANDARD CONTRACT**

2. The rate of payment and the total dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the Agency's operating budget.

3. Preferred Pricing

The Vendor represents and warrants that the prices and terms for its services under this Contract are no less favorable to the Agency than those for similar services under any existing contract with any other party. The Vendor further agrees that, within ninety (90) calendar days of the Vendor entering into a contract or contract amendment or offering to any other party services similar to those under this Contract under prices or terms more favorable than those provided in this Contract, the Vendor will report such prices and terms to the Agency, which prices or terms shall be effective as an amendment to this Contract upon the Agency's written acceptance thereof. Should the Agency discover such other prices or terms, the same shall be effective as an amendment to this Contract retroactively to the earlier of the effective date of this Contract (for other contracts in effect as of that date) or the date they were first contracted or offered to the other party (for subsequent contracts, amendments or offers) and any payment in excess of such pricing shall be deemed overpayments. The Vendor shall submit an affidavit no later than July 31st of each year during the term of this Contract attesting that the Vendor is in compliance with this provision, as required by Section 216.0113, F.S.

D. Name, Mailing and Street Address of Payee

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

Name
Address
City, State Zip Code

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

Name
Address
City, State Zip Code

E. All Terms and Conditions

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

This Contract is and shall be deemed jointly drafted and written by all Parties to it and shall not be construed or interpreted against the Party originating or preparing it. Each Party has the right to consult with counsel and has either consulted with counsel or knowingly and freely entered into this Contract without exercising its right to counsel.

**EXHIBIT A-8
STANDARD CONTRACT**

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

VENDOR NAME

**STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION**

SIGNED BY: **SAMPLE**

SIGNED BY: **SAMPLE**

NAME: **NAME**

NAME: **NAME**

TITLE: **TITLE**

TITLE: **TITLE**

DATE: _____

DATE: _____

FEDERAL ID NUMBER (or SS Number for an individual): **NUMBER**

VENDOR FISCAL YEAR ENDING DATE: **DATE**

List of Attachments included as part of this Contract:

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

**EXHIBIT A-8
STANDARD CONTRACT**

ATTACHMENT II

BUSINESS ASSOCIATE AGREEMENT

The parties to this Attachment agree that the following provisions constitute a business associate agreement for purposes of complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Attachment is applicable if the Vendor is a business associate within the meaning of the Privacy and Security Regulations, 45 C.F.R. 160 and 164.

The Vendor certifies and agrees as to abide by the following:

1. Definitions. Unless specifically stated in this Attachment, the definition of the terms contained herein shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164.
 - 1a. Protected Health Information. For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164, limited to the information created, received, maintained or transmitted by the Vendor from, or on behalf of, the Agency.
 - 1b. Security Incident. For purposes of this Attachment, security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system and includes any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity.
2. Applicability of HITECH and HIPAA Privacy Rule and Security Rule Provisions. As provided by federal law, Title XIII of the American Recovery and Reinvestment Act of 2009 (ARRA), also known as the Health Information Technology Economic and Clinical Health (HITECH) Act, requires a Business Associate (Vendor) that contracts with the Agency, a HIPAA covered entity, to comply with the provisions of the HIPAA Privacy and Security Rules (45 C.F.R. 160 and 164).
3. Use and Disclosure of Protected Health Information. The Vendor shall comply with the provisions of 45 CFR 164.504(e)(2)(ii). The Vendor shall not use or disclose protected health information other than as permitted by this Contract or by federal and state law. The sale of protected health information or any components thereof is prohibited except as provided in 45 CFR 164.502(a)(5). The Vendor will use appropriate safeguards to prevent the use or disclosure of protected health information for any purpose not in conformity with this Contract and federal and state law. The Vendor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information the Vendor creates, receives, maintains, or transmits on behalf of the Agency.

**EXHIBIT A-8
STANDARD CONTRACT**

4. Use and Disclosure of Information for Management, Administration, and Legal Responsibilities. The Vendor is permitted to use and disclose protected health information received from the Agency for the proper management and administration of the Vendor or to carry out the legal responsibilities of the Vendor, in accordance with 45 C.F.R. 164.504(e)(4). Such disclosure is only permissible where required by law, or where the Vendor obtains reasonable assurances from the person to whom the protected health information is disclosed that: (1) the protected health information will be held confidentially, (2) the protected health information will be used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and (3) the person notifies the Vendor of any instance of which it is aware in which the confidentiality of the protected health information has been breached.
5. Disclosure to Third Parties. The Vendor will not divulge, disclose, or communicate protected health information to any third party for any purpose not in conformity with this Contract without prior written approval from the Agency. The Vendor shall ensure that any agent, including a subcontractor, to whom it provides protected health information received from, or created or received by the Vendor on behalf of, the Agency agrees to the same terms, conditions, and restrictions that apply to the Vendor with respect to protected health information. The Vendor's subcontracts shall fully comply with the requirements of 45 CFR 164.314(a)(2)(iii).
6. Access to Information. The Vendor shall make protected health information available in accordance with federal and state law, including providing a right of access to persons who are the subjects of the protected health information in accordance with 45 C.F.R. 164.524.
7. Amendment and Incorporation of Amendments. The Vendor shall make protected health information available for amendment and to incorporate any amendments to the protected health information in accordance with 45 C.F.R. 164.526.
8. Accounting for Disclosures. The Vendor shall make protected health information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528. The Vendor shall document all disclosures of protected health information as needed for the Agency to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. 164.528.
9. Access to Books and Records. The Vendor shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the Vendor on behalf of the Agency, available to the Secretary of the Department of Health and Human Services ("HHS") or the Secretary's designee for purposes of determining compliance with the HHS Privacy Regulations.
10. Reporting. The Vendor shall make a good faith effort to identify any use or disclosure of protected health information not provided for in this Contract.
 - 10a. To Agency. The Vendor will report to the Agency, within ten (10) business days of discovery, any use or disclosure of protected health information not provided for in this Contract of which the Vendor is aware. The Vendor will report to the Agency, within twenty-four (24) hours of discovery, any security incident of which the Vendor is aware. A violation of this paragraph shall be a material violation of this Contract. Such notice shall include the identification of each individual whose unsecured protected health

**EXHIBIT A-8
STANDARD CONTRACT**

information has been, or is reasonably believed by the Vendor to have been, accessed, acquired, used, or disclosed during such breach.

- 10b. To Individuals. In the case of a breach of protected health information discovered by the Vendor, the Vendor shall first notify the Agency of the pertinent details of the breach and upon prior approval of the Agency shall notify each individual whose unsecured protected health information has been, or is reasonably believed by the Vendor to have been, accessed, acquired, used or disclosed as a result of such breach. Such notification shall be in writing by first-class mail to the individual (or the next of kin if the individual is deceased) at the last known address of the individual or next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. Where there is insufficient, or out-of-date contract information (including a phone number, email address, or any other form of appropriate communication) that precludes written (or, if specifically requested, electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting on the Web site of the covered entity involved or notice in major print or broadcast media, including major media in the geographic areas where the individuals affected by the breach likely reside. In any case deemed by the Vendor to require urgency because of possible imminent misuse of unsecured protected health information, the Vendor may also provide information to individuals by telephone or other means, as appropriate.
- 10c. To Media. In the case of a breach of protected health information discovered by the Vendor where the unsecured protected health information of more than 500 persons is reasonably believed to have been, accessed, acquired, used, or disclosed, after prior approval by the Agency, the Vendor shall provide notice to prominent media outlets serving the State or relevant portion of the State involved.
- 10d. To Secretary of Health and Human Services (HHS). The Vendor shall cooperate with the Agency to provide notice to the Secretary of HHS of unsecured protected health information that has been acquired or disclosed in a breach.
- (i) Vendors Who Are Covered Entities. In the event of a breach by a contractor or subcontractor of the Vendor, and the Vendor is a HIPAA covered entity, the Vendor shall be considered the covered entity for purposes of notification to the Secretary of HHS pursuant to 45 CFR 164.408. The Vendor shall be responsible for filing the notification to the Secretary of HHS and will identify itself as the covered entity in the notice. If the breach was with respect to 500 or more individuals, the Vendor shall provide a copy of the notice to the Agency, along with the Vendor's breach risk assessment for review at least 15 business days prior to the date required by 45 C.F.R. 164.408 (b) for the Vendor to file the notice with the Secretary of HHS. If the breach was with respect to less than 500 individuals, the Vendor shall notify the Secretary of HHS within the notification timeframe imposed by 45 C.F.R. 164.408(c) and shall contemporaneously submit copies of said notifications to the Agency.
- 10e. Content of Notices. All notices required under this Attachment shall include the content set forth Section 13402(f), Title XIII of the American Recovery and Reinvestment Act of 2009 and 45 C.F.R. 164.404(c), except that references therein to a "covered entity" shall be read as references to the Vendor.

**EXHIBIT A-8
STANDARD CONTRACT**

- 10f. Financial Responsibility. The Vendor shall be responsible for all costs related to the notices required under this Attachment.
11. Mitigation. Vendor shall mitigate, to the extent practicable, any harmful effect that is known to the Vendor of a use or disclosure of protected health information in violation of this Attachment.
12. Termination. Upon the Agency's discovery of a material breach of this Attachment, the Agency shall have the right to assess liquidated damages as specified elsewhere in the contract to which this Contract is an attachment, and/or to terminate this Contract.
- 12a. Effect of Termination. At the termination of this Contract, the Vendor shall return all protected health information that the Vendor still maintains in any form, including any copies or hybrid or merged databases made by the Vendor; or with prior written approval of the Agency, the protected health information may be destroyed by the Vendor after its use. If the protected health information is destroyed pursuant to the Agency's prior written approval, the Vendor must provide a written confirmation of such destruction to the Agency. If return or destruction of the protected health information is determined not feasible by the Agency, the Vendor agrees to protect the protected health information and treat it as strictly confidential.
-

The Vendor has caused this Attachment to be signed and delivered by its duly authorized representative, as of the date set forth below.

Vendor Name:

Signature 

Date

Name and Title of Authorized Signer

EXHIBIT A-8
STANDARD CONTRACT

ATTACHMENT III

CERTIFICATION REGARDING LOBBYING
CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

- (1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Signature _____ D _____
Name of Authorized Individual _____ Agency Contract Number _____
Name and Address of Organization _____

**EXHIBIT A-8
STANDARD CONTRACT
ATTACHMENT IV**

**CERTIFICATION REGARDING
DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION
CONTRACTS/SUBCONTRACTS**

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each Vendor whose contract/subcontract equals or exceeds \$25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, Vendors who audit federal programs must also sign, regardless of the contract amount. The Agency for Health Care Administration cannot contract with these types of Vendors if they are debarred or suspended by the federal government.
2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.
3. The Vendor shall provide immediate written notice to the contract manager at any time the Vendor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.
5. The Vendor agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.
6. The Vendor further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed \$25,000 in federal monies, to submit a signed copy of this certification.
7. The Agency for Health Care Administration may rely upon a certification of a Vendor that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.
8. This signed certification must be kept in the contract manager's contract file. Subcontractor's certifications must be kept at the contractor's business location.

CERTIFICATION

- (1) The prospective Vendor certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.
- (2) Where the prospective Vendor is unable to certify to any of the statements in this certification, such prospective Vendor shall attach an explanation to this certification.

Signature

Date

Name and Title of Authorized Signer

SAMPLE

**EXHIBIT A-8
STANDARD CONTRACT**

**ATTACHMENT V
VENDOR CERTIFICATION REGARDING
SCRUTINIZED COMPANIES LISTS**

Vendor Name: _____
Vendor FEIN: _____
Vendor's Authorized Representative Name and Title: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: _____
Email Address: _____

Section 287.135, Florida Statutes, prohibits agencies from contracting with companies, for goods or services over \$1,000,000, that are on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. Both lists are created pursuant to section 215.473, Florida Statutes.

As the person authorized to sign on behalf of the Vendor, I hereby certify that the company identified above in the section entitled "Vendor Name" is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List. I understand that pursuant to Section 287.135, Florida Statutes, the submission of a false certification may subject the company to civil penalties, attorney's fees, and/or costs.

Certified By: _____,
who is authorized to sign on behalf of the above referenced company.
Authorized Signature Print Name and Title: _____

SAMPLE

**ATTACHMENT B
SCOPE OF SERVICE - CORE PROVISIONS**

Table of Contents

Section I. Definitions and Acronyms	5
A. Definitions.....	5
B. Acronyms	24
Section II. General Overview	31
A. Purpose	31
Section III. Eligibility and Enrollment.....	32
A. General Provisions	32
B. Eligibility	32
C. Enrollment	32
D. Disenrollment.....	33
E. Medicaid Redetermination Assistance	34
Section IV. Marketing	36
A. General Provisions	36
B. Prohibited Statements and Claims.....	36
C. Prohibited Activities	37
D. Marketing of Multiple Lines of Business	37
E. Marketing Agents.....	37
F. Telephonic Activities and Scripts	38
G. Standards for Written Marketing Materials	39
H. Use of Superlatives in Marketing Materials	40
I. Nominal Gifts	40
J. Regional Distribution of Marketing Materials	41
K. References to Studies	41
L. Product Endorsements/Testimonials	41
M. Marketing Events.....	42
N. Individual Marketing Appointments	43
O. Marketing in the Health Care Setting	43
P. Provider-Based Activities.....	44
Q. Public Events.....	45
R. Enrollee Educational Events	46

Section V. Enrollee Services	47
A. General Provisions	47
B. Enrollee Material.....	47
C. Enrollee Services.....	53
Section VI. Coverage and Authorization of Services.....	57
A. Required Benefits	57
B. Expanded Benefits.....	58
C. Excluded Services	59
D. Coverage Provisions.....	60
E. Care Coordination/Case Management.....	60
F. Quality Enhancements.....	64
G. Authorization of Services	65
Section VII. Grievance and Appeal System	70
A. General Provisions	70
B. Use of Independent Review Organization.....	70
C. Process for Complaints.....	71
D. Process for Grievances	71
E. Notice of Adverse Benefit Determination	72
F. Standard Resolution of Plan Appeals.....	73
G. Extension of Plan Appeal.....	74
H. Expedited Resolution of Plan Appeals	75
I. Notice of Plan Appeal Resolution.....	75
J. Process for Medicaid Fair Hearings	75
K. Appellate Responsibilities	77
Section VIII. Provider Services	78
A. Network Adequacy Standards.....	78
B. Network Management.....	80
C. Provider Credentialing and Contracting	81
D. Provider Services.....	91
E. Claims and Provider Payment	96
Section IX. Quality.....	101
A. Quality Improvement.....	101
B. Performance Measures	104
C. Performance Improvement Projects.....	105
D. Satisfaction and Experience Surveys.....	107
E. Enrollee Record Requirements.....	109

F. Provider-Specific Performance Monitoring	111
G. Additional Quality Management Requirements	112
H. Continuity of Care in Enrollment	112
Section X. Administration and Management	114
A. General Provisions	114
B. Organizational Governance and Staffing	115
C. Subcontracts.....	118
D. Information Management and Systems.....	123
E. Encounter Data Requirements.....	136
F. Fraud and Abuse Prevention	139
Section XI. Method of Payment	149
A. General Provisions	149
B. Fixed Price Unit Contract.....	149
C. Payment Provisions	149
Section XII. Financial Requirements.....	162
A. Insolvency Protection.....	162
B. Surplus	165
C. Interest	166
D. Third Party Resources	166
E. Assignment.....	168
F. Financial Reporting.....	169
G. Inspection and Audit of Financial Records	169
Section XIII. Sanctions	170
A. Contract Violations and Non-Compliance	170
B. Corrective Action Plans	171
C. Performance Measure Sanctions.....	171
D. Additional Sanctions	172
E. Notice of Sanctions.....	173
F. Dispute of Sanctions.....	173
Section XIV. Liquidated Damages	175
A. Damages	175
B. Issues and Amounts	177
Section XV. Special Terms and Conditions	188
A. Applicable Laws and Regulations	188
B. Entire Agreement.....	189
C. Ownership and Management Disclosure	190

D. Conflict of Interest.....	193
E. Readiness	194
F. Withdrawing Services from a Region	194
G. Termination Procedures.....	195
H. Agency Contract Management.....	197
I. Disputes	198
J. Indemnification	198
K. Public Records Requests.....	199
L. Communications.....	200
M. Audits and Monitoring	201
N. Inspection of Records and Work Performed.....	201
O. Employment.....	202
P. Work Authorization Program.....	202
Q. Equal Employment Opportunity (EEO) Compliance	203
R. Discrimination	203
S. Patents, Royalties, Copyrights, Right to Data, and Sponsorship Statement.....	203
T. Confidentiality of Information	205
U. Legal Action Notification	206
V. Venue.....	206
W. Performance Bond.....	207
X. Fidelity Bond.....	208
Y. Insurance.....	208
Z. MyFloridaMarketPlace Vendor Registration and Transaction Fee.....	209
Section XVI. Reporting Requirements	210
A. Managed Care Plan Reporting Requirements.....	210

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Section I. Definitions and Acronyms

A. Definitions

The Florida Medicaid Definitions Policy contains definitions of commonly used terms that are applicable to all sections of Rule Chapter 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy, rule, or this Contract. (Rule 59G-1.010, F.A.C.) The following terms as used in this Contract shall be used, unless this Contract otherwise expressly requires a different construction and/or interpretation. Some defined terms do not appear in all Contracts.

Abandoned Call — A call or other type of contact initiated to a call center that is ended before any conversation occurs.

Abuse, Neglect and Exploitation — As defined in Chapter 415, F.S., and Chapter 39, F.S.

Accountable Care Organization (ACO) — An entity qualified as an accountable care organization in accordance with federal regulations (42 CFR Part 425), and which meets the requirements of a provider service network (PSN) as described in s. 409.912(2)(b) and 409.962(14) or 409.962(9), F.S.

Activities of Daily Living (ADL) — As defined in Rule 59G-4.192, F.A.C.

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

Adjudicated Claim — A claim for which a determination has been made to pay, accept, deny, or reject the claim.

Adjudicated Date — The date the Managed Care Plan processed for determination of payment, acceptance, denial, or rejection.

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

Adverse Benefit Determination — As defined in 42 CFR Part 438.400(b).

Adverse Incident — An injury of an enrollee occurring during delivery of Managed Care Plan covered services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and,
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or

Section I. Definitions and Acronyms

4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

After Hours — The hours between five PM (5pm) and eight AM (8am) local time, Monday through Friday inclusive, and all-day Saturday and Sunday. State holidays are included.

Agency — State of Florida, Agency for Health Care Administration (AHCA), its employees acting in their official capacity, or its designee.

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

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

Aging Network Service Provider — A system of essential community providers including all providers that have previously participated in home and community-based (HCB) waivers serving elders or community service programs administered by DOEA pursuant to s. 409.982(1)(c), F.S., or s. 430.205, F.S.

Ancillary Services — Diagnostic tests, laboratory tests, therapy services, radiology services, and pharmaceuticals ordered by primary care physicians or specialists.

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

Automated Phone Tree System — A telephone information system consisting of a fixed-menu of options which registers information or routes calls based on a programmed response. A phone tree prompts the caller to respond to a menu of options by pressing phone keys on a touch-tone telephone. A phone tree also includes interactive voice response (IVR) technology that allows the telephone information system to interact with a caller speaking words or short phrases and responds with prerecorded or dynamically-generated audio to further direct the caller on how to proceed to available options.

Automatic Call Distribution — A device or system that manages incoming calls, handles incoming calls based on the number called and associated automated handling instructions, and distributes incoming calls to a specific group of terminals that agents use, based on caller need, call type, or agent skill set.

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

Blog (Web Blog) — A type of website, usually maintained by an individual with regular entries of commentary, description of events, or other materials such as graphics or video. Entries are commonly displayed in reverse-chronological order.

Branding — Marketing through mass communication in some form of print media, such as newspapers, magazines, billboards, etc., with the purpose of influencing a potential enrollee

Section I. Definitions and Acronyms

to enroll and to contact the Managed Care Plan for more information.

Broadcast — Video, audio, text, or email messages transmitted through an internet, cellular, or wireless network for display on any device.

Broadcast Scripts — Written text of messages transferred or transmitted to a large group of people by Managed Care Plan staff through a form of mass communication media, such as television, radio or social networking, designed to promote the Managed Care Plan and influence individuals to enroll in the Managed Care Plan.

Business Days — A day scheduled for regular State of Florida employees to work: Monday through Friday, except holidays observed by regular State of Florida employees. Timeframes requiring completion within a number of business days shall mean by 5:00 p.m. Eastern Time on the last work day.

Calendar Day — A period of 24 hours from midnight to midnight.

Calendar Year — A twelve (12) month period of time beginning on January 1 and ending on December 31.

Call Center — A physical place equipped for receiving a large volume of requests by telephone and where telephone calls are handled, usually with some amount of computer automation, to respond to incoming inquiries from callers. Call centers may function as a component of a broader contact center, or as a customer interaction center from which all customer contacts are managed via telephone, email, fax, online chat, or other means of communication.

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

Care Coordination — Case Management as defined in Rule 59G-1.010, F.A.C.

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

Children/Adolescents — Enrollees under the age of twenty-one (21) years.

Children’s Medical Services Plan (CMS Plan) — A Medicaid Specialty Plan for children with chronic conditions operated by the Florida Department of Health’s Children’s Medical Services Network as specified in s. 409.974(4), F.S., through a single, statewide Contract with the Agency that is not subject to the SMMC procurement requirements, or regional plan limits, but must meet all other plan requirements for the MMA program.

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

Clean Claim — A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider

Section I. Definitions and Acronyms

who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

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

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

Community Living Support Plan — As defined in s. 429.02, F.S.

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

Comprehensive Assessment — As defined in Rule 59G-4.192, F.A.C.

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

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

Contract Manager — The Agency individual responsible for providing overall Contract direction, acting as liaison between the Managed Care Plan and other Agency staff and monitoring the Managed Care Plan's performance.

Contracting Officer — The Secretary of the Agency or designee.

Covered Services — Those services provided by the Managed Care Plan in accordance with this Contract, and as outlined in Section VI., Coverage and Authorization of Services, and the Exhibit B-1, MMA Exhibit or Exhibit B-2, LTC Exhibit, respectively.

Critical Incident — Critical events that negatively impact the health, safety, or welfare of a LTC Plan enrollee, including death by suicide, homicide, abuse/neglect or that is otherwise unexpected; adverse incident or major illness; sexual battery; medication errors; suicide attempts; altercations requiring medical intervention; or elopement.

Section I. Definitions and Acronyms

Customized Benefit Package (CBP) — Covered services, which may vary in amount, scope, and/or duration from those listed in Section VI., Coverage and Authorization of Services and the Exhibit B-1, MMA Exhibit. The CBP must meet State standards for actuarial equivalency and sufficiency as specified in this Contract. CBP is also referred to as “benefit grid.”

Date of Claim Receipt — The date the Managed Care Plan receives the claim at its designated claims receipt location, as indicated by its date stamp on the claim. (42 CFR 447.45(d)(5)-(6))

Date of Claim Payment — The date of the check or other form of payment. (42 CFR 447.46)

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

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

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

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

Direct Ownership Interest — The possession of equity in the capital, the stock, or the profits of the disclosing entity. (42 CFR 455.101)

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

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

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

Disaster Recovery Plan — A plan to ensure continued business processing through adequate alternative facilities, equipment, backup files, documentation and procedures in the event that the primary processing site is lost to the Managed Care Plan.

Disease Management — A system of coordinated health care intervention and communication for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of

Section I. Definitions and Acronyms

care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) — As defined by 42 U.S.C. § 1396d(r)(5) and 42 CFR 440.40(b) or its successive regulation.

Educational Event — An event designed to inform Managed Care Plan enrollees about Medicaid programs and does not include marketing.

Eligible Plan — In accordance with s. 409.962(7), F.S., means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. [409.912\(2\)](#) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

Emergency Department Care — Emergency services and care received in an emergency department or outpatient hospital.

Emergency Transportation — The provision of emergency transportation services in accordance with Rule 59G-4.015, F.A.C.

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

Enrollee Record — As used in reference to provider, a medical record, as defined in Rule 59G-1.010, F.A.C. As used in reference to the Managed Care Plan, a comprehensive file containing information regarding the management of services for an enrollee including the plan of care and documentation of care coordination/case management activities.

Enrollment — The process by which an eligible Medicaid recipient signs up to participate in a Managed Care Plan.

Enrollment Broker — The State's contracted or designated entity that performs functions related to outreach, education, enrollment, and disenrollment of potential enrollees into a Managed Care Plan.

Enrollment Files — X-12 834 files sent by the Agency's Medicaid designee to the Managed Care Plans to provide the Managed Care Plans with their official Medicaid recipient enrollment.

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

Section I. Definitions and Acronyms

Event Notification Service (ENS) — An automated alerting service that provides timely alert messages to subscribing Managed Care Plans and accountable care organizations when patients are discharged from a hospital or emergency department.

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

Exclusive Provider Organization (EPO) — Pursuant to Chapter 627, F.S., a group of health care providers that have entered into a written agreement with an insurer to provide benefits under a health insurance policy.

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

Expedited Appeal Process — The process by which the appeal of a Managed Care Plan's adverse benefit determination is accelerated because the standard timeframe for resolution of the plan appeal could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function.

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

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

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

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

Federally Qualified Health Center (FQHC) — An entity that is receiving a grant under Section 330 of the Public Health Service Act, as amended. (Also see s. 1905(l)(2)(B) of the Social Security Act.)

Fee Schedule — A list of health services or products covered by the Florida Medicaid program in the fee-for-service delivery system, which provide the associated reimbursement rates for each covered service or product and are promulgated into rule.

Fiscal Year — The State of Florida fiscal year is the twelve (12) month period beginning July 1 and ending June 30.

Florida Medical School Quality Network (FMSQN) — The network as specified in s. 409.975(2), F.S.

Section I. Definitions and Acronyms

Full-Benefit Dual Eligible — An enrollee who is eligible for full Medicaid benefits under Medicaid (Title XIX) and Medicare (Title XVIII) programs.

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

Fully Enrolled Provider — An enrollment type that is furnished to a provider that meets the full eligibility credentialing for participation in Florida Medicaid. Enrolled providers are eligible to provide services to recipients enrolled in either fee-for-service or managed care.

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

Good Cause — See Cause.

Grievance and Appeal System — As defined by 42 CFR 438.400(b). In addition, access to a review by the Subscriber Assistance Program (SAP).

Habilitation Services and Devices — As defined in 45 CFR 156.115.

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

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

Health Care-Acquired Condition (HCAC) — A condition, occurring in any inpatient hospital or inpatient psychiatric hospital setting, including CSUs, identified as a hospital-acquired condition by the Secretary of Health and Human Services under Section 1886(d)(4)(D)(iv) and (p)(3) of the Social Security Act for purposes of the Medicare program as specified in the Florida Medicaid State Plan.

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

Health Care Service Pools — As defined in s. 400.980, F.S.

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

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

Section I. Definitions and Acronyms

Health Maintenance Organization (HMO) — An organization or entity licensed in accordance with Chapter 641, F.S.

Healthy Behaviors — A program offered by Managed Care Plans in accordance with s. 409.973(3), F.S., that encourages and rewards behaviors designed to improve the enrollee's overall health.

Health Information Technology for Economic and Clinical Health (HITECH) Act — The Health Information Technology Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) — A federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

Hernandez Settlement Agreement — An agreement as a result of the Hernandez vs. Meadows lawsuit, effective May 14, 2004, relating to the type of notification a pharmacy must give a Medicaid recipient when the pharmacy refuses to fill a prescription.

Home and Community-Based Services (HCBS) — Services as defined in 42 CFR 440.180.

Home and Community-Based (HCB) Settings Requirements — As defined in 42 CFR 441.301(c)(4)

Home Health Care — As defined in Rule 59G-4.130, F.A.C.

Hospital Outpatient Care — As defined in 42 CFR 440.20(a).

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

Hospitalization — Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

In Lieu of Service — As defined in 42 CFR 438.3(e)(2).

Incentive — Related to an MMA Healthy Behaviors Program, something offered to an enrollee that encourages or motivates him or her to take action. For example, an incentive may be offered for enrolling in a series of educational classes focused on the target behavior. Incentives should be linked to effective engagement strategies. For example, providing a financial incentive to address a substance abuse problem must be supported by an effective, evidence-based approach/program.

Indirect Ownership — An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. (42 CFR 455.101) See also as calculated in 42 CFR 455.102.

Individual Marketing Appointments — One-on-one appointments that typically take place in the potential enrollee's or enrollee's home; however, these appointments can also take

Section I. Definitions and Acronyms

place in other venues such as a library or coffee shop.

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

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

Injury — Any of the following outcomes when caused by an adverse incident:

1. Death
2. Brain damage
3. Spinal damage
4. Permanent disfigurement
5. Fracture or dislocation of bones or joints
6. Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
7. Any condition requiring surgical intervention to correct or control
8. Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care

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

Institutions for Mental Disease (IMD) — As defined in 42 CFR 435.1010.

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

Interactions — Conversational exchange of messages.

Intervention — Related to an MMA Healthy Behaviors Program, any measure or action that is intended to improve or restore health or alter the course of a disease.

Section I. Definitions and Acronyms

Kick Payment — The method of reimbursing Managed Care Plans in the form of a separate one (1) time fixed payment for specific services.

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

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

Limited Enrolled Provider — An enrollment type that is furnished to a provider that meets the basic eligibility credentialing for participation in Florida Medicaid. Limited Enrollment providers are only eligible to provide services to recipients enrolled in managed care.

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

Long-term Care Level of Care (LOC) — The type of LTC required by an enrollee based on medical needs. The criteria for Intermediate LOC (Level I and II) are described in Rule 59G-4.180, F.A.C., and the criteria for Skilled LOC are described in Rule 59G-4.290, F.A.C.

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

Managed Care Plan Report Guide — A companion guide to the SMMC Managed Care Plan Contracts that provides detailed information about standard reports required by this Contract to be submitted by the Managed Care Plans to the Agency. Such detailed information includes report-specific format and submission requirements, instructions for completion, and report templates and supplemental tables.

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

Mandatory Enrollee — The categories of eligible Medicaid recipients who must be enrolled in a Managed Care Plan.

Mandatory Potential Enrollee — A Medicaid recipient who is required to enroll in a Managed Care Plan but has not yet made a choice.

Marketing — As defined in 42 CFR, 438.104(a).

Marketing Agent — In accordance with s. 626.015, F.S., a Florida licensed health insurance agent who acts on behalf of the Managed Care Plan to provide marketing activities to enrollees and potential enrollees.

Marketing Events — Any event conducted by or on behalf of any Managed Care Plan with a

Section I. Definitions and Acronyms

Medicaid recipient who is not enrolled in the Managed Care Plan or an individual potentially eligible for Medicaid that can reasonably be interpreted as intended to influence such individual to enroll in a particular Managed Care Plan.

Marketing Materials — As defined in 42 CFR, 438.104(a).

Marketing Scripts — Standardized text used by Managed Care Plan staff in verbal interactions with potential enrollees designed to provide information and/or to respond to questions and requests, and that are intended to influence such individual to enroll in the Managed Care Plan. Marketing scripts include any text included in interactive voice recognition (IVR) and on-hold messages.

Medicaid Fair Hearing — An administrative hearing conducted by the Agency to review an action taken by a Managed Care Plan that limits, denies, or stops a requested service.

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

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

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

Medically Necessary or Medical Necessity — As defined in Rule 59G-1.010, F.A.C.

Medicare Advantage Plan — As defined in 42 CFR 422.2.

Month — Also called calendar month, any of the twelve parts, such as January or February, into which the calendar year is divided. Unless otherwise specified, the term "month" in this Contract refers to calendar month.

National Correct Coding Initiative (NCCI) — A Centers for Medicare & Medicaid Services edit system that promotes national correct coding methodologies pursuant to applicable provisions of the Social Security Act, ss. 1903(r)(1)(B)(iv).

Network — As defined in s. 409.975(1), F.S.

Never Event (NE) — As defined by the National Quality Forum (NQF), an error in medical care that is of concern to both the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the procedures of the health care organization. Currently, in Florida Medicaid, never event health care settings are limited to inpatient hospitals and inpatient psychiatric hospitals, including CSUs.

Nominal Value — An individual item or service worth fifteen dollars (**\$15**) or less (based on the retail value of the item), with a maximum aggregate of seventy-five dollars (**\$75**) per

Section I. Definitions and Acronyms

person, per year.

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

Non-Participating Provider — A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the Managed Care Plan to provide services.

Non-Quantitative Limits — As defined in 42 CFR 438.900, limitations that are expressed non-numerically. Also as described in 42 CFR 438.910(d)(2).

Normal Business Hours — The hours between eight AM (8am) and five PM (5pm) local time, Monday through Friday inclusive. State holidays are excluded.

Office of Fair Hearing (Office) — The hearing authority within the Agency for Health Care Administration designated to conduct Medicaid fair hearings per s. 409.285(2), F.S.

Ongoing Course of Treatment — Services that were previously authorized or prescheduled prior to the enrollee's enrollment in the Managed Care Plan.

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

Other Benefits — Service, excluding expanded benefits, covered by Managed Care Plans for all or some enrollees (based upon criteria established by the Managed Care Plan) that exceed coverage and limitations specified under the Medicaid State Plan, including services provided in accordance with Section VI., Coverage and Authorization of Services, of this Contract.

Other Provider-Preventable Condition (OPPC) — As defined in 42 CFR 447.26(b).

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

Participant Direction Option Services (PDO Services) — Adult companion care, attendant care, homemaker services, intermittent and skilled nursing, and personal care services.

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

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

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

Section I. Definitions and Acronyms

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

Pharmacy Benefits Administrator — An entity contracted with a Managed Care Plan to accept pharmacy prescription claims for enrollees in the Managed Care Plan; assure these claims conform to coverage policy; and determine the allowed payment.

Pharmacy Benefits Manager — A person or entity doing business in this State which contracts to administer or manage prescription drug benefits on behalf of a Managed Care Plan.

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

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

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

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

Potential Enrollee — Pursuant to 42 CFR 438.2, an eligible Medicaid recipient who is subject to mandatory assignment or who may voluntarily elect to enroll in a given Managed Care Plan, but is not yet an enrollee of a specific Managed Care Plan.

Potentially Preventable Emergency Room Visit (PPV) — Emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination.

Potentially Preventable Event (PPE) — Events, including potentially preventable hospital admissions, potentially preventable readmissions, potentially preventable emergency room visits, and potentially preventable ancillary services that are unlikely to provide useful diagnostic or clinical information, that could have been prevented with better access to primary care, improved medication management, or better coordination of care.

Potentially Preventable Hospital Admissions (PPAs) — Hospital admissions that may have resulted from a lack of adequate access to care or ambulatory care coordination. PPAs are ambulatory sensitive conditions.

Potentially Preventable Readmission — A return hospitalization within thirty (30) days of the initial discharge that is clinically-related to the initial hospital admission and may have resulted from lack of follow up after discharge.

Preadmission Screening and Resident Review (PASRR) — As defined by 42 CFR Part 483 and in accordance with Rule 59G-1.040, F.A.C.

Section I. Definitions and Acronyms

Pre-Enrollment Marketing Activities — The conduct of marketing, including the provision of marketing materials, to a potential enrollee prior to the potential enrollee's enrollment in the Managed Care Plan.

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

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

Program of All-Inclusive Care for the Elderly (PACE) — A program that is operated by an approved PACE organization and that provides comprehensive services to enrollees in accordance with a PACE program agreement. (ss. 1894 and 1934 of the Social Security Act and 42 CFR Part 460.)

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

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

Provider — A person or entity eligible for a Medicaid provider agreement.

Provider Agreement — A contract between the Managed Care Plan and a health care provider to serve Managed Care Plan enrollees.

Provider-Preventable Condition (PPC) — A condition that meets the definition of a health care-acquired condition (HCAC) or other provider-preventable condition as defined in 42 CFR 447.26(b). PPCs include HCACs and other provider-preventable conditions (OPPCs) in inpatient hospital and inpatient psychiatric hospital settings, including CSUs.

Provider Service Network — An entity that meets the requirements as described in s. 409.962(14) or 409.962(9), F.S

Public Event — An event planned or sponsored by an organization to benefit and educate or assist the community with information concerning health-related matters or public awareness. At least two (2) community organizations not affiliated under common ownership must actively participate in the public event.

Public Event Materials — Materials used by the Managed Care Plan to educate or assist the community by providing information concerning health-related topics or topics which require public awareness.

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

Section I. Definitions and Acronyms

Quality Improvement (QI) — The process of monitoring that the delivery of health care services is available, accessible, timely, and medically necessary.

Quantitative Limits — As defined in 42 CFR 438.900, limitations that are expressed numerically.

Readily Accessible — As defined in 42 CFR 438.10(a) in the context of information requirements.

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

Rehabilitation Services and Devices — As defined in 42 CFR 440.130(d).

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

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

Reward — Related to an MMA Healthy Behaviors Program, if used in the program, something that may be offered to an enrollee after successful completion of a milestone (meaningful step towards meeting the goal) or goal attainment. A reward should be linked to positive behavior change. For example, a reward may be offered after successful completion of a series of educational classes focused on a target behavior.

Risk Adjustment (also Risk-Adjusted) — In a managed health care setting, risk adjustment of capitation payments is the process used to distribute capitation payments across Managed Care Plans based on the relative risk factor of the members enrolled in each Managed Care Plan.

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

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

Sanctions — In relation to Section XIII., Sanctions: Any monetary or non-monetary penalty imposed upon a provider, entity, or person (e.g., a provider entity, or person being suspended from the Medicaid program).

Securities — United States Treasury Securities which are backed by the full faith and credit of the United States government. For purposes of this Contract, the term shall be limited to those securities approved by the Agency as specified in Section XII., Financial Requirements.

Section I. Definitions and Acronyms

Service Authorization — The Managed Care Plan's approval for services to be rendered.

Service Delivery Systems — Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in s. 409.973, F.S.

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

Significant Change — As defined in s. 409.962(17), F.S.

Significant Life Change — Any event that may lead to a change in level of care or need, including but not limited to hospital admission, change in caregiver status, and decline in health.

Service Organization Control (SOC) 2 Type II Audit (SOC 2 Type II Audit) — An audit of the internal controls of a service organization according to specifications defined by the American Institute of Certified Public Accountants.

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

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

Special Health Care Needs — Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. This includes individuals with intellectual disabilities or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and all enrollees receiving LTC services under this Contract.

Special Supplemental Nutrition Program for Women, Infants & Children (WIC) — Program administered by the Department of Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women, infants and children under the age of five (5) years who are determined to be at nutritional risk and who have a low to moderate income.

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

Spoken Script — Standardized text used by Managed Care Plan staff in verbal interactions with enrollees and/or potential enrollees designed to provide information and/or to respond to questions and requests. Spoken scripts also include interactive voice recognition (IVR) and on-hold messages.

Section I. Definitions and Acronyms

State — State of Florida.

Statutory Accounting Principles — A set of accounting regulations as defined by the 2002 National Association of Insurance Commissioners Accounting Practices and Procedures Manual and as specified in s. 641.19, F.S.

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

Subcontractor — Any entity contracting with the Managed Care Plan to perform services or to fulfill any of the requirements requested in this Contract or any entity that is a subsidiary of the Managed Care Plan that performs services or fulfills the requirements requested in this Contract.

Subscriber Assistance Program (SAP) — A State external conflict resolution program authorized under s. 408.7056, F.S., available to Medicaid managed care enrollees, that provides an additional level of appeal if the Managed Care Plan's process does not resolve the conflict.

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

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

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

Systems — See Information Systems.

Tags/Tagging — Placing personal identification information within a picture or video.

Telemedicine — As defined in Rule 59G-1.057, F.A.C.

Temporary Assistance to Needy Families (TANF) — As described in 45 CFR 260.20.

Temporary Loss Period — Period in which an enrollee loses eligibility and regains it, allowing the recipient to be re-enrolled in the Managed Care Plan in which the recipient was enrolled prior to the eligibility loss.

Temporary Management — State-imposed oversight of the operation of the Managed Care Plan, upon a finding by the State that there is continued egregious behavior by the Managed Care Plan or a substantial risk to the health of the Managed Care Plan's enrollees, or to assure the health of the Managed Care Plan's enrollees, in accordance with Section 1932(e)(2)(B) of the Social Security Act.

Timely Files — When an enrollee files for continuation of benefits on or before the later of the following:

- a. Within ten (10) days of the Managed Care Plan sending the notice of adverse benefit determination; or

Section I. Definitions and Acronyms

- b. The intended effective date of the Managed Care Plan's proposed adverse benefit determination.

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

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

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

Urgent Medical — Any sudden or unforeseen situation that requires immediate action to prevent hospitalization or nursing facility placement.

Username — An identifying pseudonym associated with the author to messages or content generated.

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

Vendor — An entity submitting a proposal to become a Managed Care Plan.

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

Voluntary Enrollee — A Medicaid recipient who is not mandated to enroll in a Managed Care Plan, but chooses to do so.

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

Waste — Overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.

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

Section I. Definitions and Acronyms

Written Marketing Materials — Printed informational material targeted to potential enrollees, which promotes the Managed Care Plan, including but not limited to brochures, flyers, leaflets or other printed information about the Managed Care Plan. Written marketing material includes materials for circulation by physicians, other providers, or third parties.

B. Acronyms

AAA — Area Agencies on Aging

ACA — Patient Protection and Affordable Care Act

ACCESS — Automated Community Connection to Economic Self-Sufficiency, the DCFs' public assistance service delivery system

ACO — Accountable Care Organization

ADA — Americans with Disabilities Act of 1990

ADHC — Adult Day Health Care

ADRC — Aging and Disability Resource Center

AFCH — Adult Family Care Home

AHCA — Agency for Health Care Administration (Agency)

ALF — Assisted Living Facility

ANSI — American National Standards Institute

APD — Agency for Persons with Disabilities

ARNP — Advanced Registered Nurse Practitioner

ASA — Average Speed of Answer

ASR — Achieved Savings Rebate

BC — Business Continuity

BAA — Business Associate Agreement

CAHPS — Consumer Assessment of Healthcare Providers and Systems

CARC — Claim Adjustment Reason Code

CAP — Corrective Action Plan

CARES — Comprehensive Assessment and Review for Long-Term Care Services

CBP — Customized Benefit Package

Section I. Definitions and Acronyms

CCE — Community Care for the Elderly

CCP — Cultural Competency Plan

CDC — Centers for Disease Control and Prevention

CEO — Chief Executive Officer

CFO — Chief Financial Officer

CFR — Code of Federal Regulations (cites may be searched online at: <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>)

CHD — County Health Department

CMS — Centers for Medicare & Medicaid Services

CMS Plan — Children's Medical Services Specialty Plan

COPD — Chronic Obstructive Pulmonary Disease

CPR — Cardiopulmonary Resuscitation

CPT® — Physicians' Current Procedural Terminology

CSU — Crisis Stabilization Unit

CTD — Commission for the Transportation Disadvantaged

DCA — District Court of Appeal

DCF — Department of Children and Families

DD — Developmental Disability or Developmental Disabilities

DEA — Drug Enforcement Administration

DFS — Department of Financial Services

DHHS — United States Department of Health & Human Services

DJJ — Department of Juvenile Justice

DME — Durable Medical Equipment

DOEA — Department of Elder Affairs

DOH — Department of Health

DR — Disaster Recovery

DRG — Diagnostic Related Group

Section I. Definitions and Acronyms

DSM — Direct Secure Messaging

EDI — Electronic Data Interchange

EH — Emotionally Handicapped

EIS — Early Intervention Services

ENS — Event Notification Service

EPLS — Excluded Parties List System

EPO — Exclusive Provider Organization

EPSDT — Early and Periodic Screening, Diagnosis and Treatment Program

EQR — External Quality Review

EQRO — External Quality Review Organization

EDT — Eastern Daylight Time

EST — Eastern Standard Time

EVV — Electronic Visit Verification

F.A.C. — Florida Administrative Code

FAR — Florida Administrative Register

FFS — Fee-for-Service

FIPS — Federal Information Processing Standards Publication

FMMIS — Florida Medicaid Management Information System

FMSQN — Florida Medical School Quality Network

FMV — Fair Market Value

FQHC — Federally Qualified Health Center

F.S. — Florida Statutes

FSFN — Florida Safe Families Network (formerly HomeSafeNet), also known as SACWIS, (Statewide Automated Child Welfare Information System)

FTE — Full-Time Equivalent Position

HCAC — Health Care-Acquired Condition

HCB — Home and Community-Based

Section I. Definitions and Acronyms

HCBS — Home and Community-Based Services

HCPCS — Healthcare Common Procedure Coding System

HCV — Hepatitis C Virus

HEDIS — Healthcare Effectiveness Data and Information Set

HIE — Health Information Exchange

HIPAA — Health Insurance Portability and Accountability Act

HIPP — Health Insurance Premium Payment

HIT — Health Information Technology

HITECH Act — Health Information Technology for Economic and Clinical Health Act

HIV — Human Immunodeficiency Virus

HMO — Health Maintenance Organization

HSA — Hernandez Settlement Agreement

ICD — International Classification of Diseases

ICF/IID — Intermediate Care Facility for Individuals with Intellectual Disabilities

ICP — Institutional Care Program

IBNR — Incurred but Not Reported

IHCP — Indian Health Care Provider

IMD — Institutions for Mental Disease

ISM — Information Security Manager

IT — Information Technology

ITN — Invitation to Negotiate

LEIE — List of Excluded Individuals & Entities

LMH-ALF — Limited Mental Health Assisted Living Facility

LOC — Level of Care

LOINC — Logical Observation Identifiers Names and Codes

LTC — Long-Term Care

Section I. Definitions and Acronyms

LTSS — Long-term Services and Supports

MBHO — Managed Behavioral Health Organization

MDT —

MEDS — Medicaid Encounter Data System

MFCU — Medicaid Fraud Control Unit, Office of the Attorney General

MLR — Medical Loss Ratio

MMA — Managed Medical Assistance

MPI — Medicaid Program Integrity Bureau, Office of the AHCA Inspector General

MPO — Medicaid Program Oversight

NAIC — National Association of Insurance Commissioners

NCCI — National Correct Coding Initiative

NCPDP — National Council for Prescribed Drug Programs

NCQA — National Committee for Quality Assurance

NDC — National Drug Code

NET — Non-emergency Transportation

NIST — National Institute of Standards and Technology

NMHPA — Newborns and Mothers Health Protection Act

NPI — National Provider Identifier

ODBC — Open Database Connectivity

OIG — Office of the Inspector General

OIR — Office of Insurance Regulation

OPPC — Other Provider Preventable Condition

P&T — Pharmacy and Therapeutics

PA — Physician Assistant

PACE — Program of All-Inclusive Care for the Elderly

PASRR — Preadmission Screening and Resident Review

Section I. Definitions and Acronyms

PBM – Pharmacy Benefits Manager

PCCB — Per Capita Capitation Benchmark

PCMH — Patient-centered Medical Home

PCSB — Per Capita Services Benchmark

PCP — Primary Care Provider

PERS — Personal Emergency Response Systems

PDL — Preferred Drug List

PDO — Participant Direction Option

PHI — Protected Health Information

PII — Personal Identifying Information

PIP — Performance Improvement Project

PM — Performance Measure

PPA — Potentially Preventable Hospital Admission

PPC — Provider Preventable Condition

PPE — Potentially Preventable Event

PPEC — Prescribed Pediatric Extended Care

PPS — Prospective Payment System

PSN — Provider Service Network

QE — Quality Enhancement

QI — Quality Improvement

RARC — Remittance Advice Reason Code

RFP — Request for Proposal

RHC — Rural Health Clinic

SACWIS — Statewide Automated Child Welfare Information System, also known as Florida Safe Families Network (FSFN, formerly HomeSafeNet)

SAM — System for Award Management

SAMH — Substance Abuse & Mental Health Office of the Florida DCF

Section I. Definitions and Acronyms

SAP — Subscriber Assistance Program

SFTP — Secure File Transfer Protocol

SIPP — Statewide Inpatient Psychiatric Program

SMMC — Statewide Medicaid Managed Care Program

SNIP — Strategic National Implementation Process

SOBRA — Sixth Omnibus Budget Reconciliation Act

SOC — Service Organization Controls

SQL — Structured Query Language

SSI — Supplemental Security Income

SSN — Social Security Number

TANF — Temporary Assistance for Needy Families

TGCS — Therapeutic Group Care Services

TLS — Transport Layer Security

TPA — Third Party Administrator

UM — Utilization Management

U.S. — United States

U.S.C. — United States Code

USDA — United States Department of Agriculture

WEDI — Workgroup for Electronic Data Interchange

WIC — Special Supplemental Nutrition Program for Women, Infants & Children

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Section II. General Overview

A. Purpose

1. Under the SMMC program, the Agency for Health Care Administration (Agency) contracts with Managed Care Plans, as defined in Section I., Definitions and Acronyms, to provide services to recipients.
2. The provisions in this Contract and the terms of the applicable federal waivers apply to all Managed Care Plan types unless specifically noted otherwise. Provisions unique to a specific type of Managed Care Plan are described in this Contract and its Exhibits specific to either the LTC managed care program or the MMA managed care program, respectively. Managed Care Plans shall be responsible for complying with the provisions as follows:
 - a. Comprehensive Long-term Care Plans shall comply with the provisions of Attachment B, Exhibit B-1, and Exhibit B-2 for enrollees receiving both MMA and LTC benefits, and with the provisions of Attachment B, and Exhibit B-1 for enrollees receiving only MMA benefits.
 - b. Long-term Care Plus Plans shall comply with the provisions of Attachment B, Exhibit B-1, and Exhibit B-2 for all of its enrollees.
 - c. Managed Medical Assistance plans shall comply with the provisions of Attachment B and Exhibit B-1 for enrollees receiving only MMA benefits.
 - d. Specialty Plans shall comply with the provisions of Attachment B, Exhibit B-1, and the applicable Exhibit B-3 for its Specialty Plan enrollees.
3. The Managed Care Plan shall comply with all provisions of this Contract, including all Attachments, applicable Exhibit(s), and any amendments and shall act in good faith in the performance of this Contract provisions.

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Section III. Eligibility and Enrollment

A. General Provisions

1. The State has sole authority for determining eligibility for Medicaid. The DCF acts as the Agency's agent by enrolling recipients in the Medicaid program.
2. The Agency shall have the sole authority for determining whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Managed Care Plan, or are subject to annual open enrollment. The Agency or its enrollment broker shall be responsible for enrollment, including enrollment into the Managed Care Plan, disenrollment, and outreach and education activities. The Agency shall use an established algorithm to assign mandatory potential enrollees who do not select a Managed Care Plan during their choice period. The process may differ for the Managed Care Plan type as required by s. 409.977, F.S., and s. 409.984, F.S., and any other State law and federally approved State Plan amendments and/or waivers.
3. The Managed Care Plan shall accept Medicaid recipients without restriction in accordance with 42 CFR 438.3(d)(1) and Section 1903(m)(2)(A) of the Social Security Act. The Managed Care Plan shall not discriminate on the basis of religion, gender identity, sex, sexual orientation, race, color, age or national origin, health status, pre-existing condition or need for health care services and shall not use any policy or practice that has the effect of such discrimination in accordance with 42 CFR 438.3(d)(4) and 438.3(q)(4). The Managed Care Plan shall coordinate with the Agency and its agent(s) as necessary for all enrollment and disenrollment functions. The Managed Care Plan or its subcontractors, providers, or vendors shall not provide or assist in the completion of enrollment or disenrollment requests or restrict the enrollee's right to disenroll voluntarily in any way. (42 CFR 438.56(b)(1), (2), and (3)).

B. Eligibility

Medicaid recipients as defined in s. 409.965, F.S., shall receive Medicaid covered services through the SMMC program. The Agency shall determine eligibility for enrollment under this Contract. The Agency shall provide the Managed Care Plan a list of recipient aid categories that are eligible to enroll in the managed care program.

C. Enrollment

1. General Provisions

- a. The Managed Care Plan shall coordinate with the Agency and its agent(s) for all enrollment functions.
- b. The Managed Care Plan shall provide services to Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans.
- c. The Agency or its agents shall notify the Managed Care Plan of an enrollee's selection or assignment to the Managed Care Plan by file transfer or other Agency prescribed method. Enrollment in the Managed Care Plan shall be effective at 12:01 a.m. on the effective date of enrollment provided on the Enrollment File.

2. Verification of Enrollment

- a. The Managed Care Plan shall review its X12-834 Enrollment File to ensure that all enrollees are eligible to receive services from the Managed Care Plan.
- b. The Managed Care Plan shall notify the Agency of any discrepancies in enrollment, including enrollees not residing in the same region in which they were enrolled and enrollees not eligible for the Managed Care Plan, within five (5) business days of receipt of the enrollment file. (42 CFR 438.608(a)(3))

3. Temporarily Stopping or Limiting Enrollment

- a. The Managed Care Plan may ask the Agency to halt or reduce enrollment temporarily if continued enrollment would exceed the Managed Care Plan's capacity to provide required services under this Contract.
- b. The Agency may limit Managed Care Plan enrollments when such action is considered to be in the Agency's or enrollees' best interest in accordance with the provisions of this Contract.

D. Disenrollment

1. General Provisions

- a. The Managed Care Plan shall ensure that it does not restrict the enrollee's right to disenroll voluntarily in any way.
- b. The Managed Care Plan or its subcontractors, providers, or vendors shall not provide or assist in the completion of a disenrollment request, except as specified in the Statewide Medicaid Managed Care Plan Report Guide. (42 CFR 438.56(b)(1))
- c. The Agency shall notify enrollees of their right to request disenrollment. The Agency shall process all disenrollments from the Managed Care Plan. The Agency or its agent shall make final determinations about granting disenrollment requests and shall notify the Managed Care Plan by file transfer and the enrollee by surface mail of any disenrollment decision and the enrollee's right to request a Medicaid Fair Hearing if he or she is dissatisfied with an Agency determination.
- d. In addition to the reasons cited in Rule 59G-8.600, F.A.C., the following reason constitutes cause for disenrollment from the Managed Care Plan:

The enrollee is an American Indian or Alaskan Native as defined in 42 CFR 438.14(a).

2. Involuntary Disenrollment

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

Section III. Eligibility and Enrollment

an involuntary disenrollment request:

- (1) Fraudulent use of the enrollee identification (ID) card.
 - (2) Falsification of prescriptions by an enrollee.
- c. The Managed Care Plan shall not request disenrollment of an enrollee due to:
- (1) Health diagnosis
 - (2) Adverse changes in an enrollee's health status
 - (3) Utilization of medical services
 - (4) Diminished mental capacity
 - (5) Pre-existing medical condition
 - (6) Attempt to exercise rights under the Managed Care Plan's grievance and appeal system
 - (7) Referral by a provider of an enrollee to a non-participating provider.
- d. The Managed Care Plan shall ensure that involuntary disenrollment documents are maintained in the enrollee record.
- e. When the Managed Care Plan requests an involuntary disenrollment, it shall notify the enrollee in writing that the Managed Care Plan is requesting disenrollment, the reason for the request, and an explanation that the Managed Care Plan is requesting that the enrollee be disenrolled in the next Contract month, or earlier if necessary, pending an Agency decision. Until the enrollee is disenrolled, the Managed Care Plan shall be responsible for the provision of services to that enrollee.
- f. The Agency shall review all disenrollment requests on a case-by-case basis, and it is at the sole discretion of the Agency to approve or deny such requests. Any request not approved is final and not subject to Managed Care Plan dispute or appeal.

E. Medicaid Redetermination Assistance

1. The Agency shall provide the Managed Care Plan with Medicaid recipient redetermination date information.
2. The Managed Care Plan shall provide Medicaid redetermination assistance to enrollees receiving nursing facility services and home and community-based services as described in the applicable Exhibit(s).
3. For all other enrollees, the Managed Care Plan shall request prior written approval from the Agency to provide assistance with Medicaid eligibility redetermination to enrollees in order to promote continuous Medicaid eligibility.
4. A Managed Care Plan that chooses to participate in the use of this information shall

Section III. Eligibility and Enrollment

provide its procedures regarding this subsection to the Agency for its approval.

5. Should any complaint or investigation by the Agency result in a finding that the Managed Care Plan has violated this subsection, the Agency may sanction the Managed Care Plan in accordance with Section XIII., Sanctions.
 - a. The Agency may impose a thirty (30)-day suspension of the Managed Care Plan's use of Medicaid redetermination dates for the first such violation.
 - b. The Agency may impose additional sanctions for additional or subsequent violations, up to and including the Agency's rescinding its approval to use redetermination date information.

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Section IV. Marketing

A. General Provisions

1. The Managed Care Plan shall ensure compliance with all State and federal marketing requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the Managed Care Plan (42 CFR 438.104; s. 409.912, F.S.; s. 641.3901, F.S.; s. 641.3903, F.S.; s. 641.386, F.S.; s. 626.112, F.S.; s. 626.342, F.S.; s. 626.451, F.S.; s. 626.471, F.S.; s. 626.511, F.S.; s. 626.611, F.S.; s. 626.9541, F.S., and s. 626.9521, F.S.).
2. The Managed Care Plan shall not market nor distribute any marketing materials without first obtaining Agency approval. (42 CFR 438.104(b)(1)(i))
3. The Managed Care Plan shall ensure that marketing, including marketing plans and materials, is accurate and does not mislead, confuse, or defraud recipients or the Agency. (42 CFR 438.104(b)(2)) The Managed Care Plan shall not distribute marketing materials that are materially inaccurate, misleading, or otherwise make material misrepresentations.
4. The Managed Care Plan may use social/electronic media (e.g., Facebook, Twitter, Scan Code, YouTube, LinkedIn, or QR Code) in accordance with the requirements of this Contract and federal and State law.
5. The Managed Care Plan shall not engage in unfair methods of competition or unfair or deceptive acts or practices as defined in s. 641.3903, F.S., and s. 626.9541, F.S.
6. In accordance with s. 409.912, F.S., marketing to potential enrollees in State offices or any location where eligibility is determined is prohibited unless approved in writing and approved by the affected State agency when solicitation occurs in the office of another State agency. The Managed Care Plan shall not use any other State office or any location where eligibility is determined in the recruitment of potential enrollees, except as authorized in writing by the Agency. Request for approval of activities at State offices must be submitted to the Agency at least thirty (30) days prior to the activity.

B. Prohibited Statements and Claims

The Managed Care Plan shall not, whether orally or in writing:

1. Claim that a Medicaid recipient must enroll in the Managed Care Plan in order to obtain or to not lose Medicaid benefits or any other health or welfare benefits. (42 CFR 438.104(b)(2)(i))
2. Claim that the Managed Care Plan is recommended or endorsed by CMS, the federal or State government, or similar entity. (42 CFR 438.104(b)(2)(ii))
3. Claim that the State or the county recommends that a Medicaid recipient enroll with the Managed Care Plan.
4. Claim that marketing agents are employees of the federal, State, or county government, or of anyone other than the Managed Care Plan or the organization by whom they are

reimbursed.

C. Prohibited Activities

1. The Managed Care Plan shall not enlist the assistance of any government employee, government officer, elected official, or the State's enrollment broker in recruitment of potential enrollees, except as authorized in writing by the Agency.
2. The Managed Care Plan shall not provide any gift, commission, or any form of compensation to the enrollment broker, including its full-time, part-time, or temporary employees and subcontractors.
3. The Managed Care Plan shall not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities or market through unsolicited contacts. (42 CFR 438.104(b)(1)(v))
4. If the Managed Care Plan receives permission to call or otherwise contact a potential enrollee, the Managed Care Plan shall treat the permission as event-specific and shall not interpret the permission as an open-ended permission to contact the potential enrollee after the potential enrollee's inquiry or questions have been answered by the Managed Care Plan.
5. The Managed Care Plan shall not rent or purchase email lists to distribute information about its Medicaid Managed Care Plan to enrollees or potential enrollees.

D. Marketing of Multiple Lines of Business

1. The Managed Care Plan shall not influence enrollment in conjunction with the sale or offering of any private insurance. (42 CFR 438.104(b)(1)(iv))
2. The Managed Care Plan shall provide instructions in its marketing materials to potential enrollees or enrollees on how to opt out of receiving communications describing other health-related lines of business. The Managed Care Plan shall not send such communications to potential enrollees or enrollees who have asked to opt out of receiving future marketing communications.
3. If the Managed Care Plan advertises multiple lines of business within the same marketing material, it shall keep the Managed Care Plan's other lines of business clearly and understandably distinct from the Medicaid Managed Care Plan.
4. The Managed Care Plan shall not include enrollment applications for other health-related lines of business in Medicaid managed care marketing materials.

E. Marketing Agents

1. The Managed Care Plan shall only use insurance agents licensed to conduct face-to-face and telephonic marketing in the State of Florida, to market to potential enrollees, including pre-enrollment marketing activities. The Managed Care Plan shall ensure all such marketing agents or representatives comply with s. 626.112, F.S.

Section IV. Marketing

2. The Managed Care Plan shall report new marketing agents to the Agency within fifteen (15) days after the marketing agent's appointment to the Managed Care Plan, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency
3. The Managed Care Plan shall ensure that all marketing agents (including employed agents) are trained annually on State and federal requirements and on details specific to the Managed Care Plan. The Managed Care Plan shall ensure that its training programs are made available to the Agency upon request.
4. The Managed Care Plan shall report to the Agency any marketing agent who violates any requirements of this Contract, within fifteen (15) days of knowledge of such violation. The Managed Care Plan shall submit reports to the Agency as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.
5. The Managed Care Plan shall report the termination of any marketing agents and the reasons for the termination to the Agency, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.
6. The Managed Care Plan shall ensure that all marketing agents display, during marketing events, a Managed Care Plan nametag that includes the Managed Care Plan's name, logo, and agent's name. The marketing agent shall have business cards available to attendees of events.

F. Telephonic Activities and Scripts

1. The Managed Care Plan may do the following activities:
 - a. Call potential enrollees who have expressly given permission for the Managed Care Plan to contact them.
 - b. Return phone calls or messages from potential enrollees, as these are not unsolicited.
 - c. Include information about other lines of business in scripts.
 - d. Transfer calls to a marketing agent only at the proactive request of the potential enrollee.
 - e. Clearly inform the potential enrollee of any change in the nature of a call from informational to marketing. This shall be done with the full and active concurrence of the potential enrollee with a yes/no question.
2. The Managed Care Plan shall not engage in the following activities:
 - a. Unsolicited calls about other business as a means of generating leads for the Managed Care Plan.
 - b. Calls based on referrals. If an enrollee would like to refer a friend or relative to the Managed Care Plan, the Managed Care Plan may provide contact information such

Section IV. Marketing

as a business card that the enrollee may give to the friend or family member. In all cases, a referred individual needs to contact the Managed Care Plan directly.

- c. Calls to former enrollees or to enrollees who are in the process of voluntarily disenrolling, for the purpose of marketing the Managed Care Plan or other products.
 - d. Calls to potential enrollees to confirm receipt of marketing material.
 - e. Use language in scripts that imply the Managed Care Plan is endorsed by the Agency, calling on behalf of the Agency, or that the Agency asked the Managed Care Plan to call the recipient.
3. Any marketing scripts must be prior approved by the Agency. The Managed Care Plan shall submit all marketing scripts verbatim (bullets or talking points are unacceptable).

G. Standards for Written Marketing Materials

The Managed Care Plan shall submit Medicaid marketing material or changes in marketing materials to the Agency for review and approval prior to use.

1. The Managed Care Plan shall submit marketing material to the Agency at least forty-five (45) days before the proposed use of the enrollee material or revised material.
2. The Managed Care Plan shall submit all materials in “publication ready” form, including a sample of each version if the Managed Care Plan intends to use several versions.
3. The Managed Care Plan shall conduct a quality check and ensure that all materials are consistent with this Contract and State and federal requirements prior to submitting materials for review to the Agency. Generally, the Agency will not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.
4. The Managed Care Plan shall ensure that all marketing materials comply with the standards for written materials specified in Section IV.A., General Provisions The Managed Care Plan shall submit readability scores with its marketing material and denote any redacted wording. The Managed Care Plan may exclude the following from the readability score: addresses, phone numbers, PCP, department names, required disclaimers, medical terminology, medical conditions, proper names, legal terms, and words that cannot be easily substituted.
5. The Managed Care Plan shall include the following statements and disclaimers verbatim in any marketing materials that include information on benefits:
 - a. “[insert Managed Care Plan’s legal or marketing name] is a Managed Care Plan with a Florida Medicaid Contract.”
 - b. “The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the Managed Care Plan.”
 - c. “[Limitations, copayments, and/or restrictions] may apply.”

Section IV. Marketing

- d. “[Benefits, formulary, pharmacy network, premium and/or co-payments/co- insurance] may change.”
6. The Managed Care Plan shall include a written statement on all marketing materials promoting drawings, prizes or any promise of a free gift that there is no obligation to enroll in the Managed Care Plan. For example, “Eligible for a free drawing and prizes with no obligation.” or “Free drawing without obligation.”
7. The Managed Care Plan shall ensure that advertisements and invitations to formal marketing events include the following two statements on marketing materials:
 - a. “A health plan representative will be present with information.”
 - b. “For accommodation of persons with special needs at marketing events call <insert phone and TTY number>.”
8. The Managed Care Plan shall include a Teletypewriter Telephone (TTY) number in conjunction with the Managed Care Plan’s toll-free enrollee help line number. This requirement does not apply to outdoor advertising, banner/banner-like ads, radio ads, or marketing scripts.

H. Use of Superlatives in Marketing Materials

1. The Managed Care Plan may use statements in its logos and in its product taglines (e.g., “Your health is our major concern,” “Quality care is our pledge to you,” ”). The Managed Care Plan shall not use superlatives in logos/product taglines (e.g., “XYZ plan means the first in quality care” or “XYZ plan means the best in managed care”).
2. The Managed Care Plan may not use absolute superlatives (e.g., “the best,” “highest ranked,” “rated number 1”), unless they are substantiated with supporting data provided to the Agency as a part of the marketing review process.

I. Nominal Gifts

1. The Managed Care Plan may distribute nominal gifts as long as the gifts are provided regardless of enrollment. The Managed Care Plan shall obtain Agency approval before distributing any nominal gifts.
2. The Managed Care Plan shall ensure the following for nominal gifts offered by the Managed Care Plan:
 - a. If a nominal gift is one large gift that is available for all in attendance, the total retail cost must be fifteen dollars (**\$15**) or less per person when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
 - b. Nominal gifts may not be in the form of cash, gift card/certificates, or other monetary rebates.
3. The Managed Care Plan shall track distribution of gifts given to enrollees to ensure

enrollees gift levels do not exceed nominal value.

4. The Managed Care Plan shall not provide meals (or have meals subsidized) at marketing or educational events.

J. Regional Distribution of Marketing Materials

1. If the Managed Care Plan markets, it shall distribute marketing materials to the entire region served by the Managed Care Plan. (42 CFR 438.104(b)(1)(ii))
2. The Managed Care Plan shall not advertise outside of its contracted region unless such advertising is unavoidable. For situations in which this cannot be avoided (e.g., advertising in print or broadcast media with a statewide audience or with an audience that includes some individuals outside of the region), the Managed Care Plan shall clearly disclose its contracted regions.
3. If the Managed Care plan is a joint enterprise, it shall market the Managed Care Plan under a single name throughout the region.

K. References to Studies

1. The Managed Care Plan may only compare itself to another Managed Care Plan by referencing an independent study. If the Managed Care Plan references a study in any marketing material, it must provide the following information, either in the text or as a footnote, on the marketing material:
 - a. Reference information (e.g., publication, date, page number).
 - b. Information about the Managed Care Plan's relationship with the entity that conducted the study including funding source.
 - c. The study sample size and number of Managed Care Plans surveyed (unless the study that is referenced is a CMS or Agency study).
2. The Managed Care Plan shall not compare itself to another Managed Care Plan by name unless it has written permission from all Managed Care Plans being compared and include this documentation with the Managed Care Plan's marketing submission.

L. Product Endorsements/Testimonials

1. The Managed Care Plan shall ensure that all product endorsements and testimonials adhere to the following:
 - a. The speaker must identify the Managed Care Plan by name.
 - b. If an individual is paid to portray a real or fictitious situation, the ad must clearly state it is a "Paid endorsement."
2. An enrollee may offer endorsement of the Managed Care Plan, provided the enrollee is a current enrollee and voluntarily chooses to endorse the Managed Care Plan.

Section IV. Marketing

3. Any endorsement or testimonial by an individual shall not use any quotes by physicians or other health care providers.
4. The endorsement or testimonial shall not use negative testimonials about other Managed Care Plans.
5. The Managed Care Plan shall not pay or compensate potential enrollees in any way to endorse or promote the Managed Care Plan.
6. Re-publication of an individual user's content or comment(s) that promote a Managed Care Plan from social/electronic media sites is considered a product endorsement/testimonial and must adhere to the requirements of this Section.

M. Marketing Events

1. The Managed Care Plan shall obtain Agency approval prior to conducting any marketing events.
2. At a marketing event, the Managed Care Plan shall not:
 - a. Conduct health screening or other like activities that could give the impression of "biased selection."
 - b. Require potential enrollees to provide any contact information as a prerequisite for attending the event. The Managed Care Plan shall clearly indicate on any sign-in sheets that completion of any contact information is optional.
3. The Managed Care Plan may use personal contact information to notify potential enrollees of raffle or drawing winnings.
4. The Managed Care Plan shall notify the Agency of any change of plan attendance in advance of the scheduled event, including event cancellation and instances where the event is not cancelled but the Managed Care Plan has decided not to attend.
5. If a marketing event is cancelled or the Managed Care Plan has decided not to attend less than forty-eight (48) hours before its originally scheduled date and time, the Managed Care Plan shall:
 - a. Ensure a Managed Care Plan marketing agent is present at the site of the event, at the time that the event was scheduled to occur, to inform potential enrollees of the cancellation or decision not to attend, and distribute information about the Managed Care Plan.
 - b. Ensure a Managed Care Plan marketing agent remains onsite at least fifteen (15) minutes after the scheduled start of the event. If the event was cancelled due to inclement weather, a Managed Care Plan marketing agent is not required to be present at the site.
6. If a marketing event is cancelled or the Managed Care Plan decides not to attend more than forty-eight (48) hours before the originally scheduled date and time, the Managed

Section IV. Marketing

Care Plan shall notify potential enrollees of the cancellation or decision by the Managed Care Plan not to attend through the same means the Managed Care Plan used to advertise the event. A Managed Care Plan marketing agent is not required to be present at the site.

7. All marketing events shall be reported to the Agency, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

N. Individual Marketing Appointments

1. All individual marketing appointments with potential enrollees are considered marketing events.
2. The Managed Care Plan shall only discuss those products that have been agreed upon by the potential enrollee for that appointment ("scope of appointment"). If other products need to be discussed at the request of the potential enrollee, the Managed Care Plan shall document a second scope of appointment for the new product type and then the marketing appointment may be continued.
3. Each scope of appointment for an individual marketing event must be documented either in writing, in the form of a signed, dated agreement by the potential enrollee.
4. A potential enrollee may set a scope of appointment at a marketing event for a future individual marketing appointment.
5. The Managed Care Plan shall submit all business reply cards for documenting potential enrollee scope of appointment or agreement to be contacted to the Agency. The Managed Care Plan shall include a statement on the business reply card informing the potential enrollee that a marketing agent may call as a result of the potential enrollee returning a business reply card.
6. If the Managed Care Plan has a pre-scheduled appointment that becomes a "no-show," the Managed Care Plan may leave information at the no-show potential enrollee's residence.
7. The Managed Care Plan shall not:
 - a. Market non-health care related products (such as annuities or life insurance).
 - b. Ask a potential enrollee for referrals.
8. The Managed Care Plan shall report all individual marketing appointments to the Agency, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

O. Marketing in the Health Care Setting

1. The Managed Care Plan shall not conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and

conference rooms. If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

2. The Managed Care Plan shall not conduct marketing in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

P. Provider-Based Activities

1. If the Managed Care Plan chooses to utilize its provider network to distribute marketing materials, the Managed Care Plan shall ensure through its provider agreements that providers shall remain neutral.
2. The Managed Care Plan may permit providers to make available and/or distribute Managed Care Plan marketing materials as long as the provider does so for all Managed Care Plans with which the provider participates.
3. The Managed Care Plan may permit providers to display posters or other materials in common areas, such as the provider's waiting room.
4. The Managed Care Plan may permit LTC facilities to provide materials in admission packets announcing all Managed Care Plan contractual relationships.
5. The Managed Care Plan may not permit providers to:
 - a. Offer marketing/appointment forms.
 - b. Make phone calls or direct, urge, or attempt to persuade potential enrollees to enroll in the Managed Care Plan based on financial or any other interests of the provider.
 - c. Mail marketing materials on behalf of the Managed Care Plan.
 - d. Offer anything of value to persuade potential enrollees to select them as their provider or to enroll in a particular Managed Care Plan.
 - e. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
6. Provider Affiliation Information
 - a. Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).
 - b. Providers may make new affiliation announcements within the first thirty (30) days of the new provider agreement.

Section IV. Marketing

- c. Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.
 - d. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider has agreements.
7. Materials that indicate the provider has an affiliation with certain Managed Care Plans and that only list Managed Care Plan names, logos, product taglines, telephone contact numbers, and/or websites do not require Agency approval.

Q. Public Events

1. The Managed Care Plan may conduct, participate in, or sponsor public events. Such events must be held in a public venue. At such events, the Managed Care Plan may distribute public event materials. Such materials do not require Agency review or approval.
2. The Managed Care Plan may conduct the following permissible activities at public events:
 - a. Distribute public event material with the Managed Care Plan name, logo, product tagline, telephone contact number and/or website;
 - b. Distribute nominal gifts that may display the Managed Care Plan name, logo, product tagline, telephone contact number and/or the Managed Care Plan's website. The Managed Care Plan shall ensure that nominal gifts are free of benefit information and consistent with the requirements of nominal gift specified in this Section of this Contract; and
 - c. Display promotional material such as banners, posters, or other displays with the Managed Care Plan name, logo, product tagline, telephone contact number, and/or website.
3. The Managed Care Plan shall ensure that any public events attended by the Managed Care Plan:
 - a. Are offered to all individuals regardless of enrollment and without discrimination.
 - b. Are not items that are considered a health benefit (e.g., a free checkup).
 - c. Do not consist of lowering or waiving co-payments.
 - d. Are not used or included with the enrollee handbook.
 - e. Do not inappropriately influence the enrollee's selection of a provider, practitioner, or supplier of any item or service.
 - f. Are not tied directly or indirectly to the provision of any other covered item or service.
4. The Managed Care Plan may not do the following with regard to public events:

- a. Hold a public event at the home of an individual.
 - b. Conduct one-on-one appointments.
 - c. Conduct marketing, including the distribution of marketing material.
 - d. Discuss Managed Care Plan-specific benefits.
 - e. Distribute Managed Care Plan-specific materials.
5. Participation in public events shall be reported to the Agency, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

R. Enrollee Educational Events

1. Enrollee educational events may be hosted by the Managed Care Plan or an outside entity and must be held in a public venue. The Managed Care Plan shall ensure that events are not held at the home of an individual or as a one-on-one appointment.
2. The Managed Care Plan may conduct the following permissible activities at enrollee educational events:
 - a. Distribute public event material with the Managed Care Plan name, logo, product tagline, telephone contact number, and/or website.
 - b. Distribute nominal gifts which may display the Managed Care Plan name, logo, product tagline, telephone contact number, and/or website. The Managed Care Plan shall ensure that nominal gifts are free of benefit information and consistent with the requirements of nominal gifts specified in Section IV.I., Nominal Gifts, of this Contract.
 - c. Display promotional material such as banners, posters or other displays with the Managed Care Plan name, logo, product tagline, telephone contact number, and/or website.
3. The Managed Care Plan shall submit enrollee material for educational events to the Agency but prior Agency approval is not required. All enrollee educational events shall be reported to the Agency, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

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Section V. Enrollee Services

A. General Provisions

1. The Managed Care Plan shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities, as described in 42 CFR 438.100, through written materials, telephone, electronic and face-to-face communication.
2. The Managed Care Plan shall have the capability to answer enrollee inquiries through written materials, telephone, electronic transmission, and face-to-face communication.
3. The Managed Care Plan shall provide written notice of changes affecting enrollees to those enrollees at least thirty (30) days before the effective date of change, unless otherwise specified in this Contract.
4. The Managed Care Plan shall develop and maintain processes, compliant with applicable federal and State laws (including but not limited to 42 CFR Part 435, and Chapters 709, 744, and 765 of the F.S.), which shall ensure that the Managed Care Plan possesses accurate and current information indicating who has legal authority to make health care decisions on behalf of an enrollee.
5. The Managed Care Plan may send notices to the enrollee's guardian or legally authorized responsible person as applicable.
6. In accordance with Title VI of the Civil Rights Act of 1964, the Managed Care Plan shall provide language assistance services, including the provision of foreign language interpreter and translation services, and auxiliary aids and services to enrollees to achieve effective communication. (42 CFR 438.10(d)(3))

B. Enrollee Material

1. General Provision

The Managed Care Plan shall submit enrollee material or changes in enrollee material related to this Contract to the Agency for review and approval prior to use.

- a. The Managed Care Plan shall submit enrollee material to the Agency at least seventy-five (75) days before the proposed use of the enrollee material or revised material.
- b. The Managed Care Plan shall conduct a quality check and ensure that all materials are consistent with this Contract and State and federal requirements prior to submitting materials for review to the Agency. Generally, the Agency will not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.

2. Requirements for Written Material

- a. The Managed Care Plan shall provide enrollee information in accordance with 42 CFR 438.10(c)(1), 42 CFR 438.10(c)(7), 42 CFR 438.10(d)(6)(ii)-(iv), 42 CFR 438.10(f)(3),

Section V. Enrollee Services

and 42 CFR 438.3(i), which addresses information requirements related to written and oral information provided to enrollees

- b. The Managed Care Plan shall provide all enrollee communications, including written materials, spoken scripts, and websites in an easily understood language and format. Enrollee communications shall be at or near the fourth (4th) grade comprehension level. (42 CFR 438.10(d)(6)(i)) Readability tests to determine whether the written materials meet this requirement are:
 - (1) Fry Readability Index;
 - (2) PROSE The Readability Analyst (software developed by Education Activities, Inc.);
 - (3) Gunning FOG Index;
 - (4) McLaughlin SMOG Index;
 - (5) The Flesch-Kincaid Index; and/or
 - (6) Other readability tests approved by the Agency.
- c. The Managed Care Plan shall make all written material available in multiple languages, as prescribed by the Agency. The Managed Care Plan shall notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats. (42 CFR 438.10(d)(3))
- d. If the Managed Care Plan meets the five percent (5%) threshold for language translation, the Managed Care Plan shall place the following alternate language disclaimer on all enrollee materials:

"This information is available for free in other languages. Please contact our customer service number at [insert enrollee help line and TTY/TTD numbers and hours of operation]."

The Managed Care Plan shall include the alternate language disclaimer in both English and all non-English languages that meet the five percent (5%) threshold. The Managed Care Plan shall place the non-English disclaimer(s) below the English version and in the same font size as the English version. Information on language use may be found at <https://www.census.gov/topics/population/language-use.html#tab2>.

- e. The Managed Care Plan shall include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. Information on the top fifteen (15) non-English languages is located at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf>.

3. Requirements for Mailing Materials to Enrollees

- a. The Managed Care Plan shall provide materials to enrollees by mail or consistent with

Section V. Enrollee Services

- the enrollee's preferred method of contact.
- b. The Managed Care Plan shall display one of the following four (4) statements verbatim on the front of the envelope or, if no envelope is being sent, the mailing itself:
 - (1) Advertising pieces – “This is an advertisement”
 - (2) Managed Care Plan information – “Important Managed Care Plan information”
 - (3) Health and wellness information – “Health and wellness or prevention information”
 - (4) Non-health or non-Managed Care Plan information – “Non-health or non-Managed Care Plan related information”

The Agency does not require resubmission of envelopes based only on the envelope size.

- c. The Managed Care Plan shall ensure that its Managed Care Plan name or logo is included in every mailing to enrollees.
- d. The Managed Care Plan shall include a request for address correction in mailing envelopes for enrollee materials.
- e. The Managed Care Plan shall not send emails unless the enrollee has agreed to receive those emails and shall provide an opt-out process for enrollees no longer to receive email communications.

4. Enrollee Procedures and Materials

- a. The Managed Care Plan shall notify, in writing, within five (5) days following the receipt of the X12-834 enrollment file from the Agency or its designee, each person who is to be newly enrolled or reinstated with the Managed Care Plan.
- b. The Managed Care Plan shall furnish enrollee materials to the new enrollee:
 - (1) An enrollment notice.
 - (2) An enrollee identification (ID) card.
 - (3) A current enrollee handbook.
 - (4) A current provider directory.
 - (5) Name, telephone number and address of the enrollee's PCP assignment, unless the enrollee is a full benefit dual eligible;
- c. The Managed Care Plan shall furnish a reinstatement notice to a reinstated enrollee.

5. Required Enrollment Notice

Section V. Enrollee Services

The Managed Care Plan shall include in its enrollment notice:

- a. The effective date of enrollment;
- b. The enrollees' right to change their Managed Care Plan selections, subject to Medicaid limitations. The notifications shall distinguish between enrollees subject to open enrollment and those who are not and shall include information about change procedures for cause, or general Managed Care Plan change procedures through the Agency's enrollment broker website (www.flmedicaidmanagedcare.com) and toll-free enrollment broker telephone number as appropriate;
- c. A notice that enrollees who lose eligibility and are disenrolled shall be automatically reinstated in the Managed Care Plan if eligibility is regained within the temporary loss period;
- d. A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Managed Care Plan and through DCF and/or the Social Security Administration; and
- e. A postage-paid, pre-addressed return envelope.

6. Reinstatement Notice

The Managed Care Plan shall include in its reinstatement notice:

- a. The effective date of the reinstatement;
- b. Instructions on how the enrollee can contact the Managed Care Plan if a new enrollee card, new enrollee handbook, and/or a new provider directory are needed;
- c. A request to update the enrollee's name, address (home and mailing), county of residence and telephone number, and include information on how to update this information with the Managed Care Plan and through DCF and/or the Social Security Administration; and
- d. A postage-paid, pre-addressed return envelope.

7. Enrollee ID Card Requirements

- a. The Managed Care Plan shall include on its enrollee ID card:
 - (1) The enrollee's name and Medicaid ID number;
 - (2) The Managed Care Plan's name, address, and enrollee help line number; and
 - (3) A telephone number that a non-participating provider may call for billing information.
- b. The Managed Care Plan shall provide replacement ID cards at the enrollee's request.

8. Enrollee Handbook Requirements

- a. The Managed Care Plan shall furnish each new enrollee an enrollee handbook using the model enrollee handbook template provided by the Agency. The model enrollee handbook shall comply with the provisions of 42 CFR 438.3(j), 42 CFR 438.102(b)(2), 42 CFR 438.10(c)(4)(ii), 42 CFR 438.10(g), 42 CFR 438.62(b)(3), 42 CFR 489.102(a), and 45 CFR 147.200(a).
- b. The Managed Care Plan shall provide the enrollee handbook through one of the following methods:
 - (1) Mailing a printed copy of the information to the enrollee's address;
 - (2) Providing the information by email, as permitted by this Contract;
 - (3) Advising the enrollee in paper or electronic form that the information is available on the Managed Care Plan's website and providing the applicable internet address; or
 - (4) Providing the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

Prior to utilizing methods (2), (3), or (4) above, the Managed Care Plan shall submit a written description to the Agency Contract Manager of the process ensuring enrollees have access to a printed copy upon request.

9. Printed Provider Directory

- a. The Managed Care Plan shall include in its printed provider directory the following information:
 - (1) Provider(s) names and group affiliations;
 - (2) Street address(es);
 - (3) Telephone number;
 - (4) Website URLs, if the provider has a website;
 - (5) Specialty credentials and other certifications, as applicable;
 - (6) Whether the provider will accept new enrollees;
 - (7) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training;
 - (8) Office hours;
 - (9) Specific performance indicators;

Section V. Enrollee Services

- (10) In accordance with s. 1932(b)(3) of the Social Security Act, a statement that some providers may choose not to perform certain services based on religious or moral beliefs; and
 - (11) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment. (42 CFR 438.10(h)(1))
- b. The Managed Care Plan shall arrange the provider directory by county as follows:
 - (1) Providers listed by name in alphabetical order, showing the provider's specialty; and
 - (2) Providers listed by specialty, in alphabetical order by name.
 - c. The Managed Care Plan shall provide a copy of the printed provider directory through one of the following methods:
 - (1) Mailing a printed copy to the enrollee's address;
 - (2) Providing the information by email, as permitted by this Contract;
 - (3) Advising the enrollee in paper or electronic form that the information is available on the internet and including the applicable internet address; or
 - (4) Providing the information by any other method that can reasonably be expected to result in the enrollee receiving that information.
 - d. The Managed Care Plan shall update the printable version of the provider directory at least monthly and include the date of revision. (42 CFR 438.10(h)(3))
 - e. When distributing printed provider directories, the Managed Care Plan shall include information stating that the most current listing of providers is available by calling the Managed Care Plan at its toll-free telephone number and at the Managed Care Plan's website. The letter shall include the telephone number and the internet address that links directly to the online provider database.
 - f. The Managed Care Plan is not required to include outpatient hospital-based specialty providers in the online provider database or printed provider directory. However, the Managed Care Plan shall include these providers in the provider network file it submits to the Agency.

10. Online Enrollee Materials

- a. The Managed Care Plan shall make available electronically at the Managed Care Plan's website without requiring enrollee login, the enrollee handbook(s), the printed provider directory, and a searchable provider database.
 - (1) The Managed Care Plan must provide enrollee information electronically and meet the criteria as outlined in 42 CFR 438.10(c)(6)(i)-(v).

Section V. Enrollee Services

- (2) The Managed Care Plan may provide a link to applications (smartphone applications, or “apps”) for enrollee use that will take enrollees directly to existing Agency-approved materials (such as the Managed Care Plan’s enrollee handbook and provider directory) on the Managed Care Plan’s website.
 - (3) The online provider directory shall be made available in a machine readable file and format in compliance with 42 CFR 438.10(h)(4).
- b. The Managed Care Plan shall maintain an accurate and complete online provider database containing all the information required in the printed provider directory and as required by s. 409.967(2)(c)1, F.S. The online provider database must be searchable by:
- (1) Name
 - (2) Provider type
 - (3) Distance from the enrollee’s address
 - (4) County
 - (5) Zip code
 - (6) Whether the provider is accepting new patients
- c. The Managed Care Plan shall update the online provider database at least weekly to match the most recent provider network file submitted to the Agency.
- d. The Agency reserves the right to publish the information specified in s. 409.967(2)(c)1, F.S.

11. Procedures for Provider Network Changes

- a. The Managed Care Plan shall have procedures to inform potential enrollees and enrollees, upon request, of any changes to service delivery and/or the provider network including the following:
 - (1) Up-to-date information about any restrictions on access to providers, including providers who are not taking new patients;
 - (2) Any restrictions on counseling and referral services based on moral or religious grounds within ninety (90) days after adopting the policy with respect to any service. (42 CFR 438.102(b)(1)(i)(B); 42 CFR 438.10(g)(4))
- b. The Managed Care Plan shall have procedures to inform enrollees of adverse changes to its provider network.

C. Enrollee Services

1. General Provisions

Section V. Enrollee Services

- a. The Managed Care Plan shall establish and maintain an enrollee services function with the capability to answer enrollee inquiries and ensure that enrollees are notified of their rights and responsibilities.
- b. The Managed Care Plan shall ensure language translation quality in all enrollee materials.

2. Translation and Interpretation Services

- a. The Managed Care Plan is required to provide interpretation services at all points of contact to any potential enrollee or enrollee who speaks any non-English language regardless of whether the enrollee speaks a language that meets the threshold of a prevalent non-English language. This includes written translation, oral interpretation, and the use of auxiliary aids such as TTY/TDY and American Sign Language. (42 CFR 438.10(d)(4); and 42 CFR 438.406(a))
- b. The Managed Care Plan is required to notify its enrollees of the availability of interpretation services and to inform them of how to access such services. Interpretation services are required for all Managed Care Plan information provided to enrollees, including notices of adverse action. There shall be no charge to the enrollee for translation services. (42 CFR 438.10(d)(5)(i)-(iii), 42 CFR 438.10(d)(4))
- c. Upon request, the Managed Care Plan shall provide, free of charge, interpreters for potential enrollees or enrollees whose primary language is not English. (42 CFR 438.10(d)(4))

3. Toll-Free Enrollee Help Line

- a. The Managed Care Plan shall operate a toll-free help line equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, a telecommunication device for the deaf (TTY/TDD), and access to the interpreter services for non-English speaking beneficiaries. The Managed Care Plan shall operate its enrollee help line as part of an inbound call center or similar functional arrangement where agents or operators staff telephones to field incoming calls.
- b. The Managed Care Plan shall staff the enrollee help line twenty-four hours a day, seven days a week (24/7) to handle care related inquiries from enrollees and caregivers.
- c. The enrollee help line agents/operators shall be trained to respond to enrollee questions in all areas.
- d. The Managed Care Plan shall develop and implement an operational manual relevant to the call center. This manual shall provide information to agents/operators on how to conduct various call center tasks and provide procedures for processing enrollee inquiries, including procedures, such as call scripts, call-handling procedures, first call resolution, and escalation protocols.

Section V. Enrollee Services

- e. If the Managed Care Plan utilizes an automated phone tree system, the Managed Care Plan's phone tree must include the option for enrollees to bypass options in the automated phone tree system and speak with an enrollee help line representative.
- f. The Managed Care Plan may use a voice mail option in an automated phone tree system for callers to leave messages between the hours of 7:00 p.m. and 8:00 a.m., in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays. This phone tree must provide callers with clear instructions on what to do in case of an emergency and an option to speak to a Managed Care Plan representative.
- g. If the Managed Care Plan utilizes a voice mailbox option, the Managed Care Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A Managed Care Plan representative shall respond to all messages on the next business day.
- h. The Managed Care Plan shall have administrative procedures that include requirements for staffing, operations, technologies and performance measurement. The administrative procedures shall address:
 - (1) Personnel management such as staff development and training, scheduling and skill-based routing;
 - (2) Operational management of all call center activities such as call center shrinkage and schedule adherence, workload, and call load forecasting;
 - (3) Software and technologies, such as automatic call distribution (ACD), telephone phone tree/IVR technology and call recording systems; and
 - (4) Call center quality control metrics and measurement for the performance of agents/operators.
- i. The Managed Care Plan shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by the Agency before use, and comply with Attachment B., Section XIV., Liquidated Damages, of this Contract. The Managed Care Plan shall report its performance on these standards as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. These standards shall be measured on a monthly basis and, at a minimum, require that:
 - (1) The ASA shall not exceed thirty (30) seconds.
 - (2) The call blockage rate for direct calls to the Managed Care Plan shall not exceed one-half of one percent (0.5%).
 - (3) The average call abandonment rate for direct calls to the Managed Care Plan shall not exceed three percent (3%). A system which places calls in queue may be used but the average wait time in the queue shall not exceed sixty (60) seconds.
- j. The Managed Care Plan shall ensure that hold time messages do not include non-

Section V. Enrollee Services

health related items (e.g., life insurance, disability). The Managed Care Plan shall submit hold time messages that promote the Managed Care Plan or include benefit information to the Agency for prior approval.

4. Cultural Competency Plan

As required by 42 CFR 438.206(c)(2), the Managed Care Plan shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

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Section VI. Coverage and Authorization of Services

A. Required Benefits

1. General Provisions

- a. The Agency shall be responsible for promulgating coverage requirements applicable to Managed Care Plans through Florida Medicaid Coverage Policies, services listed in the associated Florida Medicaid fee schedules, and the Florida Medicaid State Plan, as well as plan communications specific to changes in federal and State law, rules or regulations and federal CMS waivers applicable to this Contract.
- b. The Managed Care Plan shall ensure the provision of services defined and specified in this Contract and the applicable federal waivers in sufficient amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services defined and specified in this Contract. (42 CFR 438.210(a)(3)(i))
- c. Nothing in this Contract waives the EPSDT requirements of 42 U.S.C. § 1396d(r)(5). As such, in accordance with § 1396d(r) and all binding federal precedents interpreting it, the Managed Care Plan must, for Medicaid eligible children under the age of twenty-one (21) years, pay for any “other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this Section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” (42 U.S.C. 1396d(r)(5)) The Managed Care Plan shall not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21) years. The Managed Care Plan shall develop a special services process to authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary.
- d. The Managed Care Plan shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the enrollee’s diagnosis, type of illness or condition. The Managed Care Plan may place appropriate limits on a service on the basis of medical necessity, as defined by the Agency, consistent with the terms of this Contract and as required by 42 CFR 438.210(a)(4)(i)-(ii) and 438.210(a)(1), provided the services furnished can be reasonably expected to achieve their purpose.
- e. The Managed Care Plan shall provide the services identified in Attachment B, and its Exhibits in accordance with the Florida Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G-4, F.A.C., that include the Florida Medicaid Coverage and Limitations Handbooks, Florida Medicaid Coverage Policies, and services listed in the associated Florida Medicaid fee schedules, except where the provisions of this Contract or the applicable federal waivers alter the requirements set forth in the Handbooks, Coverage Policies, and Medicaid fee schedules.
 - (1) In no instance may the Managed Care Plan impose coverage and service limitations or exclusions more stringent than those specified in the aforementioned documents.

Section VI. Coverage and Authorization of Services

- (2) The Managed Care Plan may exceed specific coverage criteria included in the above and specific coverage exclusions specified in the aforementioned documents.
- f. The Managed Care Plan is responsible for ensuring that all coverage and service requirements specified in the Florida Medicaid Services Coverage & Limitations Handbooks, Florida Medicaid Coverage Policies are incorporated into the Managed Care Plan's provider agreements. This includes professional licensure and certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in this Contract.
- g. The Agency shall be responsible for accepting complaints directly from Medicaid recipients and providers, operating the SAP, conducting Medicaid Fair Hearings, as well as reviewing complaints, grievances, and plan appeals reported by Managed Care Plans to ensure appropriate resolution and monitor for contractual compliance, the Managed Care Plan performance, and trends that may reflect policy changes or operational changes needed.
- h. This Contract shall prevail in any instance when compliance with provisions in the Medicaid State Plan, the applicable federal waivers, as well as the Florida Medicaid promulgated rules in Chapter 59G, F.A.C. conflict with the terms of this Contract.

B. Expanded Benefits

1. General Provisions

- a. The Managed Care Plan may offer expanded benefits as approved by the Agency.
- b. The Managed Care Plan shall offer the approved expanded benefits to eligible enrollees in the applicable managed care program, subject to any Agency-agreed service limitations set forth in this Contract.
- c. The Managed Care Plan shall administer the expanded benefits of Medicaid covered services in accordance with any applicable service standards pursuant to this Contract, the applicable federal waivers, and any Florida Medicaid Coverage and Limitations Handbooks and Medicaid Coverage Policies.

2. Types of Expanded Benefits

- a. The Managed Care Plan may offer the following expanded benefits:
 - (1) Services in excess of the amount, duration, and scope of those listed in this Contract for its respective enrollees.
 - (2) Other services and benefits not listed in the Exhibit B-1, MMA Exhibit and the Exhibit B-2, LTC Exhibit upon approval of the Agency.
 - (3) Over-the-counter expanded drug benefit. Over-the-counter expanded drug benefits shall not exceed the following limits:

Section VI. Coverage and Authorization of Services

- (a) For enrollees receiving MMA benefits, such benefits shall not exceed twenty-five dollars (**\$25**) per individual per month for enrollees with MMA benefits.
- (b) For enrollees receiving LTC benefits, such benefits shall not exceed fifteen dollars (**\$15**) per individual per month for enrollees with LTC benefits.

3. Changes to Expanded Benefits Offered

- a. The Managed Care Plan's expanded benefits may be changed on a Contract year basis in a manner and format approved by the Agency, if determined by the Agency to be beneficial to the enrollees.
- b. The Managed Care Plan may increase its expanded benefits upon approval by the Agency.
- c. The Managed Care Plan may exchange an expanded benefit for another, if determined to be actuarially equivalent by the Agency, upon approval by the Agency.

C. Excluded Services

1. General Provisions

- a. The Managed Care Plan is not obligated to provide any services not specified in this Contract, except as federally required under EPSDT provisions.
- b. Enrollees who require services not covered by this Contract shall receive the services through other appropriate Medicaid and non-Medicaid programs. In such cases, the Managed Care Plan's responsibility shall include care coordination/case management and referral. (42 CFR 438.208(b)(2)(iii)-(iv))

2. Moral or Religious Objections

- a. The Managed Care Plan shall provide or arrange for the provision of all covered services. If, during the course of this Contract period, pursuant to 42 CFR 438.102, the Managed Care Plan elects not to provide or reimburse for counseling or referral to a covered service because of an objection on moral or religious grounds, the Managed Care Plan shall notify:
 - (1) The Agency within one hundred twenty (120) days before implementing the policy with respect to any covered service; (42 CFR 438.102(b)(1)(i)(A)(2)) and
 - (2) Enrollees within sixty (60) days before implementing the policy with respect to any covered service.
- b. In accordance with 42 CFR 438.10, if the Managed Care Plan chooses not to cover or furnish counseling or referral service information to enrollees due to moral or religious objections, the Agency shall be responsible for providing information on how and where to obtain the service. (42 CFR 438.102(b)(1)(i)(A)(1))

D. Coverage Provisions

1. Service-Specific Requirements

The Managed Care Plan shall comply with additional provisions for covered services specified in the applicable Exhibit(s).

2. In Lieu of Services

- a. The Managed Care Plan may cover services or settings that are in lieu of services or settings covered under the State plan (i.e., "in lieu of services"), as specified in this Contract and in accordance with 42 CFR 438.3(e)(2).
- b. The Managed Care Plan shall use a clinical rationale for determining the benefit of the in lieu of service for the enrollee.
- c. The Managed Care Plan shall ensure that the enrollee has a choice of whether to receive the Medicaid covered service or an in lieu of service, and shall ensure that the choice is documented in the enrollee record.
- d. The Managed Care Plan shall submit a copy of its procedures for in lieu of services to the Agency for approval in advance of implementation.

3. Behavioral Health

The Managed Care Plan shall coordinate behavioral health services consistent with the care coordination requirements in this Section. Specific responsibilities of the Managed Care Plan as it relates to coordinating with other entities include:

- a. Preadmission Screening and Resident Review (PASRR) Level II, if the PASRR Level II of an enrollee indicates a need for specialized services not included in the nursing facility per diem.
- b. Assessment and treatment of mental health residents who reside in an assisted living facility that holds a limited mental health license, to ensure compliance with s. 394.4574, F.S.

E. Care Coordination/Case Management

1. General Provisions

- a. The Managed Care Plan shall be responsible for care coordination/case management for enrollees as specified in this Contract and the applicable Exhibit(s).
- b. The Managed Care Plan shall have protocols in place to identify enrollees who require care coordination/case management services, and maintain written procedures for identifying, assessing, and implementing interventions for enrollees.
- c. The Managed Care Plan shall ensure the following requirements are met when

Section VI. Coverage and Authorization of Services

enrollees are admitted to or discharged from a nursing facility.

- (1) The Managed Care Plan shall ensure the Florida DCF is notified when an enrollee is admitted to a nursing facility.
 - (a) The Managed Care Plan shall submit to DCF a properly completed DCF form CF-ES 2506A (Client Referral/Change) within ten (10) business days of an enrollee's admission to the nursing facility.
 - (b) The Managed Care Plan may delegate the submission of the DCF form CF-ES 2506A (Client Referral/Change) to the nursing facility, when the enrollee is under the age of 18. The Managed Care Plan must obtain a copy of the completed DCF form CF-ES 2506A (Client Referral/Change) that the facility submitted to DCF.
- (2) The Managed Care Plan shall ensure the Florida DCF is notified when an enrollee is discharged from a nursing facility.
 - (a) The Managed Care Plan shall submit to DCF a properly completed DCF form CF-ES 2506 (Client Discharge/Change Notice) within ten (10) business days of an enrollee's discharge from the nursing facility.
 - (b) The Managed Care Plan may delegate submission of the DCF form CF-ES 2506 (Client Discharge/Change Notice) to the nursing facility.
- d. The Managed Care Plan shall ensure case managers meet the appropriate experience and educational requirements.
- e. The Managed Care Plan shall ensure access to case managers and back-up case managers as follows:
 - (1) The case manager shall be available for contact by the enrollee or the enrollee's authorized representative during business hours.
 - (2) When the enrollee's case manager is unavailable, the enrollee shall be provided the opportunity to be referred to a back-up case manager for assistance. The back-up case manager shall be available for contact by the enrollee or the enrollee's authorized representative during business hours.
 - (3) The enrollee shall be provided with access to an emergency back-up case manager through an after-hours telephone line.
 - (4) The Managed Care Plan shall ensure a mechanism to ensure enrollees, authorized representatives, and providers receive timely communication when messages are left for case managers.
- f. The Managed Care Plan shall report monthly on enrollees under the age of twenty-one (21) years receiving nursing facility services or private duty nursing services, using a template provided by the Agency in accordance with Section XVI., Reporting Requirements and the Managed Care Plan Report Guide.

Section VI. Coverage and Authorization of Services

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.
- 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

The Managed Care Plan shall conduct an initial visit as specified in the applicable Exhibit(s).

4. Comprehensive Assessment/Reassessment

The Managed Care Plan shall conduct a comprehensive assessment/reassessment as specified in the applicable Exhibit(s).

5. Initial Plan of Care/Reviews

- a. The Managed Care Plan shall finalize a person-centered plan of care for the enrollee within five (5) business days of the initial visit.
- b. The Managed Care Plan shall authorize and initiate services identified on the enrollee's plan of care within fourteen (14) days of plan of care development or updates, or sooner if necessary, to ensure services are implemented with reasonable promptness, consistent with the needs of the enrollee and as medically necessary.

Section VI. Coverage and Authorization of Services

- c. The Managed Care Plan shall follow up by telephone with an enrollee residing in their home, or the enrollee's authorized representative, within fourteen (14) days after initial contact and plan of care development to ensure that services were started as authorized in the plan of care.
- d. The Managed Care Plan shall review the plan of care in a face-to-face visit quarterly or more frequently if the enrollee experiences a significant change.

6. Monthly Contact

The Managed Care Plan shall conduct monthly contact with enrollees receive care coordination/case management as specified in the applicable Exhibit(s).

7. Freedom of Choice

The Managed Care Plan shall ensure the enrollee's or enrollee's authorized representative's completion and signature of the Agency-approved Freedom of Choice Certification Form within seven (7) business days of the effective date as specified in the applicable Exhibit(s).

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

The Managed Care Plan shall:

- a. Ensure that the care coordinator verifies that the PASRR required in Rule 59G-1.040, F.A.C. is in the enrollee's nursing facility's enrollee record.
- b. Report the most recent PASRR date for enrollees entering or residing in a nursing facility in accordance with Section XVI., Reporting Requirements and the Managed Care Plan Report Guide.

The Managed Care Plan shall maintain, at a minimum, monthly telephone contact with the enrollee or enrollee's authorized representative, to verify satisfaction and receipt of services.

9. Transition of Care

- a. The Managed Care Plan shall develop and maintain transition of care procedures that address all transitional care coordination/case management requirements and submit these procedures for review and approval to the Agency. (42 CFR 438.62(b)(1)-(2)) Transition of care procedures shall include the following minimum functions:
 - (1) Appropriate support to case managers, and to enrollees and caregivers as needed, for referral and scheduling assistance for enrollees needing specialty health care, transportation, or other service supports; (42 CFR 438.208(b)(1))
 - (2) Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting with assistance, as needed, by the Agency. (42 CFR 438.208(b)(6); 42 CFR 438.224; 45 CFR 160; 45 CFR 164) Transfer of enrollee records in compliance with HIPAA privacy and security rules;

Section VI. Coverage and Authorization of Services

- (3) Documentation of referral services in enrollee records, including follow up resulting from the referral;
 - (4) Monitoring of enrollees with co-morbidities and complex medical conditions and coordination of services for high utilizers to identify gaps in services and evaluate progress of case management; and
- b. The Managed Care Plan shall be responsible for coordination of care for new enrollees transitioning into the Managed Care Plan.
 - c. The Managed Care Plan shall be responsible for coordination of care for enrollees transitioning to another Managed Care Plan or delivery system and ensure information for active services is shared with the new Managed Care Plan or delivery system within thirty (30) days following of an enrollee's enrollment date.

10. Disease Management Program

- a. The Managed Care Plan shall have procedures regarding its disease management programs that include the following:
 - (1) How enrollees are identified for eligibility and stratified by severity and risk level, including details regarding the algorithm and data sources used to identify eligible enrollees;
 - (2) How eligible enrollees are contacted for outreach and attempts are made to engage enrollees in disease management services. The Managed Care Plan shall maintain documentation that demonstrates that reasonable attempts were made by the Managed Care Plan to contact and engage eligible enrollees into disease management services;
 - (3) How the disease management program interfaces with the enrollee's PCP and/or specialist providers and ensures coordination of care; and
 - (4) How the Managed Care Plan identifies available community support services and facilitates enrollee referrals to those entities for enrollees with identified community support needs.
- b. The Managed Care Plan shall develop and use a plan of care for each disease management program participant that is tailored to the individual enrollee. The plan of care shall be on file for each disease management program participant and shall include measurable goals/outcomes and sufficient information to determine if goals/outcomes are met. The enrollee's ability to adhere to a treatment regimen shall be monitored in the plan of treatment and include interventions designed to improve the enrollee's ability to adhere to the plan of treatment. The plan of care shall be updated at least annually and as required by changes in an enrollee's condition.

F. Quality Enhancements

1. In addition to the covered services specified in this Section, the Managed Care Plan shall offer and coordinate access to quality enhancements (QEs). Managed Care Plans are not

Section VI. Coverage and Authorization of Services

reimbursed separately by the Agency for these services.

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

G. Authorization of Services

1. General Provisions

- a. The Managed Care Plan shall establish and maintain a UM system to monitor utilization of services, including an automated service authorization system for denials, service limitations, and reductions of authorization. The Managed Care Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the enrollee's diagnosis, type of illness, or condition (42 CFR 438.210(a)(3)(ii)).
- b. The Managed Care Plan shall ensure that applicable evidence-based guidelines are utilized with consideration given to characteristics of the local delivery systems available for specific enrollees as well as enrollee-specific factors, such as enrollee's age, co-morbidities, complications, progress in treatment, psychosocial situation and home environment.
- c. The Managed Care Plan must provide that compensation to individuals or entities (including subcontractors) that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee, in accordance with 42 CFR 438.210(e).
- d. The Managed Care Plan shall develop a process for authorization of any medically necessary service to enrollees under the age of twenty-one (21) years, in accordance with Section 1905(a) of the Social Security Act, when
 - (1) The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or
 - (2) The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific Handbook or Coverage Policy, or the corresponding fee schedule.
- e. Managed Care Plans may utilize a national standardized set of criteria (e.g. Interqual)

Section VI. Coverage and Authorization of Services

or other evidence-based guidelines approved by the Agency to approve services. Such criteria and guidelines shall not solely be used to deny, reduce, suspend or terminate a good or service, but may be used as evidence of generally accepted medical practices that support the basis of a medical necessity determination.

2. Utilization Management Program Description

The UM program shall be consistent with 42 CFR Parts 438 and 456 (as applicable), reflected in a written Utilization Management Program Description and include, but not be limited to:

- a. Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;
- b. Procedures for reporting fraud and abuse information identified through the UM program to the Agency's MPI as described in Section X., Administration and Management, and referenced in 42 CFR 455.1(a)(1);
- c. Procedures for enrollees to obtain a second medical opinion at no expense to the enrollee and for the Managed Care Plan to authorize claims for such services in accordance with 42 CFR 438.206(b)(3) and s. 641.51, F.S.;
- d. Protocols for prior authorization and denial of services;
- e. The process used to evaluate initial and continuing authorization;
- f. Objective evidence-based criteria to support authorization decisions;
- g. Mechanisms to ensure consistent application of review criteria for authorization decisions, including consultation with the requesting provider when appropriate;
- h. Physician profiling; and
- i. Retrospective review, meeting the predefined criteria below. The Managed Care Plan shall be responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate. (42 CFR 438.210(b)(1)-(2)(i)-(ii))

3. Service Authorization System

- a. The Managed Care Plan shall have automated authorization systems, as required in s. 409.967(2)(c)3., F.S., and may not require paper authorization in addition as a condition for providing treatment.
- b. The Managed Care Plan's service authorization systems shall provide written notice of all denials, service limitations and reductions of authorization to providers and enrollees. (42 CFR 438.210(c).)
- c. The Managed Care Plan's service authorization systems shall provide the authorization number and effective dates for authorization to providers and non-participating providers.

Section VI. Coverage and Authorization of Services

- d. The Managed Care Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Managed Care Plan is not required to approve claims for which it has received no written documentation.
- e. The Managed Care Plan shall comply with the following standards, measured on a monthly basis, for processing authorization requests in a timely manner:
 - (1) The Managed Care Plan shall process ninety-five percent (95%) of all standard authorizations within fourteen (14) days.
 - (2) The Managed Care Plan's average turnaround time for standard authorization requests shall not exceed seven (7) days.
 - (3) The Managed Care Plan shall process ninety-five percent (95%) of all expedited authorization requests within three (3) business days.
 - (4) The Managed Care Plan's average turnaround time for expedited authorization requests shall not exceed two (2) business days.
- f. The Managed Care Plan shall submit a monthly report of the authorization timeliness standards to the Agency as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

4. Practice Guidelines/Evidence-based Criteria

- a. The Managed Care Plan shall adopt practice guidelines that meet the following requirements (42 CFR 438.236(b)(1)):
 - (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; (42 CFR 438.263(b)(1))
 - (2) Consider the needs of the enrollees; (42 CFR 438.236(b)(2))
 - (3) Are adopted in consultation with providers; (42 CFR 438.236(b)(3)) and
 - (4) Are reviewed and updated periodically, as appropriate. (42 CFR 438.236(b)(4))
- b. The Managed Care Plan shall disseminate any revised practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. (42 CFR 438.236(c))
- c. The Managed Care Plan shall ensure consistency with regard to all decisions relating to UM, enrollee education, covered services and other areas to which the practice guidelines apply. (42 CFR 438.236(d))
- d. If the Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C.

Section VI. Coverage and Authorization of Services

5. Clinical Decision-Making

The Managed Care Plan shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, must be:

- a. Made by a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency, who has the appropriate clinical expertise in treating the enrollee's condition or disease (42 CFR 438.210(b)(3)); and
- b. Determined using the acceptable standards of care, State and federal laws, the Agency's medical necessity definition, and clinical judgment of a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency.

6. Service Authorization Standards for Decisions

- a. The Managed Care Plan shall notify the provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 438.210(c); 42 CFR 438.404)
- b. The Managed Care Plan shall comply with the following standards, measured on a monthly basis, for notifying providers and enrollees in a timely manner:
 - (1) The Managed Care Plan shall provide standard authorization decisions within no more than seven (7) days following receipt of the request for service. (42 CFR 438.210(d)(1))
 - (2) The Managed Care Plan may extend the timeframe for standard authorization decisions up to seven (7) additional days, if the enrollee or the provider requests extension, or the Managed Care Plan justifies the need for additional information and how the extension is in the enrollee's interest.
 - (3) The Managed Care Plan shall provide expedited authorization decisions no later than forty-eight (48) hours after receipt of the request for service. (42 CFR 438.210(d)(2))
 - (4) The Managed Care Plan may extend the timeframe for expedited authorization decisions by up to two (2) additional business days if the enrollee or the provider requests an extension or if the Managed Care Plan justifies the need for additional information and how the extension is in the enrollee's interest.
- c. If the Managed Care Plan extends the timeframe for a service authorization decision, in which case it shall:
 - (1) Notify the enrollee of the reason for extending the timeframe and advising of the right to file a grievance if the enrollee disagrees with the extension of time;
 - (2) Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires; and

Section VI. Coverage and Authorization of Services

- (3) Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.

7. Changes to Utilization Management Components

- a. The Managed Care Plan shall obtain written approval from the Agency for its service authorization protocols and any changes.
- b. The Managed Care Plan shall provide no less than sixty (60) days' written notice to the Agency before making any changes to the administration and/or management procedures and/or authorization, denial or review procedures, including any delegations, as described in this Section.

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Section VII. Grievance and Appeal System

A. General Provisions

1. The Managed Care Plan shall establish and maintain a grievance and appeal system for reviewing and resolving enrollee complaints, grievances, and appeals. Components must include a complaint process, a grievance process, a plan appeal process, access to an applicable review outside of the Managed Care Plan, and access to a Medicaid Fair Hearing. (s. 641.511, F.S.; 42 CFR 431, Subpart E; 42 CFR 438, Subpart F; and Rule 59G-1.100, F.A.C.)
2. The Managed Care Plan shall ensure that all decisions on grievances and appeals are made by health care professionals in accordance with 42 CFR 438.406(b).
3. The Managed Care Plan shall refer all enrollees who are dissatisfied with the Managed Care Plan or its activities to the Managed Care Plan's grievance and appeal system.
4. In accordance with Section V., Enrollee Services, the Managed Care Plan shall provide assistance to the enrollee in completing forms and following the procedures for filing a grievance or plan appeal or requesting a Medicaid Fair Hearing.
5. Upon request, the Managed Care Plan shall provide the enrollee and his or her authorized representative the enrollee record, including all medical records and any other documents and records considered or relied upon by the Managed Care Plan regarding a plan appeal, Medicaid fair hearing, or SAP hearing, including the opportunity before and during the plan appeal or hearing process for the enrollee or an authorized representative to examine the record. The Managed Care Plan shall provide such records free of charge, within seven (7) calendar days of request. (42 CFR 438.406(b)(5))
6. The Managed Care Plan shall maintain a complete and accurate record of all complaints, grievances, and plan appeals. The Managed Care Plan shall maintain and make complaint, grievance, and plan appeal records available upon request of the Agency and CMS. (42 CFR 438.416(c))
 - a. The Managed Care Plan shall address, log, track, and trend all complaints, regardless of the degree of seriousness or whether the enrollee or provider expressly requests filing the concern.
 - b. The record of each grievance and appeal must contain, at a minimum, the information specified in 42 CFR 438.416(b)(1)-(6) and additional information as specified in the Managed Care Plan Report Guide.
7. The Managed Care Plan shall report on complaints, grievances, and plan appeals to the Agency as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency. (42 CFR 438.416(a))

B. Use of Independent Review Organization

Section VII. Grievance and Appeal System

1. The Managed Care Plan may elect to have all of its unresolved grievances and plan appeals subject to external review processes by an independent review organization. (Section 641.185(1)(j), F.S.)
2. The Managed Care Plan must notify the Agency in writing if it elects to have all its plan appeals subject to such external review.

C. Process for Complaints

1. The Managed Care Plan shall resolve complaints by close of business on the business day following receipt.
2. If a complaint is not resolved within one business day following receipt, the Managed Care Plan shall enter the complaint as a grievance.

D. Process for Grievances

1. An enrollee may file a grievance with the Managed Care Plan, orally or in writing at any time. (42 CFR 438.402(c)(2)(i); 42 CFR 438.402(c)(3)(i))
2. The Managed Care Plan's process for handling enrollee grievances must include acknowledgement in writing within five (5) business days of receipt of each grievance. (42 CFR 438.406(b)(1); 42 CFR 438.406(a))
3. The Managed Care Plan shall review the grievance and provide written notice of results to the enrollee, as expeditiously as the enrollee's health condition requires, no later than ninety (90) calendar days from the date the Managed Care Plan receives the grievance. (42 CFR 438.408(a) and (b)(1))
4. The Managed Care Plan shall extend the timeframe for a grievance resolution up to fourteen (14) calendar days if:
 - a. The enrollee asks for an extension, or the Managed Care Plan documents that additional information is needed and the delay is in the enrollee's interest;
 - b. If the timeframe is extended other than at the enrollee's request, the Managed Care Plan shall provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay to the enrollee within two (2) calendar days of the determination. (42 CFR 438.408(c)(1)(i)-(ii); 438.408(b)(1))
 - c. If notified by the Agency of an enrollee's request for a good cause plan change pursuant to Rule 59G-8.600, F.A.C., the Managed Care Plan shall complete the grievance process within a timeframe prescribed by the Agency in accordance with 42 CFR 438.56(e). If the Managed Care Plan fails to provide the Agency with the outcome of the grievance process within the Agency-prescribed timeframes, the enrollee's request for good cause plan change is considered approved.

E. Notice of Adverse Benefit Determination

1. The Managed Care Plan shall give the enrollee written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The Managed Care Plan shall provide the enrollee with a written notice of adverse benefit determination for any service authorization decisions, using the template provided by the Agency (42 CFR 438.10(c)(4)(ii); 42 CFR 438.404(b); 42 CFR 438.402(b)-(c)).
2. The Managed Care Plan shall include an identifying number on each notice of adverse benefit determination in a manner prescribed by the Agency.
3. The Managed Care Plan shall mail the notice of adverse benefit determination as follows:
 - a. For termination, suspension or reduction of previously authorized Medicaid covered services no later than ten (10) days before the adverse benefit determination is to take effect. (42 CFR 438.404(c)(1); 42 CFR 431.211) Certain exceptions apply under 42 CFR 431.213 and 214;
 - b. By the date of the action when any of the following occur:
 - (1) The enrollee has died.
 - (2) The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result.
 - (3) The enrollee has been admitted to an institution where he or she is ineligible under the Managed Care Plan for further services.
 - (4) The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address.
 - (5) The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
 - (6) The enrollee's physician prescribes a change in the level of medical care.
 - (7) The notice involves an adverse benefit determination with regard to PASSR under s.1919(e)(7) of the Social Security Act.
 - (8) The enrollee's nursing facility has made a determination to transfer or discharge the enrollee.

(42 CFR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); s. 1919(e)(7) of the Social Security Act)
 - c. For denial of payment, at the time of any adverse benefit determination affecting the clean claim; (42 CFR 438.404(c)(2))

Section VII. Grievance and Appeal System

- d. For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.

F. Standard Resolution of Plan Appeals

1. The Managed Care Plan shall adhere to the following timeframes for processing plan appeals:
 - a. An enrollee, authorized representative, or legal representative of the estate may file a plan appeal orally or in writing within sixty (60) calendar days from the date on the notice of adverse benefit determination. (42 CFR 438.402(c)(3)(ii); 42 CFR 438.402(c)(1)(ii))
 - b. An enrollee, authorized representative, or legal representative of the estate may follow an oral appeal with a signed, dated, written appeal within ten (10) calendar days of the oral filing, unless the enrollee requests an expedited resolution. However, oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and shall be confirmed in writing by the Managed Care Plan unless the enrollee or his or her authorized representative requests expedited resolution. (42 CFR 438.402(c)(3)(ii); 42 CFR 438.406(b)(3))
 - (1) The date of oral filing shall constitute the date of receipt.
 - (2) The Managed Care Plan shall acknowledge each plan appeal in writing within five (5) business days of receipt of each plan appeal unless the enrollee requests an expedited resolution. (42 CFR 438.406(b)(1); 42 CFR 438.406(a))
 - (3) The Managed Care Plan shall ensure that enrollees who are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal on disenrollment except for the following reasons:
 - (a) Moving out of the region;
 - (b) Loss of Medicaid eligibility;
 - (c) Determination that an enrollee is in an excluded population, as defined in this Contract; or
 - (d) Enrollee death.
 - c. The Managed Care Plan shall continue and pay for the enrollee's benefits during the plan appeal if all of the following occur:
 - (1) The enrollee or the enrollee's authorized representative files the request for a plan appeal timely in accordance with 42 CFR 438.402(c)(2)(ii).
 - (2) The plan appeal involves the termination, suspension or reduction of a previously authorized course of treatment;

Section VII. Grievance and Appeal System

- (3) The services were ordered by an authorized provider;
 - (4) The period covered by the original authorization has not expired at the time the plan appeal was filed; and
 - (5) The enrollee timely files for continuation of benefits.
- d. If, at the enrollee's request, the Managed Care Plan continues or reinstates the benefits while the plan appeal is pending, the benefits must continue until one (1) of the following occurs:
- (1) The enrollee withdraws the plan appeal; or
 - (2) The enrollee fails to request a fair hearing and continuation of benefits within ten (10) calendar days after the Managed Care Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.
- e. The Managed Care Plan shall provide the enrollee a reasonable opportunity to present evidence and testimony and make allegations of fact or law in person as well as in writing. (42 CFR 438.406(b)(4))
- f. If the final resolution of the plan appeal is adverse to the enrollee, the Managed Care Plan may recover the cost of services furnished to the enrollee while the plan appeal was pending to the extent they were furnished solely because of the requirements for continuation of benefits.
- g. For resolution, a plan appeal shall be heard and notice of plan appeal resolution shall be sent to the enrollee no later than thirty (30) calendar days from the date the Managed Care Plan receives the plan appeal.
- h. If the Managed Care Plan fails to adhere to the notice and timing requirements for resolution of the plan appeal, the Managed Care Plan shall give notice on the date that the timeframes expire. In such cases, the enrollee is deemed to have completed the Managed Care Plan's appeals process, and the enrollee may initiate a Medicaid fair hearing. (42 CFR 438.408; 42 CFR 402(c)(1)(i)(A))
- i. The Managed Care Plan shall consider as parties to the plan appeal the enrollee or an authorized representative or, if the enrollee is deceased, the legal representative of the estate. (42 CFR 438.406(b)(6))

G. Extension of Plan Appeal

1. The timeframe for a plan appeal may be extended up to fourteen (14) calendar days if the enrollee asks for an extension, or the Managed Care Plan documents that additional information is needed and the delay is in the enrollee's interest. (42 CFR 438.408(c)(1); 42 CFR 438.408(b)(2))
2. If the timeframe is extended other than at the enrollee's request, the Managed Care Plan must provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay to the

Section VII. Grievance and Appeal System

enrollee within two (2) calendar days of the determination. (42 CFR 438.408(c)(2)(i)-(iii); 42 CFR 438.408(b)(2))

H. Expedited Resolution of Plan Appeals

1. The Managed Care Plan shall have an expedited review process for plan appeals for use when taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain or regain maximum function. (42 CFR 438.410(a))
2. The Managed Care Plan shall resolve each expedited plan appeal and provide notice to the enrollee, as quickly as the enrollee's health condition requires, within State established timeframes not to exceed seventy-two (72) hours after the Managed Care Plan receives the plan appeal request, whether the plan appeal was made orally or in writing. (42 CFR 438.210(d)(2))
3. The Managed Care Plan shall inform the enrollee of the limited time available to present evidence and allegations of fact or law, in the case of expedited plan appeal resolution, and ensure that the enrollee understands any time limits that may apply.
4. If the Managed Care Plan denies the request for expedited plan appeal, it shall immediately transfer the plan appeal to the timeframes for standard resolution and so notify the enrollee. (42 CFR 438.408(b)(2); 42 CFR 438.408(c)(2); 42 CFR 438.410(c))
5. If an enrollee asks for an extension, the Managed Care Plan shall treat the request as a denial for expedited plan appeal, immediately transfer the plan appeal to the timeframe for standard resolution, and so notify the enrollee. Nothing in this Section relieves the plan of its obligation to resolve the enrollee's appeal as expeditiously as the enrollee's health condition requires, in accordance with 42 CFR 438.408(b)(2).
6. In the case of an expedited plan appeal denial, the Managed Care Plan shall also provide oral notice to the enrollee by close of business on the day of resolution, and written notice to the enrollee within two (2) calendar days of the disposition.

I. Notice of Plan Appeal Resolution

1. The Managed Care Plan shall provide the enrollee with a written notice using the notice of plan appeal resolution template provided by the Agency (42 CFR 438.10(c)(4)(ii)).
2. The Managed Care Plan shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the plan appeal.

J. Process for Medicaid Fair Hearings

1. The Managed Care Plan must comply with Rule 59G-1.100, F.A.C., and all terms and conditions set forth in any orders and instructions issued by the Office of Fair Hearing or a hearing officer.
2. An enrollee may request a Medicaid Fair Hearing after completing the Managed Care Plan's appeal process. An enrollee has completed the plan appeal process after receiving

Section VII. Grievance and Appeal System

a notice of plan appeal resolution indicating that the Managed Care Plan is upholding, in whole or in part, the adverse benefit determination or after the Managed Care Plan fails to adhere to the notice and timing requirements applicable to plan appeals. (42 CFR 438.402(c)(1); 42 CFR 438.408)

3. An enrollee, or his or her authorized representative, who has completed the Managed Care Plan's appeal process may file for a Medicaid Fair Hearing in accordance with Rule 59G-1.100, F.A.C.
4. Parties to the Medicaid Fair Hearing include the Managed Care Plan as well as the enrollee, or the enrollee's authorized representative.
5. The Managed Care Plan shall attend fair hearings as scheduled. The Managed Care Plan shall attend hearings with the necessary witnesses and evidentiary materials.
6. The Managed Care Plan shall submit an evidence packet to the Agency and to the enrollee, free of charge, within ten (10) business days from the time the Managed Care Plan receives notification of the hearing and must be submitted to the Agency in accordance with any prehearing instructions. The evidence packet must include all necessary documents including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents/records considered or relied upon by the Managed Care Plan, supporting the Managed Care Plan's adverse benefit determination and plan appeal resolution.
7. Within two (2) business days of notification of the fair hearing request, the Managed Care Plan shall provide the corresponding Notice of Adverse Benefit Determination and the Notice of Plan Appeal Resolution that relate to the fair hearing request to the Agency. (42 CFR 438.228(b))
8. The Managed Care Plan must designate an email address with the Agency for Health Care Administration Office of Fair Hearings for all fair hearing-related communications from the Office and any party to the fair hearing.
9. The Managed Care Plan shall provide transportation to the enrollee and/or, the enrollee's authorized representative upon request and if the enrollee has no other means of transportation to and from the nearest hearing call-in center in accordance with Section V., Enrollee Services, of this Contract and its Exhibits.
10. The Managed Care Plan shall continue the enrollee's benefits while the fair hearing is pending if the enrollee timely files for continuation of benefits within ten (10) calendar days after the Managed Care Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.
11. If, at the enrollee's request, the Managed Care Plan continues or reinstates the benefits while fair hearing is pending, the benefits must continue until one (1) of the following occurs:
 - a. The enrollee withdraws the fair hearing request;

Section VII. Grievance and Appeal System

- b. The enrollee fails to request a fair hearing and continuation of benefits within ten (10) calendar days after the Managed Care Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor; or
 - c. The fair hearing office issues a hearing decision adverse to the enrollee.
12. If the Managed Care Plan's action is sustained by the hearing decision, the Managed Care Plan may recover the cost of services furnished to the enrollee while the plan appeal and fair hearing were pending, to the extent they were furnished solely because of the requirements for continuation of benefits.
13. If the Managed Care Plan's action is reversed by the hearing decision and services were not furnished while the plan appeal was pending, the Managed Care Plan shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Managed Care Plan receives the notice reversing the determination.

K. Appellate Responsibilities

1. Should an enrollee appeal a Medicaid Fair Hearing final order to the appropriate DCA, the Managed Care Plan shall fully participate as a party in the appellate process and shall be responsible for defending both its actions and the Hearing Officer's final order, to the extent that position on appeal is consistent with the rules governing The Florida Bar and Florida law. The Agency may choose whether or not to participate in the appellate proceeding as a party and/or whether to participate in briefing.
2. The Managed Care Plan shall file all appropriate document(s) with the DCA to participate in the appeal as a party and defend both its actions and the Hearing Officer's final order to the extent that position on appeal is consistent with the rules governing The Florida Bar and Florida law.
3. The Managed Care Plan shall bear all costs associated with completing the record and transmitting it to the DCA, including transcribing the audio recording of the Medicaid Fair Hearing proceedings. The Managed Care Plan shall ensure that a copy of the record is provided to all of the following:
 - a. The enrollee, or enrollee's authorized representative;
 - b. The enrollee's attorney, if applicable; and
 - c. The Agency's Appellate Section.
4. The Managed Care Plan shall contact the Agency's Appellate Section to coordinate the appeal within five (5) business days after receipt of notification that an appeal of a Medicaid Fair Hearing has been filed with the DCA.
5. The Managed Care Plan shall provide the Agency's Appellate Section with a copy of its draft brief(s) for review no later than ten (10) business days in advance of the filing deadline(s) set by the DCA.

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Section VIII. Provider Services

A. Network Adequacy Standards

1. General Provisions

- a. The Managed Care Plan shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements in Section VIII., Provider Services of this Contract. The Managed Care Plan shall submit model provider agreement templates to the Agency for review as specified in Section VIII., Provider Services.
- b. Pursuant to s. 409.967(2)(c)(1), F.S., the Managed Care Plan shall maintain a region-wide network of providers in sufficient numbers to meet the network capacity and geographic access standards for services with respect to the applicable SMMC program.
- c. The Agency shall be responsible for establishing standards and requirements for provider networks, reviewing Managed Care Plan's provider networks and monitoring such Managed Care Plans to ensure provider networks are capable of meeting the needs of their enrollees and are sufficient to serve the number of enrollees in the Managed Care Plan in accordance with this Contract and its Exhibits.
- d. The Managed Care Plan shall enter into provider agreements with a sufficient number of providers to provide all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided to the enrollee with reasonable promptness (within the meaning of that term as set forth in 42 U.S.C. §1396a(a)(8)). (42 CFR 438.3(q)(1) and(3)) The Managed Care Plan shall take any and all necessary action to ensure that all medically necessary covered services are provided to enrollees with reasonable promptness, including but not limited to the following:
 - (1) Utilizing out-of-network providers (42 CFR 438.206(b)(4)); and
 - (2) Using financial incentives to induce network or out-of-network providers to accept an enrollee as a patient/client and provide all medically necessary covered services with reasonable promptness.
- e. The Managed Care Plan shall develop and maintain a provider network as required by this Contract and in accordance with 42 CFR 438.68(c).
- f. The Agency reserves the right to change Provider Qualifications and Minimum Network Adequacy Requirements.
- g. The Managed Care Plan shall perform ongoing monitoring activities, including Agency-prescribed secret shopper activities.
- h. The Managed Care Plan shall allow each enrollee to choose among participating providers in accordance with 42 CFR 431.51.
- i. The Managed Care Plan shall require non-participating providers to coordinate with

Section VIII. Provider Services

respect to payment and must ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network. (42 CFR 438.206(b)(5))

- j. Managed Care Plans must maintain sufficient Indian Health Care Providers (IHCPs) in the network to ensure timely access to services available under the Contract for Indian enrollees who are eligible to receive services from such providers, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR 438.14(b), and must permit out-of-network or out-of-state IHCPs to provide covered services and make referrals to network providers for Indian enrollees.

2. Network Capacity and Geographic Access Standards

- a. The Managed Care Plan shall have sufficient facilities, service locations, and practitioners to provide the covered services as required by this Contract.
- b. The Managed Care Plan shall have the provider capacity to provide covered services to all enrollees, by region, as indicated in this Contract.

3. Demonstration of Network Adequacy

The Managed Care Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) on a weekly basis and at any time upon request of the Agency with sufficient evidence that the Managed Care Plan has the capacity to provide covered services to all enrollees up to the maximum enrollment level, including evidence that the Managed Care Plan, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. (42 CFR 438.207(b)(1))

- a. Maintains a region-wide network of providers offering an appropriate range of services in sufficient numbers to meet the access standards established by the Agency, pursuant to s. 409.967(2)(c)(1), F.S.; and
- b. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients as specified in s. 1932(b)(5) of the Social Security Act, as enacted by s. 4704(a) of the Balanced Budget Act of 1997.

4. Timely Access Standards

- a. The Managed Care Plan shall contract with and maintain a provider network sufficient to comply with timely access standards as specified in this Contract and the applicable Exhibit(s).
- b. In accordance with 42 CFR 438.206(c)(1), the Managed Care Plan shall establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply.

5. Waiver

- a. If the Managed Care Plan is unable to demonstrate network adequacy for either timely or geographic access standards, the Managed Care Plan may submit a waiver request

Section VIII. Provider Services

for review and approval by the Agency. The Managed Care Plan shall augment its network as such providers become available in order to meet the network adequacy requirements.

- b. The Managed Care Plan may submit a waiver request in a manner and format approved by the Agency.
- c. Nothing in this Section relieves the plan of its obligation to provide adequate and timely access to medically necessary services for its enrollees with reasonable promptness.

B. Network Management

1. General Provisions

The Managed Care Plan shall develop and maintain procedures to evaluate the Managed Care Plan's provider network to ensure that covered services are available and accessible, at a minimum, in accordance with the access standards in this Contract. (42 CFR 438.207(b); 42 CFR 438.206)

2. Annual Network Development Plan

- a. The Managed Care Plan shall develop and maintain an annual network development plan. The Managed Care Plan shall submit this plan by September 1 of each Contract year, to the Agency.
- b. The Managed Care Plan's annual network development plan shall include:
 - (1) The Managed Care Plan's processes and methods to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.
 - (2) The Managed Care Plan's annual network development plan must include a description of network design by region and county for each population served by the Managed Care Plan.
- c. The Managed Care Plan's annual network development plan must include a description or explanation of the current status of the network by each covered service at all levels, including:
 - (1) Immediate short-term interventions to address network gaps, including the process for enrollees to access services;
 - (2) Long-term interventions to resolve network gaps and an evaluation of the effectiveness of those interventions to resolve network gaps and barriers;
 - (3) Method for accessing a non-participating provider to address any potential gaps, including a description of the Managed Care Plan's provider outreach strategy;
 - (4) The extent to which the Managed Care Plan utilizes telemedicine services to resolve network gaps;

Section VIII. Provider Services

- (5) Ongoing activities for network development, including network management functions delegated to subcontractors.
- d. The Managed Care Plan's annual network development plan must include an organizational flowchart that outlines relationships between internal departments, including all committees and committee membership, by department/area, where this coordination occurs.
- e. The Managed Care Plan's annual network development plan shall include the results of "secret shopper" activities, including those prescribed by the Agency, and how those results are used to monitor and maintain the provider network.
- f. The Managed Care Plan's annual network development plan shall include a description of coordination with provider associations and other outside organizations.
- g. The Managed Care Plan's annual network development plan shall include a description of the overall monitoring strategy of subcontractors delegated for network management functions, including how those monitoring results are used to ensure continuous oversight across all provider network functions between the Managed Care Plan and its subcontractors.
- h. The Managed Care Plan's annual network development plan shall include a description of the evaluation of the prior year's plan including an explanation of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation.

3. Regional Network Changes

- a. The Managed Care Plan shall have procedures to address changes in the Managed Care Plan network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network.
- b. The Managed Care Plan shall provide the Agency with documentation of compliance with access requirements at any time there has been a significant change in the Managed Care Plan's regional network that would affect adequate capacity and services.
- c. The Managed Care Plan shall notify the Agency within seven (7) business days of any adverse changes to its regional provider network, as follows:
 - (1) Any change that would cause more than five percent (5%) of enrollees in the region to change the location where services are received or rendered; or
 - (2) As defined in the Exhibits.

C. Provider Credentialing and Contracting

1. General Provisions

- a. The Managed Care Plan shall be responsible for the credentialing and recredentialing

Section VIII. Provider Services

of its provider network.

- b. If the Managed Care Plan has delegated credentialing and/or recredentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Managed Care Plan's and the Agency's credentialing requirements as found in Section VIII.C., Provider Credentialing and Contracting.
- c. The Managed Care Plan may be required to contract with an SMMC single credentialing vendor, managed by the Agency.

2. Credentialing and Recredentialing

- a. The Managed Care Plan shall ensure that all providers are eligible for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements. (42 CFR 455.100-106; 42 CFR 455.400-470)
- b. The Managed Care Plan shall ensure all providers have a current provider agreement with Agency, as prescribed by the Agency.
- c. The Managed Care Plan shall require each provider to have a NPI in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The provider agreement shall require providers to submit all NPI numbers to the Managed Care Plan. The Managed Care Plan shall file the providers' NPI numbers as part of its provider network file to the Agency or its agent, as set forth in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. The Managed Care Plan need not obtain an NPI from an entity that does not meet the definition of "health care provider" found at 45 CFR 160.103.
- d. The Managed Care Plan shall deem providers with a valid Limited Enrolled or Fully Enrolled agreement with the Agency as having met all requirements described below:
 - (1) Proof of each provider's current license or authority to do business, including documentation of provider qualifications, as specified in the service-specific policy; if the provider is located in Georgia or Alabama, the provider's license and permit must be current and applicable to the respective state in which the provider is located;
 - (2) No revocation, moratorium, or suspension of the provider's license by the licensing authority in this or any state, if applicable;
 - (3) No sanctions imposed on the provider by Medicare or Medicaid, without proof of reinstatement or other documentation that all obligations under the sanction have been met;
 - (4) Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106); and
 - (5) A level II background check pursuant to s. 409.907, F.S.
- e. In order to receive payment for covered services, non-participating providers must have a Medicaid provider identification number in the FMMIS.

Section VIII. Provider Services

- f. The Managed Care Plan may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of the one hundred twenty (120)- day period without enrollment of the provider, and notify affected enrollees. [42 CFR 438.602(b)(2)]
- g. The Managed Care Plan is authorized to recoup any payments made under this Contract if the provider does not successfully complete the credentialing process within one hundred twenty (120) days and the delay is not caused by the Managed Care Plan.
- h. The Managed Care Plan's credentialing and recredentialing procedures shall be in writing and include the following:
 - (1) Formal delegations and approvals of the credentialing process;
 - (2) A designated credentialing committee;
 - (3) Identification of providers who fall under its scope of authority;
 - (4) A process that provides for the verification of the credentialing and recredentialing criteria required under this Contract;
 - (5) Approval of new providers and imposition of sanctions, termination, suspension, and restrictions on existing providers;
 - (6) Identification of quality deficiencies that result in the Managed Care Plan's restriction, suspension, termination, or sanctioning of a provider.
- i. The Managed Care Plan shall establish and verify additional provider credentialing and recredentialing criteria with respect to the applicable SMMC program in accordance with the applicable Exhibit(s).
- j. If a provider is currently suspended or terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. Suspension and termination are described further in Rule 59G-9.070, F.A.C.
- k. The Managed Care Plan shall submit provider disclosures and notifications to the federal DHHS OIG and to MPI in accordance with s. 1128, s. 1156, and s. 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in Section X.E.6., Reporting and Disclosure Requirements.
- l. The Managed Care Plan shall report suspected unlicensed ALF's and AFCH's to the Agency, and shall require its providers to do the same pursuant to 408.812 F.S.

Section VIII. Provider Services

- m. Managed Care Plan credentialing and recredentialing processes must include verification of the following additional requirements for transportation providers and shall ensure all transportation providers:
- (1) Comply with standards set forth in Chapter 427, F.S., and Rules 41-2 and 14-90, F.A.C. These standards include drug and alcohol testing, safety standards, driver accountability, and driver conduct;
 - (2) Maintain vehicles and equipment in accordance with State and federal safety standards and the manufacturers' mechanical operating and maintenance standards for any and all vehicles used for transportation of Medicaid recipients;
 - (3) Comply with applicable State and federal laws, including but not limited to the ADA and the FTA regulations;
 - (4) Immediately remove from service any vehicle that does not meet the Florida Department of Highway Safety and Motor Vehicles licensing requirements, safety standards, ADA regulations, or Contract requirements and re-inspect the vehicle before it is eligible to provide transportation services for Medicaid enrollees under this Contract. Vehicles shall not carry more passengers than the vehicle was designed to carry. All lift-equipped vehicles must comply with ADA regulations;
 - (5) Maintain sufficient liability insurance to meet requirements of Florida law.
 - (6) Ensure adequate seating for paratransit services for each enrollee and escort, child, or personal care attendant, and shall ensure that the vehicle meets the following requirements and does not transport more passengers than the registered passenger seating capacity in a vehicle at any time:
 - (a) Enrollee property that can be carried by the passenger and/or driver, and can be stowed safely on the vehicle, shall be transported with the passenger at no additional charge. The driver shall provide transportation of wheelchairs, child seats, stretchers, secured oxygen, personal assistive devices, and/or intravenous devices, as applicable, within the capabilities of the vehicle.
 - (b) Each vehicle shall have posted inside the Managed Care Plan's toll-free telephone number for enrollee complaints.
 - (c) The interior of all vehicles shall be free from dirt, grime, oil, trash, torn upholstery, damaged or broken seats, protruding metal, or other objects or materials which could soil items placed in the vehicle or cause discomfort to enrollees.
 - (d) Smoking, eating and drinking are prohibited in any vehicle, except in cases in which, as a medical necessity, the enrollee requires fluids or sustenance during transport.

Section VIII. Provider Services

- (e) All vehicles must be equipped with two-way communications, in good working order and audible to the driver at all times, by which to communicate with the transportation services hub or base of operations.
 - (f) All vehicles must have working air conditioners and heaters.
- (7) Comply with the minimum liability insurance requirement of **\$200,000** per person and **\$300,000** per incident for all transportation services purchased or provided for the transportation disadvantaged through the Managed Care Plan. (s. 768.28(5), F.S.) The Managed Care Plan shall indemnify and hold harmless the local, State, and federal governments and their entities and the Agency from any liabilities arising out of or due to an accident or negligence on the part of the Managed Care Plan and/or all transportation providers under contract to the Managed Care Plan.
- (8) Maintain a passenger/trip database that includes information for each enrollee it transports.
- (9) Develop and implement written procedures for the following:
- (a) Determining eligibility for each enrollee and what type of transportation to provide that enrollee;
 - (b) Issuing service authorization to enrollees requesting transportation services;
 - (c) Determining how the Managed Care Plan will provide transportation services outside its region, when medically necessary; and
 - (d) Providing the enrollee with boarding assistance, if necessary or requested, to the seating portion of the vehicle, including but not be limited to: opening the vehicle door, fastening the seat belt or wheelchair securing devices, storing mobility assistive devices, and closing the vehicle door. In the door-through-door paratransit service category, the driver shall open and close doors to buildings, except in situations in which assistance in opening and/or closing building doors would not be safe for passengers remaining in the vehicle. The driver shall provide assisted access in a dignified manner.
- (10) Provide shelter, security, and safety of enrollees at vehicle transfer points.
- (11) Establish 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.
- (12) Comply with Agency-prescribed pick-up windows to enrollees and transportation providers.

Section VIII. Provider Services

- (13) Provide pick up from and return to a mutually agreed-upon location for the enrollee and associated attendant/escort.
- n. The Managed Care Plan shall ensure that all vehicles used for transportation services have received annual safety inspections, and all drivers providing transportation services have passed background checks and meet all qualifications specified in law and in rule.
- o. The Managed Care Plan shall report to the Agency on transportation timeliness, in a manner and format prescribed by the Agency.

3. Minority Recruitment and Retention Plan

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

4. Prohibition Against Discriminatory Practices

- a. The Managed Care Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of the provider's license or certification under applicable State law. (42 CFR 438.12(a)(1))
- b. The Managed Care Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. (42 CFR 438.12(a)(2); 42 CFR 438.214(c))

5. Provider Agreement Requirements

- a. The Managed Care Plan shall submit all provider agreement templates for Agency review to determine compliance with Contract requirements. The Managed Care Plan shall submit to the Agency, upon request, individual provider agreements as required by the Agency. If the Agency determines, at any time, that a provider agreement is not in compliance with a Contract requirement, the Managed Care Plan shall promptly revise the provider agreement to bring it into compliance. In addition, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, and/or liquidated damages pursuant to Section XIV., Liquidated Damages.
- b. The Managed Care Plan shall ensure all provider agreements comply with Chapter 641.315, F.S., 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.
- c. All provider agreements and amendments executed by the Managed Care Plan shall be in writing, signed, and dated by the Managed Care Plan and the provider, and shall meet the following requirements:
 - (1) Not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient regarding:

Section VIII. Provider Services

- (a) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - (b) Any information the enrollee needs to decide among all relevant treatment options.
 - (c) The risks, benefits, and consequences of treatment or non-treatment.
 - (d) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (42 CFR 438.102(a)(1));
- (2) Not prohibit a provider from advocating on behalf of the enrollee in any part of the grievance and appeal system or UM process, or individual authorization process to obtain necessary services; (42 CFR 438.402(c)(1)(i)-(ii); 42 CFR 438.408)
 - (3) Require providers to offer hours of operation that are no less than the hours of operation offered to commercial Managed Care Plan members or comparable Medicaid FFS recipients if the provider serves only Medicaid recipients (42 CFR 438.206(c)(1));
 - (4) Require providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with special health care needs, including physical or mental disabilities in accordance with 42 CFR 438.206(c)(3);
 - (5) Specify covered services, including applicable prior authorization requirements, acceptable billing codes, and populations to be served under the provider agreement;
 - (6) Require providers to immediately notify the Managed Care Plan of an enrollee's pregnancy, including the mechanism of doing so, whether identified through medical history, examination, testing, claims, or otherwise;
 - (7) Require providers to meet timely access standards pursuant to this Contract;
 - (8) Require all direct service providers to complete abuse, neglect, and exploitation training, including training to identify victims of human trafficking;
 - (9) Include provisions for the provider to ensure immediate transfer to another provider if the enrollee's health or safety is in jeopardy;
 - (10) Require providers of transitioning enrollees to cooperate in all respects with providers of other Managed Care Plans to assure maximum health outcomes for enrollees;
 - (11) Provide for continuity of care for the course of treatment in the event a provider agreement terminates during the course of an enrollee's treatment;

Section VIII. Provider Services

- (12) Require the provider to look solely to the Managed Care Plan for compensation for services rendered, with the exception of cost sharing and patient responsibility (if applicable);
- (13) Establish requirements for ICP, Hospice, and ALFs regarding collection of patient responsibility, including prohibiting the assessment of late fees;
- (14) Require the provider to participate with the Managed Care Plan's peer review, grievance, QI and UM activities, as directed by the Managed Care Plan;
- (15) Include the monitoring and oversight activities the plan will follow, including monitoring of services rendered to enrollees, by the Managed Care Plan;
- (16) Identify the measures, metrics, and frequency of measurement that shall be used by the Managed Care Plan to monitor the quality and performance of the provider;
- (17) Require that any marketing materials related to this Contract that are displayed by the provider be submitted to the Agency for written approval before use;
- (18) Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Managed Care Plan's enrollees;
- (19) Require that records be maintained for a period not less than ten (10) years from the close of this Contract, and retained further if the records are under review or audit until the review or audit is complete. (42 CFR 438.3(u)) Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the provider agreement is continuous;
- (20) Require providers to cooperate fully with the Agency (or its designee), CMS, the OIG, the Comptroller General, and Attorney General's Office for the inspection, evaluation, and auditing of any records or documents (medical or financial) of the Managed Care Plan or its subcontractors at any time, related to this Contract (42 CFR 438.3(h));
- (21) Require providers to cooperate fully in any investigation by the Agency, MPI, MFCU or other State or federal entity and in any subsequent legal action that may result from such an investigation involving this Contract;
- (22) Include the specific reports and clinical information required by the Managed Care Plan for QI or other administrative purposes out of claims processing;
- (23) Require providers to submit timely, complete, and accurate claims to the Managed Care Plan in accordance with the requirements of Section X.D., Information Management and Systems, at a minimum;
- (24) Require compliance with the background screening requirements of this Contract;

Section VIII. Provider Services

- (25) Require compliance with HIPAA privacy and security provisions (42 CFR 438.224);
- (26) Require providers to submit notice of withdrawal from the network at least ninety (90) days before the effective date of such withdrawal;
- (27) Specify that any provider whose participation is terminated pursuant to the provider agreement for any reason shall utilize the applicable appeals procedures outlined in the provider agreement. No additional or separate right of appeal to the Agency or the Managed Care Plan is created as a result of the Managed Care Plan's act of terminating, or decision to terminate, any provider under this Contract.
- (28) Require an exculpatory clause, which survives provider agreement termination, including breach of provider agreement due to insolvency, which assures that neither Medicaid enrollees nor the Agency shall be held liable for any debts of the provider;
- (29) Require that the provider secure and maintain during the life of the provider agreement workers' compensation insurance (complying with the Florida workers' compensation law) for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Managed Care Plan;
- (30) Require all providers to notify the Managed Care Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida Statutes;
- (31) Contain a clause indemnifying, defending, and holding the Agency and the Managed Care Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the provider agreement. This clause must survive the termination of the provider agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Managed Care Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers shall be approved in writing by the Agency;
- (32) Specify the process for a network provider to report to the Managed Care Plan when the network provider has received an overpayment, to return the overpayment to the Managed Care Plan within sixty (60) days after the date on which the overpayment was identified, and to notify the Managed Care Plan in writing of the reason for the overpayment; (42 CFR 438.608(d)(2));
- (33) Specify that any contracts or agreements entered into by the provider for purposes of carrying out any aspect of this Contract shall include assurances that the individuals who are signing this Contract or agreement are so authorized and that it includes all the requirements of this Contract; and

Section VIII. Provider Services

- (34) If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount, less any applicable copayments.
- d. No provider agreement that the Managed Care Plan enters into with respect to performance under this Contract shall in any way relieve the Managed Care Plan of any responsibility for the provision of services or duties under this Contract. The Managed Care Plan shall assure that all services and tasks related to the provider agreement are performed in accordance with the terms of this Contract. The Managed Care Plan shall identify in its provider agreement any aspect of service that may be delegated by the provider.
 - e. The Managed Care Plan may execute provider agreements pending the outcome of the provider enrollment process. The Managed Care Plan must terminate a network provider immediately upon notification from the Agency that the network provider cannot be enrolled, or upon expiration of the one hundred twenty (120) day period without enrollment of the provider, and notify affected enrollees in accordance with 42 CFR 438.602(b)(2).

6. Network Performance Management

- a. The Managed Care Plan shall monitor the quality and performance of each participating provider.
- b. The Managed Care Plan shall monitor participating providers on performance measures specified and collected by the Agency, as well as additional measures agreed upon by the provider and the Managed Care Plan as documented in the provider agreement.
- c. Except as otherwise provided in this Contract, the Managed Care Plan may limit the providers in its network based on credentials, quality indicators, and price.
- d. The Managed Care Plan shall have procedures for imposing provider sanctions, restrictions, suspensions and/or terminations.
- e. The Managed Care Plan shall develop and implement an appeal procedure for providers against whom the Managed Care Plan has imposed sanctions, restrictions, suspensions and/or terminations.

7. Provider Termination and Continuity of Care

- a. The Managed Care Plan shall comply with all State and federal laws regarding provider termination.
- b. The Managed Care Plan shall not pay, employ, or contract with individuals on the State or federal exclusions lists.
- c. The Managed Care Plan shall notify the provider and enrollees that received services from the provider within the past six months, at least sixty (60) days before the effective date of the suspension or termination of a provider from the network. If the termination

Section VIII. Provider Services

was for "cause," the Managed Care Plan shall provide to the Agency the reasons for termination.

- d. If an enrollee is receiving care from any provider who becomes unavailable to continue to provide services, the Managed Care Plan shall notify the enrollee in writing within ten (10) days from the date the Managed Care Plan becomes aware of such unavailability. The requirements to provide notice prior to the effective dates of termination shall be waived in instances where a provider becomes physically unable to care for enrollees due to illness, death, or leaving the Managed Care Plan's region(s) and fails to notify the Managed Care Plan, or when a provider fails credentialing. Under these circumstances, notice shall be issued immediately upon the Managed Care Plan's becoming aware of the circumstances.
- e. The Managed Care Plan shall provide immediate notice to the provider, the enrollee, and the Agency in a case in which an enrollee's health is subject to imminent danger or a provider's ability to practice medicine or otherwise provide services is effectively impaired by an action by the Board of Medicine or other governmental agency. The Managed Care Plan shall develop and implement a plan for transitioning enrollees to another provider.
- f. The Managed Care Plan shall allow enrollees to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the enrollees select another provider, for a minimum of sixty (60) days after the termination of the provider's Contract. Notwithstanding the provisions in this Section, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.
- g. For continuity of care under this Section, the Managed Care Plan and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated Contract.
- h. The Managed Care Plan shall report provider terminations, suspensions, and denials, including documentation of enrollee notification and additions as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

D. Provider Services

1. General Provisions

- a. The Managed Care Plan shall establish and maintain a formal provider relations function to respond timely and adequately to inquiries, questions, and concerns from participating providers.
- b. The Managed Care Plan shall provide sufficient information and procedural guidelines to all providers in order to operate in full compliance with this Contract and all applicable federal and State laws and regulations.
- c. The Managed Care Plan shall monitor provider compliance with Contract requirements and take Contract action when needed to ensure compliance.

2. Provider Handbook and Bulletin Requirements

Section VIII. Provider Services

- a. The Managed Care Plan shall issue a provider handbook to all providers at the time provider credentialing is complete.
- b. The Managed Care Plan may choose to distribute the provider handbook from the Managed Care Plan's website. This notification shall detail how to obtain the handbook from the Managed Care Plan's website and how the provider can request a hard copy from the Managed Care Plan at no charge.
- c. The Managed Care Plan shall keep all provider handbooks and bulletins up to date and in compliance with State and federal laws. The provider handbook shall serve as a source of information regarding Managed Care Plan covered services, procedures, statutes, regulations, telephone access, and special requirements, to ensure all Contract requirements are met.
- d. The Managed Care Plan's provider handbook shall include, at a minimum, the following information:
 - (1) Description of the Medicaid program and the SMMC program;
 - (2) Emergency service responsibilities;
 - (3) Provider responsibilities;
 - (4) Requirements regarding background screening;
 - (5) Requirements regarding the recredentialing process;
 - (6) Description of where to obtain service-specific coverage requirements and medical necessity criteria;
 - (7) Description of how to obtain prior authorization and referral procedures, including required forms;
 - (8) Information on the Managed Care Plan's QE programs;
 - (9) Enrollee record standards for providers;
 - (10) Description of where to obtain claims submission protocols and standards, including instructions and all information required for a clean or complete claim;
 - (11) Protocols for submitting claims data;
 - (12) Requirements regarding marketing activities and marketing prohibitions;
 - (13) Procedures that address the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Managed Care Plan to file a provider complaint, including complaints about claims issues, and the complaint review process;
 - (14) Information on identifying and reporting abuse, neglect, and exploitation of

Section VIII. Provider Services

enrollees, including information on identifying victims of human trafficking;

- (15) Enrollee rights and responsibilities (42 CFR 438.100); and
 - (16) Required procedural steps in the Managed Care Plan's enrollee grievance process, including the address, telephone number, and office hours of the grievance staff; the enrollee's right to request continuation of benefits while utilizing the grievance and appeal system in accordance with 42 CFR 438.414; and information about the SAP. The Managed Care Plan shall specify telephone numbers to call to present a complaint, grievance, or appeal on behalf of an enrollee. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the Managed Care Plan without undue delays.
- e. The Managed Care Plan shall disseminate bulletins as needed to incorporate any needed changes to the provider handbook.

3. Provider Education and Training

- a. The Managed Care Plan shall make available training to all providers and their staff regarding the requirements of this Contract, including any Contract amendments and special needs of enrollees.
- b. The Managed Care Plan shall conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. The Managed Care Plan also shall conduct ongoing training, as deemed necessary by the Managed Care Plan or the Agency, in order to ensure compliance with this Contract.
- c. For a period of at least twelve (12) months following the implementation of this Contract, the Managed Care Plan shall conduct monthly education and training for the top five (5) specific provider types identified by the Managed Care Plan through its monitoring and QI processes, and claims submission and payment processes, which shall include, but not be limited to, an explanation of common claims submission errors and how to avoid those errors. Such period may be extended as determined necessary by the Agency.
- d. The Managed Care Plan shall ensure all participating and direct service providers required to report abuse, neglect, or exploitation of vulnerable adults under s. 415.1034, F.S., obtain training on these subjects.

4. Toll-Free Provider Help Line

- a. The Managed Care Plan shall operate a toll-free telephone help line to respond to provider questions, comments, and inquiries.
- b. The Managed Care Plan shall develop provider help line procedures that address personnel hiring and training, staffing ratios, hours of operation, response standards, monitoring of calls via recording or other means, and compliance with additional Managed Care Plan standards.
- c. The provider help line must be staffed twenty-four hours a day, seven days a week

Section VIII. Provider Services

(24/7) to respond to prior authorization requests.

- d. This provider help line shall have staff to respond to provider questions in all other areas, including but not limited to the provider complaint system and provider responsibilities, between the hours of 8 a.m. and 7 p.m. in the provider's time zone, Monday through Friday, excluding State holidays. The Managed Care Plan shall ensure that, after regular business hours, the provider help line (not the prior authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for an enrollee with an emergency or urgent medical condition. This requirement shall not be construed to mean that the provider must obtain verification before providing emergency services and care.
- e. The Managed Care Plan's (or its subcontractor's) call center systems shall have the capability to track call management metrics and shall ensure that the following metrics comply with the corresponding performance metric, including:
 - (1) The ASA shall not exceed thirty (30) seconds.
 - (2) The call blockage rate for direct calls to the Managed Care Plan shall not exceed one-half of one percent (0.5%).
 - (3) The average call abandonment rate for direct calls to the Managed Care Plan shall not exceed three percent (3%). A system, which places calls in queue, may be used but the average wait time in the queue shall not exceed sixty (60) seconds.

5. Provider Complaint System

The Managed Care Plan shall establish and maintain a provider complaint system that permits a provider to dispute the Managed Care Plan's policies, procedures, or any aspect of a Managed Care Plan's administrative functions, including proposed actions, claims/billing disputes, and service authorizations.

- a. As a part of the provider complaint system, the Managed Care Plan shall:
 - (1) Have dedicated staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems;
 - (2) Identify staff specifically designated to receive and process provider complaints;
 - (3) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider agreement provisions, collecting all pertinent facts from all parties and applying the Managed Care Plan's written procedures; and
 - (4) Ensure that Managed Care Plan executives with the authority to require corrective action are involved in the provider complaint process.
- b. The Managed Care Plan's process for provider complaints concerning claims issues

Section VIII. Provider Services

shall be in accordance with s. 641.3155, F.S.

- c. For provider complaints concerning non-claims issues, the Managed Care Plan shall:
 - (1) Allow providers forty-five (45) days from the date the issue occurred to file a written complaint for issues that are not about claims;
 - (2) Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
 - (3) Document why a complaint is unresolved after fifteen (15) days of receipt and provide written notice of the status to the provider every fifteen (15) days thereafter; and
 - (4) Resolve all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

- d. For provider complaints concerning claims issues, the Managed Care Plan shall:
 - (1) Allow providers ninety (90) days from the date of final determination of the primary payer to file a written complaint for claims issues;
 - (2) Within three (3) business days of receipt of a claim complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
 - (3) Within fifteen (15) days of receipt of a claim complaint, provide written notice of the status of the complaint to the Agency and provider. For claims issues that require additional time to research, the Managed Care Plan must submit a written request to the Agency within three (3) business days of receipt of the complaint, and shall include:
 - (a) An explanation for the need of an extension; and
 - (b) Expected time needed beyond the fifteen (15) days for research and response.

Approval of extension is contingent upon Agency review.

The Managed Care Plan must provide written notice of the status to the provider every fifteen (15) days thereafter; and
 - (4) In accordance with s. 641.3155, F.S., resolve all claims complaints within sixty (60) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

- e. The Managed Care Plan shall utilize with the Agency's contracted dispute resolution vendor, as described in s. 408.7057, F.S., for managing, addressing, and resolving

Section VIII. Provider Services

provider complaints related to claims issues. The process shall be in compliance with s. 641.3155, F.S.

- f. The Managed Care Plan shall also distribute the provider complaint system procedures, including claims issues, to non-participating providers upon request. The Managed Care Plan may distribute a summary of these procedures, if the summary includes information about how the provider may access the full procedures on the Managed Care Plan's website. This summary shall also detail how the provider can request a hard copy from the Managed Care Plan at no charge.
- g. The Managed Care Plan is prohibited from discriminating or taking punitive action against a provider for making a complaint to the Agency in good faith.
- h. The Managed Care Plan shall report provider complaints as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

E. Claims and Provider Payment

1. General Provisions

- a. The Managed Care Plan shall process claims and pay providers in compliance with the federal and State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent. (s. 409.967(2)(j), F.S.)
- b. The Managed Care Plan shall have claims payment performance metrics, including those for quality, accuracy, and timeliness. The Managed Care Plan shall also include a process for measurement and monitoring, and for the development and implementation of interventions for improvement in regards to claims processing and claims payment. The Managed Care Plan shall make documentation of such metrics available for Agency review upon request.
- c. The Managed Care Plan shall use electronic transmission of claims, transactions, notices, documents, forms, and payments to the greatest extent possible by the Managed Care Plan.
- d. Pursuant to s. 409.967(2)(m), F.S., the Managed Care Plan must provide an itemized accounting of the individual claims included in the payment to a provider, including the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Managed Care Plan.
- e. The Managed Care Plan shall not reimburse for claims for nursing facility services provided prior to the date of completion of PASRR requirements.
- f. The Managed Care Plan shall pay nursing facility providers in compliance with 42 CFR 488.417, and enforce any denial of payment for new admissions issued by CMS and as provided by the Agency.
- g. The Managed Care Plan shall pay Medicare co-insurance and deductibles for covered services in accordance with Rule 59G-1.052, F.A.C.
- h. The Managed Care Plan shall not deny Medicare crossover claims solely based on

Section VIII. Provider Services

- the period between the date of service and the date of clean claim submission, unless that period exceeds three (3) years.
- i. The Managed Care Plan shall not pay for the following:
 - (1) Home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in Section 1861(o)(7) of the Social Security Act;
 - (2) Items or services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend payments; (42 CFR 438.608(a)(8); 42 CFR 455.23);
 - (3) Any expenditures related to items or services for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (Section 1903(i) of the Social Security Act) and
 - (4) Items or services furnished by a provider during a period where the Agency has determined there is reliable evidence of circumstances giving rise to the need for a withholding of payments, which involves, fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. (s. 409.913(25)(a), F.S.)
 - j. The Managed Care Plan shall not pay for prescriptions, including refills, written by individuals that have had their Medicaid prescribing rights suspended by the Agency, as identified by the Agency.
 - k. The Managed Care Plan shall incorporate into its claim processing and claims payment system the NCCI editing programs for the HCPCS/CPT codes to promote correct coding and control coding errors, except for allowable NCCI edits exclusions in accordance with the claims processing requirements of 42 CFR 433.116 and 45 CFR 95, subpart F.
 - l. The Managed Care Plan shall submit an aging claims summary as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.
 - m. For dually eligible enrollees residing in a nursing facility and receiving hospice services, the Managed Care Plan shall not pay for hospice services and shall pay for hospice room and board.
 - n. The Agency shall ensure that no payment is made to a provider other than by the Managed Care Plan for services available under this Contract, except when these payments are specifically provided for in Title XIX of the Social Security Act, in 42 CFR Chapter IV, or when the Agency has adjusted the capitation rates paid under this Contract to make payments for graduate medical education. (42 CFR 438.60)
 - o. In the event the Agency establishes systems and processes to collect submitted claims data, including denied claims, from the providers directly, the Managed Care Plan must be capable of sending and receiving any claims information directly to the Agency in

Section VIII. Provider Services

standards and timeframes specified by the Agency within sixty (60) days' notice. The Managed Care Plan shall also work cooperatively with the Agency during any transition period for network providers to move to submitting claims through the State instead of directly to the Managed Care Plan.

2. Timely Claims Payment

For claims for services:

a. For all electronically submitted claims for services, the Managed Care Plan shall:

- (1) Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.
- (2) Pursuant to s. 409.982(5), F.S., within ten (10) business days of receipt of nursing facility and hospice clean claims, pay or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
- (3) Within fifteen (15) days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of denial reasons or codes and additional information or documents necessary to process the claim.
- (4) Pay or deny the claim within ninety (90) days after receipt of the non-nursing-facility/non-hospice claim. Failure to pay or deny the claim within one hundred twenty (120) days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim. (s. 641.3155(3)(e), F.S.)

b. For all non-electronically submitted claims for services, the Managed Care Plan shall:

- (1) Within fifteen (15) days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.
- (2) Within twenty (20) days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
- (3) Pay or deny the claim within one hundred twenty (120) days after receipt of the claim. Failure to pay or deny the claim within one hundred forty (140) days after receipt of the claim creates an uncontestable obligation for the Managed Care Plan to pay the claim.

c. The Managed Care Plan shall comply with the following standards regarding timely claims processing for all providers:

Section VIII. Provider Services

- (1) The Managed Care Plan shall pay fifty percent (50%) of all clean claims submitted within seven (7) days.
 - (2) The Managed Care Plan shall pay seventy percent (70%) of all clean claims submitted within ten (10) days.
 - (3) The Managed Care Plan shall pay ninety percent (90%) of all clean claims submitted within twenty (20) days.
- d. The Managed Care Plan shall reimburse providers for the delivery of authorized services as described in s. 641.3155, F.S., including but not limited to:
- (1) The provider must mail or electronically transfer (submit) the claim to the Managed Care Plan within six (6) months after:
 - (a) The date of service or discharge from an inpatient setting; or
 - (b) The date that the non-participating provider was furnished with the correct name and address of the Managed Care Plan, if applicable.
 - (2) When the Managed Care Plan is the secondary payer and the primary payer is an entity other than Medicare, the Managed Care Plan shall require the provider to submit the claim to the Managed Care Plan within ninety (90) days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook. When the Managed Care Plan is the secondary payer and the primary payer is Medicare, the Managed Care Plan shall require the provider to submit the claim to the Managed Care Plan in accordance with timelines established in the Medicaid Provider General Handbook.

3. Claims Provisions for Fee-for-Service Provider Networks

- a. For the purposes of this Contract, a Managed Care Plan that is an FFS PSN shall obtain a license as, or contract with, a licensed TPA under Chapter 627, F.S., in order to adjudicate claims.
- b. The Managed Care Plan shall be responsible for adjudicating all claims submitted by all providers to the Managed Care Plan, in accordance with Section XI., Method of Payment, Item C., Payment Provisions for Fee-For-Service Provider Service Networks, of Exhibit B-1 or Exhibit B-2, as applicable. The Managed Care Plan shall be responsible for adjudicating claims submitted by all providers in accordance with applicable Medicaid coverage policy and Medicaid fee schedule requirements. The Managed Care Plan shall require its providers to submit claims to the FFS PSN or its contracted TPA for Managed Care Plan-covered services provided to enrollees through the Managed Care Plan.
- c. If the Managed Care Plan is capitated by the Agency for transportation services, then the Managed Care Plan shall be responsible for paying claims for transportation services.
- d. The Managed Care Plan shall submit third party administrator subcontracts for FFS PSNs to the Agency at least one hundred twenty (120) days before the effective date

Section VIII. Provider Services

of the subcontract.

- e. Non-participating providers that provide Plan-authorized covered services to Managed Care Plan enrollees must submit claims to the Managed Care Plan or its TPA for claims adjudication.
- f. Pursuant to s. 409.967(2)(l), F.S., MMA and LTC PSNs must ensure that no entity licensed under Chapter 395, F.S., with a controlling interest in the PSN charges a Medicaid Managed Care Plan more than the amount paid to that provider by the PSN for the same service.

4. Multipayer Claims Database

Pursuant to s. 409.967(2)(o), the Managed Care Plan shall contribute all claims data from the Managed Care Plan and its affiliates for services provided to all enrollees and other covered individuals to the Agency's contracted vendor authorized under s. 408.05(3)(c), F.S., in a manner specified by the Agency.

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Section IX. Quality

A. Quality Improvement

1. General Provisions

- a. The Managed Care Plan shall have a QI program that ensures enhancement of quality of care and emphasizes improving the quality of patient outcomes, including establishing metrics for monitoring the quality and performance of each participating provider. The Managed Care Plan shall evaluate the provider's performance and determine continued participation in the network as specified in Section IX., Quality.
- b. The Agency shall be responsible for establishing standards and requirements for QI, including performance measures, targets, improvement plans, satisfaction surveys and enrollee record reviews, and providing instructions to Managed Care Plans through the Managed Care Plan Report Guide referenced in Section XVI., Reporting Requirements and Performance Measures Specifications Manual. The Agency may change these targets and/or change the timelines associated with meeting the targets. The Agency shall make these changes with sixty (60) days' advance notice to the Managed Care Plan.
- c. The Agency shall be responsible for contracting with an EQRO and conducting other QI activities, including but not limited to audits of: enrollee records, enrollee plans of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under this Contract and its Exhibits.
- d. The Agency shall be responsible for establishing incentives to high-performing Managed Care Plans and take appropriate action in accordance with the terms of this Contract if the Managed Care Plans do not meet acceptable QI and performance indicators.
- e. The Managed Care Plan shall identify and track adverse or critical incidents and shall review and analyze adverse or critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. The Managed Care Plan shall make such tracking available to the Agency upon request.

2. Accreditation

- a. Pursuant to s. 409.967(2)(f)3., F.S., the Managed Care Plan must be accredited by a nationally recognized accrediting body, or have initiated the accreditation process within one (1) year after this Contract was executed.
 - (1) If the Managed Care Plan is not accredited or has not initiated the accreditation process within one (1) year, all enrollee auto-assignments to the Managed Care Plan shall be suspended until the Managed Care Plan is accredited by a nationally recognized body. (42 CFR 438.332(a))
 - (2) If the Managed Care Plan is not accredited within eighteen (18) months after executing this Contract, the Agency may terminate this Contract for failure to

comply with this Contract.

- b. In accordance with 42 CFR 438.332, the Managed Care Plan shall authorize its accrediting body to provide the Agency a copy of its most recent accreditation review, including: its accreditation status, survey type, and level (as applicable); recommended actions or improvements, CAPs, and summaries of findings; and the expiration date of accreditation.

3. Quality Improvement Program

- a. The Managed Care Plan shall have an ongoing QI program that objectively and systematically monitors, evaluates, and improves the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. (42 CFR 438.330(a)(1) and (3); 42 CFR 438.330(b)(4); 42 CFR 438.340)
- b. The Managed Care Plan's governing body shall oversee and evaluate the impact and effectiveness of its QI program. (42 CFR 438.330(e)(2); 42 CFR 438.310(c)(2)) The role of the Managed Care Plan's governing body shall include providing strategic direction to the QI program, as well as ensuring the QI plan is incorporated into processes throughout the Managed Care Plan.
- c. The Managed Care Plan shall cooperate with the Agency and the EQRO. The Managed Care Plan shall use the methodology and standards for QI set by the Agency.

4. Quality Improvement Program Committee

- a. The Managed Care Plan shall have a QI program committee, which includes:
 - (1) The Medical Director, as chair or co-chair;
 - (2) Provider representation (either through providers serving on the committee or through a provider liaison position, such as a representative from the network management department); and
 - (3) Other committee representatives shall be selected to meet the needs of the Managed Care Plan.

Individual staff members may serve in multiple roles on the committee if they also serve in multiple positions within the Managed Care Plan.

- b. At a minimum, the committee must meet quarterly. The Managed Care Plan shall maintain minutes of all QI program committee and sub-committee meetings and make the minutes available for Agency review on request.
- c. The Managed Care Plan's QI program committee shall be responsible for development and implementation of a written QI plan, which incorporates the strategic direction provided by the Managed Care Plan's governing body.

5. Quality Improvement Plan

- a. The Managed Care Plan shall develop and maintain a written QI plan and submit its QI plan to the Agency by November 1, 2018.
- b. The QI plan must include a description of:
 - (1) The Managed Care Plan positions assigned to the QI program committee, including a description of why each position was chosen to serve on the committee and the roles each position is expected to fulfill. The resumes of QI program committee members shall be made available upon the Agency's request;
 - (2) The QI program committee structure, including development of subcommittees and task forces, and the committee's role in monitoring and evaluation of quality and appropriateness of care provided to enrollees;
 - (3) The mechanism within the Managed Care Plan for the governing body to provide strategic direction for the QI program, and for the QI program committee to communicate with the governing body.
 - (4) Specific training about quality that shall be provided by the Managed Care Plan to staff serving in the QI program committee. At a minimum, the training shall include protocols developed by CMS regarding quality. CMS protocols may be obtained from:

<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html>
 - (5) The Managed Care Plan's guiding philosophy for quality management, including any nationally recognized, standardized approach that is used (e.g., PDCA, Rapid Cycle Improvement, FOCUS-PDCA, Six Sigma). Selection of performance indicators and sources for benchmarking also shall be included in addressing the following specific components of the QI plan:
 - (a) Methods for assessment of the quality and appropriateness of care provided to enrollees with timely resolution of problems and new or continued improvement activities, including but not limited to:
 - (i) Service availability and accessibility;
 - (ii) Quality of services in accordance with acceptable professional practice standards;
 - (iii) Network quality;
 - (iv) Care planning and care coordination;
 - (v) Enrollee safety;
 - (vi) Utilization review processes;

- (vii) Grievance and appeals; and
- (viii) Adverse/critical incident reporting
- (b) The process to direct and analyze periodic review of enrollee service utilization patterns (including detection of underutilization and overutilization of services); (42 CFR 438.330(b)(3))
- (c) Monitoring and evaluation of provider network quality, including but not limited to:
 - (i) Credentialing and recredentialing processes;
 - (ii) Provider performance measurement;
 - (iii) Metrics for monitoring the quality and performance of participating providers related to their continued participation in the network.
- (6) The process for selecting evaluation and study design procedures; and
- (7) A standard describing the process the QI program shall use to review and suggest new and/or improved QI activities.
- (8) The Managed Care Plan's QI plan shall describe the process for annual QI activities evaluation, the evaluation results of the prior year's QI activities, and any subsequent revisions to the QI plan.
- c. The Managed Care Plan shall submit its updated QI plan, including the findings from its annual QI program evaluation, to the Agency by November 1 of each Contract year.

6. EQRO Coordination Requirements

The Managed Care Plan shall cooperate with and provide all information requested by the EQRO. (42 CFR 438.350)

7. Florida Medical School Quality Network Initiatives

In accordance with s. 409.975(2), F.S., the Managed Care Plan shall have a cooperative agreement with the FMSQN as directed by the Agency.

B. Performance Measures

1. General Provisions

- a. The Managed Care Plan shall meet Agency-specified performance targets for all PMs as specified in this Contract and the applicable Exhibit(s).
- b. The Agency may add or remove PM requirements with sixty (60) days' advance notice.

2. Required Performance Measures

- a. The Managed Care Plan shall collect statewide data on enrollee PMs, as defined by the Agency and as specified in the SMMC Performance Measure Table below, the Managed Care Plan Report Guide and Performance Measures Specifications Manual.

SMMC Performance Measures Table	
1	Call Answer Timeliness (CAT)

- b. The Managed Care Plan shall report results of PMs to the Agency as specified in Section XVI., Reporting Requirements, the Managed Care Plan Report Guide, and Performance Measures Specifications Manual.

3. Annual Report of Performance

- a. By July 1 of each Contract year, the Managed Care Plan shall deliver to the Agency a report on performance measure data and a certification by a NCQA certified HEDIS auditor that the performance measure data reported for the previous year are fairly and accurately presented. The HEDIS auditor shall certify the report, and the auditor must certify the actual file submitted to the Agency.
- b. The Agency may grant extensions to the due date for up to thirty (30) days and require a signed, dated, written request by the Managed Care Plan CEO or designee. The Agency must receive the request before the report due date and the delay must be due to unforeseen and unforeseeable factors beyond the Managed Care Plan’s control. Extensions shall not be granted on oral requests.
- c. The Managed Care Plan shall use a software vendor who has achieved full HEDIS Measure Certification Status from NCQA for the current reporting year to calculate its PM rates each year.
- d. The Agency shall consider deficient a report that contains a “not reportable” (NR) designation due to bias for any or all measures by the HEDIS auditor, or that contains a “false” designation.

4. Publication of Performance Measures

Pursuant to s. 409.967(2)(f)2., F.S., the Managed Care Plan shall publish its results for HEDIS measures on the Managed Care Plan’s website in a manner that allows recipients to reliably compare the performance of Managed Care Plans. The Managed Care Plans may meet this requirement by including information about the comparison of performance measures conducted by the Agency and providing a link to the Agency’s applicable website page.

C. Performance Improvement Projects

1. General Provisions

Section IX. Quality

- a. The Managed Care Plan shall develop, implement, and monitor PIPs. The Managed Care Plan shall achieve significant improvement to the quality of care and service delivery, through ongoing measurement of performance using objective quality indicators and ongoing interventions, sustained over time.
- b. By January 1 of each Contract year, the Agency shall determine and notify the Managed Care Plan if there are changes in the number and types of PIPs the Managed Care Plan shall perform for the coming Contract year.
- c. The Managed Care Plan's PIP methodology must comply with the most recent protocol set forth by CMS, Implementation of PIPs. CMS protocols may be obtained from:

<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html>

- (1) The Managed Care Plan shall include a statistically valid sample size for each PIP.
 - (2) Populations selected for study under the PIP shall be specific to this Contract and shall not include Medicaid recipients from other states, or enrollees from other lines of business.
 - (3) If the Managed Care Plan contracts with a separate entity for management of particular services, PIPs conducted by the separate entity shall not include enrollees for other Managed Care Plans served by that entity.
- d. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at the ninety-five percent (95%) confidence level and must be sustained for two (2) additional re-measurement periods.
 - e. The Agency shall consider PIPs that have successfully achieved sustained improvement, as approved by the Agency, to be complete, and such PIPs shall not meet the requirement for one (1) of the number of PIPs required by the Agency, although the Managed Care Plan may wish to continue to monitor the performance target as part of its overall QI program. In this event, the Managed Care Plan shall select a new PIP and submit it to the Agency for approval. (42 CFR 438.330(d)(2); 42 CFR 438.330(d)(2)(iv))

2. PIP Proposals

- a. The Managed Care Plan shall submit its measurement periods and methodologies to the Agency for approval before initiation of the PIP. Within thirty (30) days of Contract execution, the Managed Care Plan shall submit to the Agency, in writing:
 - (1) The initial proposed PIP topics and their indicators;
 - (2) A brief summary of the baseline data and time period that the Managed Care Plan shall use for each indicator for each of the proposed PIPs.

- (3) An estimate of how many plan members will be in the eligible/affected population for each PIP.
- (4) A brief rationale for why the Managed Care Plan has selected each proposed PIP topic.
- b. On or before October 1, 2018, the Managed Care Plan shall submit to the Agency in writing, a final proposal for each planned PIP.
- c. Each initial PIP proposal shall be submitted using the most recent version of the EQRO PIP validation form. The Managed Care Plan may obtain instructions for using the form to submit PIP proposals and updates from the Agency.
- d. Activities 1 through 6 of the EQRO PIP validation form must be addressed in the PIP proposal. These activities are listed at <http://www.myfloridaeqro.com/pips.aspx>.
- e. In the event the Managed Care Plan elects to modify a portion of the PIP proposal after initial Agency approval, the Managed Care Plan must submit a written request to the Agency for approval.

3. Annual PIP Submission

- a. The Managed Care Plan shall submit ongoing PIPs October 1 of each Contract year to the Agency for review and approval. (42 CFR 438.330(c)(1) and (2))
- b. The Managed Care Plan shall update the EQRO PIP validation form in its annual submission to reflect the Managed Care Plan's progress. The Managed Care Plan is not required to transfer ongoing PIPs to a new, updated EQRO form.
- c. The Managed Care Plan shall submit the Agency-approved EQRO PIP validation form to the EQRO upon its request for validation. The Managed Care Plan shall not make changes to the Agency-approved PIP being submitted to the EQRO unless expressly permitted and approved by the Agency in writing.

4. EQRO Validation

The Managed Care Plan's PIPs shall be subject to review and validation by the EQRO. The Managed Care Plan shall comply with any recommendations for improvement requested by the EQRO, subject to approval by the Agency.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

- a. The Managed Care Plan shall conduct an annual Enrollee Satisfaction survey. The Managed Care Plan shall submit a written proposal for survey administration and reporting to the Agency, by December 1st of each Contract year.
- b. The proposal shall include the following:
 - (1) Identification of survey administrator and evidence of the survey administrator's

NCQA certification as a CAHPS survey vendor

- (2) Sampling methodology
 - (3) Administration protocol
 - (4) Analysis plan
 - (5) Reporting description
 - (6) Copy of the survey tool
 - (7) Cover letters and/or postcards
- c. The Managed Care Plan shall provide the survey results to the Agency, in accordance with the survey results reporting templates and instructions from the Agency, along with an action plan in accordance with the applicable Exhibit(s).
 - d. The Managed Care Plan shall contract with a qualified, Agency-approved, NCQA-certified vendor to conduct annual enrollee satisfaction surveys required under this Contract. (42 CFR 438.66(c)(5))
 - e. The Agency will specify the survey requirements including survey specifications, applicable supplemental item sets and Agency-defined survey items. Annually, by January 1 of each Contract year, the Agency shall determine and notify the Managed Care Plan if there are changes in survey requirements.
 - f. The Managed Care Plan shall have its sample validated by a NCQA-certified HEDIS Auditor.
 - g. The Managed Care Plans shall report CAHPS survey results, starting with the July 1, 2019 submission, to the NCQA and the Agency. The submission to NCQA must be made by the NCQA deadline.
 - h. By October 1 of each Contract year, the Managed Care Plan shall submit its CAHPS survey vendor's final report to the Agency, along with the plan's action plan to address the results of the CAHPS survey.
 - i. The Managed Care Plan shall submit a CAP, as required by the Agency, within sixty (60) days of the request from the Agency to address any deficiencies identified in the annual CAHPS survey.
 - j. The Managed Care Plan shall use the results of the annual CAHPS survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities conducted by the Managed Care Plan pertaining to improving member satisfaction resulting from the annual member satisfaction survey must be reported to the Agency on a quarterly basis.

2. Provider Satisfaction Survey

- a. The Managed Care Plan shall conduct an annual Provider Satisfaction survey. The

Section IX. Quality

Managed Care Plan shall submit a written provider satisfaction survey plan to the Agency for written approval within ninety (90) days after initial Contract execution and by January 1 of each Contract year, thereafter. (42 CFR 438.66(c)(5))

- b. The proposal shall include the following:
 - (2) Copy of the survey tool, using a four-point Likert scale and including the following domains:
 - (a) Provider relations and communication
 - (b) Authorization processes, including denials and appeals
 - (c) Timeliness of claims payment and assistance with claims processing
 - (d) Complaint resolution process
 - (e) Care coordination/case management support.
 - (3) Sampling methodology
- c. The Agency reserves the right to require a specific survey tool, survey questions and/or survey methodology and to provide for minimum qualifications for survey vendors.
- d. The Managed Care Plan shall conduct the survey, and compile and analyze its survey results, and provide the survey results to the Agency with an action plan to address the results of the Provider Satisfaction survey by July 1 of each Contract year.

E. Enrollee Record Requirements

1. General Provisions

The Managed Care Plan shall ensure maintenance of an enrollee record for each enrollee in accordance with this Section and with 42 CFR 431 and 42 CFR 456. Enrollee records shall include documents related to the quality, quantity, appropriateness, and timeliness of services performed under this Contract.

2. Enrollee Record Review Strategy

- a. By June 1 of each Contract year, the Managed Care Plan shall submit a written strategy for conducting enrollee record reviews for Agency approval. The strategy shall include, at a minimum:
 - (1) Designated staff to perform this duty;
 - (2) Process for establishing inter-rater reliability with internal and external enrollee record reviews;
 - (3) Method for identifying enrollee records;

- (4) Anticipated number of reviews for a statistically significant sample of enrollee records maintained by the Managed Care Plan, its subcontractors, and providers;
 - (5) The tool that the Managed Care Plan shall use to review each record;
 - (6) Record review deficiencies and how results will be utilized in process improvement(s); and
 - (7) How the Managed Care Plan will link the information compiled during the review to other Managed Care Plan functions (e.g., QI, recertification, peer review).
- b. The Managed Care Plan shall conduct enrollee record reviews of all providers with a pattern of complaints regarding poor quality of service and providers with poor quality outcomes.
 - c. The Managed Care Plan shall distribute the standards, which must include all enrollee record documentation requirements addressed in this Contract, to all providers.

3. Standards for Managed Care Plan Enrollee Records

- a. The Managed Care Plan shall develop and maintain enrollee records meeting the documentation standards set forth in Rule 59G-1.054, F.A.C., below, and in the program-specific Exhibit(s):
 - (1) Include the enrollee's identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship (if any);
 - (2) Include information relating to the enrollee's use of tobacco, alcohol, and drugs/substances;
 - (3) Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up;
 - (4) Reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
 - (5) Identify enrollees needing communication assistance in the delivery of health care services;
 - (6) Include copies of any completed consent or attestation form(s) used by the Managed Care Plan or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13) years;
- b. The Managed Care Plan shall maintain written procedures for enrollee advance directives that address how the Managed Care Plan shall access copies of any advance directives executed by the enrollee. The Managed Care Plan's procedure shall be updated to reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change. (42 CFR 438.3(j)(4))

- (1) All enrollee records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether or not the enrollee has executed an advance directive. (42 CFR 438.3(j)(3))
 - (2) Neither the Managed Care Plan, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5))
- c. If the Managed Care Plan is not yet fully accredited by a nationally recognized accrediting body, the Managed Care Plan shall establish processes for enrollee record review that meet or exceed nationally recognized accrediting body enrollee record review standards.

4. Standards for Provider-Specific Enrollee Records

The Managed Care Plan shall ensure that its network of providers follow the enrollee record standards set forth in Rule 59G-1.054, F.A.C.

F. Provider-Specific Performance Monitoring

1. General Provision

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

2. Peer Review

- a. The Managed Care Plan shall have a peer review process that results in:
 - (1) Review of a provider's practice methods and patterns, morbidity/mortality rates, and all complaints and grievances filed against the provider;
 - (2) Evaluation of the appropriateness of care rendered by providers;
 - (3) Implementation of corrective action(s) when the Managed Care Plan deems it necessary to do so;
 - (4) Development of policy recommendations to maintain or enhance the quality of care provided to enrollees;
 - (5) Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider's enrollee records, adherence to standards generally accepted by a provider's peers and the process and outcome of a provider's care;

- (6) Education of enrollees and Managed Care Plan staff about the peer review process, so that enrollees and the Managed Care Plan staff can notify the peer review authority of situations or problems relating to providers.

3. Monitoring Activities

The Managed Care Plan shall comply with monitoring activities requirements as specified in the applicable Exhibit(s).

G. Additional Quality Management Requirements

1. Incident Reporting Requirements

- a. As part of the Managed Care Plan's quality management requirements, the Managed Care Plan shall implement and maintain a risk management program.
- b. The Managed Care Plan shall develop and implement an incident reporting and management system for adverse or critical incidents.
- c. The Managed Care Plan shall require participating service providers and direct service providers to report adverse or critical incidents to the Managed Care Plan.
- d. The Managed Care Plan shall provide appropriate training and take corrective action as needed to ensure its staff, participating providers, and direct service providers comply with critical incident requirements.
- e. The Managed Care Plan shall immediately report to DCF's Central Abuse Hotline any suspected cases of abuse, neglect or exploitation of enrollees, in accordance with s. 39.201 and Chapter 415, F.S. The Managed Care Plan shall maintain documentation related to the reporting of such events in a confidential file, separate from the enrollee record. Such file shall be made available to the Agency upon request.
- f. The Managed Care Plan shall report a summary of adverse and critical incidents to the Agency, as specified in Section XVI., Reporting Requirements, and in the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

2. Agency Monitoring

The Managed Care Plan shall furnish specific data requested by the Agency in order to conduct monitoring of the Managed Care Plan's compliance with this Contract.

H. Continuity of Care in Enrollment

The Managed Care Plan shall be responsible for continuity of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers for up to sixty (60) days after the effective date of enrollment. The Managed Care Plan shall reimburse non-participating providers at the rate they received

Section IX. Quality

for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless said provider agrees to an alternative rate.

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Section X. Administration and Management

A. General Provisions

1. The Agency is responsible for administering the Medicaid program. The Agency shall administer contracts, monitor Managed Care Plan performance, and provide oversight in all aspects of Managed Care Plan processes.
2. The Agency shall be responsible for the administration of the FMMIS and contracting with the State's fiscal agent to exchange data with Managed Care Plans and enroll Medicaid providers,. The Agency is responsible also for the administration of programs for Florida's Medicaid Electronic Health Record Incentive Program, the Florida Health Information Network and other efforts to provide information and resources relating to HIT and HIE, as well as collecting data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information through <http://www.floridahealthfinder.gov/index.html>.
3. The Agency shall be responsible for establishing standards and requirements to ensure receipt of complete and accurate data for program administration as required to determine compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, F.S. The Agency shall be responsible for establishing systems, processes, standards and requirements, including but not limited to encounter data collection and submission, and providing instructions to Managed Care Plans through the Medicaid Companion Guides and Pharmacy Payer Specifications. The Agency shall be responsible for validating and reporting encounter data in accordance with 42 CFR 438.818.
4. The Agency shall be responsible for coordinating Medicaid overpayment and abuse prevention, detection and recovery efforts. The Attorney General's office is responsible for investigating and prosecuting Medicaid fraud. The Agency shall operate the MPI program, which includes but is not limited to such monitoring as may be done by desk reviews or on site as determined by the Agency. These reviews may be conducted by various Agency bureaus and the Agency shall provide appropriate notice for requesting documents as needed and for conducting on-site reviews, as well as providing Managed Care Plans with the result of such reviews. The Agency, Bureau of MPI, audits and investigates providers suspected of overbilling or defrauding the Florida Medicaid Program, recovers overpayments, issues administrative sanctions and refers cases of suspected fraud for criminal investigation to the MFCU. The Agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.
5. The Managed Care Plan shall be responsible for the administration and management of all aspects of this Contract, including but not limited to delivery of services, provider network, provider education, claims resolution and assistance, and all subcontracts, employees, agents and services performed by anyone acting for or on behalf of the Managed Care Plan.

Section X. Administration and Management

6. The Managed Care Plan shall have a centralized executive administration, and must ensure adequate staffing and information systems capability to ensure the Managed Care Plan can appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter data, or other information required by this Contract.

B. Organizational Governance and Staffing

1. General Provisions

- a. The Managed Care Plan shall be responsible for the administration and management of all aspects of this Contract, including all subcontracts, employees, agents, and services performed by anyone acting for or on behalf of the Managed Care Plan.
- b. The Managed Care Plan shall have a centralized executive administration, which shall serve as the contact point for the Agency, except as otherwise specified in this Contract.
- c. The Managed Care Plan must ensure adequate staffing and information systems capability to ensure the Managed Care Plan can appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter data, or other information required by the Agency, and to comply with the HIPAA and HITECH Acts.
- d. The Managed Care Plan shall be located in the U.S. (42 CFR 438.602(c))
- e. The Managed Care Plan shall meet all requirements for doing business in the State of Florida.
- f. The Managed Care Plan shall submit any changes to its approved organizational chart to the Agency for prior approval. If any member of the minimum staffing is terminated or becomes unavailable for any reason, the Managed Care Plan shall submit to the Agency the resume of the proposed replacement(s) and offer the Agency to review the qualifications of the proposed applicant(s).
- g. The Agency reserves the right to disapprove proposed applicant(s) with reason.

2. Minimum Staffing

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

- a. The Managed Care Plan shall designate a full-time Contract Manager to work directly with the Agency. The Contract Manager shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to this Contract. The Contract Manager shall have the authority to administer the day-to-day business activities of this Contract, including revising processes or procedures and assigning additional resources as needed to

Section X. Administration and Management

maximize the efficiency and effectiveness of services required under this Contract. The Managed Care Plan shall meet in person, or by telephone, at the request of Agency. The Contract Manager shall be located in the State of Florida.

- b. The Managed Care Plan shall designate a full-time Medical Director who is a physician licensed in the State of Florida with experience providing services to the populations served under this Contract. The Medical Director shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to this Contract. The Medical Director shall oversee and be responsible for the proper provision of covered services to enrollees, the quality management program, and the grievance and appeal system.
- c. The Managed Care Plan shall designate a full-time Compliance Officer, qualified by knowledge, training, and experience in health care or risk management, to promote, implement, and oversee the compliance program and to oversee the Managed Care Plan's compliance with non-discrimination requirements in this Contract. The Compliance Officer shall be a full-time employee of the Managed Care Plan and shall dedicate one hundred percent (100%) of their time employed with the Managed Care Plan to this Contract. The Compliance Officer shall exhibit knowledge of relevant regulations, provide expertise in compliance processes, and be qualified to design, implement, and oversee a fraud and abuse program designed to ensure program integrity through fraud and abuse prevention and detection, which identifies and addresses emerging trends of fraud, abuse, and waste pursuant to this Contract and State and federal law.
- d. The Managed Care Plan shall designate a staff for each of the following functional areas within the Agency:
 - (1) Medicaid Quality
 - (2) Medicaid Recipient/Provider Assistance
 - (3) Medicaid Policy
 - (4) Medicaid Data Analytics
 - (5) Medicaid Finance
 - (6) Claims and Encounter Data
 - (7) Program Integrity
 - (8) Subcontractor Oversight

3. Medical and Professional Support Staff

The Managed Care Plan shall have an adequate number of medical and professional support staff, sufficient to conduct daily business in an orderly manner, including having enrollee services staff directly available during business hours for enrollee services consultation, as determined through management and medical reviews. The Managed

Section X. Administration and Management

Care Plan shall maintain and adequate number sufficient medical and professional support staff, available twenty-four hours a day, seven days a week (24/7), to handle emergency services and care inquiries from enrollees and caregivers.

4. Care Coordination/Case Management Staff

The Managed Care Plan shall have sufficient care coordination/case management staff, qualified by training, experience, and certification/licensure to conduct the Managed Care Plan's care coordination/case management functions.

5. Staff Training and Education

The Managed Care Plan shall educate its staff about its procedures and all applicable provisions of this Contract. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5))

6. Non-discrimination Compliance Requirements

- a. The Managed Care Plan shall comply with all applicable federal and State civil rights laws, regulations, rules and policies, including but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the ADA of 1990, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and the Age Discrimination Act of 1975.
- b. The Managed Care Plan shall develop a non-discrimination compliance plan. The Managed Care plan shall be responsible for initial and ongoing training regarding the non-discrimination compliance plan to all Managed Care Plan staff. The Managed Care Plan shall maintain documented proof of such training and provide such proof to the Agency upon request.
- c. The Managed Care Plan's non-discrimination compliance plan shall include written procedures that demonstrate non-discrimination in the provision of services to enrollees. The policy shall also demonstrate non-discrimination in the provision of language assistance services for members with limited English proficiency and those requiring communication assistance in alternative formats. See Section V.B., Enrollee Material.

7. Emergency Management Plan

- a. Before implementation of this Contract and May 1st of each Contract year, the Managed Care Plan shall submit to the Agency an emergency management plan specifying what actions the Managed Care Plan shall conduct to ensure the ongoing provision of covered services in a disaster or man-made emergency, including but not limited to localized acts of nature, accidents, and technological and/or attack-related emergencies. If the emergency management plan is unchanged from the previous year, and was approved by the Agency, the Managed Care Plan shall submit an electronic certification to the Agency that the prior year's plan is still in place.
- b. The Managed Care Plan shall comply with the provisions of s. 252.358, F.S., which allows for early prescription refills due to a Governor's Executive Order declaring a State of Emergency for Florida counties.

C. Subcontracts

1. General Provisions

a. The Managed Care Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract, and may, delegate performance of work required under this Contract to a subcontractor. The Managed Care Plan shall submit any proposed delegation to the Agency for prior written approval. The Managed Care Plan shall submit all subcontracts for Agency review at least ninety (90) days before the proposed effective date of the subcontract or change. If the submission is for management of a covered service, the Managed Care Plan shall include the following in its submission to the Agency in a manner prescribed by the Agency:

- (1) Draft subcontract
- (2) Proof of provider network adequacy
- (3) Proof of applicable licensure, if appropriate
- (4) Enrollee materials
- (5) The population covered by the subcontract
- (6) Provider materials
- (7) Model provider agreement template as specified in Section VIII., Provider Services
- (8) Approximate number of impacted enrollees

If the Agency determines, at any time, that a subcontract is not in compliance with a Contract requirement, the Managed Care Plan shall promptly revise the subcontract into compliance.

- b. All subcontracts must comply with 42 CFR 438.230, 42 CFR 438.3(k), 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106 and all applicable Medicaid laws and regulations, including applicable sub regulatory guidance and Contract provisions, and any other applicable State or federal law.
- c. The Managed Care Plan shall identify the service(s) and/or goods covered by the subcontract, as applicable.
- d. All subcontracts must contain provisions wherein the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with Section XVI., Reporting Requirements, and the SMMC Report Guide.
- e. No subcontract that the Managed Care Plan enters into with respect to performance under this Contract shall, in any way, relieve the Managed Care Plan of any responsibility for the performance of duties under this Contract. The Managed Care

Section X. Administration and Management

Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract and shall provide the Agency with its monitoring schedule for all Agency-approved subcontractors by December 1 of each Contract year.

- f. All executed subcontracts and amendments used by the Managed Care Plan under this Contract shall be in writing, signed, and dated by the Managed Care Plan.
- g. The Managed Care Plan shall immediately advise the Agency of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor.
- h. The Managed Care Plan shall have a contingency plan for each subcontract to provide for continuity of care should the subcontractor cease to provide services that are the subject of the subcontract.

2. Subcontractor Eligibility

- a. All subcontractors must be eligible for participation in the Medicaid program; however, the subcontractor is not required to participate in the Medicaid program as a provider.
- b. If a subcontractor was involuntarily terminated from the Medicaid program other than for purposes of inactivity, that entity is not considered an eligible subcontractor.
- c. The Managed Care Plan shall not delegate provider network management to a subcontractor that meets both of the following:
 - (1) The subcontractor is owner or has controlling interest in any provider(s) included in the network; and
 - (2) The subcontractor limits enrollee choice of network providers through a requirement for a referral/authorization process to access network providers.

3. Subcontract Content Requirements

- a. Payment - The Managed Care Plan agrees to make payment to all subcontractors pursuant to all State and federal laws, rules and regulations, including s. 409.967, F.S., s. 409.975(6), F.S., s. 409.982, F.S., s. 641.3155, F.S., 42 CFR 238.230, 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (5) and (6), in addition to sub regulatory guidance and the provisions of this Contract. All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall meet the following requirements:
 - (1) Identify conditions and method of payment;
 - (2) Provide for prompt submission of information needed to make payment;
 - (3) Provide for full disclosure of the method and amount of compensation or other consideration to be received from the Managed Care Plan;

Section X. Administration and Management

- (4) Require any claims processing vendors to maintain accurate enrollee and provider information, including provider agreements reflecting the correct reimbursement rate and provider specialty, to ensure the correct adjudication of claims and proper payment to providers;
 - (5) Require any payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Managed Care Plan;
 - (6) Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Managed Care Plan;
 - (7) Specify that the Managed Care Plan shall assume responsibility for cost avoidance measures for third party collections in accordance Section XII., Financial Requirements.
- b. Monitoring and Inspections - All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall meet the following requirements with respect to provisions for monitoring and inspections:
- (1) Provide that the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate, or inspect the subcontractor's premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's subcontractor, pertaining to any aspect of services and activities performed, or determination of amounts payable under the Managed Care Plan's Contract with the State. In accordance with 42 CFR 438.230(c)(3)(iii), the subcontractor shall agree that the right to audit exists through ten (10) years from the final date of this Contract period or from the date of completion of any audit, whichever is later;
 - (2) Provide that the subcontractor shall make available for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Medicaid enrollees pertinent to this Contract by the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS; (42 CFR 438.3(h); s. 1903(m)(2)(A)(iv) of the Social Security Act)
 - (3) Require full cooperation in any investigation by the Agency, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, DOEA, or other State or federal entity or any subsequent legal action that may result from such an investigation.
 - (4) In addition to record retention requirements for practitioner or provider licensure, require subcontractors to retain, as applicable, the following information in accordance with 42 CFR 438.3(u): enrollee grievance and appeal records in 42 CFR 438.416; base data in 42 CFR 438.5(c); MLR reports in 42 CFR 438.8(k); and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period not less than

Section X. Administration and Management

ten (10) years from the close of this Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the subcontract is continuous.); (42 CFR 438.3(h))

- (5) Provide for monitoring and oversight by the Managed Care Plan and the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the Managed Care Plan's and the Agency's credentialing requirements as found in Section VIII., Provider Services, if the Managed Care Plan has delegated the credentialing to a subcontractor;
 - (6) Provide for monitoring of services rendered to Managed Care Plan enrollees through the subcontractor.
- c. Protective Clauses - All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall meet the following requirements with respect to protective clauses:
- (1) Require safeguarding of information about enrollees according to 42 CFR Part 438.224.
 - (2) Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that enrollees or the Agency shall not be held liable for any debts of the subcontractor.
 - (3) Contain a clause indemnifying, defending and holding the Agency, its designees, and the Managed Care Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency may waive this requirement for itself, but not Managed Care Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency.
 - (4) Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Managed Care Plan. Such insurance shall comply with Florida's Workers' Compensation Law.
 - (5) Require that, if the Managed Care Plan delegates claims processing and payment, the subcontractor shall:
 - (a) Report its financial status (i.e. periodic financial reporting, financial statements) to the Managed Care Plan at a frequency determined acceptable to the Managed Care Plan.
 - (b) Require, if the subcontractor is at financial risk and/or is delegated to

Section X. Administration and Management

process and pay claims, the subcontractor shall maintain a surplus account to meet its obligations.

- (6) Specify that if the subcontractor delegates or subcontracts any functions of its contract with the Managed Care Plan, that the subcontract or delegation shall include all the requirements of this Contract.
 - (7) Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract.
 - (8) Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate.
 - (9) Provide that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 438.210(e))
 - (10) Provide that the subcontractor shall establish, enforce, and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.
 - (11) Require that the subcontractor timely notify the Managed Care Plan of changes in directory information.
 - (12) Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:
 - (a) The False Claims Act;
 - (b) The penalties for submitted false claims and statements;
 - (c) Whistleblower protections; and
 - (d) The entity's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

(42 CFR 438.608(a)(6); s. 1902(a)(68) of the Social Security Act)
- d. Termination Procedures - In conjunction with the Standard Contract, Section III., B., Termination, all provider agreements and subcontracts shall contain termination procedures.
 - e. Marketing - All subcontracts specify that the subcontractor shall comply with the marketing requirements specified in Section IV., Marketing.
 - f. Encounter Data - All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall require subcontractors to submit timely, complete and accurate encounter data to the Managed Care Plan in accordance with the requirements of Section X.D., Information Management Systems.

4. Other Contract Requirements

Subcontractors are subject to background checks. The Managed Care Plan shall consider the nature of the work a subcontractor or agent shall perform in determining the level and scope of the background checks in accordance with s. 408.809, F.S.

5. Minority Business Enterprises

The State supports and encourages supplier diversity and the participation of small and minority business enterprises in State contracting, both as vendors and subcontractors. The Agency supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by this Contract enthusiastically embrace diversity. The award of subcontracts should reflect the full diversity of the citizens of the State of Florida. Respondents can contact the Office of Supplier Diversity online at <http://osd.dms.state.fl.us/> for information on minority vendors who may be considered for subcontracting opportunities.

D. Information Management and Systems

1. General Provisions

The Managed Care Plan shall have information management processes and information systems of sufficient capacity that enable it to meet Agency and federal reporting requirements, other Contract requirements, and all applicable Agency policies, State and federal laws, rules and regulations, including HIPAA. The Managed Care Plan shall be responsible for establishing connectivity to the Agency's/State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency and/or State policies, standards and guidelines, as well as coordinating activities and developing cohesive systems strategies across vendors and agencies.

- a. Systems Functions - The Managed Care Plan shall have information management processes and information systems that collect, analyze, integrate, and report data, enabling the Managed Care Plan to meet Agency and federal reporting requirements. (42 CFR 438.242(a) and (b); s. 6504(a) of the ACA)
- b. Systems Capacity - The Managed Care Plan's system(s) shall possess capacity sufficient to handle the workload projected for the begin date of implementation of this Contract and shall be scalable and flexible as to be adapted as needed, within negotiated timeframes, in response to changes in Contract requirements, increases in enrollment estimates, etc.
- c. Email System - The Managed Care Plan shall provide a continuously available electronic mail communication link (email system) with the Agency. This system shall be:
 - (1) Available from the workstations of the designated Managed Care Plan contacts; and
 - (2) Capable of attaching and sending documents created using software products

Section X. Administration and Management

other than the Managed Care Plan's systems, including the Agency's currently installed version of Microsoft Office and any subsequent upgrades as adopted. The electronic mail system shall include encryption capabilities compliant with FIPS 140-2.

- d. HIPAA Compliance - The Managed Care Plan must ensure it meets all federal regulations regarding required standard electronic transactions and standards for privacy and individually identifiable health information as identified in the HIPAA of 1996 and the HITECH Act of 2009 and associated regulations.
- e. Data Security - The Managed Care Plan shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with FIPS, and/or the NIST publications regarding cryptographic standards.
- f. Security Rating Score - In order to enable the Agency to effectively measure and mitigate the Managed Care Plan's security risks, the Managed Care Plan must annually obtain a security rating score from a vendor information security rating service (e.g., BigSight Technologies, Security Scorecard, CORL Technologies, or other comparable company that rates vendor information security). If the Managed Care Plan does not maintain a top tier security rating score, the Managed Care Plan may be subject to liquidated damages and/or sanctions.
- g. Participation in Information Systems Work Groups/Committees - The Managed Care Plan shall meet as requested by the Agency, to coordinate activities and develop cohesive systems strategies across vendors and agencies.
- h. Connectivity to the Agency/State Network and Systems - The Managed Care Plan shall be responsible for establishing connectivity to the Agency's/State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency and/or State policies, standards, and guidelines. The Managed Care Plan shall notify the Agency of termination of any staff with access to the Agency's network within twenty-four (24) hours of the termination.
- i. Security Training - Managed Care Plan staff that have access connectivity to the Agency's data communications network shall be required to complete Agency Security Awareness Training and Agency HIPAA Training. The Managed Care Plan shall sign an Acceptable Use Acknowledgement Form and submit the completed form to the Agency's Information Security Manager. The requirements described in this Item must be completed before access to the Agency's network is provided.
- j. The Managed Care Plan shall adhere and comply with the Agency's Division of IT standards regarding SSL Web interface(s) and TLS.
- k. The Managed Care Plan shall adhere to the Driver Privacy Protection Act rules that address a memorandum of understanding and security requirements as well as other requirements contained in Rule.

Section X. Administration and Management

- I. The Managed Care Plan shall conform to current and updated publications of the principles, standards, and guidelines of the FIPS, the NIST publications, including but not limited to [Cybersecurity-Framework](#) and [NIST.SP.800-53r4](#).
- m. The Managed Care Plan shall employ traffic and network monitoring software and tools on a continuous basis
 - (1) To identify obstacles to optimum performance.
 - (2) To identify email and Internet spam and scams and restrict or track user access to appropriate websites.
 - (3) To identify obstacles to detect and prevent hacking, intrusion and other unauthorized use of the Managed Care Plan's resources.
 - (4) To prevent adware or spyware from deteriorating system performance.
 - (5) To update virus blocking software daily and aggressively monitor for and protect against viruses.
 - (6) To monitor bandwidth usage and identify bottlenecks that impede performance.
 - (7) To provide methods to flag recipient data to exclude PHI from data exchanges as approved by the State, and to comply with recipient rights under the HIPAA privacy law for: 1) Requests for restriction of the uses and disclosures on PHI (45 CFR 164.522(a)); 2) Requests for confidential communications (45 CFR 164.522(b)); and 3) Requests for amendment of PHI (45 CFR 164.526). The Managed Care Plan shall also enter into a BAA with the Agency. The provisions of the BAA apply to HIPAA requirements and in the event of a conflict between the BAA and the provisions of this Sub-Section, the BAA shall control. (See **Exhibit A-8**, Standard Contract).

2. Data and Document Management Requirements

- a. Adherence to Data and Document Management Standards
 - (1) The Managed Care Plan's systems shall conform to the standard transaction code sets specified in this Contract.
 - (2) The Managed Care Plan's systems shall conform to HIPAA and HITECH standards for data and document management.
 - (3) The Managed Care Plan shall collaborate with the Agency in the management of standard transaction code sets specific to the Agency. Furthermore, the Managed Care Plan shall collaborate with the Agency in the development and implementation planning of future standard code sets not specific to HIPAA or other federal efforts and shall conform to these standards as stipulated in the plan to implement the standards.
- b. Data Model and Accessibility. Managed Care Plan systems shall be SQL and/or ODBC compliant. Alternatively, the Managed Care Plan's systems shall employ a relational

Section X. Administration and Management

data model in the architecture of its databases in addition to a relational database management system to operate and maintain them.

- c. Data and Document Relationships. The Managed Care Plan shall house indexed images of documents used by enrollees and providers to transact with the Managed Care Plan in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data.
- d. Information Retention. Information in the Managed Care Plan's systems shall be maintained in electronic form for three (3) years in live systems and for an additional seven (7) years in archival systems. Enrollee grievance and appeal records (42 CFR 438.416) base data (42 CFR 438.5(c)), MLR reports (42 CFR 438.8(k)), and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 shall be maintained for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u) in live and/or archival systems, or longer for audits or litigation as specified elsewhere in this Contract.
- e. Information Ownership. All information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract is owned by the Agency. The Managed Care Plan is expressly prohibited from sharing or publishing the Agency information and reports without the prior written consent of the Agency. In the event of a dispute regarding the sharing or publishing of information and reports, the Agency's decision on this matter shall be final and not subject to change.

3. System and Data Integration Requirements

- a. Adherence to Standards for Data Exchange
 - (1) The Managed Care Plan's systems shall be able to transmit, receive and process data in HIPAA-compliant formats.
 - (2) The Managed Care Plan's systems shall be able to transmit, receive and process data in the Agency-specific formats and/or methods.
 - (3) The Managed Care Plan's systems shall conform to future federal and/or Agency-specific standards for data exchange, including HIPAA-compliant data formats, within one hundred twenty (120) days of the standard's effective date or, if earlier, the date stipulated by HHS, CMS, or the Agency. The Managed Care Plan shall partner with the Agency in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the Managed Care Plan shall conform to these standards as stipulated in the Agency agreed-upon plan to implement such standards.
- b. HIPAA Compliance Checker. All HIPAA-conforming transactions between the Agency and the Managed Care Plan shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.
- c. Data and Report Validity and Completeness. The Managed Care Plan shall institute

Section X. Administration and Management

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

- d. State/Agency Website/Portal Integration. Where deemed that the Managed Care Plan's web presence shall be incorporated to any degree to the Agency's or the State's web presence (also known as a portal), the Managed Care Plan shall conform to any applicable Agency or State standard for website structure, coding, and presentation.
- e. Functional Redundancy with Agency Systems. The Managed Care Plan's systems shall be able to transmit and receive transaction data to and from Agency Systems as required for the appropriate processing of claims and any other transaction that could be performed by either system.
- f. Data Exchange in Support of the Agency's Program Integrity and Compliance Functions. The Managed Care Plan's systems shall be capable of generating files in the prescribed formats for upload into Agency systems used specifically for program integrity and compliance purposes.
- g. Address Standardization. The Managed Care Plan's system(s) shall possess mailing address standardization functionality in accordance with U.S. Postal Service conventions.
- h. Eligibility and Enrollment Data Exchange Requirements
 - (1) The Managed Care Plan shall receive process and update enrollment files sent daily by the Agency or its agent(s).
 - (2) The Managed Care Plan shall update its eligibility/enrollment databases within twenty-four (24) hours after receipt of said files.
 - (3) The Managed Care Plan shall transmit to the Agency or its agent, in a periodicity schedule, format, and data exchange method to be determined by the Agency, specific data it may garner from an enrollee including third party liability data.
 - (4) The Managed Care Plan shall be capable of uniquely identifying a distinct Medicaid recipient across multiple systems within its span of control.

4. Systems Availability, Performance and Problem Management Requirements

- a. Availability of Critical Systems Functions. The Managed Care Plan shall ensure that critical systems functions available to enrollees and providers, functions that if unavailable would have an immediate detrimental impact on enrollees and providers, are available twenty-four hours per day, seven days per week (24/7), except during periods of scheduled system unavailability agreed upon by the Agency and the Managed Care Plan. Unavailability caused by events outside of a Managed Care

Section X. Administration and Management

- Plan's span of control should be addressed in a Business Continuity plan. The Managed Care Plan shall make the Agency aware of the nature and availability of these functions prior to extending access to these functions to enrollees and/or providers.
- b. **Availability of Data Exchange Functions.** The Managed Care Plan shall ensure that the systems and processes within its span of control associated with its data exchanges with the Agency and/or its agent(s) are available and operational according to specifications and the data exchange schedule.
 - c. **Availability of Other Systems Functions.** The Managed Care Plan shall ensure that at a minimum, all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., in the time zone where the user is located, Monday through Friday.
 - d. **Problem Notification**
 - (1) Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the Managed Care Plan and the Agency and/or its agent(s), the Managed Care Plan shall notify the applicable Agency staff via phone, fax, and/or electronic mail within one (1) hour of such discovery. In its notification, the Managed Care Plan shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes.
 - (2) The Managed Care Plan shall provide to appropriate Agency staff information on system unavailability events, as well as status updates on problem resolution. At a minimum, these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.
 - e. **Recovery from Unscheduled System Unavailability.** Unscheduled system unavailability caused by the failure of systems and telecommunications technologies within the Managed Care Plan's span of control shall be resolved, and the restoration of services implemented, within forty-eight (48) hours of the official declaration of system unavailability.
 - f. **Exceptions to System Availability Requirement.** The Managed Care Plan shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Managed Care Plan's span of control.
 - g. **Information Systems CAP.** If at any point there is a problem with a critical systems function, at the request of the Agency, the Managed Care Plan shall provide to the Agency full written documentation that includes a CAP that describes how problems with critical systems functions shall be prevented from occurring again. The CAP shall be delivered to the Agency within five (5) business days of the problem's occurrence. Failure to submit a CAP and to show progress in implementing the CAP shall make the Managed Care Plan subject to sanctions, in accordance with Section XIII., Sanctions.

Section X. Administration and Management

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

- (1) Regardless of the architecture of its systems, the Managed Care Plan shall develop, maintain, and be continually ready to invoke a BC-DR plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed. The BC-DR plan shall limit service interruption to a period of twenty-four (24) hours and shall ensure compliance with all contractual requirements. The records backup standards and BC-DR plan shall be developed and maintained for the entire Contract period.
- (2) The BC-DR plan shall include a strategy for restoring day-to-day operations, including alternative locations for the Managed Care Plan to operate. The BC-DR plan shall maintain database backups in a manner that eliminates service disruptions or data loss due to system or program failures or destruction.

The Managed Care Plan's BC-DR plan shall be submitted to the Agency. If the approved plan is unchanged from the previous year, the Managed Care Plan shall submit a certification to the Agency that the prior year's plan is still in place May 1st of each Contract year. Changes in the plan are due to the Agency within ten (10) business days after the change.

- (3) At a minimum, the Managed Care Plan's BC-DR plan shall address the following scenarios:
 - (a) The central computer installation and resident software are destroyed or damaged;
 - (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
 - (c) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system;
 - (d) System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability; and
 - (e) Malicious acts, including malware or manipulation.
- (4) The Managed Care Plan shall periodically, but no less than annually, by April 30 of each Contract year, perform comprehensive tests of its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the Agency that it can restore system functions by being ISO22301 certified (Business Continuity Management) or comparable standard (contingent upon Agency approval) certified.

Section X. Administration and Management

- (5) Outbound mail gateways used by the Managed Care Plan must be configured to only send e-mails to the Agency over an encrypted connection (currently, TLS). Additionally, all incoming mail gateways must be configured to accept encrypted connections (TLS) as the Agency shall only be transmitting mail across such connections.
 - (6) In the event that the Managed Care Plan fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Managed Care Plan shall be required to submit to the Agency a CAP in accordance with Section XIII., Sanctions, that describes how the failure shall be resolved. The CAP shall be delivered within ten (10) business days of the conclusion of the test.
- i. Data Security
- (1) The Managed Care Plan, its employees, subcontractors, and agents shall provide immediate notice within one hour to the Agency ISM in the event it becomes aware of any security breach and any unauthorized transmission or loss of any or all of the data collected or created for or provided by the Agency (State Data) or, to the extent the Managed Care Plan is allowed any access to the Agency's IT resources, provide immediate notice to the ISM, of any allegation or suspected violation of security procedures of the Agency. Except as required by law and after notice to the Agency, the Managed Care Plan shall not divulge to third parties any confidential information obtained by the Managed Care Plan or its agents, distributors, resellers, subcontractors, officers, or employees in the course of performing contract work according to applicable rules, including, but not limited to, Rule 74-2, F.A.C., and its successor regulation, security procedures, business operations information, or commercial proprietary information in the possession of the State or the Agency. After the conclusion of this Contract unless otherwise provided herein, the Managed Care Plan shall not be required to keep confidential information that is publicly available through no fault of the Plan, material that the Managed Care Plan developed independently without relying on the State's confidential information, or information that is otherwise obtainable under State law as a public record.
 - (2) In the event of loss of any State Data or record where such loss is due to the negligence of the Managed Care Plan or any of its subcontractors or agents, the Managed Care Plan shall be responsible for recreating such lost data in the manner and on the schedule set by the Agency at the Managed Care Plan's sole expense, in addition to any other damages the Agency may be entitled to by law or this Contract. In the event lost or damaged data is suspected, the Managed Care Plan shall perform due diligence and report findings to the Agency and perform efforts to recover the data. If it is unrecoverable, the Managed Care Plan shall pay all the related costs associated with the remediation and correction of the problems engendered by any given specific loss. Further, failure to maintain security that results in certain data release shall subject the Managed Care Plan to liquidated damages for failure to comply with Section 501.171, F.S., together with any costs to the Agency of such breach of security caused by the Managed Care Plan. If State Data will reside in the Managed Care Plan's system, the Agency may conduct, or request the Managed Care Plan conduct at the Managed Care Plan's expense, an annual network penetration test or

Section X. Administration and Management

information security audit of the Managed Care Plan's system(s) on which State Data resides. State-owned Data shall be processed and stored in data centers that are located only in the forty-eight (48) contiguous U.S. All successful Managed Care Plan personnel who will have access to State-owned Data shall undergo the background checks and screenings described in this Contract. Within the first year of this Contract term, the Managed Care Plan must obtain a NIST compliant information security risk assessment conducted by an independent third party unless one has been completed within the year prior to Contract execution.

5. System Testing and Change Management Requirements

- a. Notification and Discussion of Potential System Changes. The Managed Care Plan shall notify the Agency of the following changes to systems within its span of control at least ninety (90) days before the projected date of the change. If so directed by the Agency, the Managed Care Plan shall discuss the proposed change with the applicable Agency staff. This includes: (1) software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment, and data management; and (2) conversions of core transaction management systems.
- b. Response to Agency Reports of Systems Problems not Resulting in System Unavailability
 - (1) The Managed Care Plan shall respond to Agency reports of system problems not resulting in system unavailability according to the following timeframes:
 - (a) Within seven (7) days of receipt, the Managed Care Plan shall respond in writing to notices of system problems; and
 - (b) Within twenty (20) days, the correction shall be made or a requirements analysis and specifications document shall be due.
 - (2) The Managed Care Plan shall correct the deficiency by an effective date to be determined by the Agency.
- c. Valid Window for Certain System Changes. Unless otherwise agreed to in advance by the Agency as part of the activities described in this Section, scheduled system unavailability to perform system maintenance, repair, and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.
- d. Testing
 - (1) The Managed Care Plan shall work with the Agency pertaining to any testing initiative as required by the Agency.
 - (2) Upon the Agency's written request, the Managed Care Plan shall provide details of the test regions and environments of its core production information systems, including a live demonstration, to enable the Agency to corroborate the readiness of the Managed Care Plan's information systems.

Section X. Administration and Management

- (3) The Managed Care Plan shall be required to complete system integration testing with the Agency for enhancements and future initiatives, when needed.

6. Information Systems Documentation Requirements

- a. Types of Documentation. The Managed Care Plan shall develop, prepare, print, maintain, produce, and distribute distinct system process and procedure manuals, user manuals, and quick-reference guides, and any updates thereafter, for the Agency and other applicable Agency staff.
- b. Content of System Process and Procedure Manuals. The Managed Care Plan shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.
- c. Content of System User Manuals. The system user manuals shall contain information about, and instructions for, using applicable system functions and accessing applicable system data.
- d. Changes to Manuals
 - (1) When a system change is subject to the Agency's written approval, the Managed Care Plan shall draft revisions to the appropriate manuals prior to Agency approval of the change.
 - (2) Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) business days of the update's taking effect.
- e. Availability of/Access to Documentation. All of the aforementioned manuals and reference guides shall be available in printed form and/or online. If so prescribed, the manuals shall be published in accordance with the appropriate Agency and/or State standard.

7. Reporting Requirements

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

8. Community Health Record/Continuity of Care Document/Electronic Enrollee Record and Related Efforts

- a. At such times that the Agency requires, the Managed Care Plan shall participate and cooperate with the Agency to implement, within a reasonable timeframe, secure, web-accessible, community health records for enrollees.
- b. The design of the vehicle(s) for accessing the community health record/continuity of care document, the health record format, and design shall comply with all HIPAA and

Section X. Administration and Management

related regulations.

- c. The Managed Care Plan shall also cooperate with the Agency in the continuing development of the State's health care data site (www.FloridaHealthFinder.com).
- d. The Managed Care Plan shall provide to its staff and volunteers, initial and ongoing/periodic training on this Contract, including but not limited to HIPAA and the HITECH Act regarding the use and safeguarding of PHI.

9. Compliance with Standard Coding Schemes

- a. Compliance with HIPAA-Based Code Sets. Managed Care Plan systems that are required to or otherwise contain the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed; for example:
 - (1) LOINC;
 - (2) HCPCS;
 - (3) Home Infusion EDI Coalition Product Codes;
 - (4) NDC;
 - (5) NCPDP;
 - (6) ICD;
 - (7) DRG;
 - (8) CARC; and
 - (9) RARC.
- b. Compliance with Other Code Sets. Managed Care Plan systems that are required to or otherwise contain the applicable data type shall conform to the following non-HIPAA-based standard code sets:
 - (1) As described in all Agency Medicaid reimbursement handbooks, for all "covered entities," as defined under HIPAA, and which submit transactions in paper format (non-electronic format); and
 - (2) As described in all Agency Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

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

- a. HIPAA-Based Formatting Standards. Managed Care Plan systems shall conform to the following HIPAA-compliant standards for EDI of health care data effective the first day of implementation in the applicable region. The Managed Care Plan shall submit and receive transactions, ASC X12N or NCPDP (for certain pharmacy transactions),

Section X. Administration and Management

including claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits, and premium payment. The implementation specifications for ASC X12N standards may be obtained from the Washington Publishing Company on the Internet at <http://www.wpc-edi.com/>. Florida specifications may be obtained on the Florida Medicaid provider portal at: http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/default.aspx

Transaction types include, but are not limited to:

- (1) ASC X12N 820 Payroll Deducted & Other Premium Payment
- (2) ASC X12N 834 Enrollment and Audit Transaction
- (3) ASC X12N 835 Claims Payment Remittance Advice Transaction
- (4) ASC X12N 837I Institutional Claim/Encounter Transaction
- (5) ASC X12N 837P Professional Claim/Encounter Transaction
- (6) ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
- (7) ASC X12N 276 Claims Status Inquiry
- (8) ASC X12N 277 Claims Status Response
- (9) ASC X12N 278/279 Utilization Review Inquiry/Response
- (10) NCPDP D.0 Pharmacy Claim/Encounter Transaction

b. Methods for Data Exchange

- (1) The Managed Care Plan and the Agency and/or its agent shall make predominant use of SFTP and EDI in their exchanges of data.
- (2) The Managed Care Plan shall encourage network providers to participate in the Agency's DSM service.

c. Agency-Based Formatting Standards and Methods. Managed Care Plan systems shall exchange the following data with the Agency and/or its agent in formats specified by the Agency:

- (1) Provider network data;
- (2) Case management fees; and
- (3) Payments.

11. Smartphone Applications

Section X. Administration and Management

- a. The Managed Care Plan must develop and maintain procedures regarding the use of social networking or smartphone applications (apps).
- b. If the Managed Care Plan uses apps to allow enrollees direct access to Agency-approved member materials, the Managed Care Plan shall comply with the following:
 - (1) The smartphone application shall disclaim that the app being used is not private and that no PHI or personally identifying information should be published on this application by the Managed Care Plan or end user; and
 - (2) The Managed Care Plan shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines.

12. Social Networking

- a. The Managed Care Plan shall adhere to the following user requirements for procedure development, permitted uses of apps, and acceptable content for social networking applications/tools in performance of this Contract. These requirements shall apply to all interactions/communications by the Managed Care Plan or its subcontractors with enrollees, providers, and website requirements, when conducted through social networking applications.
- b. The Managed Care Plan is vicariously liable for any social networking violations of its employees, agents, volunteers, providers, or subcontractors.
- c. User Requirements
 - (1) The Managed Care Plan's presence on such social networking sites must include an avatar and/or a username that clearly indicates the Managed Care Plan that is being represented and cannot use any Agency logo or State of Florida seal. When registering for social networking applications, the Managed Care Plan shall use its email address. If the application/tool requires a username, the following syntax shall be used: `http://twitter.com/<Managed Care Plan_identifier><username>`.
 - (2) The enrollee or prospective enrollee, or friend/follower, and not the Managed Care Plan, must initiate all Social Networking interactions/communications. Any communication resulting from such a subscription shall include a link/method to opt-out of the subscription.
 - (3) The Managed Care Plan shall place photographs on pages that are hosted on the site and not linked from outside Web pages. The Managed Care Plan shall not post information, photos, links/URLs or other items online that would reflect negatively on any individual(s), its enrollees, the Agency or the State.
 - (4) The Managed Care Plan shall not tag photographic or video content and must remove all tags placed by others upon discovery.
- d. Functionalities

Section X. Administration and Management

The following functionalities are prohibited:

- (1) Authoring – The ability to create and update content leads to the collaborative work of many rather than just a few Web authors such as in wikis and/or blogs. In wikis, users may extend, undo and redo each other’s work. In blogs, posts and the comments of individuals build up over time;
- (2) Tags – Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories;
- (3) Extensions – Software that makes the Web an application platform as well as a document server; and
- (4) Forums – Sites hosted by a company that allow users to create topics (threads) and post comments, questions, etc., that are available for public conversation among all members in the forum.

E. Encounter Data Requirements

1. General Provisions

- a. Encounter data collection and submission is required from the Managed Care Plan for all services, including expanded benefits, rendered to its enrollees (excluding services paid directly by the Agency on a FFS basis). The Managed Care Plan shall submit encounter data that meets established Agency data quality standards as defined herein. These standards are defined by the Agency to ensure receipt of complete and accurate data for program administration and to set actuarially sound capitation rates. These standards are closely monitored and enforced. (42 CFR 438.242(b)(1); 42 CFR 438.604(a)(1); 42 CFR 438.606; 42 CFR 438.818)
- b. The Managed Care Plan shall receive amended standards with advance notice as described in this Section to ensure continuous QI. The Managed Care Plan shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with the Agency’s data quality standards. The Managed Care Plan shall receive:
 - (1) No notice for Medicaid Companion Guide updates that are informational and/or limited to clarification of existing standards, or setting an edit from deny to pay.
 - (2) Thirty (30) days’ notice for setting a pay edit to deny or informing the plan of new CARC and RARC combinations.
 - (3) Sixty (60) days’ notice for adding a new and unique plan-related edit.
 - (4) Ninety (90) days’ notice of a system change resulting in a process change for the Managed Care Plan.

The Managed Care Plan must be capable of sending and receiving any claims information directly to the Agency meeting the above standards and timeframes.

Section X. Administration and Management

- c. The Managed Care Plan must certify all data to the extent required in 42 CFR 438.606. Such certification must be submitted to the Agency concurrently with the data and must be based on the knowledge, information and belief of the CEO, CFO, Chief Medical Officer or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO that all data submitted in conjunction with the encounter data and all documents requested by the Agency are accurate, truthful, and complete. (42 CFR 438.604(a)(2); 42 CFR 438.606; 42 CFR 438.3; 42 CFR 438.5(c))
- d. The Managed Care Plan shall have the capacity to identify encounter data anomalies and shall provide a description of that process to the Agency for review and approval.
- e. The Managed Care Plan shall designate sufficient IT and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.
- f. The Managed Care Plan shall retain submitted encounter data for a period not less than ten (10) years as specified in the Standard Contract, Section I., Item D., Retention of Records.
- g. The Managed Care Plan shall participate in Agency-sponsored workgroups directed at continuous improvements in encounter data quality and processes.

2. Requirements for Complete and Accurate Encounters

- a. The Managed Care Plan shall have a comprehensive automated and integrated encounter data system capable of meeting the requirements below:
- b. All Managed Care Plan encounters shall be submitted to the Agency in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P — Professional; I — Institutional; D — Dental), and, for pharmacy services, in the NCPDP format. The Managed Care Plan's encounters shall also follow the standards in the Agency's 5010 Companion Guides, the Florida D.0 Payer Specification – Encounters and in this Section. Encounters must include Managed Care Plan amounts paid to the providers and shall be submitted for all providers (capitated and non-capitated).
- c. The Managed Care Plan shall follow the instructions in the User Guide and Report Guide regarding the reporting of pharmacy encounter data using the NCPDP standard D. 0. Format and field definitions. Additionally the Managed Care Plan shall submit all denied pharmacy claims data and the reason code(s) for denial.
- d. The Managed Care Plan shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.
- e. For any services in which a Managed Care Plan has entered into capitation reimbursement arrangements with providers, the Managed Care Plan shall comply with all encounter data submission requirements in this Section. The Managed Care Plan shall require timely submissions from its providers as a condition of the capitation payment.
- f. The Managed Care Plan shall implement and maintain review procedures to validate

Section X. Administration and Management

encounter data submitted by providers.

- g. The Managed Care Plan shall submit complete, accurate and timely encounter data to the Agency as defined below.
- h. For all services rendered to its enrollees (excluding services paid directly by the Agency on a FFS basis), the Managed Care Plan shall submit encounter data, without alteration or omission of provider submitted data, no later than seven (7) days following the date on which the Managed Care Plan adjudicated the claims. The Managed Care Plan may append to the provider-submitted data the Managed Care Plan data required by the Agency as described in the Medicaid Companion Guides.
- i. Non-Pharmacy Encounters (X12)
 - (1) Complete: The Managed Care Plan shall submit encounters for ninety-five percent (95%) of the covered services provided by participating and non-participating providers, as defined in D.1. of this Sub-Section.
 - (2) Accurate: No less than ninety-five percent (95%) of the Managed Care Plan's encounter lines submission shall pass FMMIS system edits as specified by the Agency.
- j. For encounter data acceptance purposes the Managed Care Plan must ensure the provider information it supplies to the Agency is sufficient to ensure providers are recognized in FMMIS.

3. Encounter Data Submission

- a. The Managed Care Plan shall collect and submit encounter data to the Agency's fiscal agent. The Managed Care Plan shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on its behalf.
- b. The encounter data submission standards required to support encounter data collection and submission are defined by the Agency in the Medicaid Companion Guides, Pharmacy Payer Specifications and this Section. In addition, encounter data reporting requirements shall be posted on the following websites:

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

http://portal.flmmis.com/flpublic/Provider_ManagedCare/Provider_ManagedCare_Encounter/Provider_ManagedCare_Pharmacy/tabid/82/desktopdefault/+Default.aspx
- c. The Managed Care Plan shall implement and maintain review procedures to validate the successful loading of encounter files by the Agency's fiscal agent's EDI clearinghouse. The Managed Care Plan shall use the EDI response (acknowledgement) files to determine if files were successfully loaded. Within seven (7) days of the original submission attempt, the Managed Care Plan shall correct and resubmit files that fail to load.

Section X. Administration and Management

- d. Encounter Resubmission – Adjustments, Reversals or Corrections
 - (1) Within thirty (30) days after encounters fail NCPDP edits, X12 (EDI) edits or FMMIS system edits, the Managed Care Plan shall correct and resubmit all encounters for which errors can be remedied.
 - (2) The Managed Care Plan shall correct and resubmit one hundred percent (100%) of previously submitted X12 encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.
 - (3) The Managed Care Plan shall correct and resubmit one hundred percent (100%) of previously submitted NCPDP encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within seven (7) days of the respective action.
- e. If the Managed Care Plan fails to comply with the encounter data reporting requirements of this Contract, the Managed Care Plan may be subject to sanctions pursuant to Section XIII., Sanctions, or liquidated damages pursuant to Section XIV., Liquidated Damages.

F. Fraud and Abuse Prevention

1. General Provisions

- a. The Managed Care Plan shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all State and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 75; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S., and Rules 59A-12.0073, 59G and 69D-2, F.A.C.; 2 CFS Part 200 and 2 CFR 300.1.
- b. The Managed Care Plan shall have adequate Florida-based staffing and resources to enable the compliance officer to investigate indicia of fraud, abuse, waste and develop and implement CAPs relating to fraud, abuse, waste and overpayment.
- c. The Managed Care Plan's written fraud and abuse prevention program shall have internal controls and procedures in place that are designed to prevent, reduce, detect, investigate, correct and report known or suspected fraud, abuse, and waste activities. This shall include reporting instances of fraud and abuse pursuant to 42 CFR 438.608, ss. 409.91212, 626.989, and 641.3915, F.S.
- d. In accordance with s. 6032 of the federal Deficit Reduction Act of 2005, the Managed Care Plan shall make available written fraud and abuse policies to all employees. If the Managed Care Plan has an employee handbook, the Managed Care Plan shall include specific information about s. 6032, the Managed Care Plan's policies, and the rights of employees to be protected as whistleblowers.
- e. The Managed Care Plan shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect, exploitation and overpayment issues.

Section X. Administration and Management

- f. The Agency may impose sanctions and/or liquidated damages for failure to timely comply with the provisions of this Section.

2. Compliance Officer

The Managed Care Plan's compliance officer as described in Section X., Administration and Management, shall have unrestricted access to the Managed Care Plan's governing body for compliance reporting, including fraud, abuse, waste and overpayment.

3. Fraud Investigation Unit

- a. The Managed Care Plan shall establish and maintain a fraud investigative unit to investigate possible acts of fraud, abuse, waste, or overpayment, or may subcontract such functions.
- b. If a Managed Care Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Managed Care Plan shall file the following with the Bureau of MPI for approval at least sixty (60) days before subcontract execution:
 - (1) The names, addresses, telephone numbers, e-mail addresses and fax numbers of the principals of the entity with which the Managed Care Plan wishes to subcontract;
 - (2) A description of the qualifications of the principals of the entity with which the Managed Care Plan wishes to subcontract; and
 - (3) The proposed subcontract.
- c. The Managed Care Plan shall submit to MPI such executed subcontracts, attachments, exhibits, addendums or amendments thereto, within thirty (30) days after execution.

4. Compliance Plan and Anti-Fraud Plan

- a. The Managed Care Plan shall submit its compliance plan and anti-fraud plan, including its fraud and abuse procedures, and any changes to these items, to MPI for written approval at least forty-five (45) days before those plans and procedures are implemented. (ss. 409.91212, F.S., and 409.967(2)(g), F.S.) The Managed Care Plan shall submit these documents via the MPI-MC SFTP site. Failure to implement an MPI approved anti-fraud plan within ninety (90) days may result in liquidated damages. MPI may reassess the implementation of the anti-fraud plan every ninety (90) days until MPI deems the Managed Care Plan to be in compliance. (Section XIV., Liquidated Damages.)
- b. At a minimum the Managed Care Plan shall submit its compliance plan to MPI September 1 of each Contract year. The compliance plan shall comply with 42 CFR 438.608 and include:
 - (1) Written policies, procedures and standards of conduct that articulate the

Section X. Administration and Management

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

Section X. Administration and Management

overpayment which were conducted during the previous fiscal year by the Managed Care Plan's fraud investigative unit. For purposes of this summary, a case includes any action, whether an investigation, audit, provider payment review, provider on-site review, or other provider-specific evaluation. This summary shall include information pertaining to the State fiscal year that concluded immediately prior to the submission of this report. This summary shall include:

- (a) Total number of cases opened;
- (b) Total number of cases closed;
- (c) Total number of cases that remain open as of the last day of the previous fiscal year;
- (d) Total of overpayments identified for recovery which were identified as waste;
- (e) Total amount of overpayments identified for recovery which were identified as fraud or abuse;
- (f) Total amount of overpayments identified as waste which were actually recovered; and
- (g) Total amount of overpayments identified as fraud or abuse that was actually recovered.

(42 CFR 438.608(a); 42 CFR 438.608(a)(1)(i)-(vii); 42 CFR 438.604(a)(7); 42 CFR 438.606; 42 CFR 438.608(d)(3))

- d. At a minimum, the Managed Care Plan's compliance plan, anti-fraud plan, and fraud and abuse procedures shall comply with s. 409.91212, F.S., and with the following:
 - (1) Ensure that all officers, directors, managers and employees know and understand the provisions;
 - (2) Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. Nothing in this Contract shall require that the Managed Care Plan assure that non-participating providers are compliant with this Contract, but the Managed Care Plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected;
 - (3) Describe the Managed Care Plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols. Such internal investigational methodology and reporting protocols shall ensure the unit's primary purpose is for the investigation (or supervision of the investigation) of suspected insurance/Medicaid fraud and fraudulent claims;
 - (4) Describe the method(s), including detailed procedures, for verifying enrollees'

Section X. Administration and Management

identity and if services billed by providers were actually received.

- (a) The Managed Care Plan shall describe procedures that include provisions to verify, by sampling or other methods, delivery of services by network providers to enrollees. Such methods include, but are not limited to, electronic verification, biometric technology, sending enrollee explanations of Medicaid benefits, contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses; (42 CFR 438.608(a)(5))
 - (b) Notwithstanding the above provisions, the Managed Care Plan shall describe the process by which the delivery of personal care services and home health services shall be monitored and validated via an EVV system effective January 1, 2019 (as required by federal law in the “21st Century Cures Act”). The description shall include details on EVV system reports and costs. The Managed Care Plan may use any EVV vendor and/or proprietary EVV system; however, the EVV system shall offer interoperability and compatibility among EVV platforms and be compatible with the Agency’s EVV system as prescribed by the Agency.
- (5) Incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:
- (a) An effective pre-payment and post-payment review process, including but not limited to data analysis, claims and other system edits, and auditing of participating providers. (s. 409.967(2)(g), F.S.);
 - (b) Provider profiling, credentialing, and recredentialing, and ongoing provider monitoring including a review process for claims and encounters that shall include providers and non-participating providers who:
 - (i) Demonstrate a pattern of submitting falsified encounter data or service reports;
 - (ii) Demonstrate a pattern of overstated reports or up-coded levels of service;
 - (iii) Alter, falsify, or destroy enrollee record documentation;
 - (iv) Make false statements related to credentials;
 - (v) Misrepresent medical information to justify enrollee referrals;
 - (vi) Fail to render medically necessary covered services they are obligated to provide according to their provider agreements;
 - (vii) Charge enrollees for covered services; and
 - (viii) Bill for services not rendered;
 - (c) Prior authorization;

Section X. Administration and Management

- (d) UM;
 - (e) Subcontract and provider agreement provisions;
 - (f) Provisions from the provider and the enrollee handbooks; and
 - (g) Standards for a code of conduct.
- (42 CFR 438.608(a)(7))
- (6) Contain provisions pursuant to this Section for the confidential reporting of Managed Care Plan violations to MPI and other agencies as required by law;
 - (7) Include provisions for the investigation and follow-up of any reports;
 - (8) Ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud and abuse;
 - (9) Require all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including but not limited to Managed Care Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under State and/or federal law be reported to MPI within fifteen (15) days of detection, as specified in s. 409.91212, F.S., and in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. Additionally, any final resolution reached by the Managed Care Plan shall include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter;
 - (10) Ensure that the Managed Care Plan and all providers and subcontractors, upon request and as required by State and/or federal law, shall:
 - (a) Make available to all authorized federal and State oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS any and all administrative, financial and enrollee records and data relating to the delivery of items or services for which Medicaid monies are expended; (42 CFR 438.242(b)(4)) and
 - (b) Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS to any place of business and all enrollee records and data, as required by State and/or federal law. Access shall be during Normal Business Hours, except under special circumstances when the Agency, the Florida Attorney General, and DFS shall have After Hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances.
 - (11) Ensure that the Managed Care Plan shall cooperate fully in any investigation by federal and State oversight agencies and any subsequent legal action that may

Section X. Administration and Management

result from such an investigation;

- (12) Ensure that the Managed Care Plan does not retaliate against any individual who reports violations of the Managed Care Plan's fraud and abuse procedures or suspected fraud and abuse;
- (13) Not knowingly employ or contract with individuals or entities debarred or excluded from participation in any federal health care program under ss. 1128 and 1128A of the Social Security Act, nor with an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610 (a)(1); or subcontractors on the discriminatory vendor list maintained by the Department of Management Services in accordance with s. 287.134, F.S.; (42 CFR 438.808(a) and (b)(2); 42 CFR 431.55(h); 42 CFR 438.610(b); ss. 1128(b)(8) and 1903(i)(2) of the Social Security Act; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); State Medicaid Director Letters 6/12/08 and 1/16/09; Executive Order No. 12549)
- (14) On at least a monthly basis check current staff, subcontractors and providers against the federal LEIE and the federal SAM (includes the former EPLS) or their equivalent, to identify excluded parties. The Managed Care Plan shall also check monthly the Agency's listing of suspended and terminated providers at the Agency website below, to ensure the Managed Care Plan does not include any non-Medicaid eligible providers in its network:
http://apps.ahca.myflorida.com/dm_web.

The Managed Care Plan shall also conduct these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. The Managed Care Plan shall not employ or contract with an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act; (42 CFR 438.214(d)(1))

- (15) Provide details and educate employees, subcontractors and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:
 - (a) The Federal False Claims Act;
 - (b) The penalties and administrative remedies for submitting false claims and statements;
 - (c) Whistleblower protections under federal and State law;
 - (d) The entity's role in preventing and detecting fraud, waste and abuse;
 - (e) Each person's responsibility relating to detection and prevention; and
 - (f) The toll-free State telephone numbers for reporting fraud and abuse.
- (16) If the Managed Care Plan provides telemedicine, the Managed Care Plan shall include procedures specific to prevention and detection of potential or suspected fraud and abuse of telemedicine in its fraud and abuse detection activities.

Section X. Administration and Management

5. Retention Policy for the Treatment of Fraud, Abuse, and Waste Recoveries

- a. The Managed care Plan shall diligently engage in efforts to recover overpayments. Where the recovery efforts are time barred by the provisions of section 641.3155, F.S., (hereinafter "time barred") and the Managed Care Plan has properly reported the suspected fraud, abuse, or waste as required by 42 CFR 438.608 and s. 409.91212, F.S., recoveries made by the Agency may be shared with the Managed Care Plan. Where the recovery efforts are time barred and the Managed Care Plan has not properly reported the suspected waste, abuse, or fraud, recoveries made by the Agency are retained by the Agency. Where the recovery efforts are not time barred, recoveries by the Managed Care Plan are retained by the Managed Care Plan. However, the Agency may identify overpayments that are not time barred, and after notice to the Managed Care Plan, if the Managed Care Plan does not engage in recovery efforts and the Agency recovers the overpayments, the Agency shall retain the recoveries. Managed Care Plan subcontracts with providers shall ensure that providers are obligated to cooperate with recovery efforts, including participate in audits and repay overpayments.
- b. In addition to the Managed Care Plan's obligations to establish and maintain comprehensive program integrity efforts, the Managed Care Plan shall maximize efforts to recover overpayments. Overpayments may be in the form of fraud, abuse, or waste.
- c. The provisions of 42 CFR 438.608 and s. 409.91212, F.S., require the Managed Care Plan to timely report to the Agency's Bureau of MPI the identification of suspected or confirmed fraud, abuse, and waste.
 - (1) The Office of Attorney General, MFCU, and MPI evaluate reports of fraud. Fraud is further investigated, and as appropriate prosecuted or pursued civilly by MFCU or other law enforcement/prosecutorial entities. The Managed Care Plan shall fully participate in fraud investigations and prosecutions, and may be entitled to recoveries related to fraud reports initiated by the Managed Care Plan.
 - (2) The Agency's Bureau of MPI also evaluates abuse and waste. When MPI pursues recoveries related to abuse and waste, except as specified in this retention policy regarding time barred overpayments, the Agency retains the recoveries. MPI shall refrain from engaging in duplicative recovery efforts
- d. The Managed Care Plan shall ensure that all participating providers are required to cooperate with recovery efforts, including participate in audits and repay overpayments, whether such efforts are taken by the Managed Care Plan, the Agency, MFCU, or other authorized entity.

6. Reporting and Disclosure Requirements

- a. The Managed Care Plan shall comply with all reporting requirements as set forth below and in 42 CFR 438.608 and s. 409.91212, F.S.
- b. The Managed Care Plan shall report on a quarterly basis a comprehensive fraud and

Section X. Administration and Management

abuse prevention activity report regarding its investigative, preventive and detective activity efforts, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide

- c. The Managed Care Plan shall, by September 1 of each year, report to MPI its experience in implementing an anti-fraud plan, and on conducting or subcontracting for investigations of possible fraudulent or abusive acts during the prior State fiscal year, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. The report must include, at a minimum:
 - (1) The dollar amount of Managed Care Plan losses and recoveries attributable to overpayment, abuse and fraud; and
 - (2) The number of Managed Care Plan referrals to MPI.
- d. The Managed Care Plan shall notify DHHS OIG and MPI within ten (10) business days of discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per s. 1128, s. 1156, and s.1892 of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1.
- e. In accordance with 42 CFR 455.106, the Managed Care Plan shall disclose to DHHS OIG, with a copy to MPI within ten (10) business days after discovery, the identity of any person who:
 - (1) Has ownership or control interest in the Managed Care Plan, or is an agent or managing employee of the Managed Care Plan; and
 - (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.
- f. In addition to the disclosure required under 42 CFR 455.106, the Managed Care Plan shall also disclose to DHHS OIG with a copy to MPI within ten (10) business days after discovery, the identity of any person described in 42 CFR 1002.3 and 42 CFR 1001.1001(a)(1), and to the extent not already disclosed, to additionally disclose any person who has ownership or control interest in a Managed Care Plan participating provider, or subcontractor, or is an agent or managing employee of a Managed Care Plan participating provider or subcontractor, and meets at least one of the following requirements:
 - (1) Has been convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs;
 - (2) Has been denied entry into the Managed Care Plan's network for program integrity-related reasons; or
 - (3) Is a provider against whom the Managed Care Plan has taken any action to limit the ability of the provider to participate in the Managed Care Plan's provider network, regardless of what such an action is called. This includes, but is not

Section X. Administration and Management

limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program or Managed Care Plan provider network to avoid a formal sanction.

- g. The Managed Care Plan shall submit the written notification referenced above to DHHS OIG as instructed by the Agency. Document information examples include, but are not limited to, court records such as indictments, plea agreements, judgments and conviction/sentencing documents.
- h. The Managed Care Plan shall notify MPI and provide a copy of any corporate integrity or corporate compliance agreements within thirty (30) days after execution of such agreements.
- i. The Managed Care Plan shall notify MPI and provide a copy of any CAPs required by the DFS and/or federal governmental entities, excluding the Agency, within thirty (30) days after execution of such plans.
- j. The Managed Care Plan shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI.

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Section XI. Method of Payment

A. General Provisions

1. The Agency shall deny payments to the Managed Care Plan for new enrollees when payment for those enrollees is denied by CMS based on the Agency's recommendation in accordance with 42 CFR 438.726(b) and 42 CFR 438.730(e).
2. In accordance with s. 409.967(3), F.S., the Agency shall be responsible for verifying the Managed Care Plan's ASR as specified in Section XI., Method of Payment in this Contract. The Agency shall contract with independent certified public accountants (CPAs) to conduct compliance audits for the purpose of auditing Managed Care Plan financial information in order to determine and validate the Managed Care Plan's ASR.

B. Fixed Price Unit Contract

This is a fixed price (unit cost) Contract awarded through procurement. The Agency, through its fiscal agent, shall make payment to the Managed Care Plan on a monthly basis for the Managed Care Plan's satisfactory performance of its duties and responsibilities as set forth in this Contract.

C. Payment Provisions

1. Fee-for-Service Provider Service Networks

a. Payment Provisions for Fee-for-Service Provider Service Networks

- (1) Pursuant to s. 409.968, F.S., a Managed Care Plan that is a FFS PSN may receive FFS rates with a shared savings settlement.
- (2) The FFS PSN shall develop and implement an Agency-approved transition plan to assure the Managed Care Plan's timely transition to a fully capitated reimbursement methodology, as required by the Agency.
- (3) If the PSN chooses to be reimbursed on an FFS basis with a shared savings settlement, cost reconciliations shall be conducted annually by the Agency to determine the amount of cost savings achieved, if any, by the FFS PSN for the dates of service within the period being reconciled.
- (4) This is a fixed price (unit cost) Contract awarded through procurement. The Agency will manage this fixed price Contract for the delivery of services to enrollees. The FFS PSN will be paid through the Medicaid fiscal agent in accordance with the terms of this Contract, subject to the availability of funds and the amount of shared cost savings, if any, experienced through this Contract. To accommodate payments, the FFS PSN shall be eligible for enrollment, and enrolled as a Medicaid provider with the fiscal agent. Payments made to the FFS PSN resulting from this Contract will include reimbursement for claims adjudicated by the FFS PSN, monthly administrative allocation payments, transportation capitation rates and shared cost savings, if any, as specified below.

Section XI. Method of Payment

- (5) Reimbursement of Claims. The Agency may make monthly payments to the FFS PSN to reimburse the FFS PSN for properly adjudicated and paid FFS claims submitted by providers to the FFS PSN. The FFS PSN shall be responsible for adjudicating all claims submitted by all providers to the FFS PSN. Each week, the FFS PSN shall submit an invoice to the Agency for reimbursement of claims paid. The FFS PSN shall ensure that all claims included in the invoice for reimbursement are adjudicated in accordance with applicable Medicaid Coverage and Limitation Handbooks and fee schedule. The nature and format of the invoice shall be determined by the Agency at a later date.
- (6) Upon review and approval of the claims invoice, the Agency shall reimburse the FFS PSN through the fiscal agent.
- (7) The FFS PSN shall pay claims in accordance with Section VIII.E., Claims and Provider Payment. Failure to pay providers in accordance with Section VIII.E., may result in sanctions as specified in Section XIII., Sanctions or liquidated damages as specified in Section XIV., Liquidated Damages.
- (8) Administrative Allocation. The Agency may make monthly payments to the FFS PSN as an allocation for administrative activities undertaken by the FFS PSN. The amount of the administrative allocation is a PMPM amount for each person enrolled in the FFS PSN for the month. The administrative allocation is paid to cover reasonable administrative costs the FFS PSNs are expected to incur in providing contractually required services. In the first year of the Contract term, the administrative allocation will be negotiated by the Agency and the FFS PSNs based on their cost proposals and guidance received from Agency actuaries. After the first year no further rate negotiations will be conducted, but the Agency may adjust the administrative allocation to reflect changes in the expected costs of providing contractually required services. The administrative allocation is a percentage of the per capita service benchmark (PCSB) as defined below.
 - (a) The FFS PSN is at risk for a maximum of fifty percent (50%) of each administrative allocation due from the Agency as indicated in Exhibit B-1, Section XI.C.4., below.
 - (b) The Agency reserves the right to adjust the administrative allocation on an as needed basis.
- (9) Per Capita Service Benchmark (PCSB). A PCSB shall be established for each region in which the FFS PSN provides services and for those services the FFS PSN provides. The PCSB is an Agency-established PMPM cost that reflects the non-transportation services component of the capitation rate in effect for the population and region for the dates of service being reconciled. This PMPM does not include any allowance for administration or profit, and will be risk adjusted to reflect the population enrolled in the FFS PSN.
 - (a) For MMA plans, the PCSB is calculated by the enrollees' Medicaid eligibility groups (MEG), including newborns retroactive to birth. If an enrollee changes eligibility groups and the change is identified in the

Section XI. Method of Payment

system, then the enrollee's final eligibility group will be used by the Agency in establishing the PCSB. However, the enrollee's age group at the time of each month's FFS PSN payment shall be used when establishing the PCSB.

- (b) For LTC plans, the PCSB is calculated in the same manner as the payments to capitated plans, reflecting a blend of the base HCBS and non-HCBS base rates. The blend percentage will be based on the FFS PSN's case mix, adjusted by the region specific Agency-required transition percentage.
- (c) The aggregate PCSB is the sum of all PCSBs for all enrollees as calculated by the Agency.

b. Cost Reconciliation Process for Fee-for-Service Provider Service Networks

- (1) The aggregate PCSB is used in the Agency's cost reconciliation process to determine shared cost savings, if any. If the actual Medicaid costs for FFS PSN covered non-transportation services are less than the aggregate PCSB for all Contract regions served, then cost savings have occurred, and the FFS PSN may receive a share of those cost savings. If the actual Medicaid costs for FFS PSN-covered non-transportation services are greater than the aggregate PCSB, then cost savings have not occurred.
- (2) The Agency's reconciliation process will occur on a periodic basis, culminating with a final reconciliation for each reconciliation period.
- (3) In performing the reconciliation process, the Agency will compare actual Medicaid payments for FFS PSN-covered non-transportation services, through encounter claims submitted by the FFS PSN to the Agency, to the aggregate PCSB for the time period being reconciled.
- (4) If the FFS PSN provides transplant services for which kick payments would have been paid under a Capitated Managed Care Plan Contract, these payments will be added to the aggregate PCSB for reconciliation.

c. Annual Reconciliations for Fee-for-Service Provider Service Networks

- (1) The Agency shall conduct annual cost reconciliations in accordance with s. 409.968, F.S., to determine the amount of cost savings achieved, if any, by the FFS PSN for the dates of service in the period being reconciled. The aggregate amount of actual payments made by the FFS PSN to its providers shall be calculated by the Agency. The aggregate of amount of payments shall be based on encounter claims submitted by the FFS PSN. Only payments for covered services for dates of service within the reconciliation period and paid by the FFS PSN within twelve (12) months after the last date of service in the reconciliation period will be included. This allows for a complete payment of all claims for the reconciliation period. The Agency will make the necessary adjustments to any amounts owed to or payable by the Agency based on the results of the annual

Section XI. Method of Payment

reconciliation.

- (2) The aggregated PCSB minus the aggregate adjusted actual payments for the dates of service included in the reconciliation period results in the savings pool.
- (3) If the savings pool is greater than zero (0) for the dates of service included in the reconciliation, fifty percent (50%) of the savings pool to the FFS PSN shall be allocated by the Agency, provided the FFS PSN meets the following minimum quality standards.
- (4) In order to be eligible to receive an allocation from the savings pool, the FFS PSN shall achieve performance measure rates as specified by the Agency.
- (5) The Agency may amend the performance measures and the thresholds required for a FFS PSN to be eligible to receive an allocation from the savings pool with sixty (60) days' advance notice.
- (6) If the savings pool is less than the administrative allocation, the FFS PSN will refund to the Agency the lesser of:
 - (a) The difference between the savings pool and the total administrative allocation due for the time period included in the reconciliation; or
 - (b) Fifty percent (50%) of the total administrative allocation due.
- (7) If the administrative allocation has been garnished (withheld) by the Agency for sanctions incurred, the amount of the administrative allocation accounted for in the reconciliation will include the entire allocation, both paid and withheld.

d. **Annual Reconciliation Review for Fee-for-Service Provider Service Networks**

- (1) The Agency will begin the annual reconciliation process thirteen (13) months after the last date of service in the reconciliation period and will provide the results to the FFS PSN within forty-five (45) days thereafter. The FFS PSN shall review and provide written comments or a letter of concurrence to the Agency within forty-five (45) days after receipt of the reconciliation results. This reconciliation is considered final if the FFS PSN concurs with the results.
- (2) Comments and errors identified are limited to the claims completion, correct application of the methodology, and/or calculations.
- (3) If the FFS PSN or the Agency comments that such an error has occurred, a new forty-five (45)-day review period shall start on the date the FFS PSN receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive. The FFS PSN may dispute the Agency's decision as per Attachment B., Section XV., Special Terms and Conditions, if it does not concur with the results.
- (4) If the FFS PSN does not provide comments within the forty-five (45)-day period,

Section XI. Method of Payment

no further opportunity for review consideration will be provided.

- (5) If the FFS PSN fails to timely submit any refund due, the Agency may garnish/withhold future allocations, sanction the Managed Care Plan in accordance with Attachment B., Section XIII., Sanctions, or impose liquidated damages in accordance with Section XIV., Liquidated Damages.

e. **Reconciliation upon Termination for Fee-for-Service Provider Service Networks**

- (1) Following the final reconciliation completed under this Contract, any money due to either party, per the terms of this Contract, will be distributed or collected.
- (2) Termination of this Contract prior to the Contract end date would not eliminate the reconciliation processes. All outstanding financial reconciliation processes will continue to occur, but will only apply to the months within the reconciliation period during which the FFS PSN had enrollees and received administrative allocation payments.
- (3) The FFS PSN shall be notified of any refund due. The FFS PSN shall submit the refund to the Agency within thirty (30) days after the date of the Agency's notice. If the FFS PSN has commented that an error in calculation has occurred, the thirty (30)-day period for the refund to be submitted shall start on the date the FFS PSN receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive.
- (4) If the FFS PSN fails to timely submit any refund due, the Agency may garnish/withhold future allocations, sanction the FFS PSN in accordance with Attachment B., Section XIII., Sanctions, or impose liquidated damages in accordance with section XIV., Liquidated Damages.

f. **Capitation Payments for Transportation Services**

- (1) The Agency shall pay the Managed Care Plan the applicable transportation capitation rate for each eligible enrollee whose name appears on the HIPAA-compliant X12 820 file for each month, except that the Agency shall not pay for, and shall recoup, any part of the payment for the total enrollment that exceeds the required and actual enrollment level(s). The total payment amount to the FFS PSN shall depend upon the number of enrollees in each eligibility category and each rate group, as provided for by this Contract, or as adjusted pursuant to the Contract when necessary.
- (2) The FFS PSN is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the FFS PSN has received capitation payment or for whom the Agency has assured the FFS PSN that capitation payment is forthcoming.
- (3) The rates shall be actuarially sound in accordance with 42 CFR 438.6(c).

Section XI. Method of Payment

- (4) The Agency may use, or may amend and use these rates, only after certification by its actuary and approval by the CMS. Inclusion of these rates is not intended to convey or imply any rights, duties or obligations of either party, nor is it intended to restrict, restrain or control the rights of either party that may have existed independently of this Section of the Contract.
- (5) By signature on this Contract, the parties explicitly agree that this Section shall not independently convey any inherent rights, responsibilities, or obligations of either party, relative to these rates, and shall not itself be the basis for any cause of administrative, legal, or equitable action brought by either party. In the event that the rates certified by the actuary and approved by CMS are different from the rates included in this Contract, the FFS PSN agrees to accept a reconciliation performed by the Agency to bring payments to the FFS PSN in line with the approved rates. The Agency may amend and use the CMS-approved rates by notice to the FFS PSN through an amendment to the Contract.
- (6) Unless otherwise specified in this Contract, the FFS PSN shall accept the capitation payment received each month as payment in full by the Agency for all transportation services provided to enrollees covered under this Contract. Any and all transportation costs incurred by the FFS PSN in excess of the capitation payment shall be borne in total by the FFS PSN.

g. Enrollee Payment Liability Protection for Transportation Services

- (1) Pursuant to s. 1932 (b)(6), Social Security Act (as enacted by section 4704 of the Balanced Budget Act of 1997), the FFS PSN shall not hold enrollees liable for the following:
 - (a) For debts of the FFS PSN, in the event of the FFS PSN's insolvency;
 - (b) For payment of covered services provided by the FFS PSN if the FFS PSN has not received payment from the Agency for the covered services, or if the provider, under contract or other arrangement with the FFS PSN, fails to receive payment from the Agency or the FFS PSN; and/or
- (2) For payments to a provider, including referral providers, that furnished covered services under a contract, or other arrangements with the FFS PSN, that are in excess of the amount that normally would be paid by the enrollee if the covered services had been received directly from the FFS PSN.

h. Rate Increases

The Agency may not approve any request from the FFS PSN for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act.

2. Capitated Managed Care Plans

a. Capitation Rates

Section XI. Method of Payment

- (1) The Managed Care Plan shall be paid the applicable capitation rate for each Medicaid-eligible enrollee whose name appears on the HIPAA-compliant X12 820 file for each month, except that the Agency shall not pay for, and shall recoup, any part of the total payment for enrollment that exceeds the maximum authorized payment amount expressed in this Contract, as applicable. The total payment amount to the Managed Care Plan shall depend upon the number of enrollees in each eligibility category and each rate group, as provided for by this Contract, or as adjusted pursuant to this Contract when necessary. The Managed Care Plan is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the Managed Care Plan has received capitation payment or for whom the Agency has assured the Managed Care Plan that capitation payment is forthcoming. (42 CFR 438.3(c)(2))
- (2) In accordance with ss. 409.968, 409.976 and 409.983, F.S., the capitation rates reflect historical utilization and spending for covered services projected forward and shall be adjusted to reflect the level of care profile (risk) for enrollees in each Managed Care Plan.
- (3) Utilization and expenditures for services by a provider outside the U.S. shall not be included in the development of capitation rates.
- (4) The rates shall be actuarially sound in accordance with 42 CFR 438.6(c).
- (5) The base capitation rates prior to risk adjustment shall be included in this Contract.
- (6) The Agency may use, or may amend and use these rates, only after certification by its actuary and approval by CMS. Inclusion of these rates is not intended to convey or imply any rights, duties or obligations of either party, nor is it intended to restrict, restrain or control the rights of either party that may have existed independently of this Section of this Contract.
- (7) By signature on this Contract, the parties explicitly agree that this Section shall not independently convey any inherent rights, responsibilities or obligations of either party, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by either party. In the event that the rates certified by the actuary and approved by CMS are different from the rates included in this Contract, the Managed Care Plan agrees to accept a reconciliation performed by the Agency to bring payments to the Managed Care Plan in line with the approved rates. The Agency may amend and use the CMS-approved rates by notice to the Managed Care Plan through an amendment to this Contract.
- (8) Unless otherwise specified in this Contract, the Managed Care Plan shall accept the capitation payment received each month as payment in full by the Agency for all services provided to enrollees covered under this Contract and the administrative costs incurred by the Managed Care Plan in providing or arranging for such services. Any and all costs incurred by the Managed Care Plan in excess

Section XI. Method of Payment

of the capitation payment shall be borne in total by the Managed Care Plan.

b. Rate Adjustments and Reconciliations

- (1) The Managed Care Plan and the Agency acknowledge that the capitation rates paid under this Contract are subject to approval by the federal government.
- (2) The Managed Care Plan and the Agency acknowledge that adjustments to funds previously paid, and to funds yet to be paid, may be required. Funds previously paid shall be adjusted when capitation rate calculations are determined to have been in error, or when capitation rate payments have been made for enrollees who are determined not to have been eligible for Managed Care Plan membership during the period for which the capitation rate payments were made. In such events, the Managed Care Plan and any subcontractor shall report to the State within sixty (60) days when it has identified capitation payments or other payments in excess of amounts specified in this Contract. The Managed Care Plan agrees to refund any overpayment and the Agency agrees to pay any underpayment. (42 CFR 438.608(c)(3))
- (3) Capitation rates shall be adjusted to reflect budgetary changes in the Medicaid program. The rate of payment and total dollar amount may be adjusted with a properly executed amendment when Medicaid expenditure changes have been established through the appropriations process and subsequently identified in the Agency's operating budget. Legislatively-mandated changes shall take effect on the dates specified in the legislation. The Agency may not approve any Managed Care Plan request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act. (s. 409.968(3), F.S.).
- (4) In accordance with s. 409.967(3), F.S., the Managed Care Plan's ASR shall be verified as specified in this Contract.
- (5) The Agency shall conduct annual cost reconciliations to determine the amount of cost savings achieved by the FFS PSN for the dates of service in the period being reconciled.

c. Errors

The Managed Care Plan shall carefully prepare all reports and monthly payment requests for submission to the Agency. If after preparation and electronic submission, the Managed Care Plan discovers an error, including but not limited to errors resulting in capitated payments or other payments in excess of amounts specified in this Contract, either by the Managed Care Plan or the Agency, the Managed Care Plan has sixty (60) days from its discovery of the error, or sixty (60) days after receipt of notice by the Agency, to correct the error and re-submit accurate reports. Failure to respond within the sixty (60)-day period shall result in a loss of any money due to the Managed Care Plan for such errors and/or sanctions against the Managed Care Plan pursuant to Section XIII., Sanctions.

d. Enrollee Payment Liability Protection

Section XI. Method of Payment

- (1) Pursuant to s. 1932(b)(6), Social Security Act (as enacted by Section 4704 of the Balanced Budget Act of 1997), the Managed Care Plan shall not hold enrollees liable for debts of the Managed Care Plan, in the event of the Managed Care Plan's insolvency; (42 CFR 438.106(a))
- (2) The Managed Care Plan shall not hold enrollees liable for payment of covered services provided by the Managed Care Plan if the Managed Care Plan has not received payment from the Agency for the covered services, or if the provider, under contract or other arrangement with the Managed Care Plan, fails to receive payment from the Agency or the Managed Care Plan; (42 CFR 438.106(b)(1)-(2); 42 CFR 438.3(k); 42 CFR 438.230) and/or
- (3) The Managed Care Plan shall not hold enrollees liable for payments to a provider, including referral providers, that furnished covered services under a contract or other arrangements with the Managed Care Plan, that are in excess of the amount that normally would be paid by the enrollee if the covered services had been received directly from the Managed Care Plan. (42 CFR 438.106(c); 42 CFR 438.3(k); 42 CFR 438.230)

e. Achieved Savings Rebate

- (1) In accordance with s. 409.967(3), F.S., and as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide, the Managed Care Plan shall submit:
 - (a) Quarterly and annual unaudited ASR Financial Reports, and an annual financial statement audit conducted by an independent CPA;
 - (b) Quarterly and annual NAIC Financial Statements filed with the OIR and prepared in accordance with statutory accounting principles.
- (2) In accordance with s. 409.967(3)(g), F.S., as part of the ASR process, a Managed Care Plan that exceeds Agency-defined quality measures as specified in Section XI., Method of Payment, in the reporting period may retain an additional one percent (1%) of revenue.
- (3) The Managed Care Plan shall pay to the Agency the expenses of the Agency's ASR audit at the rates established by the Agency. Expenses shall include actual travel expenses, reasonable living expense allowances, compensation of the CPA, and necessary attendant administrative costs of the Agency directly related to the audit/examination. The Managed Care Plan shall pay the Agency within twenty-one (21) days after presentation by the Agency of the detailed account of the charges and expenses. Failure to pay shall result in liquidated damages as specified in Section XIV., Liquidated Damages.
- (4) The Managed Care Plan shall make available all books, accounts, documents, files and information that relate to the Managed Care Plan's Medicaid transactions at a Florida location by the Agency's contracted CPA.

Section XI. Method of Payment

- (a) The Managed Care Plan shall cooperate in good faith with the Agency and the CPA.
 - (b) Records not in the Managed Care Plan's immediate possession must be made available to the Agency or the CPA in the Florida location specified by the Agency or the CPA within three (3) days after a request is made by the Agency or the CPA. If original records are required, and they cannot be made available in a Florida location as specified herein, the Managed Care Plan shall make the records available for the CPA to review at the applicable location and shall pay any expenses related to the CPA's review at that location.
 - (c) Failure to comply with such record requests, including failure to provide records, reports, and documentation to the Agency or CPA by the dates requested, shall be deemed a breach of Contract, and the Managed Care Plan shall be subject to sanctions as specified in Section XIII., Sanctions.
- (5) In accordance with s. 409.967(3)(g), F.S., and as specified below, if the Managed Care Plan exceeds the Agency-defined quality measures as specified in the applicable Exhibit(s), the Managed Care Plan may retain up to an additional one percent (1%) of its revenue.
- (a) Managed Care Plans that meet the quality standards for only one program component (LTC or MMA), may retain up to one percent (1%) of ASR-allowed revenue associated with the component for which they meet the quality standards.
 - (b) The Agency may amend the performance measures and the thresholds required for an Managed Care Plan to retain up to an additional one percent (1%) of revenue with sixty (60) days' advance notice.
- (6) The Agency CPA shall validate the ASR, and the results shall be provided to the Agency. If the CPA validates the ASR submitted by the Managed Care Plan in accordance with the Managed Care Plan Report Guide, these results shall be final and dispositive. If the CPA fails to validate the ASR submitted by the Managed Care Plan, the Managed Care Plan shall receive written notice of the CPA's findings and be provided with the opportunity to review and respond to the CPA's findings in writing within the timeframe specified by the Agency. The CPA shall review the Managed Care Plan's response and issue final results. These results are dispositive.
- (7) The Managed Care Plan shall receive the final results of the audit, and the Managed Care Plan shall pay the rebate to the Agency within thirty (30) days after the results are provided.
- (8) The ASR is established by determining pretax income as a percentage of revenues and applying the following income ratios:
- (a) One hundred percent (100%) of income up to and including five percent (5%) of revenue shall be retained by the Managed Care Plan.

Section XI. Method of Payment

- (b) Fifty percent (50%) of income above five percent (5%) and up to ten percent (10%) shall be retained by the Managed Care Plan, and the other fifty percent (50%) refunded to the State.
 - (c) One hundred percent (100%) of income above ten percent (10%) of revenue shall be refunded to the State.
- (9) As further specified in the Managed Care Plan Report Guide, for purposes of the ASR:
- (a) Pretax income is defined as pre-tax revenue minus those expenses permitted in the Managed Care Plan Report Guide.
- (10) Revenue includes but is not limited to all capitation premium payments made by the State to the Managed Care Plan. Revenue does not include additions to, or components of, premium payments made to provide funds for payment of the ACA Section 9010 Health Insurance Providers Fee, or the additional amounts to provide for the payment of State premium taxes or federal income tax on such amounts. Revenue is to be reduced by the State premium tax or other State assessments based on the premium.
- (11) Expenses generally include reasonable and appropriate medical expenses and general and administrative expenses, as determined by the Agency, other than interest expense, of operating the Managed Care Plan in accordance with the requirements of this Contract. Any State premium tax or other State assessment based on premium that is treated as a reduction to premium revenue cannot be included in the allowable expenses.
- (12) In accordance with s. 409.967(3)(h), F.S., the following expenses are not allowable expenses for purposes of determining the pre-tax income subject to the ASR:
- (a) Payment of ASRs;
 - (b) Any financial incentive payments made to the Managed Care Plan outside of the capitation rate;
 - (c) Expenses associated with any lobbying or political activities;
 - (d) Cash value or equivalent cash value of bonuses of any type paid or awarded to the Managed Care Plan's executive staff other than base salary;
 - (e) Reserves and reserve accounts other than those expressly permitted by the Managed Care Plan Report Guide;
 - (f) Administrative costs in excess of actuarially sound maximum amounts set by the Agency; and

Section XI. Method of Payment

- (g) Other costs excluded in accordance with 42 CFR 438.6.
- (13) The actuarially sound maximum amount for administrative costs shall be set by the Agency in consultation with the actuary developing the capitation rates as part of the rate setting process.
- (14) In accordance with s. 409.967(3)(i), F.S., if the Managed Care Plan incurs a loss in the first year of operation subject to the achieved saving rebate, it may apply the full amount of such loss as an offset to income in the second year. If the Managed Care Plan elects to carry forward such a loss, then the life-years of coverage for the first year of coverage shall also carry over to the second year.
- (15) In accordance with s. 409.967(3)(j), F.S., if the Agency later determines that the Managed Care Plan owes an additional rebate, the Managed Care Plan shall have thirty (30) days after notification by the Agency to make payment. If the Managed Care Plan fails to pay the rebate, future payments shall be withheld until the entire amount of the rebate is recouped. If the Agency determines that the Managed Care Plan made an overpayment, the Managed Care Plan shall be returned the overpayment within thirty (30) days of such determination.
- (16) If the Managed Care Plan purchases or acquires part or all of the business of another Managed Care Plan, the Managed Care Plan's information and reports regarding its ASR shall include information for the purchased business, including for that part of the reporting period that was prior to the purchase. If the Managed Care Plan is unable to include information for the purchased business prior to the purchase date, the Managed Care Plan shall pay for the cost of the audit for the reporting period prior to the purchase date.
- (17) If the Managed Care Plan's enrollment in a reporting period is fewer than five thousand (5,000) life-years, the Managed Care Plan shall not owe a rebate for the reporting period. However, the information from that reporting period shall be carried over and included with information for the next reporting period. When the cumulative life-years of such combined reporting periods equal or exceed five thousand (5,000) life-years, the achieved saving rebate calculation shall be performed.
- (18) If the Agency determines that payment of an ASR by the Managed Care Plan would result in the Managed Care Plan being put at significant risk of insolvency, the Agency may defer all or a portion of the rebate payment owed by the Managed Care Plan.
- (19) The ASR shall be calculated in accordance with s. 409.967(3)(f), F.S., as illustrated below.

Note: The following three (3) increments shall be applied to the Managed Care Plan's (Plan's) pre-tax income (AKA: net operating income [NOI])

Achieved Savings Rebates Table – Effective 8/1/2018 – 12/31/2023

Section XI. Method of Payment

	NOI Range Category	Amount Managed Care Plans shall retain	Amount Managed Care Plans shall be required to refund to the Agency
I	NOI ranging from Zero (0) up to and including five percent (5%) of the Managed Care Plan's premium revenue:	Managed Care Plans shall retain 100% of NOI within this range.	Managed Care Plans shall not be required to refund any of their NOI within this range.
II	NOI above five percent (5%) and up to and including ten percent (10%) of the Managed Care Plan's premium revenue:	Managed Care Plans shall retain 50% of the NOI within this range.	Managed Care Plans shall be required to refund 50% of the NOI within this range.
III	NOI above ten percent (10%) of the Managed Care Plan's premium revenue:	Managed Care Plans shall not be allowed to retain any of the NOI within this range.	Managed Care Plans shall have to refund to the Agency 100% of the NOI within this range.

Example: If the Managed Care Plan's premium revenues are **\$1,000,000** and allowed expenses are **\$850,000**, the Managed Care Plan has a pre-tax net operating income (NOI) of **\$150,000**. The NOI is calculated to be 15% of premium revenue (NOI/Revenue):

NOI Range as Percent of Revenue	Plan Retains		Plan Refunds to the State	
0.00% to 5.00% = \$50,000.00	100% of NOI within this range	\$50,000.00	0% of NOI within this range:	\$0.00
5.00% to 10.00% = \$50,000.00	50% of NOI within this range	\$25,000.00	50% of NOI within this range:	\$25,000.00
above 10.00% = \$50,000.00	0% of NOI within this range	\$0.00	100% of NOI within this range:	\$50,000.00
TOTAL = \$150,000.00		\$75,000.00		\$75,000.00

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Section XII. Financial Requirements

The Managed Care Plan shall meet all financial requirements established by this Contract and report financial information, including but not limited to quarterly and annual financial statements, in accordance with Section XVI., Reporting Requirements, the Managed Care Plan Report Guide and other Agency instructions. The Managed Care Plan shall certify that information it submits to the Agency is accurate, truthful, and complete in accordance with 42 CFR 438.606.

A. Insolvency Protection

1. Insolvency Protection Requirements

- a. The Managed Care Plan shall establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997). The Managed Care Plan shall deposit into that account five percent (5%) of the capitation payments made by the Agency each month until a maximum total of two percent (2%) of the annualized total current Contract amount is reached and maintained. No interest may be withdrawn from this account until the maximum Contract amount is reached and withdrawal of the interest shall not cause the balance to fall below the required maximum amount. This provision shall remain in effect as long as the Managed Care Plan continues this Contract with the Agency.
- b. The restricted insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by the Managed Care Plan and two (2) representatives of the Agency. The Multiple Signature Verification Agreement Form shall be resubmitted to the Agency within thirty (30) days of Contract execution and resubmitted within thirty (30) days after a change in authorized Managed Care Plan personnel occurs. If the authorized persons remain the same, the Managed Care Plan shall submit to the Agency an attestation to this effect April 1 of each Contract year to the Agency along with a copy of the latest bank statement. The Managed Care Plan may obtain a sample Multiple Signature Verification Agreement form from the Agency or its agent or download from the Agency website at:

http://ahca.myflorida.com/Medicaid/statewide_mc/report_guide.shtml .

The Managed Care Plan shall submit all such agreements or other signature cards to the Agency for prior approval.

- c. In the event that the Agency determines the Managed Care Plan is insolvent, the Agency may draw upon the amount solely with the two (2) authorized signatures of representatives of the Agency, and the Agency may disburse funds to meet financial obligations incurred by the Managed Care Plan under this Contract. A statement of account balance shall be provided by the Managed Care Plan within fifteen (15) days of the request from the Agency.
- d. If the Agency terminates or does not renew this Contract, the Agency shall release the account balance to the Managed Care Plan upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.

Section XII. Financial Requirements

- e. In the event the Agency terminates or does not renew this Contract and the Managed Care Plan is insolvent, the Agency may draw upon the insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency, including, but not limited to, overpayments made to the Managed Care Plan and fines imposed under this Contract or, for HMOs, s. 641.52, F.S., for EPOs, Chapter 627, F.S., and for health insurers, Chapter 624, F.S., for which a final order has been issued. In addition, if the Agency terminates or does not renew this Contract, and the Managed Care Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Managed Care Plan shall agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

2. Insolvency Protection Account Waiver

The Agency may waive the insolvency protection account in writing when evidence of adequate insolvency insurance and reinsurance are on file with the Agency to protect enrollees in the event the Managed Care Plan is unable to meet its obligations. (42 CFR 438.6(b)(1))

3. Insolvency Protection Investment Option

- a. At the discretion of and upon written permission granted by the Agency, a Managed Care Plan that has fully funded their restricted insolvency protection account in accordance with this Section, and has met surplus requirements in accordance with this Section for the previous six (6) consecutive quarters may invest the full value of the required insolvency protection account balance in U.S. Treasury Securities (Securities) which are backed by the full faith and credit of the U.S. government through the utilization of a custodial account at a federally guaranteed financial institution licensed to do business in Florida in accordance with s. 1903(m)(1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997), and s. 409.912, F.S. A listing of approved Securities is specified in the table below. Securities held in the custodial account shall not be pledged to any entity other than the Agency, and trading on margin shall be prohibited.
- b. The Managed Care Plan shall safeguard against potential losses in value by depositing an additional amount equal to the estimated decrease in account value that would occur for a one hundred (100) basis points (1%) increase in the Federal Funds rate. The amount of this deposit shall be approved by the Agency upon account inception and can be held in either Securities or cash.
- c. The custodial investment insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by the Managed Care Plan and two (2) representatives of the Agency. The Multiple Signature Verification Agreement for Custody Arrangements Form shall be submitted to the Agency within thirty (30) calendar days of account execution and resubmitted within thirty (30) calendar days after a change in authorized Managed Care Plan personnel occurs. If the authorized persons remain the same, the Managed Care Plan shall submit an attestation to this effect April 1 of each Contract year to the Agency along with a copy of the latest bank statement and summary of transactions for the month prior.

Section XII. Financial Requirements

- d. The Managed Care Plan assumes sole responsibility for monitoring the custodial investment insolvency account to ensure the total value of all Securities shall not fall below the required insolvency protection account balance pursuant this Section. The Managed Care Plan shall submit to the Agency a monthly account valuation within fifteen (15) calendar days after the end of each reporting month. The monthly account valuation shall include a complete transaction history of purchased and/or sold Securities within the reporting period, the custodial investment insolvency protection account balance, and shall take into consideration all factors that may affect the total value of the custodial investment insolvency protection account. In the event that the total value of the custodial investment insolvency protection account is less than the required insolvency protection account balance at any time, the Managed Care Plan shall make a capital contribution in the form of cash and/or Securities within five (5) business days equal to the difference between the current value and the required insolvency protection account balance. Documentation evidencing this contribution shall be included with the monthly valuation. Should the Managed Care Plan fail to maintain the required insolvency protection account balance, the Agency, at its sole discretion, reserves the right to require the Managed Care Plan to re-establish a restricted insolvency protection account in accordance with Section X.A.1. (42 CFR 438.604(a)(4); 42 CFR 438.606)
- e. The Agency, at its sole discretion, may require the plan to re-establish a restricted insolvency protection account in accordance with this Section. The re-established account shall be funded by the liquidated proceeds of all Securities held in the insolvency protection investment account at the time the Agency required its re-establishment, plus any additional cash required to fully fund the account on its opening.
- f. Upon receipt of the executed Multiple Signature Verification Agreement for Custody Arrangements, the Managed Care Plan may initiate the purchase or sale of Securities with only the Managed Care Plan's authorized representatives' signatures, provided that the Securities sold or purchased are in accordance with the Agency's guidelines of approved Securities as listed in the table below, and the transaction results in an equal amount of incoming cash or Securities on the same day of the transaction. Withdrawals from the investment insolvency protection account that do not result in an equal amount of incoming cash or Agency-approved Securities on the same day of the transaction requires the authorized signatures of two (2) Managed Care Plan representatives and two (2) Agency representatives.
- g. In the event that a determination is made by the Agency that the Managed Care Plan is insolvent, the Agency may draw upon or initiate the sale of Securities from the custodial investment insolvency protection account solely with the two (2) authorized signatures of representatives of the Agency and funds may be disbursed to meet financial obligations incurred by the Managed Care Plan under this Contract. The Managed Care Plan shall not initiate any transactions subsequent to notification by the Agency that the Agency has determined the Managed Care Plan to be insolvent. The Managed Care Plan shall provide a statement of account balance within fifteen (15) calendar days of request of the Agency.
- h. If this Contract is terminated or not renewed, the custodial investment insolvency protection account balance shall be released by the Agency to the Managed Care Plan

Section XII. Financial Requirements

upon the receipt of proof of satisfaction for all outstanding obligations incurred under this Contract.

- i. In the event this Contract is terminated, not renewed, and/or the Managed Care Plan is declared insolvent, the Agency may draw upon or initiate the sale of Securities from the investment insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency, including but not limited to overpayments made to the Managed Care Plan, and fines imposed under this Contract or, for HMOs, s. 641.52, F.S., for EPOs, s. 627, F.S., and for health insurers, s. 624, F.S. In addition, if the above occurs and the Agency, in its sole discretion, determines that it would be in the best interest of the providers for the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the custodial or controlled account, the Managed Care Plan shall agree to the appointment. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

Custodial Investment Insolvency Protection Account Approved Securities		
Security	Maturity Term	Guarantee
U.S Treasury Bills	All	Full Faith & Credit of the U.S. Government
U.S. Treasury Notes	Not to Exceed 3 Years	Full Faith & Credit of the U.S. Government

B. Surplus

1. Surplus Requirement

- a. The Managed Care Plan shall maintain at all times in the form of cash and investments allowable as admitted assets by the DFS and restricted funds of deposits controlled by the Agency (including the Managed Care Plan’s insolvency protection account) or the DFS, a surplus amount equal to the greater of **\$1.5 million**, ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the Managed Care Plan’s prepaid revenues. In the event that the Managed Care Plan’s surplus (as defined in Section I., Definitions and Acronyms) falls below the amount specified in this paragraph, the Managed Care Plan is prohibited from engaging in marketing activities, shall not receive new enrollments until the required balance is achieved, or may have its Contract terminated statewide.
- b. In lieu of the surplus requirements under this Section, the Agency may consider the following:
 - (1) If the organization is a public entity, the Agency may take under advisement a statement from the public entity that a county supports the Managed Care Plan with the county’s full faith and credit. In order to qualify for the Agency’s consideration, the county must own, operate, manage, administer or oversee the Managed Care Plan, either partly or wholly, through a county department or agency;
 - (2) The State guarantees the solvency of the organization;

Section XII. Financial Requirements

- (3) The organization is a FQHC or is controlled by one (1) or more FQHCs and meets the solvency standards established by the State for such organization pursuant to s. 409.912(4)(b), F.S.; or
- (4) The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 CFR 422.380 through 422.390 and the solvency requirements established in approved federal waivers or Florida's Medicaid State Plan.

C. Interest

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

D. Third Party Resources

1. Covered Third Party Collections

- a. The Managed Care Plan shall determine the legal liability of third parties to pay for services rendered to enrollees under this Contract and notify the Agency of any third party liability discovered.
- b. The Managed Care Plan shall assume full responsibility for covered third party collections in accordance with this Section. Covered third party collections include only recoveries initiated within one year after the Managed Care Plan's claims payment date for the cost of covered services incurred by the Managed Care Plan on behalf of an enrollee for services that should have been paid through a third party. The Managed Care Plan shall be considered to have initiated a recovery by filing a claim of lien in a court of law or filing a claim for reimbursement with the liable third party for the full amount of medical assistance provided. The Managed Care Plan shall have the sole right to subrogation for one (1) year from when the Managed Care Plan incurred the cost to recovery of any third party resource. All recoveries outside this period that were not initiated by the Managed Care Plan shall be pursued by the Agency. Covered third party collections exclude all estate, trust and annuity recoveries.
- c. The Managed Care Plan shall enter into a coordination of benefits agreement with Medicare and participate in the automated claims crossover process. (42 CFR 438.3(t))
- d. The following standards govern recovery of covered third party collections:
 - (1) If the Managed Care Plan has determined that third party liability exists for part or all of the services provided directly by the Managed Care Plan to an enrollee, the Managed Care Plan shall make reasonable efforts to recover from third party liable sources the value of services rendered.
 - (2) If the Managed Care Plan has determined that third party liability exists for part or all of the services provided to an enrollee by a subcontractor or referral provider, and the third party is reasonably expected to make payment within one

Section XII. Financial Requirements

hundred twenty (120) days, the Managed Care Plan may pay the subcontractor or referral provider only the amount, if any, by which the subcontractor's allowable claim exceeds the amount of the anticipated third party payment; or, the Managed Care Plan may assume full responsibility for third party collections for service provided through the subcontractor or referral provider.

- (3) The Managed Care Plan may not withhold payment for services provided to an enrollee if third party liability or the amount of liability cannot be determined, or if payment shall not be available within a reasonable time, beyond one hundred twenty (120) days from the date of receipt.
- e. When the Agency has a FFS lien against a third party resource and the Managed Care Plan has also extended services potentially reimbursable from the same third party resource, the Agency's lien shall be entitled to priority.
- f. The Managed Care Plan shall provide necessary data for recoveries in a format prescribed by the Agency.

2. Optional Third Party Recovery Services

- a. The Agency may, at its sole discretion, offer to provide third party recovery services to the Managed Care Plan for covered third party collections.
- b. If the Managed Care Plan elects to authorize the Agency to recover covered third party collections on its behalf, the Managed Care Plan shall be required to provide the necessary data for recovery in the format prescribed by the Agency.
- c. If the Managed Care Plan elects to authorize the Agency to recover covered third party collections on its behalf, all recoveries, less the Agency's cost to recover, shall be income to the Managed Care Plan. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the Managed Care Plan elects to authorize the Agency to recover on its behalf.
- d. All funds recovered from third parties shall be treated as income for the Managed Care Plan.

3. Patient Responsibility

- a. The Managed Care Plan shall be responsible for collecting patient responsibility as determined by DCF and shall have policies and procedures to ensure that, where applicable, enrollees are assessed for and pay their patient responsibility. Some enrollees have a patient responsibility amount of zero dollars (**\$0**) either because of their limited income or the methodology used to determine patient responsibility.
- b. The Managed Care Plan may transfer the responsibility for collecting its enrollees' patient responsibility to residential providers and compensate these providers net of the patient responsibility amount. The Managed Care Plan shall either collect patient responsibility from all of its residential providers or transfer collection to all of its residential providers.

Section XII. Financial Requirements

- c. The Managed Care Plan shall have a system in place to track the receipt of patient responsibility at the enrollee level irrespective of which entity collects the patient responsibility. This data shall be available upon request by the Agency. The Managed Care Plan or its providers shall not assess late fees for the collection of patient responsibility from enrollees.

E. Assignment

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

1. No plan subject to this procurement or any entity outside this procurement shall be allowed to be merged with or acquire all the Managed Care Plans within the region. When a merger or acquisition of a Managed Care Plan has been approved, the assignment or transfer of the appropriate Medicaid Managed Care Plan Contract upon the request of the surviving entity of the merger or acquisition if the Managed Care Plan and the surviving entity have been in good standing with the Agency for the most recent twelve (12) month period, unless the Agency determines that the assignment or transfer would be detrimental to Medicaid recipients or the Medicaid program. The entity requesting the assignment or transfer shall notify the Agency of the request ninety (90) days before the anticipated effective date.
 - a. Entities regulated by the DFS or OIR must comply with provisions of s. 628.4615, F.S., and receive OIR approval before a merger or acquisition can occur.
 - b. For the purposes of this Section, a merger or acquisition means a change in controlling interest of a Managed Care Plan, including an asset or stock purchase.
 - c. To be in good standing, a Managed Care Plan shall not have failed accreditation or committed any material violation of the requirements of s. 641.52, F.S., and shall meet the Medicaid Contract requirements.
2. The Managed Care Plan requesting the assignment or transfer of its enrollees and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, as required by the Agency and to ensure a seamless transition for enrollees, particularly those hospitalized, those requiring care coordination/case management and those with complex medical needs. The notice to enrollees shall contain the same information as required for a notice of termination according to Section XV.G., Termination Procedures. The Managed Care Plan requesting assignment or transfer of its enrollees shall perform as follows:
 - a. Notice its enrollees, providers and subcontractors of the change in accordance with this Contract; and
 - b. Provide to the Agency the data needed, including encounter data, by the Agency to

maintain existing case relationships.

F. Financial Reporting

1. Financial Reports

- a. The Managed Care Plan shall submit to the Agency quarterly and annual NAIC Health Statements, quarterly and annual Achieved Savings Rebate Financial Reports, and annual audited financial statements.
- b. The Managed Care Plan shall submit to the Agency the annual NAIC Health Statement and annual audited financial statements no later than three (3) calendar months after the end of the calendar year. The Managed Care Plan shall submit the quarterly NAIC Health Statements no later than forty-five (45) days after the end of each calendar quarter. A quarterly NAIC Health Statement is not required for the quarter ending December 31st. The quarterly and annual NAIC Health Statement, as well as the annual audited financial statements, shall be prepared using statutory accounting principles. The quarterly and annual Achieved Savings Rebate Financial Report shall be submitted in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.
- c. The Managed Care Plan shall submit annual and quarterly financial statements that are specific to the processes of the Managed Care Plan rather than to a parent or umbrella organization.
- d. The Managed Care Plan shall submit all financial reports to the Agency in accordance with Section XVI., Reporting Requirements, and the instructions for Achieved Savings Rebate Financial Reports in the Managed Care Plan Report Guide. (42 CFR 438.3(m))

G. Inspection and Audit of Financial Records

The State, CMS, and DHHS may inspect and audit any financial records of the Managed Care Plan or its subcontractors, as well as financial records from parent companies relating to corporate or administrative charges included on financial reports submitted by the Managed Care Plan to the Agency. Pursuant to s. 1903(m)(4)(A) of the Social Security Act and the State Medicaid Manual 2087.6(A-B), non-federally qualified Managed Care Plans shall report to the State, upon request, and to the Secretary and the Inspector General of DHHS, a description of certain transactions with parties of interest as defined in s. 1318(b) of the Social Security Act. The Managed Care Plan shall make any reports of transactions between the Managed Care Plans and parties in interest that are provided to the State or other agencies to its enrollees, upon reasonable request. (Section 1903(m)(4)(A)-(B) of the Social Security Act)

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Section XIII. Sanctions

A. Contract Violations and Non-Compliance

1. The Managed Care Plan shall comply with all requirements and performance standards set forth in this Contract.
2. The Managed Care Plan agrees that failure to comply with all provisions of this Contract may result in the assessment of sanctions and/or termination of this Contract, in whole or in part, in accordance with Section XIII., Sanctions.
3. The Agency shall be responsible for imposing sanctions for Contract violations or other non-compliance and requiring corrective actions for a violation of or any other non-compliance with this Contract and its Exhibits.
4. In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Managed Care Plan pursuant to any of the following, as allowable: s. 409.912 (6), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR Part 438, Subpart I (Sanctions) and ss.1905(t), 1932 and s. 1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to Section XIV., Liquidated Damages.
 - a. The Agency may impose temporary management in accordance with 42 CFR 438.706(a) only if it finds any of the following:
 - (1) There is continued egregious behavior by the Managed Care Plan, including but not limited to behavior described in 42 CFR 438.700 or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act.
 - (2) There is substantial risk to enrollees' health.
 - (3) The sanction is necessary to ensure the health of the Managed Care Plan's enrollees while improvements are made to remedy violations or until there is an orderly termination or reorganization of the Managed Care Plan.
 - b. The Managed Care Plan shall be subject to mandatory temporary management when the Managed Care Plan repeatedly fails to meet substantive requirements in ss. 1903(m) or 1932 of the Social Security Act or 42 CFR 438. The imposition of such temporary management must not be delayed to provide a hearing and may not be terminated until it is determined that the Managed Care Plan can ensure the sanctioned behavior shall not reoccur. (42 CFR 438.706(b)-(d); s. 1932(e)(2)(B)(ii) of the Social Security Act)
 - c. The Managed Care Plan may be subject to temporary management and enrollees shall notified by the Agency of the right to terminate enrollment without cause, when the Managed Care Plan repeatedly fails to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act, or 42 CFR 438.706. (42 CFR 438.706(b))

Section XIII. Sanctions

- d. If the Agency imposes a civil monetary penalty on the Managed Care Plan pursuant to 42 CFR 438.704 for charging premiums or charges in excess of the amounts permitted under Medicaid, the amount of the overcharge shall be deducted from the penalty and return it to the affected enrollee. (42 CFR 438.704(c))
5. For purposes of this Section, violations involving individual, unrelated acts shall not be considered arising out of the same action.
6. In addition to imposing sanctions for a Contract violation or other non-compliance, the Agency may require the Managed Care Plan to submit to the Agency a CAP within a timeframe specified by the Agency. The Agency may also require the Managed Care Plan to submit a CAP for a violation of or any other non-compliance with this Contract.
7. If the Agency imposes monetary sanctions, the Managed Care Plan must pay the monetary sanctions to the Agency within thirty (30) days from receipt of the notice of sanction, regardless of any dispute in the monetary amount or interpretation of policy that led to the notice. If the Managed Care Plan fails to pay, the Agency reserves the right to recover the money by any legal means, including but not limited to the withholding of any payments due to the Managed Care Plan. If the Deputy Secretary determines that the Agency should reduce or eliminate the amount imposed, the appropriate amount shall be returned to the Managed Care Plan within sixty (60) days from the date of a final decision rendered.
8. The Agency may terminate the Managed Care Plan Contract and place enrollees into a different Managed Care Plan or provide Medicaid benefits through other State plan authority, if the Agency determines that the Managed Care Plan has failed to carry out the substantive terms of its Contract or meet the applicable requirements of ss. 1932, 1903(m), or 1905(t) of the Social Security Act. (42 CFR 438.708(a)-(b))

B. Corrective Action Plans

1. If a CAP is required as determined by the Agency, the Managed Care Plan's proposed CAP shall be approved or disapproved by the Agency. If the Agency disapproves the CAP, the Managed Care Plan shall submit a new CAP within ten (10) business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency. The Managed Care Plan shall accept and implement an Agency-defined CAP if required by the Agency.
2. The Agency may impose a monetary sanction of **\$200** per day on the Managed Care Plan for each day the Managed Care Plan does not implement, to the satisfaction of the Agency, the approved CAP.

C. Performance Measure Sanctions

1. The Managed Care Plan may be subject to sanctions for failure to achieve minimum performance scores on performance measures specified by the Agency after the first year of poor performance, as specified in this Contract and its Exhibits, as applicable. The Agency shall develop performance measures and may impose monetary sanctions for some or all performance measures. The Agency shall develop performance targets for each performance measure with a methodology for application of the sanction specified by the Agency.

Section XIII. Sanctions

2. The Agency may sanction the Managed Care Plan for failure to achieve minimum scores on performance measures after the first year of poor performance on any measure as specified in the table below. The Agency may impose monetary sanctions and/or CAPs as described above.
3. One (1) HEDIS measure shall be compared to the National Committee for Quality Assurance HEDIS National Means and Percentiles. The HEDIS Call Answer Timeliness measure has a threshold rate (percentage) that may trigger a sanction, as indicated in the Performance Measure Sanction Table below.

Performance Measure Sanction Table – Effective 8/01/2019 – 8/31/2024	
HEDIS Measures	Rate and applicable sanction
Call Answer Timeliness	Rate < 25 th percentile – immediate monetary sanction and CAP may be imposed Rate < 50 th percentile – CAP may be required

4. The Managed Care Plans shall be subject to sanction by the Agency for failure to achieve minimum scores on additional performance measures after the first year of poor performance on any measure specified in this Contract and its Exhibits.

D. Additional Sanctions

1. Pursuant to s. 409.967(2)(i)2., F.S., if the Managed Care Plan fails to comply for thirty (30) days with the encounter data reporting requirements as specified in this Contract, the Managed Care Plan shall be subject to the following actions on the thirty-first (31st) day:
 - (a) The Managed Care Plan shall be assessed a fine of five thousand dollars (**\$5,000**) per day for each day of noncompliance; and
 - (b) The Managed Care Plan shall be notified that the Agency shall initiate Contract termination procedures on the ninetieth (90th) day unless the Managed Care Plan comes into compliance before that date.
2. Fraud and Abuse – See Section X.F., Fraud and Abuse Prevention.
3. Pursuant to s. 409.967(2)(i)1., F.S., if the Managed Care Plan leaves a region before the end of this Contract term, the Managed Care Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities. If more than one (1) Managed Care Plan providing services under the same program component leaves a region at the same time, the exiting Managed Care Plans shall share the costs in a manner proportionate to their enrollments. In addition to the payment of costs, departing PSNs shall pay a per-enrollee penalty of up to three (3) months’ payment and continue to provide services to enrollees for ninety (90) days or until the enrollee is enrolled in another Managed Care Plan, whichever occurs first. In addition to payment of costs, all other departing Managed Care Plans must pay a penalty of twenty-five percent (25%) of that portion of the minimum surplus maintained pursuant to s. 641.225(1), F.S., which is

Section XIII. Sanctions

attributable to the provision of coverage to Medicaid enrollees. The Managed Care Plan shall provide at least one hundred eighty (180) days' notice to the Agency before withdrawing from a region. If the Managed Care Plan leaves a region before the end of this Contract term, all of the Managed Care Plan's Contracts Plan in other regions shall be terminated.

4. Pursuant to 42 CFR 438.702(a)(4), after the date the Secretary of DHHS or the Agency notifies the Managed Care Plan of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Act the Managed Care Plan may be subject to suspension of all new enrollment, including default enrollment.
5. Pursuant to 42 CFR 438.702(a)(5), the Managed Care Plan may be subject to suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the Agency is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

E. Notice of Sanctions

1. Except as noted in 42 CFR Part 438, Subpart I (Sanctions), before imposing any of the sanctions specified in this Section, the Agency shall provide written notice to the Managed Care Plan that explains the basis and nature of the sanction, cites the specific Contract section(s) and/or provision of law and the methodology for calculation of any fine, and the process to dispute sanctions. (42 CFR 438.710(a)(1))
2. If the Managed Care Plan fails to carry out any substantive terms of this Contract or fails to meet applicable requirements in Sections 1932, 1903(m), or 1905(t) of the Social Security Act, the Agency may terminate the Managed Care Plan's Contract for cause.
 - (a) Before terminating this Contract, the Agency must provide to the Managed Care Plan a pre-termination hearing and give advance written notice of intent to terminate, which includes the reason for termination and the time and place of the hearing.
 - (b) After the hearing, Managed Care Plan shall receive written notice of the decision affirming or reversing the proposed termination of this Contract and, if affirmed, the effective date of termination.
 - (c) The Agency must notify Managed Care Plan enrollees of the termination and provide information on their options for receiving Medicaid services following the effective date of termination, which may include disenrolling from the Managed Care Plan immediately and without cause.
3. Unless the Agency specifies the duration of a sanction, a sanction shall remain in effect until the Agency is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

F. Dispute of Sanctions

1. To dispute a sanction, the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute.

Section XIII. Sanctions

- a. The Managed Care Plan must submit a written dispute of the sanction directly to the Deputy Secretary or designee by U.S. mail and/or commercial courier service (hand delivery shall not be accepted); this submission must be received by the Agency within twenty-one (21) days after the issuance of a sanction and shall include all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation and exhibits). A Managed Care Plan submitting such written requests for appeal or dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such appeal or dispute to the following mailing address:

Deputy Secretary for Medicaid
Agency for Health Care Administration
Managed Care Appeals/Disputes, MS 70
2727 Mahan Drive
Tallahassee, FL 32308

Regardless of whether delivered by U.S. mail or commercial courier service, appeals not delivered to the mailroom shall be denied.

- b. The Managed Care Plan waives any dispute not raised within twenty-one (21) days of receiving the sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving the sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission submitted within the twenty-one (21) days following its receipt of the sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).
 - (1) The Deputy Secretary or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Managed Care Plan. This written decision shall be final.
 - (2) The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Deputy Secretary or his/her designee, shall be Circuit Court in Leon County, Florida; in any such action, the Managed Care Plan agrees to waive its right to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Managed Care Plan shall receive notice of the appropriate administrative remedy.

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Section XIV. Liquidated Damages

The Agency shall be responsible for imposing liquidated damages as a result of failure to meet any aspect of the responsibilities of this Contract and its Exhibits.

The Managed Care Plan agrees that failure to meet any aspect of the responsibilities of this Contract may result in the assessment of damages in accordance with Section XIV., Liquidated Damages.

A. Damages

1. If the Managed Care Plan breaches this Contract, the Agency shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages. In some cases, the actual damage to the Agency as a result of the Managed Care Plan's failure to meet any aspect of the responsibilities of this Contract and/or to meet specific performance standards set forth in this Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of a breach of this Contract, the Managed Care Plan shall be subject to the imposition of liquidated damages in writing against the Managed Care Plan. The Managed Care Plan shall be assessed liquidated damages regardless of whether the breach is the fault of the Managed Care Plan (including the Managed Care Plan's subcontractors, agents and/or consultants), provided the Agency has not materially caused or contributed to the breach. The Agency may impose liquidated damages in addition to any sanctions imposed pursuant to Section XIII., Sanctions.
2. The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the Agency's projected financial loss and damage resulting from the Managed Care Plan's nonperformance, including financial loss as a result of project delays. Accordingly, in the event the Managed Care Plan fails to perform in accordance with this Contract, the Agency may assess liquidated damages as provided in this Section.
3. If the Managed Care Plan fails to perform any of the services described in this Contract, the Agency may assess liquidated damages for each occurrence listed in the table in this Section. Any liquidated damages assessed by the Agency shall be due and payable to the Agency within thirty (30) days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. The Agency shall have sole authority to determine the application of an occurrence (e.g., per unit of service, per date of service, per episode of service, per complaint, per enrollee, etc.).
4. The Agency may elect to collect liquidated damages:
 - a. Through direct assessment and demand for payment delivered to the Managed Care Plan; or
 - b. By deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Managed Care Plan or that become due at any time after assessment of the liquidated damages. The Managed Care Plan shall be subject to deductions until the Agency has collected the full amount payable by the Managed

Section XIV. Liquidated Damages

Care Plan.

5. The Managed Care Plan shall not pass through liquidated damages imposed under this Contract to a provider and/or subcontractor, unless the provider and/or subcontractor caused the damage through its own action or inaction. Nothing described herein shall prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction.
6. All liquidated damages imposed pursuant to this Contract, whether paid or due, shall be paid by the Managed Care Plan out of administrative costs and profits.
7. Subject to legislative approval, the Agency reserves the right to redirect any amounts assessed as liquidated damages towards QI activities that target and support Agency goals or initiatives.
8. To dispute the imposition of liquidated damages, the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute.
 - a. The Managed Care Plan must submit a written dispute of the liquidated damages directly to the Deputy Secretary for Medicaid or designee by U.S. mail and/or commercial courier service (hand delivery shall not be accepted. This submission must be received by the Agency within twenty-one (21) days after receiving notice of the imposition of liquidated damages and shall include all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation and exhibits). A Managed Care Plan submitting such written requests for dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such dispute to the following mailing address:

Deputy Secretary for Medicaid
Agency for Health Care Administration
Managed Care Appeals/Disputes, MS 70
2727 Mahan Drive
Tallahassee, FL 32308
 - b. The Managed Care Plan waives any dispute not raised within twenty-one (21) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission within the twenty-one (21) days following its receipt of the notice in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).
9. The Deputy Secretary or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Managed Care Plan. This written decision shall be final.

Section XIV. Liquidated Damages

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

B. Issues and Amounts

The Managed Care Plan shall pay the Agency up to the amount for each issue as specified below.

Liquidated Damages Issues and Amounts

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
1.	Failure to respond to an Agency communication within the time prescribed by the Agency as described in this Contract.	\$500 for each day beyond the due date until provided to the Agency.
2.	Failure to provide covered services with reasonable promptness.	\$2,500 per occurrence.
3.	Failure by the Managed Care Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach as described in this Contract. See also ancillary BAA between the parties.	\$500 per enrollee per occurrence, not to exceed \$10,000,000 .
4.	Failure to meet plan readiness goals set by the Agency	\$5,000 per occurrence
5.	Failure to submit a timely notice of involuntary disenrollment to the enrollee as described in this Contract.	\$1,000 per occurrence.
6.	Failure to comply with marketing requirements as described in this Contract.	\$2,500 per occurrence.
7.	Failure to timely report staff or marketing agent violations as described in this Contract.	\$250 per occurrence.
8.	Failure to obtain approval of enrollee materials, as required by this Contract.	\$1,000 per occurrence.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
9.	Failure to comply with enrollee notice requirements as described in this Contract (excluding denials, reductions, terminations or suspensions of services).	\$250 per occurrence.
10.	Failure to comply with time frames for providing Enrollee Handbooks, I.D. cards and Provider Directories, as required in this Contract.	\$5,000 per occurrence.
11.	Failure to update online and printed provider directory as described in this Contract.	\$1,000 per occurrence.
12.	Failure to comply in any way with the toll-free enrollee help line requirements as described in this Contract (excluding the failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as required by the Agency).	\$10,000 per month, for each month that the Agency determines that the Managed Care Plan is not in compliance.
13.	Failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as described this Contract.	\$500 per day, per occurrence
14.	Failure to timely submit any complete plan as described in this Contract, including, but not limited to a CCP. Note: The Anti-Fraud plan liquidated damages listed in this table is separate and not included in this program issue.	\$250 per day for every day plans are late.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
15.	Failure to comply with the notice requirements described in this Contract, the Agency rules and regulations, and all court orders governing appeal procedures, as they become effective.	<p>\$500 per occurrence in addition to \$500 per day for each day required notices are late or deficient or for each day beyond the required time frame that the appeal is unanswered in each and every aspect and/or day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Contract or required by the Agency.</p> <p>\$1,000 per occurrence if the Agency notice remains defective plus a per day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective.</p>
16.	Failure to comply with all orders/official decisions relating to claim disputes, grievances, appeals and/or fair hearings, as they are issued.	\$10,000 per occurrence.
17.	Failure to provide continuation of services during the pendency of a Medicaid fair hearing and/or the Managed Care Plan's appeal process where the enrollee has challenged a reduction or elimination of services as required by this Contract, applicable State or federal law, and all court orders governing appeal procedures as they become effective.	The value of the reduced or eliminated services as determined by the Agency for the timeframe specified by the Agency and \$500 per day for each day the Managed Care Plan fails to provide continuation or restoration as required by the Agency.
18.	Failure to submit a fair hearing evidence packet with the required materials described in this Contract.	\$1,000 per occurrence.
19.	Failure to submit a fair hearing evidence packet within the time-frame described in this Contract and prehearing instructions.	\$1,000 per occurrence.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
20.	Failure to provide necessary witnesses and evidentiary materials for fair hearings in accordance with this Contract.	\$1,000 per occurrence.
21.	Failure to attend fair hearings as scheduled in accordance with this Contract.	\$2,500 per occurrence.
22.	Failure to provide restoration of services after the Managed Care Plan receives an adverse determination as a result of a Medicaid fair hearing or the Managed Care Plan's appeal process as required by this Contract, applicable State or federal law and all court orders governing appeal procedures as they become effective.	The value of the reduced or eliminated services as determined by the Agency and \$500 per day for each day the Managed Care Plan fails to provide continuation or restoration as required by the Agency.
23.	Failure to provide medically necessary services to enrollees under the age of twenty-one (21) years in accordance with this Contract.	\$2,500 per occurrence.
24.	Failure to comply with transportation provisions as specified by this Contract.	\$1,000 per occurrence
25.	Failure to transport an enrollee to a pre-scheduled appointment on time which results in a missed appointment for the enrollee.	\$2,500 per occurrence
26.	Imposition of arbitrary utilization guidelines or other quantitative coverage limits as prohibited in this Contract.	\$25,000 per occurrence.
27.	Failure to complete a comprehensive assessment, develop a treatment or service plan or plan of care, or authorize and initiate all services specified in the plan for an enrollee within specified timelines as described in this Contract.	\$5,000 per occurrence.
28.	Failure to maintain case manager caseload ratios pursuant to this Contract.	\$1,000 per occurrence.
29.	Failure to facilitate transfers between health care settings as described in this Contract.	\$1,000 per occurrence.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
30.	Failure to develop and/or implement a transition plan for recipients including the provision of data to the Agency, as specified in this Contract.	\$10,000 per occurrence.
31.	Failure to develop and document a treatment or service plan for an enrollee, that shall be documented in writing as described in this Contract.	\$500 per deficient/missing treatment or service plan.
32.	Failure to ensure compliance with PASRR requirements prior to reimbursement for nursing facility services as described in this Contract.	\$500 per occurrence.
33.	Failure to comply with provider network requirements specified in this Contract.	\$1,000 per occurrence.
34.	Failure to submit a Provider Network File that meets the Agency's specifications as described in this Contract.	\$250 per occurrence.
35.	Failure to provide covered services within the timely access standards in this Contract.	\$500 per day, per occurrence.
36.	Failure to provide covered services within the geographic access standards in this Contract.	\$500 per day, per occurrence.
37.	Failure to timely report, or provide notice for, significant network changes as described in this Contract.	\$5,000 per occurrence.
38.	Failure to meet provider credentialing requirements, including background screening requirements, specified in this Contract.	\$5,000 per occurrence.
39.	Failure to comply with licensure or background screening requirements for Managed Care Plan principals in this Contract.	\$5,000 per occurrence that owner/staff is not licensed or qualified as required by applicable State or local law plus the amount paid to the owner/staff during that period.
40.	Failure to comply with licensure or background screening requirements for subcontractors in this Contract.	\$5,000 per occurrence that subcontractor/driver/agent is not licensed or qualified as required by applicable State or local law plus the amount paid to the subcontractor/driver/agent during that period.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
41.	Failure to report notice of provider termination, suspension, or denial of participation in the Managed Care Plan as described in this Contract.	\$500 per day, per occurrence.
42.	Failure to timely report notice of terminated providers due to imminent danger/impairment as described in this Contract.	\$5,000 per occurrence.
43.	Failure to timely report termination or suspension of providers for “for cause” as described in this Contract.	\$250 per occurrence.
44.	Failure to suspend or terminate providers who become ineligible for Medicaid participation.	\$500 per occurrence, in addition to \$250 per day until the provider is suspended or terminated.
45.	Failure to obtain and/or maintain national accreditation as described in this Contract.	\$500 per day for every day beyond the day accreditation status must be in place as described in this Contract.
46.	Failure to cooperate with the Agency’s contracted EQRO as described in this Contract.	\$5,000 per occurrence.
47.	Failure to comply with the quality requirements specified in this Contract under Section IX. of Attachment B. and its Exhibits.	\$1,000 per occurrence.
48.	Failure to submit audited HEDIS, CAHPS, and Agency-defined measures results by July 1 as described in this Contract.	\$250 per day for every day reports are late.
49.	Failure to timely submit appropriate PIPs as described in this Contract.	\$1,000 per day for every day PIPs are late.
50.	Failure to timely submit enrollee records within time frames requested by the Agency or the EQRO.	\$250 per day for each day records are late, up to a maximum of \$5,000 per occurrence.
51.	Failure to allow an enrollee to obtain a second medical opinion at no expense and regardless of whether the provider is participating or not, as described in this Contract.	\$5,000 per occurrence.
52.	Failure to acknowledge or act timely upon a request for prior authorization in accordance with this Contract.	\$1,000 per occurrence

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
53.	Failure to comply with any of the standards for timely service authorization as specified in this Contract.	\$5,000 per month, for each month that the Agency determines that the Managed Care Plan is not in compliance, per standard
54.	Failure to comply with enrollee notice for denials, reductions, terminations, or suspensions of services within the timeframes specified in this Contract as described in this Contract.	\$2,500 per occurrence.
55.	Failure to provide continuity of care and a seamless transition consistent with the services in place prior to the new enrollee's enrollment in the Managed Care Plan as described in this Contract.	\$2,500 per occurrence.
56.	Failure to comply in any way with Managed Care Plan staffing requirements as specified in this Contract.	\$250 per day for each day that staffing requirements are not met.
57.	Failure to timely report changes in Managed Care Plan staffing as described in this Contract.	\$500 per occurrence.
58.	Failure to provide no less than thirty (30) days' written notice before making any changes to the administration and/or management procedures and/or authorization, denial or review procedures, including any delegations, as described in this Contract.	\$25,000 per occurrence.
59.	Failure of a provider agreement to comply with a requirement of this Contract.	\$1,000 per failure per provider agreement
60.	Failure to receive prior written Agency approval of delegation to a subcontractor.	\$25,000 per occurrence
61.	Failure of a subcontract to comply with a requirement of this Contract.	\$5,000 per failure per subcontract
62.	Failure to maintain and/or provide proof of required insurance as described in this Contract.	\$500 per day.
63.	Failure to comply with subcontract requirements for providers dually offering UM and service provision.	\$500 per day.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
64.	Failure to maintain and/or provide proof of the Managed Care Plan's fidelity bond as required in this Contract.	\$500 per day.
65.	Failure by the Managed Care Plan to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, BAA or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to this Contract. See also ancillary BAA between the parties.	\$500 per enrollee per occurrence.
66.	Failure by the Managed Care Plan to ensure that all data containing PHI, as defined by HIPAA, is secured through commercially reasonable methodology in compliance with the HITECH Act, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Agency enrollee's PHI as specified in this Contract. See also ancillary BAA between the parties.	\$1,000 per enrollee per occurrence. If the State determines credit monitoring and/or identity theft safeguards are needed to protect those enrollees whose PHI was placed at risk by Managed Care Plan's failure to comply with the terms of this Contract, the Managed Care Plan shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
67.	Failure to complete or comply with CAPs as described in this Contract.	\$500 per day for each day the corrective action is not completed or complied with as required.
68.	Failure to provide notice of noncompliance to the Agency within five (5) days or other Contract-specified period of time in accordance with this Contract.	\$500 per day beginning on the next day after default by the Managed Care Plan.
69.	Failure to provide proof of compliance to the Agency within five (5) days of a directive from the Agency or within a longer period of time that has been approved by the Agency	\$500 per day beginning on the next day after default by the Managed Care Plan.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
70.	Failure to comply with claims processing as described in this Contract.	\$10,000 per month, for each month that the Agency determines that the Managed Care Plan is not in compliance.
71.	Failure to submit all claims data in accordance with the format and timeframes specified by the Agency.	\$500 per day, per occurrence.
72.	Failure to submit all claims data in accordance with s. 409.967(2)(o), F.S.	\$500 per day, per occurrence.
73.	Failure to comply with encounter data submission requirements as described in this Contract (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency).	\$25,000 per occurrence.
74.	Failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency and described in this Contract.	\$500 per day, per occurrence.
75.	Failure to comply with fraud and abuse provisions as described in this Contract.	\$500 per day per occurrence/issue.
76.	Failure to establish an investigative unit as required in this Contract, by the time the Managed Care Plan has enrolled its first recipient.	\$10,000 per occurrence.
77.	Failure to staff the Compliance Officer position with a qualified individual in accordance with this Contract.	\$500 per day starting ninety (90) days from the date of the position vacancy.
78.	Failure to implement an anti-fraud plan as required by this Contract, within ninety (90) days of its approval by the Agency.	\$10,000 per occurrence.
79.	Failure to cooperate fully with the Agency and/or State during an investigation of fraud or abuse, complaint, or grievances as described in this Contract.	\$500 per incident for failure to fully cooperate during an investigation.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
80.	Failure to timely report, or report all required information for, all suspected or confirmed instances of provider or recipient fraud or abuse as required by this Contract.	\$1,000 per day, until MPI deems the Managed Care Plan to be in compliance.
81.	Failure to timely submit an acceptable anti-fraud plan, quarterly fraud and abuse report or the annual report required by this Contract.	\$2,000 per day, until MPI deems the Managed Care Plan to be in compliance.
82.	Failure to comply with the requirement to pay the expenses of the Agency's Achieved Savings Rebate Audit as described in this Contract.	\$100 per day.
83.	Failure to achieve and/or maintain insolvency requirements in accordance with this Contract.	\$1,000 per day for each day that insolvency requirements are not met.
84.	Failure to submit timely to the Agency all items of the monthly account valuation.	\$250 per day.
85.	Failure to purchase Securities in accordance with Agency guidelines.	\$2,500 per day for every unapproved security purchased until the Security is replaced with an approved Security.
86.	Failure to achieve and/or maintain financial surplus requirements as described in this Contract.	\$1,000 per day for each day Contract requirements are not met.
87.	Failure to timely submit complete and accurate quarterly unaudited and audited annual financial statements as described in this Contract.	\$500 per day for each day that reporting requirements are not met.
88.	Failure to have a rate at or above the 50 th percentile for this Call Answer Timeliness measures as described in this Contract.	\$100 per each case in the denominator not present in the numerator for the measure up to the 50 th percentile rate.
89.	Failure to require and ensure compliance with ownership and disclosure requirements as required in this Contract.	\$5,000 per provider disclosure/attestation for each disclosure/attestation that is not received timely or is not in compliance with the requirements outlined in 42 CFR Part 455, Subpart B.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
90.	Failure to timely report changes in ownership and control as described in this Contract.	\$5,000 per occurrence.
91.	Failure to timely initiate a background screening via the Clearinghouse for newly hired principals as described in this Contract.	\$500 per occurrence.
92.	Failure to timely report information about offenses listed in s. 435.04, F.S., as described in this Contract.	\$500 per occurrence.
93.	Failure to comply with conflict of interest or lobbying requirements as described in this Contract.	\$10,000 per occurrence.
94.	Failure to disclose lobbying activities and/or conflict of interest as required by this Contract.	\$1,000 per day that disclosure is late.
95.	Failure to meet plan readiness review deadlines set by the Agency	\$2,000 per day per occurrence
96.	Failure to comply with public records laws, in accordance with s. 119.0701, F.S.	\$5,000 per occurrence.
97.	Submission of inappropriate report certifications and/or failure to submit report attestations as described in this Contract.	\$250 per occurrence.
98.	Failure to file required reports timely as described in this Contract.	\$500 per occurrence.
99.	Failure to file accurate reports as described in this Contract.	\$1,000 per occurrence.
100.	Failure to respond to an Agency request or ad-hoc report for documentation within the time prescribed by the Agency as described in this Contract.	\$500 per day.

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Section XV. Special Terms and Conditions

A. Applicable Laws and Regulations

1. The Managed Care Plan shall comply with all applicable federal and State laws, rules and regulations including but not limited to:
 - a. Title IX of the Education Amendments of 1972;
 - b. Title IX of the Education Amendments of 1972 (regarding education programs and activities);
 - c. Title 42 CFR 422.208 and 422.210 on Physician Incentive Plans;
 - d. The Rehabilitation Act of 1973, as amended, 29 USC 794 (which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance);
 - e. Medicare - Medicaid Anti-Fraud and Abuse Amendments of 1977;
 - f. 42 CFR part 438,
 - g. 42 CFR part 438, Subpart K and the Mental Health Parity and Addictions Equity Act;
 - h. Section 1557 of the ACA;
 - i. 2 CFR part 200; and 2 CFR 300.1; and 45 CFR part 75;
 - j. Section 508 of the Federal Water Pollution Control Act as amended (33 U.S.C. 1251, et seq.);
 - k. Executive Order 11738 as amended;
 - l. Environmental Protection Agency regulations 40 CFR 30, as applicable;
 - m. Title 2 CFR part 200 and Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR part 60, if applicable;
 - n. The Pro-Children Act of 1994 (20 U.S.C. 7183);
 - o. Title 2 CFR parts 180 and 376 and Executive Orders 12549 and 12689 "Debarment and Suspension";
 - p. Title 2 CFR part 175 relating to trafficking in persons;
 - q. Title 2 CFR part 170, relating to the Transparency Act, as applicable;
 - r. Section 501.171, F.S., the Florida Information Protection Act of 2014;

Section XV. Special Terms and Conditions

- s. Sections 1903(i)(16)-(17) and 1903(i)(2)(A)-(C) of the Social Security Act;
- t. Chapter 409, F.S.;
- u. Section 403.7065, F.S.;
- v. Rule 62-730.160, F.A.C. pertaining to standards applicable to generators of hazardous waste;
- w. All applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 USC 7401 et seq.;
- x. 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;
- y. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended;
- z. 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;
- aa. Other federal omnibus budget reconciliation acts; and
- bb. All regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

In addition to the above, the terms of the applicable federal waivers shall apply.

2. The Managed Care Plan is subject to any changes in federal and State law, rules or regulations and federal CMS waivers applicable to this Contract and shall implement such changes in accordance with the required effective dates upon notice from the Agency without waiting for an amendment to this Contract. However, an amendment to this Contract shall be processed to incorporate the changes.

B. Entire Agreement

This Contract, including all Attachments and Exhibits, represents the entire agreement between the Managed Care Plan and the Agency and supersedes all other contracts between the parties when it is executed by duly authorized signatures of the Managed Care Plan and the Agency. Correspondence and memoranda of understanding do not constitute part of this Contract. In the event of a conflict of language between this Contract and the Attachments (which includes the ITN), the provisions of this Contract shall govern, unless otherwise noted. The Agency reserves the right to clarify any contractual relationship in writing and such clarification shall govern. Pending final determination of any dispute over any Agency decision, the Managed Care Plan shall proceed diligently with the performance of its duties as specified under this Contract and in accordance with the direction of the Agency's Division of Medicaid. The Parties, notwithstanding any other term of this Contract, do not intend to create through this Contract, and hereby disclaim and reject, any rights enforceable by third-parties or non-parties to this Contract, through a third party beneficiary cause of action or under any other contractual claim in equity or in law.

C. Ownership and Management Disclosure

1. The Managed Care Plan shall fully disclose any business relationships, ownership, management and control of disclosing entities in accordance with State and federal law. A Managed Care Plan providing SMMC services shall not contract with the Agency to operate as a Managed Care Plan that has a business relationship with another Managed Care Plan providing SMMC services and operating in the same region. (s. 409.966(3)(b), F.S.) The Agency may contract with a Managed Care Plan to operate as a Specialty Plan which has a business relationship with another Managed Care Plan operating as a Managed Care Plan providing SMMC services in the same region.
2. If the Managed Care Plan fails to disclose a business relationship or is considering a business relationship with a Managed Care Plan that has a Contract with the Agency under the SMMC program, the Managed Care Plan shall immediately disclose such business relationship to the Agency pursuant to s. 409.966(3)(b), F.S., within five (5) days after discovery. The disclosure shall include but not be limited to the identifying information for each Managed Care Plan, the nature of the business relationship, the regions served by each Managed Care Plan, and the signature of the authorized representative for each Managed Care Plan. In addition, PSNs must disclose changes in the percentages of provider ownership interest and changes in the provider make-up of the board of directors or members and/or managers if structured as a limited liability company.
3. The Managed Care Plan shall submit the following for the areas of ownership and control interest:
 - a. The name and address of any person (individual or corporation) with an ownership or control interest in the Managed Care Plan and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
 - b. The date of birth and SSN of any individual with an ownership or control interest in the Managed Care Plan and its subcontractors.
 - c. Other tax identification number of any corporation with an ownership or control interest in the Managed Care Plan and any subcontractors in which the Managed Care Plan has a five (5) percent or more interest.
 - d. Information on whether an individual or corporation with ownership or control interest in the Managed Care Plan as a spouse, parent, child, or sibling.
 - e. Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the Managed Care Plan has a five (5) percent or more interest is related to another person with ownership or control interest in the Managed Care Plan as a spouse, parent, child, or sibling.
 - f. The name of any other disclosing entity in which an owner of the Managed Care Plan has an ownership or control interest.
 - g. The name, address, date of birth, and SSN or any managing employee of the Managed Care Plan.

Section XV. Special Terms and Conditions

(42 CFR 438.604(a)(6); 42 CFR 455.104(b)(1)(i)-(iii); 42 CFR 455.104(b)(2)-(4); 42 CFR 438.230; 42 CFR 438.608(c)(2))

- h. In addition, PSN shall also file all additional information required in Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest, which is not specifically required in a.-g. above.
4. Disclosure shall be made on forms prescribed by the Agency for business transactions (42 CFR 455.105); conviction of crimes (42 CFR 455.106); public entity crimes (s. 287.133(2)(a), F.S.); disbarment and suspension (52 Fed. Reg., pages 20360-20369, and Section 4707 of the Balanced Budget Act of 1997); and, for PSNs, an attestation disclosing any changes in the percentages of provider ownership interest and changes in the provider make-up of the board of directors or members and/or managers if structured as a limited liability company, or any change to information originally provided in response to the ITN on Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest. The forms are available through the Agency and are to be submitted to the Agency by September 1 of each Contract year. In addition, the Managed Care Plan shall submit to the Agency for review, full disclosure of ownership and control of the Managed Care Plan and any subcontractors as required in 42 CFR 438.608(c), and any changes in management within five (5) days of knowing the change shall occur and at least sixty (60) days before any change in the Managed Care Plan's ownership or control takes effect.
5. The following definitions apply to ownership disclosure:
 - a. A person with an ownership interest or control interest means a person or corporation that:
 - (1) Owns, indirectly or directly, five percent (5%) or more of the Managed Care Plan's capital or stock, or receives five percent (5%) or more of its profits;
 - (2) Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Managed Care Plan or by its property or assets and that interest is equal to or exceeds five percent of the total property or assets;
 - (3) Is an officer or director of the Managed Care Plan, if organized as a corporation, or is a partner in the Managed Care Plan, if organized as a partnership; or
 - (4) Has a controlling interest in a PSN as defined by the Affiliation Criteria to Determine Controlling Interest for Purposes of the SMMC ITN contained in Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest.
 - b. The percentage of direct ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the Managed Care Plan's assets used to secure the obligation. Thus, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of the Managed Care Plan's assets, the person owns six percent (6%) of the Managed Care Plan.
 - c. The percent of indirect ownership or control is calculated by multiplying the percentage of ownership in each organization. Thus, if a person owns ten percent (10%) of the

Section XV. Special Terms and Conditions

stock in a corporation, which owns eighty percent (80%) of the Managed Care Plan's stock, the person owns eight percent (8%) of the Managed Care Plan.

6. The following definitions apply to management disclosure:
 - a. Changes in management are defined as any change in the management control of the Managed Care Plan. Examples of such changes are those listed below and in Section X., Administration and Management, or equivalent positions by another title.
 - b. Changes in the board of directors or officers of the Managed Care Plan, medical director, CEO, administrator and CFO.
 - c. Changes in the management of the Managed Care Plan where the Managed Care Plan has decided to contract out the operation of the Managed Care Plan to a management corporation. The Managed Care Plan shall disclose such changes in management control and provide a copy of the contract to the Agency for approval at least sixty (60) days prior to the management contract start date.
 - d. Changes in management control disclosed by a PSN in Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest.
7. The Managed Care Plan shall conduct criminal history record check on all principals of the Managed Care Plan, and all persons with five percent (5%) or more ownership interest in the Managed Care Plan, or who have executive management responsibility for the Managed Care Plan, or have the ability to exercise effective control of the Managed Care Plan. (s. 435.04, F.S.)
 - a. Principals of the Managed Care Plan shall be as defined in s. 409.907, F.S.
 - b. The Managed Care Plan shall initiate the criminal history check on newly hired principals (officers, directors, agents, and managing employees) within thirty (30) days of the hire date, if the individual's fingerprints are not already retained in the Care Provider Background Screening Clearinghouse (Clearinghouse, see s. 435.12, F.S.).
 - c. The Managed Care Plan shall conduct this verification as follows:
 - (1) By requesting screening results through the Agency's background screening system. (See the Agency's background screening website.) If the person's fingerprints are not retained in the Clearinghouse and/or eligibility results are not found, the Managed Care Plan shall submit complete sets of the person's fingerprints electronically for Medicaid Level II screening following the process described on the Agency's Care Provider Background Screening Clearinghouse website.
 - (2) The Managed Care Plan shall complete and email a Background Screening (BGS) Managed Care User Registration Agreement to the Agency at: BGSSCREEN@ahca.myflorida.com.
 - (3) In accordance with s. 435.12(2)(c), F.S., the Managed Care Plan shall register with the Clearinghouse and maintain the employment status of all employees within the Clearinghouse. The Managed Care Plan shall report initial

Section XV. Special Terms and Conditions

employment status and changes to the Clearinghouse within ten (10) business days after the initial employment or change.

- (4) The Managed Care Plan shall comply with the employment screening regulations described in Chapter 435, F.S.
 - (5) By the five (5) year expiration date of retained fingerprints for a Managed Care Plan principal, the Managed Care Plan shall initiate and complete a new background screening via the Agency's Care Provider Background Screening Clearinghouse website for that individual.
8. The Managed Care Plan shall submit to the Agency, within five (5) business days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Managed Care Plan who has been found guilty of, regardless of adjudication, or who entered a plea of *nolo contendere* or guilty to, any of the offenses listed in s. 435.04, F.S. The Managed Care Plan shall submit information to the Agency for such persons who have a record of illegal conduct according to the background check. The Managed Care Plan shall keep a record of all background checks to be available for Agency review upon request.
 9. The Managed Care Plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Managed Care Plan, who has committed any of the above listed offenses shall not contract with the Agency. (42 CFR 455.434 and s. 435.04, F.S.) In order to avoid termination, pursuant to a timeline as determined by the Agency, the Managed Care Plan shall submit a CAP, acceptable to the Agency, which ensures that such person is divested of all interest and/or control and has no role in the operation and/or management of the Managed Care Plan.
 10. The Managed Care Plan shall submit to the Agency reports regarding current administrative subcontractors and affiliates as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

D. Conflict of Interest

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

E. Readiness

1. Prior to enrolling recipients in the Managed Care Plan in each authorized region, the Agency shall conduct a plan-specific readiness review to assess the Managed Care Plan's readiness and ability to provide services to recipients. The plan readiness review may include, but is not limited to, desk and onsite review of plan procedures and corresponding documents, the Managed Care Plan's provider network and corresponding Contracts, a walk-through of the Managed Care Plan's processes, system demonstrations, and interviews with Plan staff. The scope of the plan readiness review may include any and all Contract requirements, as determined by the Agency.
2. If the Managed Care Plan does not meet the plan readiness review deadlines established by the Agency for its respective region, the Agency may exercise the following options:
 - a. The Agency may impose liquidated damages for failure to meet plan readiness review deadlines and/or specific plan readiness goals set by the Agency.

F. Withdrawing Services from a Region

1. If the Managed Care Plan intends to withdraw services from a region, the Managed Care Plan shall provide the Agency with one hundred eighty (180) days' notice. Once the Agency receives the request for withdrawal, the Managed Care Plan shall not receive new voluntary enrollments, mandatory assignments, and reinstatements going forward.
2. The Managed Care Plan shall work with the Agency to develop a transition plan for enrollees, particularly those in the hospital, those under care coordination/case management and those with complex medical needs. The Managed Care Plan withdrawing from a region shall perform as follows:
 - a. Notice its enrollees, providers and subcontractors of the change at least sixty (60) days before the last day of service; and
 - b. Provide to the Agency the data, including encounter data, needed by the Agency to maintain existing case relationships.
3. The notice to enrollees shall contain the same information as required for a notice of termination according to Section XV.G., Termination Procedures.
4. If the Managed Care Plan withdraws from a region before the end of the term of this Contract, the Managed Care Plan shall pay the costs and penalties specified in s. 409.967(2)(i)1, F.S., and Section XIII., Sanctions, and this Contract through which the Managed Care Plan operates in any other region shall be terminated in accordance with the termination procedures in s. 409.967(2)(i)3, F.S., this Section and Section XIII., Sanctions.
5. As specified in s. 409.967(2)(i)1. F.S., if the Managed Care Plan intends to withdraw services from a region, the Managed Care Plan shall provide the Agency with one hundred eighty (180) days' notice and work with the Agency to develop a transition plan for enrollees, particularly those under case management and those with complex medical

Section XV. Special Terms and Conditions

needs, and provide data needed to maintain existing case relationships.

6. As specified in s. 409.967 (2)(i)1., F.S., Managed Care Plans that limit enrollment levels or leave a region before the end of this Contract term must continue to provide services to the enrollee for ninety (90) days or until the enrollee is enrolled in another Managed Care Plan, whichever occurs first.

G. Termination Procedures

1. In conjunction with the Standard Contract, Section III., Item A., Termination, all provider agreements and subcontracts shall contain termination procedures. The Managed Care Plan agrees to extend the thirty (30)-day termination notice found in the Standard Contract, Section III., Item A.1., Termination at Will, to one hundred eighty (180) days' notice. Depending on the volume of Managed Care Plan enrollees affected, the Agency may require an extension of the termination date. Once the Agency receives the request for termination, the Managed Care Plan shall not receive new voluntary enrollments, mandatory assignments, and reinstatements going forward.
2. The Managed Care Plan shall work with the Agency to create a transition plan that shall ensure the orderly and reasonable transfer of enrollee care and progress whether or not the enrollees are hospitalized, under care coordination/case management, and/or have complex medical needs. The Managed Care Plan shall perform as follows:
 - a. Notice its enrollees, providers and subcontractors of the change in accordance with this Contract; and
 - b. Provide to the Agency the data needed by the Agency to maintain existing case/care relationships.
3. The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination shall specify the nature of termination, the extent to which performance of work under this Contract is terminated, and the date on which such termination shall become effective. In accordance with s. 1932(e)(4), Social Security Act, the Managed Care Plan shall be provided with an opportunity for a hearing prior to termination for cause. This does not preclude the Agency from terminating without cause.
4. Upon receipt of final notice of termination, on the date and to the extent specified in the notice of termination, the Managed Care Plan shall:
 - a. Continue work under this Contract until the termination date unless otherwise required by the Agency;
 - b. Cease enrollment of new enrollees under this Contract;
 - c. Terminate all marketing activities and subcontracts relating to marketing;
 - d. Assign to the State those subcontracts as directed by the Agency's contracting officer including all the rights, title and interest of the Managed Care Plan for performance of those subcontracts;

Section XV. Special Terms and Conditions

- e. In the event the Agency has terminated the Managed Care Plan's Medicaid participation in one region, complete the performance of this Contract in all other regions in which the Managed Care Plan's participation was not terminated;
 - f. Take such action as may be necessary, or as the Agency's contracting officer may direct, for the protection of property related to this Contract that is in the possession of the Managed Care Plan and in which the Agency has been granted or may acquire an interest;
 - g. Not accept any payment after this Contract ends, unless the payment is for the time period covered under this Contract. Any payments due under the terms of this Contract may be withheld until the Agency receives from the Managed Care Plan all written and properly executed documents as required by the written instructions of the Agency; and
 - h. At least sixty (60) days before the termination effective date, provide written notification to all enrollees of the following information: the date on which the Managed Care Plan shall no longer participate in the State's Medicaid program and instructions on contacting the Agency's enrollment broker help line to obtain information on enrollment options and to request a change in Managed Care Plans.
5. If the Managed Care Plan fails to disclose any business relationship, as defined in s. 409.966(3)(b), F.S., with another Managed Care Plan in the same region during the procurement process, the Managed Care Plan's Contract and all other SMMC contracts with the Managed Care Plan shall be terminated.
6. In the event the Agency terminates the Managed Care Plan's participation in more than one region due to non-compliance with Contract requirements, the Managed Care Plan's entire Contract shall be terminated in accordance with s. 409.967(2)(i)3., F.S.
7. If the Managed Care Plan received an additional award pursuant to s. 409.966(3)(e), F.S., and is subject to penalties pursuant to s. 409.967(2)(i), F.S., for activities in Region 1 or Region 2, the additional awarded regions shall automatically be terminated from this Contract one hundred eighty (180) days after the imposition of the penalties. The Managed Care Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities.
8. If the Managed Care Plan fails to meet regional plan readiness criteria by the Agency's specified monthly enrollment calculation date prior to the region becoming operational in SMMC, the Managed Care Plan shall be terminated from participation in that region. In addition, the following requirements apply to the Managed Care Plan:
- a. If the Managed Care Plan received an additional award pursuant to s. 409.966(3)(e), F.S., and fails to meet plan readiness criteria in Region 1 or Region 2, the Managed Care Plan's additional awarded region(s) shall be terminated within one hundred eighty (180) days after the respective Region 1 and/or Region 2 termination from this Contract.
 - b. If the Managed Care Plan has been terminated from participation in all regions of its Contract, the Managed Care Plan's entire Contract shall be terminated with thirty (30)

Section XV. Special Terms and Conditions

days' notice, as specified in the Standard Contract, Section III., Item B., Termination at Will.

9. If the Managed Care Plan Contract is terminated by either the Managed Care Plan or the Agency (with cause) prior to the end of this Contract period, the Managed Care Plan shall be assessed the performance bond required under this Contract to cover the costs of issuing a solicitation and selecting a new Managed Care Plan. The Agency's damages in the event of termination shall be considered to be the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

H. Agency Contract Management

1. The Agency shall be responsible for management of this Contract. Contract management shall be conducted in good faith, with the best interest of the State and the Medicaid recipients it serves being the prime consideration. The Agency shall make all statewide policy decisions via issuance of a Policy Transmittal or Contract Interpretation, which shall be included in the next amendment.
2. The Managed Care Plan shall submit all procedures to the Agency as required by this Contract. Unless specified elsewhere in this Contract, procedures required by this Contract shall be submitted to the Agency at least seventy-five (75) days before the proposed effective date of the policy and procedure or change. Other procedures related to this Contract shall be submitted to the Agency upon request. If the Agency has requested procedures, the Managed Care Plan shall notify the Agency of any subsequent changes in such materials. Managed Care Plans providing MMA and LTC services shall submit one (1) set of procedures that include all MMA and LTC contractually required provisions.
3. The Managed Care Plan may seek an interpretation from the Agency of any Contract requirement or Medicaid policy. When an interpretation of this Contract is sought, the Managed Care Plan shall submit a written request to the Agency's Deputy Secretary for Medicaid in a format prescribed by the Agency.
4. The terms of this Contract do not limit or waive the ability, authority or obligation of the OIG, MPI, its contractors, DOEA, or other duly constituted government units (State or federal) to audit or investigate matters related to, or arising out of this Contract.
5. This Contract shall be amended only as follows (unless specified elsewhere in this Contract):
 - a. The parties cannot amend or alter the terms of this Contract without a written amendment and/or change order to this Contract.
 - b. The Agency and the Managed Care Plan understand that any such written amendment to amend or alter the terms of this Contract shall be executed by an officer of each party, who is duly authorized to bind the Agency and the Managed Care Plan.
 - c. The Agency reserves the right to amend this Contract within the scope set forth in the procurement (to include original Contract and all Attachments) in order to clarify requirements or if it is determined by the Agency that modifications are necessary to better serve or provide covered services to the eligible population.

I. Disputes

1. To dispute an interpretation of this Contract, the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid hear and decide the dispute. The Managed Care Plan must submit a written dispute of this Contract interpretation directly to the Deputy Secretary; by U.S. mail and/or commercial courier service (hand delivery shall not be accepted); this submission must be received by the Agency within twenty-one (21) days after the interpretation of this Contract and shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation and exhibits). A Managed Care Plan submitting such written requests for appeal or dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such appeal or dispute to the following mailing address:

Deputy Secretary for Medicaid
Agency for Health Care Administration
Managed Care Appeals/Disputes, MS 70
2727 Mahan Drive
Tallahassee, FL 32308

Regardless of whether delivered by U.S. mail or commercial courier service, appeals not delivered to the mailroom shall be denied.

The Managed Care Plan waives any dispute not raised within twenty-one (21) days of receiving a notice of this Contract interpretation. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving a Contract interpretation, and waives the right to use any materials, data, and/or information not contained in or accompanying the Managed Care Plan's submission submitted within the twenty-one (21) days following its receipt of the notice of this Contract interpretation in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

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

J. Indemnification

1. The Managed Care Plan, agrees to indemnify, defend, and hold harmless the Agency, as provided in this Clause.

Section XV. Special Terms and Conditions

2. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the “Duty to Indemnify and Defend”), extend to any completed, actual, pending, or threatened action, suit, claim, or proceeding, whether civil, criminal, administrative, or investigative (including any action by or in the right of the Managed Care Plan), and whether formal or informal, in which the Agency is, was, or becomes involved and which in any way arises from, relates to, or concerns the Managed Care Plan’s acts or omissions related to this Contract (inclusive of all Attachments, etc.) (collectively “Proceeding”).
 - a. Duty to Indemnify. The Managed Care Plan agrees to hold harmless and indemnify the Agency to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages, and costs of whatsoever name and description, including attorneys’ fees, arising from or relating to any Proceeding.
 - b. Duty to Defend. With respect to any Proceeding, the Managed Care Plan agrees to fully defend the Agency and shall timely reimburse all of the Agency’s legal fees and costs; provided, however, that the amount of such payment for attorneys’ fees and costs is reasonable pursuant to Rule 4-1.5, Rules Regulating the Florida Bar. The Agency retains the exclusive right to select, retain, and direct its defense through defense counsel funded by the Managed Care Plan pursuant to the Duty to Indemnify and Defend the Agency.
3. Expense Advance. The presumptive right to indemnification of damages shall include the right to have the Managed Care Plan pay the Agency’s expenses in any Proceeding as such expenses are incurred and in advance of the final disposition of such Proceeding.
4. Enforcement Action. In the event that any claim for indemnity, whether an Expense Advance or otherwise, is made hereunder and is not paid in full within sixty (60) days after written notice of such claim is delivered to the Managed Care Plan, the Agency may, but need not, at any time thereafter, bring suit against the Managed Care Plan to recover the unpaid amount of the claim (hereinafter “Enforcement Action”). In the event the Agency brings an Enforcement Action, the Managed Care Plan shall pay all of the Agency’s attorneys’ fees and expenses incurred in bringing and pursuing the Enforcement Action.
5. Contribution. In any Proceeding in which the Managed Care Plan is held to be jointly liable with the Agency for payment of any claim of any kind (whether for damages, attorneys’ fees, costs, or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Managed Care Plan shall contribute toward satisfaction of the claim whatever portion is or would be payable by the Agency in addition to that portion which is or would be payable by the Managed Care Plan, including payment of damages, attorneys’ fees, and costs, without recourse against the Agency. No provision of this part, or of any other section of this Contract (inclusive of all Attachments, etc.), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the State or the Agency’s immunity to suit or limitations on liability; (ii) obligate the State or the Agency to indemnify the Managed Care Plan for the Managed Care Plan’s own negligence, or otherwise assume any liability for the Managed Care Plan’s own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

K. Public Records Requests

1. In accordance with s.119.0701, F.S., and notwithstanding Standard Contract, Section I.,

Section XV. Special Terms and Conditions

Item M., Requirements of Section 287.058, F.S., in addition to other Contract requirements provided by law, the Managed Care Plan shall comply with public records laws, as follows:

- a. The Managed Care Plan shall keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Contract;
- b. The Managed Care Plan shall provide the public with access to public records on the same terms and conditions that the Agency would provide the records and at a cost that does not exceed the cost provided in s. 119.0701, F.S., or as otherwise provided by law;
- c. The Managed Care Plan agrees that it is the custodian of any and all recordings for purposes of the Public Records Act, Chapter 119, F.S., and is solely responsible for responding to any public records requests for recordings. This responsibility includes gathering, redacting, duplication, and provision of the recordings, as well as defense of any actions for enforcement brought pursuant to Section 119.11, F.S.;
- d. The Managed Care Plan shall ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law;
- e. The Managed Care Plan shall meet all requirements for retaining public records and transfer, at no cost, to the Agency all public records in possession of the Managed Care Plan upon termination of this Contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Agency in a format that is compatible with the IT systems of the Agency; and
- f. If the Managed Care Plan does not comply with a public records request, the Managed Care Plan shall be subject to enforcement of this Contract provisions in accordance with this Contract.

L. Communications

1. Notwithstanding any term or condition of this Contract to the contrary, the Managed Care Plan bears sole responsibility for ensuring that its performance of this Contract (and that of its subcontractors related to this Contract) fully complies with all State and federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including but not limited to the Florida Security of Communications Act, Sections 934.01, et seq., F.S., and the Electronic Communications Privacy Act, 18 U.S.C. 2510 et seq. (hereafter, collectively, "Communication Privacy Laws").
2. Prior to intercepting, recording or monitoring any communications which are subject to Communication Privacy Laws, the Managed Care Plan must:
 - a. Submit a plan which specifies in detail the manner in which the Managed Care Plan (and its subcontractors related to this Contract) shall ensure that such actions are in full compliance with Communication Privacy Laws (the "Privacy Compliance Plan"); and

Section XV. Special Terms and Conditions

- b. Obtain written approval, signed and stamped by the Agency Contract Manager, of the Privacy Compliance Plan.
3. No modifications to an approved Privacy Compliance Plan may be implemented by the Managed Care Plan unless an amended Privacy Compliance Plan is submitted to the Agency, and written approval of the amended Plan is signed and stamped by the Agency Contract Manager. Agency approval of the Managed Care Plan's Privacy Compliance Plan in no way constitutes a representation by the Agency that the Privacy Compliance Plan is in full compliance with applicable Communication Privacy Laws, or otherwise shifts or diminishes the Managed Care Plan's sole burden to ensure full compliance with applicable Communication Privacy Laws in all aspects of the Managed Care Plan's performance of this Contract. Violation of this term may result in sanctions to include termination of this Contract and/or liquidated damages.

M. Audits and Monitoring

1. The Agency may conduct, or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by the Agency. The Agency may conduct a review of a sample of analyses performed by the Managed Care Plan to verify the quality of the Managed Care Plan's analyses. Reasonable notice shall be provided for reviews conducted at the Managed Care Plan's place of business.
2. Reviews may include, but shall not be limited to, reviews of procedures, computer systems, recipient records, accounting records, and internal quality control reviews. The Managed Care Plan shall work with any reviewing entity selected by the Agency.
3. During this Contract period, these records shall be available at the Managed Care Plan's office at all reasonable times. After this Contract period and for ten (10) years following, the records shall be available at the Managed Care Plan's chosen location subject to the approval of the Agency. If the records need to be sent to the Agency, the Managed Care Plan shall bear the expense of delivery. Prior approval of the disposition of the Managed Care Plan and subcontractor records must be requested and approved by the Agency. This obligation survives termination of this Contract.
4. The Managed Care Plan shall comply with all applicable federal requirements pertaining to procurement, including but not limited to Chapter 2 of the CFR and any other final or interim rules with respect to audit requirements of federal contracts administered through State and local public agencies.
5. The Managed Care Plan shall ensure an annual SOC 2 Type II audit is performed on the application hosting center. The Managed Care Plan shall provide a copy of the most recent audit report to the Agency.

N. Inspection of Records and Work Performed

1. The Agency and its authorized representatives shall, at all reasonable times, have the right to enter the Managed Care Plan's premises, or other places where duties under this Contract are performed. All inspections and evaluations shall be performed in such a manner as not to unduly delay work.

Section XV. Special Terms and Conditions

2. The Managed Care Plan shall retain all financial records, enrollee records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to performance under this Contract for a period of ten (10) years after termination of this Contract, or if an audit has been initiated and audit findings have not been resolved at the end of ten (10) years, the records shall be retained until resolution of the audit findings.
3. Refusal by the Managed Care Plan to allow access to all records, documents, papers, letters, other materials or on-site activities related to this Contract performance shall constitute a breach of this Contract.
4. The right of the Agency and its authorized representatives to perform inspections shall continue for as long as the Managed Care Plan is required to maintain records.
5. The Managed Care Plan shall be responsible for all storage fees associated with all records maintained under this Contract. The Managed Care Plan is also responsible for the destruction of all records that meet the retention schedule noted above.
6. Failure to retain all records as required may result in cancellation of this Contract. The Agency shall give the Managed Care Plan advance notice of cancellation pursuant to this provision and shall pay the Managed Care Plan only those amounts that are earned prior to the date of cancellation in accordance with the terms and conditions of this Contract. Performance by the Agency of any of its obligations under this Contract shall be subject to the Managed Care Plan's compliance with this provision.
7. In accordance with Section 20.055, F.S., the Managed Care Plan and its subcontractors shall cooperate with the OIG in any investigation, audit, inspection, review or hearing; and shall grant access to any records, data or other information the OIG deems necessary to carry out its official duties.

O. Employment

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

P. Work Authorization Program

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

Q. Equal Employment Opportunity (EEO) Compliance

The Managed Care Plan awarded a Contract shall not discriminate in its employment practices with respect to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap.

R. Discrimination

Pursuant to s. 287.134(2)(a), F.S., an entity or affiliate who has been placed on the discriminatory vendor list may not submit a Bid, Proposal, or Reply on a contract to provide any goods or services to a public entity; may not submit a Bid, Proposal, or Reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit Bids, Proposals, or Replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity. The Florida Department of Management Services is responsible for maintaining the discriminatory vendor list. Questions regarding the discriminatory vendor list may be directed to the Florida Department of Management Services, Office of Supplier Diversity at (850) 487-0915.

S. Patents, Royalties, Copyrights, Right to Data, and Sponsorship Statement

1. The Managed Care Plan, without exception, shall indemnify and hold harmless the Agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unattended invention, process, or article manufactured or supplied by the Managed Care Plan. The Managed Care Plan has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by the Managed Care Plan or is based solely and exclusively upon the Agency's alteration of the article.
2. The Agency shall provide prompt written notification of a claim of copyright or patent infringement and shall afford the Managed Care Plan full opportunity to defend the action and control the defense. Further, if such a claim is made or is pending, the Managed Care Plan may, at its option and expense procure for the Agency the right to continue the use of, replace, or modify the article to render it non-infringing (if none of the alternatives is reasonably available, the Agency agrees to return the article on request to the Managed Care Plan and receive reimbursement, if any, as may be determined by a court of competent jurisdiction).
3. If the Managed Care Plan brings to the performance of this Contract a pre-existing patent, patent-pending, and/or copyright, the Managed Care Plan shall retain all rights and entitlements to that pre-existing patent, patent pending and/or copyright, unless this Contract provides otherwise.
4. If the Managed Care Plan uses any design, device, or materials covered by letter, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work. Prior to the initiation of services

Section XV. Special Terms and Conditions

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

5. If any discovery or invention arises or is developed in the course of, or as a result of, work or services performed under this Contract, or in any way connected herewith, the Managed Care Plan shall refer the discovery or invention to the Agency for a determination whether patent protection shall be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida. All materials to which the Agency is to have patent rights or copyrights shall be marked and dated by the Managed Care Plan in such a manner as to preserve and protect the legal rights of the Agency.
6. Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation, and works of any similar nature, the Agency has the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the Agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, shall vest in the State of Florida, Department of State for the exclusive use and benefit of the State. Pursuant to s. 286.021, F.S., no person, firm, corporation, including parties to this Contract shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Florida Department of State.
7. The Agency shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Managed Care Plan under any Contract.
8. Pursuant to s. 286.25, F.S., all non-governmental vendors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the Managed Care Plan shall include the statement: "Sponsored by (name of Managed Care Plan) and the State of Florida, Agency for Health Care Administration." If the sponsorship reference is in written material, the words, "State of Florida, Agency for Health Care Administration" shall appear in the same size letters or type as the name of the organization.
9. All rights and title to works for hire under this Contract, whether patentable or copyrightable or not, shall belong to the Agency and shall be subject to the terms and conditions of this Contract.
10. The computer programs, data, materials and other information furnished by the Agency to the Managed Care Plan hereunder shall be and remain the sole and exclusive property of the Agency, free from any claim or right of retention by or on behalf of the Managed Care Plan. The services and products listed in this Contract

Section XV. Special Terms and Conditions

shall become the property of the Agency upon the Managed Care Plan's performance and delivery thereof. The Managed Care Plan hereby acknowledges that said computer programs, materials and other information provided by the Agency to the Managed Care Plan hereunder, together with the products delivered and services performed by the Managed Care Plan hereunder, shall be and remain confidential and proprietary in nature to the extent provided by Chapter 119, F.S., and that the Managed Care Plan shall not disclose, publish, or use same for any purpose other than the purposes provided in this Contract; however, upon the Managed Care Plan first demonstrating to the Agency's satisfaction that such information, in part or in whole, (1) was already known to the Managed Care Plan prior to its receipt from the Agency; (2) became known to the Managed Care Plan from a source other than the Agency; or (3) has been disclosed by the Agency to third parties without restriction, the Managed Care Plan shall be free to use and disclose same without restriction. Upon completion of the Managed Care Plan's performance or otherwise cancellation or termination of this Contract, the Managed Care Plan shall surrender and deliver to the Agency, freely and voluntarily, all of the above-described information remaining in the Managed Care Plan's possession.

11. The Managed Care Plan warrants that all materials produced hereunder shall be of original development by the Managed Care Plan and shall be specifically developed for the fulfillment of this Contract and shall not knowingly infringe upon or violate any patent, copyright, trade secret, or other property right of any third party, and the Managed Care Plan shall indemnify and hold the Agency harmless from and against any loss, cost, liability, or expense arising out of any breach or claimed breach of this warranty.
12. The terms and conditions specified in this Sub-Section shall also apply to any subcontract made under this Contract. The Managed Care Plan shall be responsible for informing the subcontractor of the provisions of this Sub-Section and obtaining disclosures.

T. Confidentiality of Information

1. The Managed Care Plan shall not use or disclose any information, that is confidential by State or federal law, including but not limited to Social Security numbers that may be supplied under this Contract pursuant to law, and also including the identity or identifying information concerning a Medicaid recipient or services under this Contract for any purpose not in conformity with State and federal laws, except upon written consent of the recipient, or his/her guardian.
2. Confidential information, including Medicaid information, shall be used only as authorized for purposes directly related to the administration of this Contract. The Managed Care Plan must have a process that specifies that patient-specific information remains confidential, is used solely for the purposes of data analysis or other Managed Care Plan responsibilities under this Contract, and is exchanged in a manner compliant with HIPAA/HITECH and only for the purpose of conducting a review or other duties outlined in this Contract.
3. Any patient-specific information and/or data constituting protected health care information received by the Managed Care Plan can be shared only with those

Section XV. Special Terms and Conditions

agencies that have legal authority to receive such information and cannot be otherwise transmitted for any purpose other than those for which the Managed Care Plan is retained by the Agency. The Managed Care Plan must have in place written confidentiality procedures to ensure confidentiality and to comply with all federal and State laws (including the HIPAA and HITECH Acts) governing confidentiality, including electronic treatment records, facsimile mail, and electronic mail).

4. The Managed Care Plan's subcontracts must explicitly State expectations about the confidentiality of information, and the subcontractor is held to the same confidentiality requirements as the Managed Care Plan. If provider-specific data are released to the public, the Managed Care Plan shall have procedures for exercising due care in compiling and releasing such data that address statutory protections of quality assurance and confidentiality while assuring that open records requirements of Chapter 119, F.S., are met.
5. Any releases of information to the media, the public, or other entities require prior approval from the Agency.

U. Legal Action Notification

The Managed Care Plan shall give the Agency, by certified mail, immediate written notification (no later than thirty (30) calendar days after service of process) of any action or suit filed or of any claim made against the Managed Care Plan by any subcontractor, vendor, or other party that results in litigation related to this Contract for disputes or damages exceeding the amount of **\$50,000.00**.

V. Venue

1. In the event of any legal challenges to this Contract, the Managed Care Plan shall agree and shall consent that hearings and depositions for any administrative or other litigation related to this procurement shall be held in Leon County, Florida. The Agency, in its sole discretion, may waive this venue for depositions.
2. The Managed Care Plan (and their successors, including but not limited to their parent(s), affiliates, subsidiaries, subcontractors, assigns, heirs, administrators, representatives, and trustees) acknowledges that this Contract and its Exhibits, Attachments, or amendments are not rules nor subject to rulemaking under Chapter 120 (or its successor) of the Florida Statutes and are not subject to challenge as a rule or non-rule policy under any provision of Chapter 120, F.S.
3. This Contract shall be delivered in the State of Florida and shall be construed in accordance with the laws of Florida. Wherever possible, each provision of this Contract shall be interpreted in such a manner as to be effective and valid under applicable law, but if any provision shall be found ineffective, then to the extent of such prohibition or invalidity, that provision shall be severed without invalidating the remainder of such provision or the remaining provisions of this Contract.
4. The exclusive venue and jurisdiction for any action in law or in equity to adjudicate rights or obligations arising pursuant to or out of this Contract for which there is no administrative remedy shall be the Second Judicial Circuit Court in and for Leon

Section XV. Special Terms and Conditions

County, Florida, or, on appeal, the First District Court of Appeal (and, if applicable, the Florida Supreme Court). Any administrative hearings hereon or in connection herewith shall be held in Leon County, Florida.

W. Performance Bond

1. A performance bond in the amount of **\$5,000,000** shall be furnished to the Agency for each Region in which the Managed Care Plan is awarded a Contract. If the Managed Care Plan is awarded a Contract in more than one (1) region, the Managed Care Plan shall furnish a single bond for the total amount (e.g., if the Managed Care Plan is awarded a Contract in two (2) regions, the Managed Care Plan shall submit one (1) bond for **\$10,000,000**). The bond shall be furnished to the Issuing Officer identified in Attachment A, Section A.5 within thirty (30) calendar days after execution of the resulting Contract and prior to commencement of any work under this Contract.
2. For Managed Care Plans awarded a Contract as a Specialty Plan, a performance bond in the amount of **\$1,000,000** shall be furnished to the Agency for each region in which the vendor is awarded a Contract. If the Managed Care Plan is awarded a Contract in more than one (1) region, the vendor shall furnish a single bond for the total amount (e.g., if the Managed Care Plan is awarded a Contract in two (2) regions, the Managed Care Plan shall submit one (1) bond for **\$2,000,000**). The bond shall be furnished to the Issuing Officer identified in Attachment A, Section A.5 within thirty (30) calendar days after execution of the resulting Contract and prior to commencement of any work under this Contract.
3. The bond must be furnished to the Issuing Officer identified in Attachment A, Section A., Overview, Item 5., Issuing Officer, within thirty (30) calendar days after execution of the resulting Contract and prior to commencement of any work under the resulting Contract. Thereafter, the bond shall be furnished on an annual basis, thirty (30) calendar days prior to the new Contract year and be in the amount of number percent (number%) of the current annual Contract amount. A copy of all performance bonds shall be submitted to the Agency's Contract Manager. The performance bond must not contain any provisions that shorten the time for bringing an action to a time less than that provided by the applicable Florida Statute of Limitations. See Section 95.03, F.S. No payments shall be made to the Managed Care Plan until an acceptable performance bond is furnished to the Agency.
4. The Managed Care Plan shall maintain an effective performance bond for the full term of this Contract. The performance bond shall remain in effect for the full term of the resulting Contract, including any renewal period. The Agency shall be named as the beneficiary of the Managed Care Plan's bond. The bond shall provide that the insurer or bonding company(s) pay losses suffered by the Agency directly to the Agency.
5. The Managed Care Plan shall bear cost of the performance bond.
6. Should the Managed Care Plan terminate the resulting Contract prior to the end of the resulting Contract period, an assessment against the bond shall be made by the Agency to cover the costs of issuing a new solicitation and selecting a new Managed Care Plan. The Managed Care Plan agrees that the Agency's damages in the event

Section XV. Special Terms and Conditions

of termination by the Managed Care Plan shall be considered to be for the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

X. Fidelity Bond

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

Y. Insurance

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

Section XV. Special Terms and Conditions

4. The Managed Care Plan shall submit insurance certificates evidencing such insurance coverage prior to execution of a Contract with the Agency.

Z. MyFloridaMarketPlace Vendor Registration and Transaction Fee

1. MyFloridaMarketPlace Vendor Registration. Each vendor doing business with the State of Florida for the sale of commodities or contractual services as defined in Section 287.012, F.S., shall register in MyFloridaMarketPlace, in compliance with Rule 60A-1.033, F.A.C., unless exempt under Rule 60A-1.033(3), F.A.C.
2. MyFloridaMarketPlace Transaction Fee. This Contract has been exempted by the Florida Department of Management Services from paying the transaction fee per Rule 60A-1.031(4)(a and b), F.A.C.

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Section XVI. Reporting Requirements

A. Managed Care Plan Reporting Requirements

1. General Provisions

- a. The Managed Care Plan shall comply with all reporting requirements set forth in this Contract.
- b. The Managed Care Plan may be required to provide to the Agency or its agents any other information, documentation, or data relative to this Contract in accordance with 42 CFR 438.604(b). In such instances, and at the direction of the Agency, the Managed Care Plan shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested. The Managed Care Plan shall have at least thirty (30) days to fulfill such ad hoc requests, unless the Agency directs the Managed Care Plan to provide data or information in less than thirty (30) days. The Managed Care Plan shall certify that data and information it submits to the Agency is accurate, truthful, and complete in accordance with 42 CFR 438.606.
- c. The Managed Care Plan shall comply with the Managed Care Plan Report Guide in submitting required reports, including the report formats, templates, instructions, data specifications, submission timetables and locations, and other materials contained in the guide. The Managed Care Plan Report Guide shall be posted on the Agency's website. The Managed Care Plan shall be furnished with appropriate technical assistance in using the Managed Care Plan Report Guide.
- d. Unless otherwise specified, all reports shall be submitted electronically, as prescribed in the reporting guidelines. Materials including PHI shall be submitted to the Agency SFTP sites.

2. Submission Deadlines

- a. Deadlines for report submission referred to in this Contract specify the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.
- b. If a reporting due date falls on a weekend or State holiday, the report shall be due to the Agency on the following business day.
- c. All reports filed on a quarterly basis shall be filed on a calendar year quarter.

3. Required Reports

- a. The Managed Care Plan shall comply with reports required by the Agency as specified in the Managed Care Plan Report Guide. All reports shall be submitted to the Agency Contract Manager unless otherwise indicated in the Managed Care Report Guide.

Summary of Reporting Requirements		
Report Name	Plan Type	Frequency
Marketing Agent Status Report	All Plans	Quarterly

Section XVI. Reporting Requirements

Summary of Reporting Requirements		
Report Name	Plan Type	Frequency
Marketing/Public/Educational Events Report	All Plans	Monthly
Enrollee Complaints, Grievance and Plan Appeals Report	All Plans	Monthly
Enhanced Care Coordination for Enrollees Under Age 21 Receiving Skilled Nursing Facility or Private Duty Nursing Services	All Plans	Monthly
PASRR Report	All Plans	Quarterly
Provider Network File	All Plans	Weekly
Provider Termination and New Provider Notification Report	All Plans	Weekly
Provider Complaint Report	All Plans	Monthly
Performance Measure Report	All Plans	Annually
Adverse and Critical Incident Summary Report	All Plans	Monthly
Claims Aging Report	All Plans	Quarterly
Suspected/ Confirmed Fraud & Abuse Reporting	All Plans	Within fifteen (15) days of detection
Quarterly Fraud and Abuse Activity Report	All Plans	Quarterly
Annual Fraud and Abuse Activity Report	All Plans	Annually
ASR Financial Reports	All Plans	Annually Quarterly
NAIC Health Statements	All Plans	Annually Quarterly
Audited Financial Statements	All Plans	Annually
Administrative Subcontractors and Affiliates Report	All Plans	Quarterly

4. Modifications to Reporting Requirements

- a. The Agency reserves the right to modify the reporting requirements and to provide technical assistance to the Managed Care Plan for up to ninety (90) day notice, to allow the Managed Care Plan to complete implementation, unless otherwise required by law.
- b. The Managed Care Plan shall be provided with written notification of any modifications to the reporting requirements.

5. Certification of Timely, Complete and Accurate Submission

- a. The Managed Care Plan shall assure the accuracy, completeness and timely submission of each report.

Section XVI. Reporting Requirements

- b. The Managed Care Plan's CEO, CFO or an individual who reports to the CEO or CFO and who has delegated authority to certify the Managed Care Plan's reports, shall attest, based on his/her best knowledge, information and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful and complete. (42 CFR 438.606(a) and (b).)
- c. The Managed Care Plan shall submit its certification at the same time it submits the certified data reports. (42 CFR 438.606(c).) The certification page shall be scanned and submitted electronically.
- d. If the Managed Care Plan fails to submit the required reports accurately or within the timeframes specified, the Managed Care Plan shall be subject to fines or otherwise sanctioned in accordance with Section XIII., Sanctions.

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**EXHIBIT B-1
MANAGED MEDICAL ASSISTANCE (MMA) PROGRAM**

Section I. Definitions and Acronyms

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

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Section II. General Overview

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

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Section III. Eligibility and Enrollment

A. General Provisions

There are no additional general provisions for eligibility and enrollment unique to the MMA managed care program.

B. Eligibility

Medicaid recipients as defined in s. 409.972, F.S., shall receive Medicaid covered services through the SMMC program.

C. Enrollment

1. Notification of Enrollee Pregnancy

- a. The Managed Care Plan shall be responsible for newborns of pregnant enrollees from the date of their birth. The Managed Care Plan shall comply with all requirements and procedures set forth by the Agency or its agent related to unborn activation and newborn enrollment.
- b. Newborns are enrolled in the Managed Care Plan of the mother unless the mother chooses another plan or the newborn does not meet the enrollment criteria of the mother's plan. When a newborn does not meet the criteria of the mother's plan, the newborn will be enrolled in a plan in accordance with Attachment B., Section III.B., Eligibility of this Contract.

2. If the enrollee has not chosen a PCP, the Agency's enrollment confirmation notice will advise the enrollee that a PCP will be assigned by the Managed Care Plan.

D. Disenrollment

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

E. Medicaid Redetermination Assistance

The Managed Care Plan shall develop a process for tracking redeterminations for the Medicaid ICP when an enrollee under the age of eighteen (18) years resides in a nursing facility, and for documenting the assistance provided by the Managed Care Plan, to ensure the enrollee continues to meet medical/functional eligibility for the Medicaid ICP.

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Section IV. Marketing

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

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Section V. Enrollee Services

A. General Provisions

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

B. Enrollee Material

1. Provider Directory

In addition to the requirements in the Core Scope, the Managed Care Plan is not required to include outpatient-based specialty providers in ambulatory surgical centers in the online provider database or printed provider directory. However, the Managed Care Plan shall include these providers in the provider network file it submits to the Agency.

2. Online Enrollee Materials

The Managed Care Plan shall provide a link to the Agency's Medicaid PDL on the Managed Care Plan's website without requiring enrollee login. Such Managed Care Plans shall also post the list of covered drugs that are not on the Agency's Medicaid PDL, and that are subject to prior authorization.

C. Enrollee Services

1. Reinstatement Notice

a. In addition to requirements in Attachment B., Section V.B.6., Reinstatement Notice, the Managed Care Plan shall include in its reinstatement notice:

- (1) The enrollee's PCP, unless the enrollee is a dual eligible.

2. Enrollee ID Card Requirements

a. The Managed Care Plan shall include on its enrollee ID card:

- (1) The enrollee's PCP, unless the enrollee is a dual eligible.

3. Toll-Free Enrollee Help Line

The Managed Care Plan shall operate, as part of its emergency services, a crisis emergency hotline available to all enrollees twenty-four hours a day, seven days a week (24/7).

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Section VI. Coverage and Authorization of Services

A. Required MMA Benefits

1. Specific MMA Services to be Provided

- a. The Managed Care Plan shall provide covered services specified in s. 409.973, F.S., in accordance with Attachment B., Section VI., Coverage and Authorization of Services, the approved federal waiver for the MMA managed care program, and the following Medicaid rules and services listed on the associated fee schedules:

Rule No.	Policy Name
59G-4.013	Allergy Services Coverage Policy
59G-4.015	Ambulance Transportation Services Coverage Policy
59G-4.020	Ambulatory Surgical Center Services Coverage Policy
59G-4.022	Anesthesia Services Coverage Policy
59G-4.025	Assistive Care Services Coverage and Limitations Handbook
59G-4.125	Behavior Analysis Services Coverage Policy ¹
59G-4.027	Behavioral Health Overlay Services Coverage and Limitations Handbook
59G-4.033	Cardiovascular Services Coverage Policy
59G-8.700	Child Health Services Target Case Management
59G-4.040	Chiropractic Services Coverage Policy
59G-4.050	Community Behavioral Health Services Coverage and Limitations Handbook
59G-4.055	County Health Department Services
59G-4.105	Dialysis Services Coverage Policy
59G-4.070	Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook
59G-4.085	Early Intervention Services
59G-4.015	Emergency Transportation Services Coverage Policy
59G-4.087	Evaluation and Management Services Coverage Policy
59G-4.100	Federally Qualified Health Center Services
59G-4.026	Gastrointestinal Services Coverage Policy
59G-4.108	Genitourinary Services Coverage Policy
59G-4.110	Hearing Services Coverage Policy
59G-4.130	Home Health Services Coverage Policy
59G-4.140	Hospice Services Coverage Policy
59G-4.150	Inpatient Hospital Services Coverage Policy
59G-4.032	Integumentary Services Coverage Policy
59G-4.190	Laboratory Services Coverage Policy
59G-1.045	Medicaid Forms
59G-4.197	Medical Foster Care Services

¹ Behavior analysis services shall be implemented upon direction of the Agency.

Section VI. Coverage and Authorization of Services

59G-4.199	Mental Health Targeted Case Management Handbook
59G-4.201	Neurology Services Coverage Policy
59G-4.330	Non-Emergency Transportation Services Coverage Policy
59G-4.200	Nursing Facility Services Coverage Policy
59G-4.318	Occupational Therapy Services Coverage Policy
59G-4.207	Oral and Maxillofacial Surgery Services Coverage Policy
59G-4.211	Orthopedic Services Coverage Policy
59G-4.160	Outpatient Hospital Services Coverage Policy
59G-4.222	Pain Management Services Coverage Policy
59G-4.320	Physical Therapy Services Coverage Policy
59G-4.220	Podiatry Services Coverage Policy
59G-4.250	Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook
59G-4.261	Private Duty Nursing Services Coverage Policy
59G-4.002	Provider Reimbursement Schedules and Billing Codes
59G-4.240	Radiology and Nuclear Medicine Services Coverage Policy
59G-4.264	Regional Perinatal Intensive Care Center Services
59G-4.030	Reproductive Services Coverage Policy
59G-4.235	Respiratory System Services Coverage Policy
59G-4.322	Respiratory Therapy Services Coverage Policy
59G-4.280	Rural Health Clinic Services
59G-4.295	Specialized Therapeutic Services Coverage and Limitations Handbook
59G-4.324	Speech-Language Pathology Services Coverage Policy
59G-4.120	Statewide Inpatient Psychiatric Program Coverage Policy
59G-4.360	Transplant Services Coverage Policy
59G-4.340	Visual Aid Services Coverage Policy
59G-4.210	Visual Care Services Coverage Policy

(1) Behavior Analysis Services

There are no additional coverage provisions unique to behavior analysis services. The Managed Care Plan shall cover behavior analysis services upon direction of the Agency.

(2) Clinic Services

(a) The Managed Care Plan shall provide RHC services. Rural Health Clinics provide ambulatory primary care to a medically underserved population in a rural geographical area. An RHC provides primary health care and related diagnostic services, including

(i) RHC services reimbursed through the clinic encounter (PPS) include:

- Adult health screening services
- Well-child visits
- Chiropractic services
- Family planning services

Section VI. Coverage and Authorization of Services

- HIV counseling services
 - Medical primary care services
 - Mental health services
 - Optometric services
 - Podiatric services.
- (ii) RHC services reimbursed outside the clinic encounter (PPS) include:
- Emergency services
 - Immunization services
 - Any health care services rendered away from the RHC, at a hospital, or a nursing facility, including off-site radiology services and off-site clinical laboratory services
 - Radiology and other diagnostic imaging services
 - Home health services
 - Prescribed drug services
 - WIC certifications or recertifications
 - Clinic visits for the sole purpose of obtaining lab specimens or to obtain results from a diagnostic test
 - Clinic visits for the sole purpose of obtaining immunizations
 - Mental health services for chronic conditions without acute exacerbation
- (b) The Managed Care Plan shall provide FQHC Services. An FQHC provides primary health care and related diagnostic services.
- (i) FQHC services reimbursed through the clinic encounter (PPS) include:
- Adult health screening services
 - Well-child visits
 - Chiropractic services
 - Family planning services
 - Medical primary care

Section VI. Coverage and Authorization of Services

- Mental health services
 - Optometric services
 - Podiatric services
 - Diagnostic and treatment radiology services
- (ii) FQHC services reimbursed outside of the clinic encounter (PPS) include:
- Emergency services
 - Services rendered away from the FQHC clinic or satellite clinic
 - Immunization services
 - Home health services
 - Prescription drug services
 - WIC certifications and recertifications
 - Mental health services for chronic conditions without acute exacerbation
- (c) The Managed Care Plan shall provide CHD Services. County Health Departments provide public health services in accordance with Chapter 154, F.S. A CHD provides primary and preventive health care, and related diagnostic services, including but not limited to:
- (i) Adult health screening services
 - (ii) Well-child visits
 - (iii) Family planning services
 - (iv) Immunization services
 - (v) Medical primary care services
 - (vi) Registered nurse services.

(3) Community Behavioral Health Services

The Managed Care Plan shall provide behavioral health services in compliance with 42 CFR 438.3(n) with respect to quantitative and non-quantitative limits.

(4) Early Intervention Services

Section VI. Coverage and Authorization of Services

Children's programs shall promote increased use of prevention and early intervention services for at-risk enrollees. The Managed Care Plan shall authorize covered services recommended by the Early Steps Program when medically necessary. The Managed Care Plan shall make a good faith effort to enter into and maintain agreements with the Local Early Steps Program Office to establish methods of communication and procedures for the timely approval of services covered by Medicaid in accordance with s. 391.308, F.S., and Section VI., Coverage and Authorization of Services.

(5) Immunizations

- (a) The Managed Care Plan shall provide immunizations in accordance with the Recommended Childhood and Adolescent Immunization Schedule for the United States, or when medically necessary for the enrollee's health.
- (b) The Managed Care Plan shall participate, or direct its providers to participate, in the VFC. See s. 1905(r)(1)(B)(iii) of the Social Security Act.
- (c) The Managed Care Plan shall provide coverage and reimbursement to the participating provider for immunizations covered by Medicaid, but not provided through VFC.
- (d) The Managed Care Plan shall ensure that providers have a sufficient supply of vaccines if the Managed Care Plan is enrolled in the VFC program. The Managed Care Plan shall direct those providers that are directly enrolled in the VFC program to maintain adequate vaccine supplies.
- (e) The Managed Care Plan shall enroll as a data partner with Florida SHOTS (State Health Online Tracking System) and submit immunization data using the process and format specified by the Agency.

(6) Emergency Services

- (a) The Managed Care Plan shall provide pre-hospital and hospital-based trauma services and emergency services and care to enrollees. See ss. 395.1041, 395.4045 and 401.45, F.S.
- (b) When an enrollee presents at a hospital seeking emergency services and care, a physician of the hospital or, to the extent permitted by applicable law, other appropriate personnel under the supervision of a hospital physician, shall make a determination that an emergency medical condition exists for the purposes of treatment. See ss. 409.9128, 409.901, and 641.513, F.S.
- (c) The Managed Care Plan shall not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, the Managed Care Plan shall not deny payment for treatment obtained when a representative of the Managed Care Plan instructs the enrollee to seek emergency services and care in accordance with s. 743.064, F.S.

Section VI. Coverage and Authorization of Services

- (d) The Managed Care Plan shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as the Managed Care Plan can safely transport the enrollee to a participating facility. The Managed Care Plan may transfer the enrollee, in accordance with State and federal law, to a participating hospital that has the service capability to treat the enrollee's emergency medical condition. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.
- (a) In accordance with 42 CFR 438.114 and s. 1932(b)(2)(A)(ii) of the Social Security Act, the Managed Care Plan shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service through a participating or non-participating provider. Those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Managed Care Plan can choose not to cover non-emergency services if they are provided by a non-participating provider, except in those circumstances detailed below.
 - (i) Post-stabilization care services that were pre-approved by the Managed Care Plan;
 - (ii) Post-stabilization care services that were not pre-approved by the Managed Care Plan because the Managed Care Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request; or
 - (iii) The treating provider could not contact the Managed Care Plan for pre-approval.
- (b) The Managed Care Plan shall provide emergency services and care without any specified dollar limitations.
- (c) The Managed Care Plan shall authorize payment for non-participating physicians for emergency ancillary services provided in a hospital setting.
- (d) The Managed Care Plans shall provide emergency behavioral health services pursuant, but not limited, to s. 394.463, F.S.; s. 641.513, F.S.; and Title 42 CFR Chapter IV. Emergency service providers shall make a reasonable attempt to notify the Managed Care Plan within twenty-four (24) hours of the enrollee's presenting for emergency behavioral health services. In cases in which the enrollee has no identification, or is unable to identify himself/herself orally when presenting for behavioral health services, the provider shall notify the Managed Care Plan within twenty-four (24) hours of learning the enrollee's identity.
- (e) In addition to the requirements outlined in s. 641.513, F.S., the Managed Care Plan will ensure:

Section VI. Coverage and Authorization of Services

- (i) The enrollee has a follow-up appointment scheduled within seven (7) days after discharge; and
- (ii) All required prescriptions are authorized at the time of discharge.

(7) Family Planning Services and Supplies

- (a) The Managed Care Plan shall furnish family planning services on a voluntary and confidential basis.
- (b) The Managed Care Plan shall allow enrollees freedom of choice of family planning methods covered under the Medicaid program, including Medicaid-covered implants, where there are no medical contra-indications.
- (c) The Managed Care Plan shall allow each enrollee to obtain family planning services from any provider and shall not require prior authorization for such services.
- (d) The Managed Care Plan shall make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, including discussion of all appropriate methods of contraception, counseling, and services for family planning to all women and their partners. The Managed Care Plan shall direct providers to maintain documentation in the enrollee records to reflect this provision. (Section 409.967(2), F.S.)
- (e) The Managed Care Plan shall implement an outreach program and other strategies for identifying every pregnant enrollee. This shall include care coordination/case management, claims analysis, and use of health risk assessment, etc. The Managed Care Plan shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant.

(8) Hearing Services

Newborn and infant hearing screenings are covered through the Medicaid FFS delivery system.

(9) Hospital Services

- (a) Inpatient services also include inpatient care for any diagnosis including tuberculosis and renal failure, when provided by general acute care hospitals in both emergent and non-emergent conditions.
- (b) The Managed Care Plan shall adhere to the provisions of the NMHPA of 1996 regarding postpartum coverage for mothers and their newborns. Therefore, the Managed Care Plan shall provide for no less than a forty-eight (48) hour hospital length of stay following a normal vaginal delivery, and at least a ninety-six (96) hour hospital length of stay following a Cesarean section. In connection with coverage for maternity care, the

Section VI. Coverage and Authorization of Services

hospital length of stay shall be decided by the attending physician in consultation with the mother.

- (c) The Managed Care Plan shall prohibit the following practices related to the NMHPA:
 - (i) Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum protections available under NMHPA;
 - (ii) Penalizing or otherwise reducing or limiting the reimbursement of an attending physician because the physician provided care in a manner consistent with NMHPA; and
 - (iii) Providing incentives (monetary or otherwise) to an attending physician to induce the physician to provide care in a manner inconsistent with NMHPA.
- (d) For all child/adolescent enrollees (under the age of twenty-one (21) years) and pregnant adults, the Managed Care Plan shall be responsible for providing up to three hundred sixty-five (365) days of health-related inpatient care, including behavioral health, for each State fiscal year. For all non-pregnant adults, the Managed Care Plan shall be responsible for up to forty-five (45) days of inpatient coverage and up to three hundred sixty-five (365) days of emergency inpatient care, including behavioral health, in accordance with the Inpatient Hospital Coverage Policy, for each State fiscal year.
- (e) The Managed Care Plan shall count inpatient days based on the lesser of the actual number of covered days in the inpatient hospital stay and the average length of stay for the relevant All Patient Refined Diagnosis Related Group (APR-DRG or DRG). This requirement applies whether or not the Managed Care Plan uses DRGs to pay the provider. DRGs can be found at the following website:
http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.
- (f) If a non-pregnant adult enrollee has not yet met his/her forty-five day (45-day) hospital inpatient limit per State fiscal year at the start of a new hospital admission, the enrollee's Managed Care Plan at the time of admission must cover the entire new stay. This requirement applies even if the actual or average length of stay for the DRG puts the person over the inpatient limit. There is no proration of inpatient days.
- (g) Unless otherwise specified in this Contract, where an enrollee uses non-emergency services available under the Managed Care Plan from a non-participating provider, the Managed Care Plan shall not be liable for the cost of such services unless the Managed Care Plan referred the enrollee to the non-participating provider or authorized the out-of-network service.
- (h) The Managed Care Plan shall provide medically necessary transplants and related services as outlined in the chart below. For transplant services

Section VI. Coverage and Authorization of Services

specified with one (1) asterisk, Managed Care Plans are paid by the Agency through kick payments. See Section XI., Method of Payment, for payment details. Transplant services specified with two (2) asterisks are covered through Medicaid on a FFS basis and not by the Managed Care Plan.

SUMMARY OF RESPONSIBILITY		
Transplant Service	Adult (21 and Over)	Pediatric (20 and Under)
Evaluation	Managed Care Plan	Managed Care Plan
Bone Marrow	Managed Care Plan	Managed Care Plan
Cornea	Managed Care Plan	Managed Care Plan
Heart	Managed Care Plan*	Managed Care Plan*
Intestinal/ Multivisceral	Medicaid**	Medicaid**
Kidney	Managed Care Plan	Managed Care Plan
Liver	Managed Care Plan*	Managed Care Plan*
Lung	Managed Care Plan*	Managed Care Plan*
Pancreas	Managed Care Plan	Managed Care Plan
Pre- and Post- Transplant Care, including Transplants <u>Not</u> Covered by Medicaid	Managed Care Plan	Managed Care Plan
Other Transplants <u>Not</u> Covered by Medicaid	Not Covered	Not Covered

- (i) The Managed Care Plan shall be responsible for the reimbursement of care for enrollees who have been diagnosed with Tuberculosis disease, or show symptoms of having Tuberculosis and have been designated a threat to the public health by the Florida DOH Tuberculosis Program and shall observe the following:
 - (i) Treatment plans and discharge determinations shall be made solely by DOH and the treating hospital;

Section VI. Coverage and Authorization of Services

- (ii) For enrollees determined to be a threat to public health and receiving Tuberculosis treatment at a DOH contracted hospital, the Managed Care Plan shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and DOH, and shall also pay any wrap-around costs not included in the per-diem rate; and
- (iii) The Managed Care Plan shall not deny reimbursement for failure to prior authorize admission or for services rendered pursuant to s. 392.62 F.S.
- (j) The Managed Care Plan shall not:
 - (i) Limit inpatient days for services that are unrelated to the PPC diagnosis present on admission.
 - (ii) Reduce authorization to a provider when the PPC existed prior to admission.
- (k) The Managed Care Plan shall enroll and participate in the Florida Health Information Exchange Event Notification Service as directed by the Agency.

(10) Laboratory and Imaging Services

Newborn screening services in accordance with s. 383.14, F.S., which outlines the required laboratory screening process to test for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect. These required laboratory tests shall be processed through the State Public Health Laboratory. The Managed Care Plan shall reimburse for these screenings at the established Medicaid rate and must enter into a provider agreement or a contract with the State Public Health Laboratory.

(11) Prescribed Drug Services

- (a) The Agency shall be responsible for administration of the Medicaid prescribed drug program. The Agency shall maintain the Medicaid P&T Committee review of drug options to maintain an array of choices for prescribers within each therapeutic class on the Agency's Medicaid PDL.
- (b) The Managed Care Plan shall provide those products and services associated with the dispensing of medicinal drugs pursuant to a valid prescription, as defined in Chapter 465, F.S., Prescribed drug services shall include all prescription drugs listed in the Agency's Medicaid PDL.
- (c) The Managed Care Plan shall make available those drugs and dosage forms listed on the Agency's Medicaid PDL, and shall comply with the requirements of s. 409.912(8)(a)5., F.S., regarding the use of counterfeit-proof prescription pads.

Section VI. Coverage and Authorization of Services

- (d) The Managed Care Plan may make available generic drugs in a therapeutic category that are not on the Agency's Medicaid PDL, unless a brand-name drug containing the same active ingredient is on the Agency's Medicaid PDL.
- (e) The Managed Care Plan shall make available those brand name drugs that are not on the Agency's Medicaid PDL, when medically necessary, if the prescriber:
 - (i) Writes in his/her own handwriting on the valid prescription that the "Brand Name is Medically Necessary" (pursuant to s. 465.025, F.S.); and
 - (ii) Submits a completed "Multisource Drug and Miscellaneous Prior Authorization" form to the Managed Care Plan indicating that the enrollee has had an adverse reaction to a generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug.
- (f) The Managed Care Plan may have a pharmacy lock-in program that shall be submitted in writing and approved by the Agency in advance of implementation.
- (g) The Managed Care Plan shall notify providers who may prescribe or are currently prescribing a drug that is being deleted from the Agency's Medicaid PDL within thirty (30) days of the Managed Care Plan being notified of the change by the Agency.
- (h) The Agency shall reimburse for Hemophilia factor-related drugs on a FFS basis. The Agency shall identify Hemophilia factor-related drugs distributed through the Comprehensive Hemophilia Disease Management Program.
- (i) During operation of the Comprehensive Hemophilia Disease Management Program, the Managed Care Plan shall coordinate the care of its enrollees with Agency-approved organizations.

(12) Transportation Services

The Managed Care Plan shall provide NET and emergency transportation services to eligible enrollees twenty-four (24) hours per day, seven (7) days per week for its enrollees who have no other means of transportation available to any covered service and transportation to services not covered by the Managed Care Plan specified in Section VI.C., Excluded Services, including prepaid dental services, prescribed drugs, and expanded benefits.

2. 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 B., Section VI., Coverage and Authorization of Services, after obtaining approval from the Agency.

Section VI. Coverage and Authorization of Services

- a. The Managed Care Plan may provide services in a nursing facility in lieu of inpatient hospital services. Such services shall not be counted as inpatient hospital days.
- b. Crisis stabilization units (CSU) and Class III and Class IV freestanding psychiatric specialty hospitals may be used in lieu of inpatient psychiatric hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If CSU beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Managed Care Plan shall demonstrate adequate capacity for psychiatric inpatient hospital care in anticipation of such transfers.
- c. Detoxification or addictions receiving facilities licensed under s. 397, F.S., may be used in lieu of inpatient detoxification hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If detoxification or addictions receiving facility beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Managed Care Plan shall demonstrate adequate capacity for inpatient detoxification hospital care in anticipation of such transfers.
- d. Partial hospitalization services in a hospital may be provided in lieu of inpatient psychiatric hospital care for up to ninety (90) days annually for adults ages twenty-one (21) and older; there is no annual limit for children under the age of twenty-one (21).
- e. Mobile crisis assessment and intervention for enrollees in the community may be provided in lieu of emergency behavioral health care.
- f. Ambulatory detoxification services may be provided in lieu of inpatient detoxification hospital care when determined medically appropriate.
- g. The following services and corresponding HCPCS or Revenue codes may be used in lieu of community behavioral health services:
 - (1) Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services.
 - (2) Respite Care Services in lieu of Specialized Therapeutic Foster Care services.
 - (3) Drop-In Center in lieu of Clubhouse services.
 - (4) Infant Mental Health Pre and Post Testing Services in lieu of Psychological Testing services.
 - (5) Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services.
 - (6) Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.

Section VI. Coverage and Authorization of Services

3. Customized Benefits

- a. The Managed Care Plan may customize expanded benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services.
- b. Submitted proposals for customized benefit packages must comply with instructions available from the Agency. The Agency shall evaluate the Managed Care Plan's CBP for actuarial equivalency and sufficiency of benefits before approving the CBP. Actuarial equivalency is tested by using a proposal that:
 - (1) Compares the value of the level of benefits in the proposed package to the value of the contracted benefit package for the average member of the covered population;
 - (2) Ensures that the overall level of benefits is appropriate; and
 - (3) Compares the proposed CBP to State-established standards. The standards are based on the covered population's historical use of Medicaid services. These standards are used to ensure that the proposed CBP is adequate to cover the needs of the vast majority of the enrollees.
- c. If, in its CBP, the Managed Care Plan limits a service to a maximum annual dollar value, the Managed Care Plan must calculate the dollar value of the service using the Medicaid fee schedule.
- d. The CBPs may change on a Contract year basis and only if approved by the Agency in writing. The Managed Care Plan shall submit to the Agency a proposal for its proposed CBP for evaluation of actuarial equivalency and sufficiency standards no later than the date established by the Agency each year.
- e. The Managed Care Plan shall send letters of notification to enrollees regarding exhaustion of benefits for services restricted by unit amount if the amount is more restrictive than Medicaid. The Managed Care Plan shall send an exhaustion of benefits letter, including notification of the enrollee's right to a Medicaid Fair Hearing, for any service restricted by a dollar amount. The Managed Care Plan shall implement said letters upon the written approval of the Agency. The letters of notification include the following:
 - (1) A letter notifying an enrollee when he/she has reached fifty percent (50%) of any maximum annual dollar limit established by the Managed Care Plan for a benefit;
 - (2) A follow-up letter notifying the enrollee when he/she has reached seventy-five (75%) of any maximum annual dollar limit established by the Managed Care Plan for a benefit; and
 - (3) A final letter notifying the enrollee that he/she has reached the maximum dollar limit established by the Managed Care Plan for a benefit.
- f. The Managed Care Plan shall submit the Customized Benefit Notifications Report to the Agency in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

Section VI. Coverage and Authorization of Services

B. Expanded Benefits

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

C. Excluded Services

The following services are not provided by the Managed Care Plan, but are available to eligible Medicaid recipients through the Medicaid FFS delivery system:

1. CHD Certified Match Program services
2. Developmental Disabilities Individual Budgeting (iBudget) HCBS Waiver services
3. Familial Dysautonomia HCBS Waiver services
4. Hemophilia Factor-related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program services
5. ICF/IID services
6. School-based services provided through the Medicaid Certified School Match Program
7. Model HCBS Waiver services
8. Newborn Hearing services
9. Prescribed Pediatric Extended Care services
10. Program for All-Inclusive Care for Children services
11. Substance Abuse County Match Program services
12. PACE services

D. Coverage Provisions

1. Primary Care Provider Initiatives

- a. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall establish a program to encourage enrollees to establish a relationship with their PCP.
- b. This program shall provide information to each enrollee on the importance of selecting a PCP and the procedure for selecting a PCP (s. 409.973(4), F.S.).
- c. The Managed Care Plan shall offer each enrollee a choice of PCPs. After making a choice, each enrollee shall have a single or group PCP.

Section VI. Coverage and Authorization of Services

- d. The Managed Care Plan shall allow pregnant enrollees to choose Managed Care Plan obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP, as specified in Section VIII., Provider Services.
- e. No later than the beginning of the last trimester of gestation, the Managed Care Plan shall assign a pediatrician or other appropriate PCP to all pregnant enrollees for the care of their newborn babies if the enrollee has not selected a provider for a newborn.
- f. The Managed Care Plan shall assign a PCP to those enrollees who did not choose a PCP at the time of Managed Care Plan selection. The Managed Care Plan shall take into consideration the enrollee's last PCP (if the PCP is known and available in the Managed Care Plan's network), closest PCP to the enrollee's ZIP code location, keeping children/adolescents within the same family together, enrollee's age (adults versus children/adolescents), and PCP performance measures.
 - (1) If the language and/or cultural needs of the enrollee are known to the Managed Care Plan, the Managed Care Plan shall assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee.
 - (2) If the enrollee is a full-benefit dual eligible:
 - (a) The Managed Care Plan shall not assign or require the enrollee to choose a new PCP through the Managed Care Plan.
 - (b) The Managed Care Plan shall not prevent the enrollee from receiving primary care services from the enrollee's existing Medicare PCP.
 - (c) The Managed Care Plan may assist the enrollee in choosing a PCP, if the enrollee does not have a Medicare assigned PCP.
- g. The Managed Care Plan shall permit enrollees to request to change PCPs at any time. If the enrollee request is not received by the Managed Care Plan's established monthly cut-off date for system processing, the PCP change will be effective the first day of the next month.
- h. The Managed Care Plan shall assign all enrollees that are reinstated after a temporary loss of eligibility to the PCP who was treating them prior to loss of eligibility, unless the enrollee specifically requests another PCP or the PCP no longer participates in the Managed Care Plan or is at capacity.
- i. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall report on the number of enrollees assigned to each participating PCP and the number of enrollees who have not had an appointment with their PCP within their first year of enrollment as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.
- j. Pursuant to s. 409.973(4), F.S., the Managed Care Plan shall report on the number of emergency room visits by enrollees who have not had at least one appointment with their PCP as specified in the Managed Care Plan Report Guide and as referenced in Section XVI., Reporting Requirements.

2. Enrollee Screening and Education

Section VI. Coverage and Authorization of Services

- a. Within thirty (30) days of enrollment, the Managed Care Plan shall notify enrollees of, and ensure the availability of, a screening for all enrollees known to be pregnant or who advise the Managed Care Plan that they may be pregnant. The Managed Care Plan shall refer enrollees who are, or may be, pregnant to a provider to obtain appropriate care.
- b. The Managed Care Plan shall use the enrollee's health risk assessment and/or released enrollee record to identify enrollees who have not received child health screenings in accordance with the Agency-approved periodicity schedule.
- c. The Managed Care Plan shall develop and implement an education and outreach program to increase the number of eligible enrollees receiving well-child visits. This program shall include, at a minimum, the following:
 - (1) A tracking system to identify enrollees for whom a screening is due or overdue;
 - (2) Systematic reminder notices sent to enrollees before a screening is due. The notice shall include an offer to assist with scheduling and transportation;
 - (3) If the Managed Care Plan's well-child visit rate is below eighty percent (80%), contacts (which may include automated calls) to all new enrollees under the age of twenty-one (21) years to inform them of well-child visit services and offer to assist with scheduling and transportation;
 - (4) A process for following up with enrollees who do not get timely screenings. This shall include contacting, twice if necessary, any enrollee more than two (2) months behind in the Agency-approved periodicity screening schedule to urge those enrollees, or their legal representatives, to make an appointment with the enrollee's PCP for a screening visit and offering to assist with scheduling and transportation. The Managed Care Plan shall document all outreach education attempts. For this subsection "contact" is defined as mailing a notice to or calling an enrollee at the most recent address or telephone number available; and
 - (5) Provision of enrollee education and outreach in community settings.
- d. The Managed Care Plan shall develop and implement an education outreach program to encourage wellness visits to prevent illness or exacerbations of chronic illness.
- e. The Managed Care Plan shall take immediate action to address any identified urgent medical needs.
- f. Pursuant to s. 409.966(3)(c)2, F.S., the Managed Care Plan may have program for recognizing PCMHs and providing increased compensation for recognized PCMHs, as defined by the Managed Care Plan. If the Managed Care Plan has a patient centered medical home program, it shall submit its procedures for such program to the Agency, which shall include recognition standards and increased compensation protocols developed by the Managed Care Plan for the program.

3. New Enrollee Procedures

Section VI. Coverage and Authorization of Services

- a. The Managed Care Plan shall contact each new enrollee at least twice, if necessary, within sixty (60) days of the enrollee's enrollment to offer to schedule the enrollee's initial appointment with the PCP. This appointment is to obtain an initial health assessment, including a well-child visit, if applicable. For this subsection "contact" is defined as mailing a notice to or telephoning an enrollee at the most recent address or telephone number available. Contact may also include emailing as permitted by Attachment B., Section V.B.3, Requirements for Mailing Materials to Enrollees.
- b. Within thirty (30) days of enrollment, the Managed Care Plan shall ask the enrollee to authorize release of the provider's enrollee records to the new PCP or other appropriate provider and shall assist by requesting those records from the enrollee's previous provider(s).
- c. The Managed Care Plan shall honor any written documentation of prior authorization of ongoing covered services for a period of up to sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.
- d. For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services shall include the following, provided that the services were prearranged prior to enrollment with the Managed Care Plan:
 - (1) Prior existing orders
 - (2) Provider appointments (e.g., transportation, dental appointments, surgeries, etc.)
 - (3) Prescriptions (including prescriptions at non-participating pharmacies)
 - (4) Prior authorizations
 - (5) Treatment plan/plan of care.
- e. The Managed Care Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Managed Care Plan is not required to approve claims for which it has received no written documentation.

4. Telemedicine Coverage Provisions

- a. The Managed Care Plan may use telemedicine in accordance with Rule 59G-1.057, F.A.C., and as specified in this Contract.
- b. When providing services through telemedicine, the Managed Care Plan shall ensure:
 - (1) The telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable;

Section VI. Coverage and Authorization of Services

- (2) The Managed Care Plan's providers using telemedicine comply with Health Insurance Portability and Accountability Act and other State and federal laws pertaining to patient privacy;
 - (3) The Managed Care Plan's telemedicine procedures comply with the requirements in this Contract; and
 - (4) The Managed Care Plan provides training to providers regarding the telemedicine requirements in this Contract.
- c. The Managed Care Plan shall ensure the enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter. The Managed Care Plan shall ensure that the enrollee record includes documentation, as applicable, when telemedicine services are provided.

5. Protective Custody Coverage Provisions

- a. The Managed Care Plan shall provide a physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter, or the foster care program by the DCF. (Rule 65C-29.008, F.A.C.)
- b. The Managed Care Plan shall provide these required examinations without requiring prior authorization, or, if DCF uses a non-participating provider, approve and process the claim.

E. Care Coordination/Case Management

1. General Provisions

The Managed Care Plan shall implement case management processes for enrollees under the age of twenty-one (21) years who are receiving services in a skilled nursing facility, receiving private duty nursing services in their family home or other community based setting.

2. Case Management Program Description

In addition to the provisions of Attachment B., Section VI.E.2., Case Management Program Description, the Managed Care Plan shall maintain written procedures for the case management of enrollees under the age of twenty-one (21) years receiving private duty nursing services or nursing facility services, which shall include:

- a. A description of the Managed Care Plan procedures for assigning a case manager to enrollees.
- b. A description of the Managed Care Plan's procedures for documenting an enrollee's or the enrollee's authorized representative's rejection of case management services.
- c. The responsibilities of the case manager in participating in all scheduled and any ad hoc Children's Multidisciplinary Assessment Team meeting(s) for assigned enrollees.

Section VI. Coverage and Authorization of Services

3. Initial Visit

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

4. Comprehensive Assessment/Reassessment

There are no additional comprehensive assessment/reassessment provisions unique to the MMA managed care program.

5. Initial Plan of Care/Reviews

- a. The Managed Care Plan shall convene an MDT every six (6) month to provide a comprehensive review of the services and supports that the enrollee needs, and to authorize any Medicaid reimbursable services that are prescribed for the enrollee. The Managed Care Plan shall convene an MDT meeting more frequently, if needed, based on any changes in the enrollee's medical condition or a significant life change. The MDT meeting shall include at a minimum: the enrollee's care coordinator, the enrollee (if able), the enrollee's authorized representative, and other health care professionals involved in that enrollee's care. The Managed Care Plan shall develop, update, and maintain, with input from the MDT attendees, a person-centered, individualized service plan that reflects the services and supports that the enrollee needs
- b. The Managed Care Plan shall participate in interagency staffings (e.g., DCF and DJJ) or school staffings that may result in the provision of behavioral health services to an enrolled child/adolescent. The Managed Care Plan or designee shall participate in such staffings upon request of the enrollee or enrollee's case manager.
- c. If an enrollee under the age of twenty-one (21) years receiving private duty nursing or nursing facility services, or their authorized representative, declines to receive case management services, the Managed Care Plan shall nevertheless comply with all requirements specified in this Section of the Contract, with the exception of maintaining monthly contact with the enrollee or the authorized representative, and shall offer case management services to the enrollee or the enrollee's authorized representative no less than annually. The Managed Care Plan shall document all such activities in the enrollee record.

6. Monthly Contact

The Managed Care Plan shall ensure an enrollee under the age of twenty-one (21) years receiving private duty nursing services, or the enrollee's authorized representative, signs and dates a completed Agency-approved form to document voluntary suspension of private duty nursing services, if applicable.

7. Freedom of Choice

The Managed Care Plan shall ensure the enrollee or enrollee's authorized representative signs and dates a completed Agency-approved Freedom of Choice Certification Form every six (6) months for enrollees residing in a nursing facility.

Section VI. Coverage and Authorization of Services

8. Pre-Admission Screening and Resident Review

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

9. Disease Management Program

- a. Disease management programs provided by the Managed Care Plan shall address enrollees with cancer, diabetes, or other special health care needs.
- b. Within ninety (90) calendar days of enrollment, beginning the first of the month after the month of enrollment, the Managed Care Plan shall identify every new individual with special health care needs.
- c. The Managed Care Plan shall implement mechanisms to comprehensively assess each Medicaid enrollee identified as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.
- d. Disease Management programs provided by the Managed Care Plan shall include, but are not limited to, the following components:
 - (1) Education based on the enrollee assessment of health risks and chronic conditions;
 - (2) Symptom management including addressing needs such as working with the enrollee on health goals;
 - (3) Emotional issues of the caregiver;
 - (4) Behavioral management issues of the enrollee;
 - (5) Communicating effectively with providers; and
 - (6) Medication management, including the review of medications that an enrollee is currently taking to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications.

10. Transition of Care

- a. In addition to the provisions of **Attachment B., Section VI.E.2.**, Case Management Program Description, the Managed Care Plan's transition of care procedures shall include the following minimum functions:
 - (1) Coordination of hospital/institutional discharge planning and post discharge care;
 - (2) Assisting with schedule any follow-up appointments;
 - (3) Collaborating with the hospital/institution discharge planner/coordinator to implement the discharge plan in the enrollee's home; and

Section VI. Coverage and Authorization of Services

- (4) Facilitating communication with community service providers.
 - (5) Coordination of care after emergency department visits. (42 CFR 438.208(b)(2)(i))
- b. The Managed Care Plan shall ensure referrals with the required medical documentation needed to complete the clinical eligibility process for the LTC program are submitted to CARES as follows:
- (1) Six (6) months prior to an enrollee turning the age of eighteen (18) years for enrollees residing in a nursing facility; and
 - (2) Six (6) months prior to an enrollee turning the age of twenty-one (21) years for enrollees receiving private duty nursing services, if the enrollee or their authorized representative has expressed a desire to enroll in the LTC program.
- c. The Managed Care Plan shall maintain written protocols that address the transition/discharge planning process for enrollees who are receiving services in a skilled nursing facility. The Managed Care Plan shall ensure that transition planning begins upon admission to a skilled nursing facility. In those cases where the enrollee has been residing in a skilled nursing facility prior to enrollment in the Managed Care Plan, the Managed Care Plan shall begin the transition planning process upon enrollment in the Managed Care Plan.

11. Additional Care Coordination/Case Management Requirements

- a. The Managed Care Plan's shall maintain written care coordination and continuity of care procedures that include the following minimum functions:
- (1) Appropriate referral and scheduling assistance for enrollees needing specialty health care or transportation services, including those identified through well-child visits;
 - (2) Care coordination follow-up services for children/adolescents whom the Managed Care Plan identifies through blood screenings as having abnormal levels of lead; and
 - (3) A mechanism for access to specialists, without the need for a referral, for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs.
- b. Pursuant to s. 409.975(4)(b), F.S., the Managed Care Plan shall establish specific procedures to improve pregnancy outcomes and infant health, inter-conception care, and reproductive life planning, in coordination with the Healthy Start program.
- c. Prenatal Care

The Managed Care Plan shall:

Section VI. Coverage and Authorization of Services

- (1) Require care coordination through the gestational period according to the needs of the enrollee.
 - (2) Contact those enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care.
 - (3) Assist enrollees in making delivery arrangements, if necessary.
- d. The Managed Care Plan shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:
- (1) Identifying eligible enrollees and stratifying enrollees by severity and risk level including developing an algorithm to identify and stratify eligible enrollees, including:
 - (a) Identifying enrollees with co-morbid mental health and substance abuse disorders, including a depression screening, and addressing those disorders;
 - (b) Identifying enrollees with co-morbid medical conditions and addressing the co-morbid medical conditions; and
 - (c) Identifying enrollees in out-of-home behavioral health placements;
 - (2) Developing different types of interventions and specifying minimum touch frequency for each severity and/or risk level;
 - (3) Determining maximum caseloads for each case manager and support staff and managing and monitoring caseloads;
 - (4) Specifying experience and educational requirements for case managers and case management support staff;
 - (5) Providing training and continuing education for case management staff;
 - (6) Using evidence-based guidelines to enhance enrollee engagement;
 - (7) Developing treatment plans that address all of the following:
 - (a) Incorporate the health risk issues identified during the assessment;
 - (b) Incorporate the treatment preferences of the enrollee;
 - (c) Contain goals that are outcomes based and measurable;
 - (d) Include the interventions and services to be provided to obtain goals;

Section VI. Coverage and Authorization of Services

- (e) Include community service linkage, improving support services, and lifestyle management as appropriate based on the enrollee's identified issues.
- (f) Assessing enrollees for literacy levels and other hearing, vision or cognitive functions that may impact an enrollee's ability to participate in his/her care and implementing interventions to address the limitations;
- (g) Assessing enrollees for community, environmental or other supportive services needs and referring enrollees to get needed assistance;

The Managed Care Plan shall ensure treatment plans are updated at least every six (6) months when there are significant changes in enrollee's condition;

- (8) Interfacing with the enrollee's PCP and/or specialists; and
 - (9) Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services for enrollees who have justice system involvement.
- e. The Managed Care Plan shall work in coordination with DCF's behavioral health managing entity to establish specific organizational supports and protocols that enhance the integration and coordination of primary care and behavioral health services for enrollees, in accordance with s. 409.973(6), F.S.
- f. The Managed Care Plan shall maintain written procedures for discharge planning through the evaluation of an enrollee's medical care needs, mental health service needs, and substance use service needs and coordination of appropriate care after discharge from one level of care to another. The Managed Care Plan shall:
- (1) Monitor all enrollee discharge plans from behavioral health inpatient admissions to ensure that they incorporate the enrollee's needs for continuity in existing behavioral health therapeutic relationships;
 - (2) Ensure enrollees' family members, guardians, outpatient individual practitioners and other identified supports are given the opportunity to participate in enrollee treatment to the maximum extent practicable and appropriate, including behavioral health treatment team meetings and discharge plan development. For adult enrollees, family members and other identified supports may be involved in the development of the discharge plan only if the enrollee consents to their involvement;
 - (3) Designate care coordination/case management staff who are responsible for identifying and providing care coordination/case management to enrollees who remain in the hospital for non-clinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk enrollees and enrollees with multiple agency involvement);
 - (4) Develop and implement a plan that monitors and ensures that clinically indicated behavioral health services are offered and available to enrollees within seven (7) days of discharge from an inpatient setting;

Section VI. Coverage and Authorization of Services

- (5) Ensure that a behavioral health program clinician provides medication management to enrollees requiring medication monitoring within seven (7) days of discharge from a behavioral health program inpatient setting. The Managed Care Plan shall ensure that the behavioral health program clinician is duly qualified and licensed to provide medication management; and
- (6) Upon the admission of an enrollee, the Managed Care Plan shall make its best efforts to ensure the enrollee's smooth transition to the next service or to the community and shall require that behavioral health care providers:
 - (a) Assign a mental health targeted case manager to oversee the care given to the enrollee;
 - (b) Develop an individualized discharge plan, in collaboration with the enrollee where appropriate, for the next service or program or the enrollee's discharge, anticipating the enrollee's movement along a continuum of services; and
 - (c) Document all significant efforts related to these activities, including the enrollee's active participation in discharge planning.
- g. The Managed Care Plan shall report monthly on the enrollees under the age of twenty-one (21) years receiving out-of-home behavioral health treatment, in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

12. Healthy Behaviors Program

- a. Pursuant to s. 409.973(3), F.S., the Managed Care Plan shall establish and maintain programs to encourage and reward healthy behaviors. At a minimum, the Managed Care Plan must establish a medically-approved smoking cessation program, a medically-directed weight loss program, and a medically-approved alcohol or substance abuse recovery program. The Managed Care Plan must identify enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance use in order to establish written agreements to secure the enrollees' commitment to participation in these programs.
 - (1) A medically-approved smoking cessation program shall be evidence-based and recognized by medical professionals as an effective treatment method in addressing tobacco/nicotine dependence. The program may include interventions such as counseling and/or the use of medications (nicotine replacement products) as a part of the overall therapeutic process.
 - (2) A medically directed weight loss program shall require ongoing supervision by a physician and may include the use of prescription drugs/supplements depending upon the need and goals of the enrollee, along with other physician approved interventions (e.g., diet, exercise, etc.).
 - (3) A medically approved alcohol or substance abuse recovery program shall be evidenced-based and recognized by medical professionals as an effective

Section VI. Coverage and Authorization of Services

treatment method/approach. The program may include interventions such as medically-assisted detoxification, medication and behavioral therapy, followed by treatment and relapse prevention as a part of the overall therapeutic process.

- b. The Managed Care Plan shall receive written approval of its healthy behavior programs from the Agency before implementing the programs. The Managed Care Plan's program shall include a detailed description of the program, including the goals of the program, how targeted enrollees will be identified, the interventions the Managed Care Plan intends to use, rewards for or incentives to participate, research to support the effectiveness of the program, and evidence that the program is medically approved or directed, as applicable. Programs administered by the Managed Care Plan must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States DHHS OIG. The Managed Care Plan is encouraged to seek an advisory opinion from OIG once the specifics of its Healthy Behaviors programs are determined.
- c. The Managed Care Plan may, through its healthy behavior programs, deploy a number of interventions as part of the overall therapeutic process. Examples of interventions:
 - (1) Series of counseling sessions;
 - (2) Series of health educational classes;
 - (3) Gym membership;
 - (4) Nicotine replacement therapy patches;
 - (5) Meal planning services (e.g. NutriSystem®);
 - (6) The provision of medication therapy management support services provided by a community health worker; and
 - (7) Diabetes prevention programs with a status of recognized, pending recognition, or preliminary recognition on the CDC registry.
- d. The Managed Care Plan shall make all programs, including incentives and rewards available to all enrollees and shall not use incentives or rewards to direct individuals to select a particular provider.
- e. The Managed Care Plan shall inform new participants in the healthy behaviors program and actively engage in outreach and communication about the health benefits of its healthy behavior programs, including incentives and rewards.
- f. The Managed Care Plan shall consider partnering with other agencies such as State and local public health entities, provider organizations, local community groups, or other entities to educate enrollees about the program or to help administer it.
- g. The Managed Care Plan shall annually inform PCP providers of the availability of healthy behavior programs and incentives to support enrollee engagement.

Section VI. Coverage and Authorization of Services

- h. The Managed Care Plan shall not include the provision of gambling, alcohol, tobacco or drugs (except for over-the-counter drugs) in any of its incentives or rewards and shall state on the incentive or reward that it may not be used for such purposes.
- i. The Managed Care Plan's healthy behavior program shall include a detailed description of the rewards and incentives offered to enrollees. Incentives by themselves do not constitute an effective program. Incentives or rewards may have some health- or child development-related function (e.g., clothing, food, books, safety devices, infant care items, subscriptions to publications that include health-related subjects, membership in clubs advocating educational advancement and healthy lifestyles, etc.). Incentive or reward dollar values shall be in proportion to the importance of the healthy behavior being encouraged or rewarded (e.g., a tee-shirt for attending one (1) smoking cessation class, but a gift card for completion of a series of classes).
- j. Both incentives and rewards offered to enrollees shall be reasonable, simple, and provided on a timely basis. Incentives or rewards may include any of the following:
 - (1) Money through debit cards;
 - (2) Gift cards;
 - (3) Flexible spending accounts that may be used for health and wellness items;
 - (4) Vouchers for health and wellness related items; and
 - (5) Points or credits which are redeemable for goods or services.
- k. Incentives and rewards shall be limited to a value of twenty dollars (**\$20**). The exceptions to this monetary limit are as follows:
 - (1) Programs that require the enrollee to complete a series of activities (e.g.; completion of a series of health education classes). In these instances, the incentive or reward shall be limited to a value of fifty dollars (**\$50**).
 - (2) Infant car seats, strollers, and cloth baby carriers/slings that are offered as incentives to engage in a healthy behavior program or rewards for completion of an action or a series of activities may have a special exception to the dollar value, with Agency approval.
 - (3) Participation in multiple healthy behavior programs (e.g.; smoking cessation and substance abuse recovery program). In these instances, the incentive or reward shall be limited to a value of fifty dollars (**\$50**) for each healthy behavior program.
- l. The Managed Care Plan shall not include in the dollar limits on incentives or rewards any money spent on the transportation of enrollees to services or child care provided during the delivery of services; or the healthy behavior program or associated interventions.
- m. Healthy Behavior incentives/rewards are non-transferable from one Managed Care Plan to another.

Section VI. Coverage and Authorization of Services

- n. As part of its smoking cessation program, the Managed Care Plan shall provide participating PCPs with the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions. (The Managed Care Plan can obtain copies of the guide by contacting the DHHS, Agency for Health Care Research & Quality (AHR) Publications Clearinghouse at (800) 358-9295 or P.O. Box 8547, Silver Spring, MD 20907.)
- o. As part of its medically-approved alcohol or substance abuse recovery program, the Managed Care Plan shall offer annual alcohol or substance abuse screening training to its providers. The Managed Care Plan shall have all PCPs screen enrollees for signs of alcohol or substance abuse as part of prevention evaluation at the following times:
 - (1) Initial contact with a new enrollee;
 - (2) Routine physical examinations;
 - (3) Initial prenatal contact;
 - (4) When the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services; and
 - (5) When documentation of emergency room visits suggests the need.
- p. The Managed Care Plan shall report on its healthy behavior programs in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. This shall include submitting data related to each healthy behavior program, caseloads (new and ongoing) for each healthy behavior program, and the amount and type of rewards/incentives provided for each healthy behavior program.
- q. The Managed Care Plan shall annually evaluate enrollee engagement, program completion, and health benefit outcomes in all healthy behaviors programs for effectiveness.

F. Quality Enhancements

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

1. Children's Programs

The Managed Care Plan shall provide regular general wellness programs targeted specifically toward enrollees from birth to the age of five (5) years, or the Managed Care Plan shall make a good faith effort to involve enrollees in existing community children's programs.

2. Domestic Violence

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

Section VI. Coverage and Authorization of Services

3. Pregnancy Prevention

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

4. Pregnancy Related Programs

- a. The Managed Care Plan shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Managed Care Plan's prenatal and postpartum programs. The Managed Care Plan shall coordinate its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services.
- b. The Managed Care Plan shall ensure that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate.
- c. The Managed Care Plan shall ensure that providers give all women of childbearing age HIV counseling and offer them HIV testing. (Chapter 381, F.S.)

5. Healthy Start Services

- a. The Managed Care Plan shall develop agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants.
- b. The program for pregnant women and infants must be aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes.
- c. The Managed Care Plan shall collaborate with the Healthy Start care coordinator within the enrollee's county of residence to assure delivery of risk-appropriate care.
- d. The Managed Care Plan shall submit a completed Practitioner Disease Report Form (DH Form 2136) to the Perinatal Hepatitis B Prevention Coordinator at the local CHD for all prenatal or postpartum enrollees and their infants who test HBsAg-positive.

6. Nutritional Assessment/Counseling

- a. The Managed Care Plan shall ensure that its providers supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children.
- b. The Managed Care Plan shall determine the need for non-covered services and referral of the enrollee for assessment and refer the enrollee to the appropriate service setting (to include referral to WIC and Healthy Start and other social services) with assistance.

Section VI. Coverage and Authorization of Services

c. The Managed Care Plan shall:

- (1) Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes.
- (2) Offer a mid-level nutrition assessment.
- (3) Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or physician following the nutrition assessment.
- (4) Refer all enrollees under the age of five (5), and pregnant, breast-feeding and postpartum enrollees to the local WIC program office using the Florida WIC Program Medical Referral Form (DH 3075).

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

Each time the provider completes a WIC referral form, the Managed Care Plan shall ensure that the provider gives a copy of the form to the enrollee.

7. Behavioral Health Programs

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

G. Authorization of Services

1. General Provisions

There are no additional general authorization of service provisions unique to the MMA managed care program.

2. Utilization Management Program Description

- a. The Managed Care Plan shall provide timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. Written follow-up documentation of the approval must be provided to the non-participating provider within one (1) business day after the approval.
- b. The Managed Care Plan shall require prior authorization for all non-emergency inpatient hospital admissions.
- c. In accordance with s. 409.967(2)(c)2, F.S., the Managed Care Plan shall assure that the prior authorization process for prescribed drugs is readily accessible to health care

Section VI. Coverage and Authorization of Services

- providers, including posting appropriate contact information on its website and providing timely responses to providers.
- d. The Managed Care Plan shall develop prior authorization criteria and protocols for reviewing requests for brand name drugs that are not on the Agency's Medicaid PDL. The Managed Care Plan's prior authorization criteria and protocols may not be more restrictive than that used by the Agency as indicated in the Florida Statutes, the Florida Administrative Code, the Medicaid State Plan and criteria posted on the Agency website.
 - e. The Managed Care Plan shall operate a drug utilization review (DUR) program in compliance with 42 CFR 438.3(s)(4).
 - (1) The Managed Care Plan shall design and implement a DUR program to encourage coordination between an enrollee's PCP and a prescriber of a psychotropic or similar prescription drug for behavioral health problems. The Managed Care Plan's DUR program shall identify those medications for other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems), where this is a significant risk to the enrollee posed by potential drug interactions between drugs for these conditions and behavioral-related drugs.
 - (2) The Managed Care Plan's DUR program shall notify all related prescribers that certain drugs may be contra-indicated due to the potential for drug interactions and shall encourage the prescribers to coordinate their care. Notice may be provided electronically or via mail, or by telephonic or direct consultation, as the Managed Care Plan deems appropriate.
 - (3) The Managed Care Plan shall provide an annual, detailed description of its drug utilization review program activities to the Agency.
 - f. The Managed Care Plan shall continue the medication prescribed to the enrollee in a State mental health treatment facility for at least ninety (90) days after the facility discharges the enrollee, unless the Managed Care Plan's prescribing psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications:
 - (1) Are not medically necessary; or
 - (2) Are potentially harmful to the enrollee.
 - g. The Managed Care Plan shall make available those drugs and dosage forms listed on the Agency's Medicaid PDL, and shall comply with the following requirements listed in s. 409.912(8)(a), F.S.:
 - (1) The requirements of s. 409.912(8)(a)1.a. and b., F.S., regarding responding to requests for prior authorization and 72-hour drug supplies;
 - (2) The requirements of s. 409.912(8)(a)14., 15., and 16., F.S., regarding prior authorization.

Section VI. Coverage and Authorization of Services

For enrollees with special health care needs determined through an assessment by appropriate individuals meeting home and community-based service (HCBS) coordination requirements (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, the Managed Care Plan shall have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

3. Service Authorization System

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

4. Practice Guidelines/Evidence-based Criteria

There are no additional practice guidelines/evidence-based criteria provisions unique to the MMA managed care program.

5. Clinical Decision-Making

There are no additional clinical decision-making provisions unique to the MMA managed care program.

6. Service Authorization Standards for Decisions

There are no additional service authorization standards for decisions provisions unique to the MMA managed care program.

7. Changes to Utilization Management Components

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

Section VII. Grievance and Appeal System

A. General Provisions

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

B. Use of Independent Review Organization

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

C. Process for Complaints

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

D. Process for Grievances

Title XXI MediKids enrollees are entitled to file an appeal with the SAP. Title XXI MediKids enrollees are not eligible to participate in the Medicaid Fair Hearing process.

E. Notice of Adverse Benefit Determination

1. In addition to the requirements in Attachment B., Section VI.G., Authorization of Services, the Managed Care Plan shall ensure a notice of action is provided to enrollees under the age of twenty-one (21) years receiving residential psychiatric treatment (including SIPP and TGC 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. Hernandez Settlement Agreement Requirements

a. The Managed Care Plan shall ensure all participating pharmacy locations provide notice to an enrollee when the payment is denied for a prescription, in compliance with the Settlement Agreement to *Hernandez, et al v. Medows* (case number 02-20964 Civ-Gold/Simonton) (HSA). An HSA situation arises when an enrollee attempts to fill a prescription at a participating pharmacy location and is unable to receive the prescription as a result of:

- (1) An unreasonable delay in filling the prescription;
- (2) A denial of the prescription;
- (3) The reduction of a prescribed good or service; and/or
- (4) The expiration of a prescription.

b. The Managed Care Plan shall maintain a log of all correspondence and communications from enrollees relating to the HSA ombudsman process. The Managed Care Plan shall submit the ombudsman log report quarterly to the Agency,

Section VII. Grievance and Appeal System

as required in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

F. Standard Resolution of Plan Appeals

There are no additional standard resolution of plan appeals provisions unique to the MMA managed care program.

G. Extension of Plan Appeal

There are no additional extension of plan appeal provisions unique to the MMA managed care program.

H. Expedited Resolution of Plan Appeals

There are no additional expedited resolution of plan appeals provisions unique to the MMA managed care program.

I. Notice of Plan Appeal Resolution

There are no additional notice of plan appeal resolution provisions unique to the MMA managed care program.

J. Process for Medicaid Fair Hearings

There are no additional process for Medicaid Fair Hearings provisions unique to the MMA managed care program.

K. Appellate Responsibilities

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

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Section VIII. Provider Services

A. Network Adequacy Standards

1. General Provisions

There are no additional general provisions for network adequacy standards unique to the MMA managed care program.

2. Network Capacity and Geographic Access Standards

- a. Pursuant to s. 409.967(2)(c)(1) and 42 CFR 438.68(b)(1)(i)-(viii), Managed Care Plans must maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all plan enrollees. At a minimum, Managed Care Plans shall contract with the providers specified in the MMA Provider Network Standards Table (table) below. Managed Care Plans shall ensure regional provider ratios and provider-specific geographic access standards for enrollees in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the table. The regional provider ratios shall be based upon one hundred twenty percent (120%) of the Managed Care Plan's actual monthly enrollment measured at the first of each month, by region, for all regions except Region 1 and Region 2. For Region 1 and Region 2, the Agency shall determine regional provider ratios based upon two hundred percent (200%) of the Managed Care Plan's actual monthly enrollment measured at the first of each month, by region.

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Section VIII. Provider Services

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

Section VIII. Provider Services

Managed Medical Assistance Provider Network Standards Table					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Providers per Enrollee
Pharmacy	15	10	15	10	1:2,500 enrollees
24-hour Pharmacy	60	45	60	45	n/a
Podiatry	60	45	75	60	1:5,200
Pulmonology	60	45	75	60	1:7,600 enrollees
Rheumatology	100	75	110	90	1:14,400 enrollees
Therapist (Occupational)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Occupational)	30	20	60	45	1:1,500 enrollees
Therapist (Speech)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Speech)	30	20	60	45	1:1,500 enrollees
Therapist (Physical)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Physical)	30	20	60	45	1:1,500 enrollees
Therapist (Respiratory)	100	75	110	90	1:8,600 enrollees
Therapist, Pediatric (Respiratory)	60	45	75	60	1:1,500 enrollees
Urology	60	45	75	60	1:10,000 enrollees
Facility/ Group/ Organization					
Hospitals (acute care)	30	20	30	20	1 bed: 275 enrollees
Hospital or Facility with Birth/Delivery Services (including Birthing Center)	30	20	30	20	1 bed: 275 enrollees
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	n/a	n/a	n/a	n/a	2: County
Hospice	n/a	n/a	n/a	n/a	2: County
DME/HME	30	20	30	20	2: County

Section VIII. Provider Services

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

3. Primary Care Providers

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

Section VIII. Provider Services

ARNP or PA affiliated with a physician's office. The Managed Care plan shall ensure a sufficient selection of FTE PCPs in each of the following four (4) specialty areas within the geographic access standards indicated above:

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

b. The Managed Care Plan shall ensure the following:

- (1) The PCP provides, or arranges for, coverage of services, consultation, or approval for referrals twenty-four hours per day, seven days per week (24/7) by a Medicaid-enrolled PCP(s). After-hours coverage must be accessible using the medical office's daytime telephone number. After-hours coverage shall consist of an answering service, call forwarding, provider call coverage, or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision.
- (2) The PCP arranges for coverage of primary care services during PCP absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

4. Specialists and Other Providers

a. The Managed Care Plan shall enter into provider agreements with a sufficient number of specialists to ensure adequate accessibility for enrollees of all ages. The Managed Care Plan shall ensure the following:

- (1) A sufficient selection of the network infectious disease specialists has expertise in HIV/AIDS and its treatment and care, based on the actual number of enrollees with HIV/AIDS;
- (2) Female enrollees have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist; and
- (3) In accordance with s. 641.31, F.S., low-risk enrollees have access to midwifery services from providers licensed in accordance with Chapter 467, F.S.

b. For pediatric specialists not listed on the Managed Medical Assistance Provider Network Standards Table, the Managed Care Plan may assure access by providing telemedicine consultations with participating pediatric specialists, at an agreed upon location or at a PCP's office within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code. Alternatively, for pediatric specialists not listed in the Managed Medical Assistance Provider Network Standards Table, for which

Section VIII. Provider Services

- there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code, the Managed Care Plan may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.
- c. The Managed Care Plan may increase the Psychiatrist's ratio by seven hundred fifty (750) enrollees for each FTE ARNP with a certificate of psychiatric nursing through the American Nurses Credentialing Center or physician's assistant (PA) with a Certificate of Added Qualifications in psychiatry through the National Commission on Certification of Physician Assistants, affiliated with a board certified or board eligible psychiatrist.
 - d. The Managed Care Plan shall comply with the requirements in s. 409.912(8)(a)4., F.S., regarding limiting pharmacy networks.
 - e. For each county it serves, the Managed Care Plan shall designate an emergency service facility that operates twenty-four hours a day, seven days a week, (24/7) with Registered Nurse coverage and on-call coverage by a behavioral health specialist. (42 CFR 438.3(q))
 - f. The Managed Care Plan may provide transportation services directly through its own network of transportation providers or through a subcontractor. The Managed Care Plan shall ensure a transportation network of sufficient size to ensure the ability to provide the services required in this Contract.

5. Public Health Providers

- a. The Managed Care Plan shall enter into provider agreements, as specified in this Sub-Section, with public health providers, including:
 - (1) CHDs qualified pursuant to rule 59G-4.055, F.A.C.;
 - (2) RHCs qualified pursuant to rule 59G-4.280, F.A.C.; and
 - (3) FQHCs qualified pursuant to rule 59G-4.100, F.A.C.
- b. The Managed Care Plan shall pay at the contracted rate or the Medicaid FFS rate, without authorization, all authorized claims for the following services provided by a CHD, migrant health center funded under Section 329 of the Public Health Services Act, or community health center funded under Section 330 of the Public Health Services Act. The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD encounter rate as specified by the County Health Department Clinic Rule and the associated Florida Medicaid fee schedule for applicable rates for the following services:
 - (1) Office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis.
 - (2) The diagnosis and treatment of sexually transmitted diseases and other reportable infectious diseases, such as tuberculosis and HIV;

Section VIII. Provider Services

- (3) The provision of immunizations;
- (4) Family planning services and related pharmaceuticals;
- (5) School health services provided by CHDs, and for services rendered on an urgent basis by such providers; and
- (6) In the event that a vaccine-preventable disease emergency is declared, claims from the CHD for the cost of the administration of vaccines.

The Managed Care Plan may require prior authorization for all other covered services provided by CHDs.

- b. The Managed Care Plan shall pay, without prior authorization, at the contracted rate or the Medicaid fee-for-service rate, all valid claims initiated by any CHD for office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis. The Managed Care Plan shall reimburse the CHD when the CHD notifies the Managed Care Plan and provides the Managed Care Plan with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.
 - a.
 - b. The Managed Care Plan shall not deny claims for services delivered by CHD providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.
 - c. The Managed Care Plan shall not deny reimbursement for failure to prior authorize services rendered pursuant to s. 392.62 F.S.
 - d. The Managed Care Plan shall reimburse CHDs for services at the entity's cost-based reimbursement rate set by the Agency.
 - e. The Managed Care Plan shall reimburse CHDs for authorized prescription drugs at Medicaid's standard pharmacy rate.
 - f. The Managed Care Plan shall reimburse FQHCs and RHCs at the PPS rates set by the Agency (42 USC 1396b(m)(2)(A)(ix) and s. 1903(m)(2)(A)(ix) of the Social Security Act)
 - g. The Managed Care Plan shall make a good faith effort to execute memoranda of agreement with private schools, charter schools, and school districts participating in the certified match program regarding the coordinated provision of school-based services pursuant to ss. 1011.70, 409.9071, F.S., 409.908(22), F.S., and 409.9072, F.S.

6. Facilities and Ancillary Providers

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

Section VIII. Provider Services

- a. Network emergency service facilities have one (1) or more physicians and one (1) or more nurses on duty in the facility at all times;
- b. Network facilities are licensed as required by law and rule;
- c. Hospital providers in the Managed Care Plan's provider network participate in the ENS; the Managed Care Plan shall achieve and maintain ENS participation of at least eighty percent (80%) of total hospital beds in each region of the Managed Care Plan's provider network.
- d. Care for medically high-risk perinatal enrollees is provided in a facility with a NICU sufficient to meet the appropriate level of need for the enrollee;
- e. Pursuant to s. 409.967(2)(c)1, F.S., the Managed Care Plan may use mail-order pharmacies; however mail-order pharmacies shall not count towards the Managed Care Plan's pharmacy network access standards.
- f. The Managed Care Plan may have procedures to assign enrollees to specialty pharmacies for specialty drugs. The Managed Care Plan shall notify an enrollee in writing at the time of a specialty pharmacy assignment of how to opt-out of a specialty pharmacy assignment and choose among participating providers. The Managed Care Plan shall allow an enrollee to request to opt-out of a specialty pharmacy assignment at any time. The Managed Care Plan shall provide the Agency a copy of its procedures for approval in advance of implementation; and
- g. In accordance with s. 409.975(1)(e), F.S., the Managed Care Plan may offer a provider agreement to each licensed home medical equipment and supplies provider and to each Medicaid enrolled DME provider in the region, as specified by the Agency, that meets quality and fraud prevention and detection standards established by the Managed Care Plan and that agrees to accept the lowest price previously negotiated between the Managed Care Plan and another such provider, by service and provider type, as specified by the Agency.
- h. The Managed Care Plan's provider network shall include a sufficient number of qualified providers to cover all services in accordance with the service-specific coverage policy.

7. Essential Providers

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

Section VIII. Provider Services

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

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

- (2) RHCs.
- (3) SIPP providers

8. Timely Access Standards

- a. The Managed Care Plan must ensure that appointments for medical services and behavioral health services are available on a timely basis.
 - (1) Appointments for urgent medical or behavioral health care services shall be provided:
 - (a) Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.
 - (b) Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization.
 - (2) Appointments for non-urgent care services shall be provided:
 - (a) Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
 - (b) Within fourteen (14) days for initial outpatient behavioral health treatment.
 - (c) Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
 - (d) Within thirty (30) days of a request for a primary care appointment.
 - (e) Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.
- b. Quarterly, the Managed Care Plan shall review a statistically valid sample of PCP, specialist, and behavioral health offices' average appointment wait times to ensure services are in compliance with this subsection (a) above, and report the results to the Agency as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. (42 CFR 438.206(c)(1)(iv),(v), and (vi))
- c. Transportation Timeliness.
 - (1) The Managed Care Plan shall ensure that enrollees arrive on time at pre-arranged times for appointments are picked up on time at pre-arranged times for the return trip if the covered service follows a reliable schedule. The pre-arranged times may not be changed by the transportation provider or driver without prior permission from the enrollee.
 - (2) The following transportation standards shall be maintained:

Section VIII. Provider Services

- (a) The average monthly enrollee waiting time for pick-up at the originating site shall not exceed fifteen (15) minutes based on the scheduled time of pick-up for each transportation provider.
- (b) The average monthly enrollee waiting time for pick-up (scheduled pick-up) from their medically necessary covered service shall not exceed thirty (30) minutes for each transportation provider.
- (c) The average monthly enrollee waiting time for pick-up (will-call pick-up) from their medically necessary covered service shall not exceed sixty (60) minutes for each transportation provider.
- (d) The average monthly enrollee waiting time for pick-up from a facility discharge for each transportation provider shall not exceed three (3) hours from the time the Managed Care Plan is notified of the discharge for each transportation provider. If the facility is located in a county other than the enrollee's county of residence, the provider may add additional time to the pick-up period at the rate of thirty (30) minutes for every fifteen (15) miles the provider must travel outside of the enrollee's county of residence.
- (e) The average monthly enrollee waiting time for pick-up for an urgent care appointment shall not exceed three (3) hours from the time of the call for each transportation provider.

9. Network Adequacy Measures

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

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Section VIII. Provider Services

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

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B. Network Management

1. Annual Network Development Plan

- a. The Managed Care Plan's annual network development plan must include a description or explanation of the current status of the network by each covered service at all levels, including:
 - (1) The assistance and communication tools provided to PCPs when they refer enrollees to specialists and the methods used to communicate the availability of this assistance to the providers; and
 - (2) Pharmacy features (The availability of non-sterile compounding, and home delivery pharmacy services).

2. Regional Network Changes

In addition to the requirements of Attachment B., Section VIII.B., Network Management, the Managed Care Plan shall notify the Agency within seven (7) business days of a decrease in the total number of PCPs by more than five percent (5%).

C. Provider Credentialing and Contracting

1. General Provisions

There are no additional general provisions applicable to provider credentialing and contracting.

2. Credentialing and Recredentialing

- a. The Managed Care Plan's credentialing and recredentialing processes must include verification of the following additional requirements for physicians:
 - (1) Good standing of privileges at the hospital designated as the primary admitting facility by the physician or, if the physician does not have admitting privileges, good standing of privileges at the hospital by another physician with whom the physician has entered into an arrangement for hospital coverage.
 - (2) Valid Drug Enforcement Administration certificates, where applicable.
 - (3) Attestation that the total active patient load (all populations, including but not limited to Medicaid FFS, Children's Medical Services, SMMC plans, Medicare, KidCare, and commercial coverage) is no more than three thousand (3,000) patients per physician. An active patient is one that is seen by the provider a minimum of two (2) times per year.
 - (4) A good standing report on a site visit survey. For each provider, documentation in the Managed Care Plan's credentialing files regarding the site survey shall include the following:

Section VIII. Provider Services

- (a) Evidence that the Managed Care Plan has evaluated the provider's facilities using the Managed Care Plan's organizational standards;
 - (b) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; and
 - (c) Evidence that the Managed Care Plan has evaluated the provider's enrollee record keeping practices at each site to ensure conformity with the Managed Care Plan's organizational standards.
- (5) Attestation to the correctness/completeness of the provider's application.
 - (6) Statement regarding any history of loss or limitation of privileges or disciplinary activity as described in s. 456.039, F.S.
 - (7) A statement from each provider applicant regarding the following:
 - (a) Any physical or behavioral health problems that may affect the provider's ability to provide health care; and
 - (b) Any history of chemical dependency/substance abuse.
 - (8) Current curriculum vitae or completed credentialing application, which includes at least five (5) years of work history.
 - (9) Proof of the provider's medical school graduation, completion of residency or other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training, if applicable.
 - (10) Evidence of specialty board certification, if applicable.
- b. The Managed Care Plan shall recredential its providers at least every three (3) years using information from ongoing provider monitoring.
 - c. Hospital ancillary providers are not required to be independently credentialed if those providers serve Managed Care Plan enrollees only through the hospital.

3. Hernandez Settlement Agreement Surveys

The Managed Care Plan shall comply with the following requirements of the HSA.

- a. The Managed Care Plan shall conduct annual HSA onsite surveys of no less than five percent (5%) of all participating pharmacy locations to ensure compliance with the HSA.
- b. The Managed Care Plan may survey less than five percent (5%), with written approval from the Agency, if the Managed Care Plan can show that the number of participating pharmacies it surveys is a statistically significant sample that adequately

Section VIII. Provider Services

represents the pharmacies that have contracted with the Managed Care Plan to provide pharmacy services.

- c. The Managed Care Plan shall not include in the HSA survey any participating pharmacy location that the Managed Care Plan found to be in complete compliance with the HSA requirements within the past twelve (12) months.
- d. The Managed Care Plan shall require all participating pharmacy locations that fail any aspect of the HSA survey to undergo mandatory training within six (6) months and then be re-evaluated within one (1) month of the training to ensure that the pharmacy location is in compliance with the HSA.

The Managed Care Plan shall ensure that it complies with all aspects and surveying requirements set forth in the Managed Care Plan Report Guide.

- e. The Managed Care Plan shall submit an annual report to the Agency by August 1 of each Contract year providing survey results in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

4. Provider Agreement Requirements

- a. The Managed Care Plan shall include the following additional provisions in its MMA provider agreements:
 - (1) For a Managed Care Plan physician incentive plan, include a statement that the Managed Care Plan shall make no specific payment directly or indirectly under a physician incentive plan to a provider as an inducement to reduce or limit, medically necessary services to an enrollee, and that incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care;
 - (2) Require that all providers agreeing to participate in the network as PCPs fully accept and agree to responsibilities and duties associated with the PCP designation;
 - (3) Contain no provision that prohibits the PCP from providing inpatient services in a participating hospital to an enrollee if such services are determined to be medically necessary and covered services under this Contract;
 - (4) For hospital contracts, include rates that are in accordance with s. 409.975(6), F.S.;
 - (5) For hospital contracts, include a clause that states whether the Managed Care Plan or the hospital will complete the DCF Excel spreadsheet for unborn activation;
 - (6) For hospital contracts, include PPC reporting requirements as specified in Section X., Administration and Management;
 - (7) For pharmacy contracts, ensure its pharmacy benefits manager provides the following electronic message alerting the pharmacist to provide Medicaid

Section VIII. Provider Services

recipients with the HSA notice/pamphlet when coverage is rejected due to the drug not being on the PDL:

Non-preferred drug; Contact provider for change to preferred drug or to obtain prior authorization. Give Medicaid pamphlet if not corrected; and

- (8) If the provider has been approved by the Managed Care Plan to provide services through telemedicine, specify that the provider be required to have protocols to prevent fraud and abuse. The provider must implement telemedicine fraud and abuse protocols that address:
 - (a) Authentication and authorization of users;
 - (b) Authentication of the origin of the information;
 - (c) The prevention of unauthorized access to the system or information;
 - (d) System security, including the integrity of information that is collected, program integrity and system integrity; and
 - (e) Maintenance of documentation about system and information usage; and
- (9) For contracts with public health providers, require such providers to contact the Managed Care Plan before providing health care services to enrollees and provide the Managed Care Plan with the results of the office visit, including test results.

5. Provider Termination and Continuity of Care

- a. The Managed Care Plan shall notify enrollees in accordance with the provisions of this Contract and State and federal law regarding provider termination. (42 CFR 438.10(f)(1))
- b. Pursuant to s. 409.975(1)(c), F.S., if the Managed Care Plan excludes any essential provider from its network for failure to meet quality or performance criteria, the Managed Care Plan shall provide written notice at least thirty (30) days before the effective date of the exclusion to all enrollees who have chosen that provider for care.
- b. The Managed Care Plan shall allow pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the completion of postpartum care.

D. Provider Services

1. Provider Handbook and Bulletin Requirements

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

Section VIII. Provider Services

- a. Well-child visit program services and standards;
- b. Procedures to obtain authorization of any medically necessary service to enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.
- c. PCP responsibilities; and
- d. If the Managed Care Plan allows the use of telemedicine, telemedicine requirements for providers.

2. Provider Education and Training

The Managed Care Plan shall offer training to all new and existing participating pharmacy locations about the HSA requirements.

E. Claims and Provider Payment

1. Pursuant to s. 409.967(2)(a), F.S., and as specified by the Agency, the Managed Care Plan's physician payment rates shall equal or exceed Medicare rates for services provided.
2. The Managed Care Plan shall not deny claims submitted by a non-participating provider rendering services pursuant to Section VI.D.1., Primary Care Provider Initiatives, of this Exhibit, solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.
3. The Managed Care Plan shall not deny claims for the provision of emergency services and care submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.
4. Pursuant to s. 409.975(6), F.S., an MMA Managed Care Plan and hospital(s) shall negotiate mutually acceptable rates, methods, and terms of payment. Such payments to hospitals may not exceed one hundred twenty percent (120%) of the rate the Agency would have paid on the first day of the Contract between the provider and the Managed Care Plan, unless specifically approved by the Agency. Payment rates may be updated periodically.
5. Regardless of how an inpatient facility is reimbursed (Diagnosis Related Group or per diem), the enrollee's MMA Managed Care Plan at the time of admission shall be responsible for payment of the entire inpatient stay for that admission, even if the recipient changes Managed Care Plans during the hospital stay.
6. Pursuant to s. 409.975(1)(a) and (b), F.S., except for payment for emergency services, an MMA Managed Care Plan shall make payments to essential providers as specified in the

Section VIII. Provider Services

this Exhibit. In accordance with s. 409.976(2), F.S., a MMA Managed Care Plan shall pay statewide inpatient psychiatric program (SIPP) providers, at a minimum, the payment rates established by the Agency.

7. The Managed Care Plan shall make payments for institutional hospice services in accordance with Section 1902(a)(13) of the Social Security Act.
8. When the Managed Care Plan or its authorized physician authorizes medically necessary ancillary medical services in a hospital setting (either inpatient or outpatient), the Managed Care Plan shall reimburse the provider of the service at the Medicaid line item rate, unless the Managed Care Plan and the hospital have negotiated another reimbursement rate.
9. Pursuant to s. 409.967(2)(b), F.S., the Managed Care Plan shall pay for services required by ss. 395.1041 and 401.45, F.S., provided to an enrollee for the provision of emergency services and care by a non-participating provider. The Managed Care Plan must comply with s. 641.3155, F.S., Reimbursement for services under this paragraph is the lesser of:
 - a. The non-participating provider's charges;
 - b. The usual and customary provider charges for similar hospital-based services in the community where the services were provided;
 - c. The charge mutually agreed to by the Managed Care Plan and the non-participating provider within sixty (60) days after the non-participating provider submits a claim.
 - d. The Medicaid rate which, for the purposes of this paragraph, means the amount the provider would collect from the Agency on a FFS basis, less any amounts for the indirect costs of graduate medical education that are otherwise included in the Agency's FFS payment, as required under 42 U.S.C. s.1396u-2(b)(2)(D). For the purpose of establishing amounts specified in this paragraph, the applicable FFS fee schedules and their effective dates shall be published on the Agency's website annually, or more frequently as needed, less any amounts for indirect costs of graduate medical education that are otherwise included in the Agency's FFS payments.

The Managed Care Plan shall reimburse nonparticipating freestanding psychiatric specialty hospitals in accordance with a., b., or c. above, s. 409.975(6), F.S., and 42 CFR 438.3(e)(2)(i).

10. Notwithstanding the requirements set forth for coverage of emergency services and care, the Managed Care Plan shall approve all claims for emergency services and care by non-participating providers pursuant to the requirements set forth in s. 641.3155, F.S., and 42 CFR 438.114.
11. In accordance with s. 409.967(2), F.S., the Managed Care Plan shall reimburse any hospital or physician that is outside the Managed Care Plan's authorized service area for Managed Care Plan-authorized services at a rate negotiated with the hospital or physician or according to the lesser of the following:
 - a. The usual and customary charge made to the general public by the hospital provider;
or

Section VIII. Provider Services

- b. The Florida Medicaid reimbursement rate established for the hospital or provider.
12. If the enrollee is a full-benefit dual eligible and has an existing Medicare provider authorized through Medicare:
- a. The Managed Care Plan shall not require an enrollee's assigned Medicare provider to enter into a contract or agreement to receive payment for copayments, co-insurance, or deductibles.
 - b. The Medicare provider must be either limited enrolled or fully enrolled with the Florida Medicaid program in order to be reimbursed for any copayments, co-insurance, or deductibles by the Managed Care Plan.
13. Provider Preventable Conditions
- a. Pursuant to Section 2702 of the ACA, the Florida Medicaid State Plan and 42 CFR 434.6(12) and 447.26, the Managed Care Plan shall comply with the following requirements:
 - (1) Deny reimbursement for PPCs occurring after admission in any inpatient hospital or inpatient psychiatric hospital setting, including CSUs, as listed under Forms at:
http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/Managed_Care_contracting/MHMO/docs/Forms/ProviderPreventableConditions-PPC-3-1-13.pdf;
 - (2) Ensure that non-payment for PPCs does not prevent enrollee access to services;
 - (3) Ensure that documentation of PPC identification is kept and accessible for reporting to the Agency;
 - (4) Relative to all above requirements, not:
 - (a) Deny reimbursement to inpatient hospitals and inpatient psychiatric hospitals, including CSUs, for services occurring prior to the PPC event;
 - (b) Deny reimbursement to surgeons, ancillary and other providers that bill separately through the CMS-1500;
 - (c) Deny reimbursement for health care settings other than inpatient hospital and inpatient psychiatric hospital, including CSUs; or
 - (d) Deny reimbursement for clinic services provided in clinics owned by hospitals.
 - b. By federal law, Deep Vein Thrombosis/Pulmonary Embolism, as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, are not reportable PPCs/HCACs. HCACs also include never events.

Section VIII. Provider Services

14. The Managed Care Plan shall pay no more than the Medicaid program vaccine fee for immunizations.
15. The Managed Care Plan shall pay the Medicaid program vaccine administration fee when an enrollee receives immunizations from a non-participating provider so long as:
 - a. The non-participating provider contacts the Managed Care Plan at the time of service delivery;
 - b. The Managed Care Plan is unable to provide documentation to the non-participating provider that the enrollee has already received the immunization; and
 - c. The non-participating provider submits a claim for the administration of immunization services and provides medical records documenting the immunization to the Managed Care Plan.
16. The Managed Care Plan shall reimburse IHCPs, whether participating in the network or not, for covered managed care services provided to Indian enrollees who are eligible to receive services from the IHCP either at a negotiated rate between the Managed Care Plan and the IHCP or, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made to a participating provider which is not an IHCP, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR 438.14(b).
17. The Managed Care Plan may request to be notified, but shall not deny claims payment based solely on lack of notification, for the following:
 - a. Inpatient emergency admissions (within ten (10) days);
 - b. Obstetrical care (at first visit);
 - c. Obstetrical admissions exceeding forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for caesarean section; and
 - d. Transplants.

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Section IX. Quality

A. Quality Improvement

1. Quality Improvement Plan

The Managed Care Plan and its QI plan shall demonstrate specific interventions in its behavioral health care coordination/case management to better manage behavioral health services and promote positive enrollee outcomes. The Managed Care Plan's written procedures shall address components of effective behavioral health care coordination/case management including but not limited to: anticipation, identification, monitoring, measurement, evaluation of enrollee's behavioral health needs, and effective action to promote quality of care; participation in the DCF planning process outlined in s. 394.75, F.S.; and the provision of enhanced care coordination and management for high-risk populations. Such populations shall include, at a minimum, enrollees that meet any of the following conditions:

- a. Have resided in a State mental health facility for at least six (6) of the past thirty-six (36) months;
- b. Reside in the community and have had two (2) or more admissions to a State mental health facility in the past thirty-six (36) months;
- c. Reside in the community and have had three (3) or more admissions to a crisis stabilization unit, short-term treatment facility, inpatient psychiatric unit, or any combination of these facilities within the past twelve (12) months;
- d. Have been diagnosed with a behavioral health disorder in conjunction with a complex medical condition and have been prescribed numerous prescription medications;
- e. Have been identified as exceeding the Managed Care Plan's prescription limits as permitted under Section VI., Coverage and Authorization of Services;
- f. Are under the age of six (6) years and are prescribed a psychotropic medication; or
- g. Have had two (2) or more admissions to residential psychiatric treatment (e.g., SIPP services and comparable treatment settings).

B. Performance Measures (PMs)

1. Required Performance Measures

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

Healthcare Effectiveness Data and Information Set (HEDIS)	
1.	Adolescent Well-Care Visits - (AWC)

Section IX. Quality

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

Section IX. Quality

21.	Annual Monitoring for Patients on Persistent Medications - (MPM)
22.	Frequency of Ongoing Prenatal Care - (FPC)
23.	Adherence to Antipsychotic Medications for Individuals With Schizophrenia – (SAA)
24.	Metabolic Monitoring for Children and Adolescents on Antipsychotics – (APM)
25.	Use of Multiple Concurrent Antipsychotics in Children and Adolescents - (APC)
26.	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – (APP)
27.	Follow-Up After Emergency Department Visit for Mental Illness – (FUM)
28.	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Treatment – (FUA)
29.	Plan All-Cause Readmissions – (PCR)
HEDIS & Agency-Defined	
30.	Follow-Up after Hospitalization for Mental Illness – (FHM)
Agency-Defined	
31.	Mental Health Readmission Rate – (RER)
Child Core Set	
32.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents – (WCC)
33.	Contraceptive Care – Postpartum Women
34.	Elective Delivery – (PC-01)
35.	Cesarean Section – (PC-02)
Adult Core Set	
36.	HIV Viral Load Suppression - (VLS)
37.	Medical Assistance with Smoking and Tobacco Use Cessation – (MSC)
38.	Contraceptive Care – Postpartum Women

- b. The Managed Care Plan shall submit the first Performance Measure Report to the Agency no later than July 1, 2019, covering the measurement period of year 2018.

Section IX. Quality

Measures should be collected based on the technical specifications for the measure, across the current Contract and the previous Managed Care Plan Contract, as applicable.

- c. Due to year 2018 being a transition year across Contracts, the Agency shall 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 related to where performance measure results fall relative to the National Medicaid Means and Percentiles (as published by the National Committee for Quality Assurance), but shall assess liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting.
- d. Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2020, covering the measurement period of year 2019 all performance measure-related liquidated damages and sanctions will be in effect.
- e. Managed Care Plans shall submit their HEDIS data to the NCQA by the NCQA deadline as well as to the Agency by July 1 of each year.
- f. The Agency will not assess liquidated damages for the following performance measures for the first reporting period:
 - (1) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – (APP)

2. Well-Child Visit Performance Measures

- a. Pursuant to s. 409.975(5), F.S., the Managed Care Plan shall achieve a well-child visit rate of at least eighty percent (80%) for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1 – September 30). This screening compliance rate shall be based on the well-child visit data reported by the Managed Care Plan in its Child Health Check-Up (CMS-416) and FL 80% Screening Report and/or supporting encounter data, and due to the Agency as specified in Section XVI., Reporting Requirements. The data shall be monitored by the Agency for accuracy. Any data reported by the Managed Care Plan that is found to be inaccurate shall be disallowed by the Agency, and such findings shall be considered in violation of the Contract. Failure to meet the eighty percent (80%) screening rate may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit.
- b. The Managed Care Plan shall adopt annual participation goals to achieve at least an eighty percent (80%) well-child visit participation rate, as required by the Centers for Medicare & Medicaid Services. This participation compliance rate shall be based on the well-child visit data reported by the Managed Care Plan in its Child Health Check-Up (CMS-416) and FL 80% Screening Report (see sub-item a. above) and/or supporting encounter data. Upon implementation and notice by the Agency, the Managed Care Plan shall submit additional data, as required by the Agency for its submission of the CMS-416, to the Centers for Medicare & Medicaid Services, within the schedule determined by the Agency. Any data reported by the Managed Care Plan that is found to be inaccurate shall be disallowed by the Agency, and the such findings shall be considered in violation of the Contract. Failure to meet the eighty percent

(80%) participation rate during a federal fiscal year may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit. (s. 1902(a)(43)(D)(iv) of the Social Security Act)

C. Performance Improvement Projects

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

1. One (1) of the PIPs shall combine a focus on improving perinatal care, including prenatal care and/or postpartum care;
2. One (1) of the PIPs shall focus on reducing potentially preventable events;
3. One (1) of the PIPs shall be an administrative PIP focusing on a topic prior approved by the Agency; and
4. One (1) PIP shall be a choice of PIP in one of two topic areas: behavioral health or integrating primary care and behavioral health.
5. One or more of the PIPs may be a collaborative PIP coordinated by the Agency and the EQRO. The EQRO will put together proposed methodologies for the collaborative PIPs, which will be sent to the Managed Care Plans for review. Once the proposed methodologies for the collaborative PIPs have been sent to the Managed Care Plans, the Managed Care Plan has two (2) weeks to submit feedback to the Agency and the EQRO on the methodologies.

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 CAHPS Health Plan Survey - Medicaid Survey 5.0.
- b. In addition to the core survey, the Managed Care Plan shall include items MH1 through MH4 (related to Behavioral Health) and H.17 through H.20 (related to medical assistance with smoking and tobacco use cessation) from the CAHPS Health Plan Survey – Supplemental Items for the Adult Questionnaires. The Managed Care Plan shall include the following item in its Adult and Child CAHPS surveys.

(1) How would you rate the number of doctors you had to choose from?

Response options: Excellent, Very Good, Good, Fair, Poor, No Experience

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

- d. The Managed Care Plan shall use the results of the annual CAHPS survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities conducted by the Managed Care Plan pertaining to improving member satisfaction resulting from the annual member satisfaction survey must be reported to the Agency on a quarterly basis.

E. Enrollee Record Requirements

1. In addition to the requirements of Attachment B., Section IX.E., Enrollee Record Requirements, the Managed Care Plan shall ensure the following documentation is included in the enrollee record:

- a. A copy of the completed screening instrument in the enrollee record and provides a copy to the enrollee.
- b. Documentation of preterm delivery risk assessments in the enrollee record by week twenty-eight (28) of pregnancy.
- c. Documentation of referral services in the enrollee record, including reports resulting from the referral.
- d. Documentation of emergency care encounters in the enrollee record with appropriate medically indicated follow-up.
- e. Documentation of the express written and informed consent of the enrollee's authorized representative prescriptions for psychotropic medication (i.e., antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years. In accordance with s. 409.912(16), F.S., the Managed Care Plan shall ensure the following requirements are met:

- (1) The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription.
- (2) The prescriber must ensure completion of an appropriate attestation form. Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link:

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

- (a) The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years.
- (b) Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
- (c) Every new prescription will require a new informed consent form.
- (d) The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents under the age of eighteen (18) years.

F. Provider-Specific Performance Monitoring

There are no additional provider-specific performance monitoring provisions unique to the MMA managed care program.

G. Additional Quality Management Requirements

1. Incident Reporting Requirements

- a. The Managed Care Plan shall develop a reporting and management system for critical and adverse incidents that occur in all service delivery settings applicable to enrollees with MMA benefits only.
 - b. The Managed Care Plan shall require providers to report adverse incidents to the Managed Care Plan within forty-eight (48) hours of the incident.
 - c. The Managed Care Plan shall not require provider submission of adverse incident reports from the following providers: health maintenance organizations and health care clinics reporting in accordance with s. 641.55, F.S.; ambulatory surgical centers and hospitals reporting in accordance with s. 395.0197, F.S.; assisted living facilities reporting in accordance with s. 429.23, F.S.; nursing facilities reporting in accordance with s. 400.147, F.S.; and crisis stabilization units, residential treatment centers for children and adolescents, and residential treatment facilities reporting in accordance with s. 394.459, F.S., adverse incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.
2. The Managed Care Plan shall participate in the Medicaid Pharmaceutical and Therapeutics Committee and Drug Utilization Review Board by asking qualified plan administrators (MDs, DOs or pharmacists) to volunteer for committee appointment by the Governor's Office.

H. Continuity of Care in Enrollment

1. The Managed Care Plan shall provide continuation of services until the enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee's treatment plan, in accordance with Attachment B., Section IX.H., Continuity of Care in Enrollment.
2. The following services may extend beyond the sixty (60) day continuity of care period, and the Managed Care Plan shall continue the entire course of treatment with the recipient's current provider as described below:
 - a. Prenatal and postpartum care – The Managed Care Plan shall continue to pay for services provided by a pregnant woman's current provider for the entire course of her pregnancy, including the completion of her postpartum care (six (6) weeks after birth), regardless of whether the provider is in the Managed Care Plan's network.
 - b. Transplant services (through the first year post-transplant) – The Managed Care Plan shall continue to pay for services provided by the current provider for one (1) year

Section IX. Quality

- post-transplant, regardless of whether the provider is in the Managed Care Plan's network.
- c. Oncology (Radiation and/or Chemotherapy services for the current round of treatment)
– The Managed Care Plan shall continue to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in the Managed Care Plan's network.
 - d. Full course of therapy for Hepatitis C treatment drugs.

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Section X. Administration and Management

A. General Provisions

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

B. Organizational Governance and Staffing

1. Case Management Staff Qualifications and Experience

The Managed Care Plan shall utilize case managers for enrollees under the age of twenty-one (21) years who are receiving services in a skilled nursing facility or private duty nursing services, and who possess the following qualifications:

- a. State of Florida licensed registered nurse with at least two (2) years of pediatric experience;
- b. State of Florida licensed practical nurse with four (4) years of pediatric experience; or
- c. Master's degree in social work with at least one (1) year of related professional experience.

2. Caseload Ratio Requirements

- a. The Managed Care Plan shall ensure that case manager caseloads for enrollees under the age of twenty-one (21) years who are receiving services in a skilled nursing facility or private duty nursing services do not exceed a ratio of:
 - (1) Fifteen (15) enrollees to one (1) care coordinator for enrollees who are receiving services in a skilled nursing facility.
 1. 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. The Managed Care Plan may submit a request to the Agency to implement a mixed caseload of enrollees in the community and in nursing facilities. 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 revoke the Managed Care Plan's authorization to exceed caseload ratios at any time.

C. Subcontracts

1. The Managed Care Plan may delegate any or all functions to one (1) or more PBMs. Before entering into a subcontract, the Managed Care Plan shall obtain the Agency's prior written approval of the delegation in accordance with Section X.C., Subcontracts.

Section X. Administration and Management

- a. The Managed Care Plan shall work with the Agency's fiscal agent to ensure that the transfer of accurate and complete Managed Care Plan encounter prescription data, including actual amounts paid to the provider, is initiated within forty-five (45) days of PBM implementation. The Managed Care Plan acknowledges that the transfer of prescription data is required by the ACA and that the Agency will invoice pharmaceutical manufacturers for federal rebates mandated under federal law, and for supplemental rebates negotiated by the Agency according to s. 409.912(8)(a)7, F.S.
 - b. Failure to provide the necessary data to the Agency will result in immediate action by the Agency that may include (but not be limited to) sanctions, application of liquidated damages, or reduction of capitation payments in the amount of estimated combined federal and supplemental rebates.
 - c. Failure to provide claim and provider information that assists the Agency in dispute resolution between the Agency and a drug manufacturer regarding federal drug rebates and that prevents the Agency from collecting drug rebates shall result in the Agency's recouping from the Managed Care Plan any determined uncollected rebates.
2. If there is a Managed Care Plan physician incentive plan, all model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall include a statement that the Managed Care Plan shall make no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care. (42 CFR 422.208(c)(1); 42 CFR 438.3(i)) If the physician incentive plan places a physician or physician group at substantial financial risk (pursuant to 42 CFR 422.208(a)(d)) for services that the physician or physician group does not furnish itself, the Managed Care Plan shall assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(c)(2). The Managed Care Plan shall provide assurances to the Secretary of CMS that the requirements of 42 CFR 422.208 are met in accordance with 42 CFR 422.210(a).
 3. The Managed Care Plan may delegate any or all functions relating to behavioral health services. Before entering into a subcontract, the Managed Care Plan shall develop and submit an analysis of the subcontractor's compliance with 42 CFR 438.3(n) with respect to quantitative and non-quantitative limits, and obtain the Agency's prior written approval of the delegation in accordance with Section X.C., Subcontracts.

D. Information Management and Systems

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

E. Encounter Data Requirements

1. The Managed Care Plan shall submit complete, accurate, and timely pharmacy encounters consistent with the NCPDP to the Agency as defined below:

Section X. Administration and Management

- a. Complete: The Managed Care Plan shall submit encounters for ninety-five percent (95%) of the covered services provided by participating and non-participating providers, as defined in Attachment B., Section X.E., Encounter Data Requirements
- b. Accurate: For each encounter data submission, ninety-five percent (95%) of the Managed Care Plan's encounter lines submissions shall pass NCPDP edits and the pharmacy benefits system edits as specified by the Agency. The NCPDP edits are described in the National Council for Prescription Drug Programs Telecommunications Standard Guides. Pharmacy benefits system edits are defined on the following website:

http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Encounter/Provider_ManagedCare_Pharmacy/tabId/82/Default.aspx.

2. The Managed Care Plan shall ensure all encounter data submissions include PPC information in order to meet the PPC identification requirements.
3. The Managed Care Plan shall ensure all encounter data submissions include the actual amount paid to providers.

F. Fraud and Abuse Prevention

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

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Section XI. Method of Payment

A. General Provisions

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

B. Fixed Price Unit Contract

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

C. Payment Provisions

1. Fee-for-Service Provider Service Networks

a. Payment Provisions for Fee-for-Service Provider Service Networks

- (1) In order to be eligible to receive an allocation from the savings pool, the FFS PSN shall achieve performance measure rates at or above the seventy-fifth (75th) percentile for five (5) of the ten (10) performance measures listed below, with none of the rates below the fiftieth (50th) percentile.

The performance measures are as follows:

- (a) Antidepressant Medication Management – Effective Acute Phase Treatment
- (b) Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- (c) Comprehensive Diabetes Care – HbA1c Control (<8%)
- (d) Controlling High Blood Pressure
- (e) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Day – Total
- (f) Follow-Up After Emergency Department Visit for Mental Illness – 7 Day
- (g) Follow-Up After Hospitalization for Mental Illness – 7 Day
- (h) HIV Viral Load Suppression
- (i) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total
- (j) Medication Management for People With Asthma – 75% Compliance - Total

b. Cost Reconciliation Process for Fee-for-Service Provider Service Networks

Section XI. Method of Payment

There are no additional cost reconciliation process for FFS PSN provisions for the MMA managed care program.

c. Annual Reconciliations for Fee-for-Service Provider Service Networks

There are no additional annual reconciliation for FFS PSN provisions for the MMA managed care program.

d. Annual Reconciliation Review for Fee-for-Service Provider Service Networks

There are no additional annual reconciliation review for FFS PSN provisions for the MMA managed care program.

e. Reconciliation upon Termination for Fee-for-Service Provider Service Networks

There are no additional reconciliation upon termination for FFS PSN networks provisions for the MMA managed care program.

f. Capitation Payments for Transportation Services

There are no additional capitation payments for transportation services provisions for the MMA managed care program.

g. Enrollee Payment Liability Protection for Transportation Services

There are no additional enrollee payment liability protection for transportation services provisions for the MMA managed care program.

h. Rate Increases

There are no additional rate increase provisions for the MMA managed care program.

2. Capitated Managed Care Plans

a. Capitation Rates

- (1) The Agency shall pay the Managed Care Plan a retroactive capitation rate for each newborn enrolled in a Managed Care Plan retroactive to the month of birth. (s. 409.977(3), F.S.)
- (2) The Managed Care Plan shall be responsible for payment of all covered services provided to newborns.
- (3) The Agency shall be responsible for administration of the Medicaid prescribed drug program, including negotiating supplemental rebates and favorable net pricing for drugs on the Agency's Medicaid Preferred Drug List (PDL). For prescribed drug services under this Contract, the Managed Care Plan shall not negotiate any drug rebates with pharmaceutical manufacturers for drugs on the Agency's Medicaid PDL. The Agency will be the sole negotiator of pharmaceutical rebates for drugs on the Agency's Medicaid PDL, and all rebate payments for drugs on the Agency's Medicaid PDL will be made to the Agency.

b. Rate Adjustments and Reconciliations

- (1) The Agency shall be responsible for adjusting applicable capitation rates to reflect budgetary changes in the Medicaid program.
- (2) Pursuant to s. 409.976(2), F.S., the Managed Care Plan's actual payments to SIPP providers shall be reconciled for enrollees with MMA benefits to ensure actual claim payments are, at a minimum, the same as Medicaid FFS claim payments. The Managed Care Plan accepts and assumes all risks of excess payments as a cost of doing business.

c. Kick Payments

- (1) The Managed Care Plan shall be paid one kick payment for the following covered services for enrollees who are not also eligible for Medicare or other third-party coverage:
 - (a) Each obstetrical delivery; and
 - (b) Each heart, liver, and lung transplant.
- (2) The Managed Care Plan shall receive kick payments for covered services specified in this Section in the amounts specified in the Contract. For kick payment purposes, an obstetrical delivery includes all births resulting from the delivery; therefore, if an obstetrical delivery results in multiple births, the Agency will make only one kick payment. This includes still births. The kick payment amount is the same, regardless of the delivery outcome (live or still birth), the mode of delivery (vaginal or cesarean), or the setting in which the delivery occurs (hospital, birth center, or in the home).
- (3) To receive a kick payment for covered services specified in this Section, the Managed Care Plan must adhere to the specific requirements listed in subsection d. below and adhere to the following requirements:
 - (a) The Managed Care Plan must have provided the covered service while the recipient was enrolled in the Managed Care Plan;
 - (b) The Managed Care Plan must submit corresponding encounters for these services in accordance with Attachment B., Section X.E., Encounter Data Requirements; and
 - (c) The Managed Care Plan shall submit any required documentation to the Agency upon its request in order to receive the kick payment.
- (4) In addition to subsection c. above, to receive a kick payment for covered services specified in this Section, provided to an enrollee without Medicare, the Managed Care Plan shall comply with the following requirements:
 - (a) The Managed Care Plan shall submit an X12 837 Professional (837P) (non-encounter) transaction or through the direct data entry or trade files

Section XI. Method of Payment

option on the Medicaid Provider Web Portal, within the required Medicaid FFS claims submittal timeframes;

- (b) The Managed Care Plan shall use the following list of obstetrical delivery procedure codes relative to the type of delivery performed when completing transactions or claims:

CPT CODE	DESCRIPTION
59410	Vaginal Delivery with Post-Delivery Care
59515	Cesarean Delivery with Post-Delivery Care

- (c) The Managed Care Plan shall list itself as both the pay-to and the treating provider on the transaction or claim; and
- (d) The Managed Care Plan shall use the following tables:
 - i. The Managed Care Plan shall receive kick payments in the amounts indicated in Kick Payment Rates for Covered Obstetrical Delivery Services.

**KICK PAYMENT RATES FOR COVERED OBSTETRICAL DELIVERY SERVICES;
NOT FOR USE UNLESS APPROVED BY CMS.**

Region	Amount
1	To be negotiated
2	To be negotiated
3	To be negotiated
4	To be negotiated
5	To be negotiated
6	To be negotiated
7	To be negotiated
8	To be negotiated
9	To be negotiated
10	To be negotiated
11	To be negotiated

1. A kick payment is triggered if a member in a capitated plan is not also eligible for Medicare and receives delivery services.

2. The kick payment is the same regardless of the delivery outcome (live or still birth).

- ii. Kick Payment Rates for Covered Transplant Services, Effective Date: January 1, 2016, that includes transplant procedure codes relative to the type of transplant performed when submitting the transaction or claim.

KICK PAYMENT RATES FOR COVERED TRANSPLANT SERVICES;

Section XI. Method of Payment

**NOT FOR USE UNLESS APPROVED BY CMS.
EFFECTIVE DATE: August 1, 2016**

CPT Code	Transplant Description	CPT Code	Children/Adolescents or Adult	All Areas
32851	Lung single, without bypass		Children/Adolescents	\$489,321.63
32851	Lung single, without bypass		Adult	\$363,025.40
32852	Lung single, with bypass		Children/Adolescents	\$489,321.63
32852	Lung single, with bypass		Adult	\$363,025.40
32853	Lung double, without bypass		Children/Adolescents	\$489,321.63
32853	Lung double, without bypass		Adult	\$363,025.40
32854	Lung double, with bypass		Children/Adolescents	\$489,321.63
32854	Lung double, with bypass		Adult	\$363,025.40
33945	Heart transplant with or without cardiectomy	with or recipient	All Age Groups	\$247,101.32
47135	Liver, allotransplantation, orthotopic, partial or whole from cadaver or living donor		All Age Groups	\$187,003.84

d. Health Insurance Providers Fee

(1) General

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

- (a) The entity which comprises the Managed Care Plan or of which the Managed Care Plan is a part and which is required to submit the IRS Form 8963 pursuant to the above mentioned federal regulations (referred to hereinafter as the “Reporting Plan”) shall submit to the Agency a copy of the IRS Form 8963 submitted to the IRS by April 15 after each year for which it intends to be reimbursed.
- (b) The Reporting Plan shall submit to the Agency a copy of the IRS Notice of final fee calculation (as described in 26 CFR s. 57.7) by September 5 after each year for which it intends to be reimbursed.

Section XI. Method of Payment

- (c) The Reporting Plan shall submit its annual statement (which includes information pertinent to the tax impact of this subject fee) once it is issued for the preceding year for which it intends to be reimbursed.
- (d) All documents listed above and any additional data or information requested by the Agency shall be submitted with an attestation by the Reporting Plan in accordance with the certification requirements specified in Section XVI., Reporting Requirements, of this Contract. Following the determination of the amount to be reimbursed and the federal and State income tax impact related to this health insurance providers fee, the capitated per member per month Fee for the plan will be timely reprocessed. This process is subject to approval by the Centers for Medicare and Medicaid Services and any change in federal or State law.

(2) Health Insurance Providers Fee Methodology

- (a) Table 1 is to be used to enter revenue information for the data year related to the fee payment year. The data year is the year preceding the year in which the fee is to be paid. The total premiums taken into account are to be allocated proportionately to total premiums by State and line of business.
- (b) The information in Table 1 will be used by the Agency to calculate the portion of the Health Insurance Providers Fee related to Medicaid activities for the Reporting Plan using the formula $(A / I) * J$. The proportion denoted by (A / I) represents the percentage of total premiums taken into account related to Medicaid for the Reporting Plan, and J represents the total Health Insurance Providers Fee amount allocated to the Reporting Plan as documented by the Reporting Plan's IRS notice. Note that items I and J should be taken directly from the IRS memos received by the Reporting Plan.

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

- (3) An actuarially sound approach will be developed to calculate the amount of federal and State income tax related to the Health Insurance Providers Fee.

e. Achieved Savings Rebate

In order to be eligible to retain up to an additional one percent (1%) of revenue, the Managed Care Plan shall achieve performance measure rates at or above the 75th percentile for five (5) of the ten (10) performance measures listed below, with none of the rates below the 50th percentile. The performance measures are as follows:

- (1) Antidepressant Medication Management – Effective Acute Phase Treatment;
 - (2) Adherence to Antipsychotic Medications for Individuals With Schizophrenia;
 - (3) Comprehensive Diabetes Care – HbA1c Control (<8%);
 - (4) Controlling High Blood Pressure;
 - (5) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Day – Total;
 - (6) Follow-Up After Emergency Department Visit for Mental Illness – 7 Day;
 - (7) Follow-Up After Hospitalization for Mental Illness – 7 Day;
 - (8) Human Immunodeficiency Virus (HIV) Viral Load Suppression;
 - (9) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total; and
 - (10) Medication Management for People With Asthma – 75% Compliance – Total.
- f. The Managed Care Plan shall submit dual eligible enrollees identified with an HIV/AIDS diagnosis to the Agency in a report format and transmittal method approved by the Agency and as specified in the Agency's Managed Care Plan Report Guide. See Section XVI., Reporting Requirements, of this Exhibit.
- g. The Managed Care Plan shall only receive a monthly capitation payment for an enrollee aged twenty-one (21) to sixty-four (64) years receiving inpatient treatment in an Institution for Mental Diseases (IMD), so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care, or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short-term stay of no more than fifteen (15) days during the period of the monthly capitation payment. (42 CFR 438.6(e))
- h. Value Based Purchasing Programs. The Managed Care Plan shall develop and implement a value-based purchasing program to reduce costs associated with potentially preventable events and improved birth outcomes. The Agency reserves the right to develop mandatory program parameters, performance metrics, and alternative payment methodologies at a later date.

Section XII. Financial Requirements

A. Insolvency Protection

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

B. Surplus

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

C. Interest

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

D. Third Party Resources

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

E. Assignment

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

F. Financial Reporting

1. Medical Loss Ratio

- a. The Managed Care Plan shall maintain an annual (January 1 – December 31) medical loss ratio (MLR) of a minimum of eighty-five percent (85%) for the first full year of MMA program operation and subsequent years, beginning January 1, 2019.
- b. The Agency will calculate the MLR in a manner consistent with 42 CFR 438.8, 45 CFR Part 158 and s. 409.9122(9)(a), (b), and (c), F.S., To demonstrate ongoing compliance, the Managed Care Plan shall complete and submit appropriate financial reports, as specified in Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.
- c. The federal Centers for Medicare & Medicaid Services will determine the corrective action for non-compliance with this requirement.

G. Inspection and Audit of Financial Records

Upon request of the Agency, the Managed Care Plan shall disclose to the Agency all financial terms and arrangements for payment of any kind that apply between the Managed Care Plan or the Managed Care Plan's Pharmacy Benefits Manager and any provider of outpatient drugs, any prescription drug manufacturer, or labeler. Such financial terms and arrangements include: formulary/PDL management; drug-switch programs; educational support; claims processing; discounts, including but not limited to end of period discounts, pharmacy network fees, data sales fees, and any other fees.

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Section XIII. Sanctions

A. Contract Violations and Non-Compliance

There are no additional Contract violations and non-compliance provisions unique to the MMA managed care program.

B. Corrective Action Plans

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

C. Performance Measure Sanctions

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

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

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

Section XIII. Sanctions

- (4) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total
 - (5) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Day – Total
 - (6) Follow-Up After Emergency Department Visit for Mental Illness – 7 Day
- b. Well-Child
- (1) Adolescent Well Care Visits
 - (2) Childhood Immunization Status – Combination 3
 - (3) Immunizations for Adolescents – Combination 1
 - (4) Well-Child Visits in the First 15 Months of Life – 6 or More Visits
 - (5) Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
 - (6) Lead Screening in Children
- c. Other Preventive Care
- (1) Adults' Access to Preventive/Ambulatory Health Services – Total
 - (2) Adult BMI Assessment
 - (3) Breast Cancer Screening
 - (4) Cervical Cancer Screening
 - (5) Children and Adolescents' Access to Primary Care (12-19 years)
 - (6) Chlamydia Screening in Women – Total
- d. Prenatal/Perinatal
- (1) Prenatal and Postpartum Care (includes two (2) measures)
 - (2) Frequency of Ongoing Prenatal Care (\geq eighty-one percent (81%) of expected visits)
- e. Diabetes – Comprehensive Diabetes Care measure components

Section XIII. Sanctions

- (1) HbA1c Testing
 - (2) HbA1c Control (< 8%)
 - (3) Eye Exam
 - (4) Medical Attention for Nephropathy
- f. Other Chronic and Acute Care
- (1) Controlling High Blood Pressure
 - (2) Medication Management for People with Asthma – 75 % Compliance – Total
 - (3) Annual Monitoring for Patients on Persistent Medications – Total

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

D. Other Sanctions

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

E. Notice of Sanctions

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

F. Dispute of Sanctions

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

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Section XIV. Liquidated Damages

A. Damages

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

B. Issues and Amounts

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

Liquidated Damages Issues and Amounts		
#	MMA PROGRAM ISSUES	DAMAGES
1.	Failure to comply with the enrollee records documentation requirements pursuant to the Contract.	\$1,000 per enrollee record that does not include all of the required elements.
2.	Failure to comply with the federal and/or State well-child visit eighty percent (80%) screening rate and/or federal eighty percent (80%) well-child visit participation rate requirements described the Contract.	\$50,000 per occurrence in addition to \$10,000 for each percentage point less than the target.
3.	Failure to attend scheduled or ad hoc CMAT staffing(s) for their assigned enrollees receiving private duty nursing services or receiving services in a skilled nursing facility.	\$1,000 per occurrence
4.	Failure to convene an MDT meeting focused on transition planning, as required in the Contract, for enrollees receiving services in a skilled nursing facility.	\$500 per occurrence
5.	Failure to develop and maintain a person centered individualized service plan, as required in the Contract, for enrollees receiving private duty nursing services or receiving services in a skilled nursing facility.	\$500 per occurrence

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	MMA PROGRAM ISSUES	DAMAGES
6.	Failure to provide coordination of aftercare services at least thirty (30) days prior to discharge from a residential treatment setting for enrollees receiving residential psychiatric treatment.	\$1,000 per occurrence
7.	Failure to pay physician payment rates equal to or in excess of Medicare rates for services provided as part of a physician incentive plan approved by the Agency in accordance with s. 409.967(2)(a), F.S.	\$1,000 per occurrence, plus \$100 per day for each day the physician has not received payment.
8.	Failure to develop and document a treatment or service plan for an enrollee with complex medical issues, high service utilization, intensive health care needs, or who consistently accesses services at the highest level of care, that shall be documented in writing as described in the Contract.	\$500 per deficient/missing treatment or service plan.

C. Performance Measure Liquidated Damages

1. The Agency may impose liquidated damages for performance measures as described below in the event that the Managed Care Plan fails to perform at the level of the Agency's expected minimum standards, as specified in sub-item 2 of this item.
2. The Managed Care Plan's performance measure rates shall be compared to the NCQA HEDIS National Means and Percentiles for Medicaid plans. For each measure where the Managed Care Plan's rate falls below the 50th percentile, the Managed Care Plan may receive liquidated damages. Liquidated damages will be calculated based on the number of members eligible for the measure who did not receive the service being measured up to the 50th percentile rate. For measures calculated using a sample, liquidated damages will be calculated based on the extrapolated number of eligible members who did not receive the service being measured, not just those in the sample, up to the 50th percentile rate.
3. For performance measures in Tier 1 where the Managed Care Plan's rate falls below the 50th percentile, liquidated damages may be assessed at one hundred fifty dollars (**\$150**)

Section XIV. Liquidated Damages

per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.

4. For performance measures in Tier 2 where the Managed Care Plan's rate falls below the 50th percentile, liquidated damages may be assessed at one hundred dollars (**\$100**) per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.
5. For performance measures in Tier 3 where the Managed Care Plan's rate falls below the 50th percentile, liquidated damages may be assessed at eighty dollars (**\$80**) per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.
6. The Agency may assess liquidated damages for each of the following measures:
 - a. Tier 1:
 - (1) Antidepressant Medication Management – Effective Acute Phase Treatment
 - (2) Adherence to Antipsychotic Medications for Individuals with Schizophrenia
 - (3) Comprehensive Diabetes Care – HbA1c Control (<8%)
 - (4) Controlling High Blood Pressure
 - (5) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 day – Total
 - (6) Follow-Up After Emergency Department Visit for Mental Illness – 7 day
 - (7) HIV Viral Load Suppression
 - (8) Initiation and Engagement of Alcohol and Other drug Dependence Treatment – Initiation – Total
 - (9) Medication Management for People with Asthma – 75% Compliance – Total
 - b. Tier 2:
 - (1) Adolescent Well-Care Visits
 - (2) Adults' Access to Preventive/Ambulatory Health Services – Total
 - (3) Childhood Immunization Status – Combination 3
 - (4) Children and Adolescents' Access to Primary Care Practitioners – includes 4 age group rates
 - (5) Frequency of Ongoing Prenatal Care - ≥ 81% of expected visits
 - (6) Immunizations for Adolescents – Combination 1

Section XIV. Liquidated Damages

- (7) Timeliness of Prenatal Care
 - (8) Well-Child Visits in the First 15 Months of Life – 6 or more visits
 - (9) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- c. Tier 3:
- (1) Adult BMI Assessment
 - (2) Annual Monitoring for Patients on Persistent Medications – Total
 - (3) Breast Cancer Screening
 - (4) Cervical Cancer Screening
 - (5) Chlamydia Screening in Women – Total
 - (6) Comprehensive Diabetes Care – HbA1c Testing
 - (7) Comprehensive Diabetes Care – Eye Exam
 - (8) Comprehensive Diabetes Care – Medical Attention for Nephropathy
 - (9) Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase
 - (10) Lead Screening in Children
 - (11) Postpartum Care
 - (12) Well-Child Visits in the First 15 Months of Life (0 visits)
7. The Agency may amend the performance measure listing with sixty (60) days' advance notice.

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Section XV. Special Terms and Conditions

The special terms and conditions in Attachment B., Section XV., Special Terms and Conditions, apply to all Managed Care Plans covering MMA services. There are no additional special terms and conditions unique to the MMA managed care program.

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Section XVI. Reporting Requirements

A. Required Reports

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

Summary of Reporting Requirements		
Report Name	Program Type	Frequency
Well-child Visit (CMS-416) and FL 80% Screening	MMA Program	Annually
HSA Ombudsman Log	MMA Program	Quarterly
HSA Survey	MMA Program	Annually
PCP Appointment Report	MMA Program	Annually
ER Visits for Enrollees without PCP appointment	MMA Program	Annually
Customized Benefit Notification	MMA Program	Monthly
Healthy Behaviors	MMA Program	Quarterly
Timely Access/PCP Wait Times Report	MMA Program	Annually
Supplemental HIV/AIDS Report	MMA Program	Monthly
Residential Psychiatric Treatment Report	MMA Program	Monthly

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**EXHIBIT B-2
LONG-TERM CARE (LTC) PROGRAM**

Section I. Definitions and Acronyms

The definitions and acronyms in Attachment B., 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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Section II. General Overview

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

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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
 - e. If appropriate, assisting enrollees to obtain an authorized representative.

Section III. Eligibility and Enrollment

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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Section IV. Marketing

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

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.

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 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 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 the comprehensive assessment 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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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 B., 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 the approved federal waivers for the LTC program and Rule 59G-4.192, F.A.C.

Section VI. Coverage and Authorization of Services

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

- 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 B., 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

Section VI. Coverage and Authorization of Services

- (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 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 B 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.

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

Section VI. Coverage and Authorization of Services

- (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 hours per day, seven 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.
- (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.

Section VI. Coverage and Authorization of Services

- (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.
- 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

Section VI. Coverage and Authorization of Services

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.
 - (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; and
 - (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.
- 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

Section VI. Coverage and Authorization of Services

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 B., Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

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 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 forty-five (45) days 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 a plan of care that is developed using a person-centered care planning process described herein. 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.

Section VI. Coverage and Authorization of Services

- (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.

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.

Section VI. Coverage and Authorization of Services

- (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.
 - (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 forty-five (45) days prior to initial implementation and any substantive changes thereafter.
 - (4) The Managed Care Plan shall ensure that copies of the plan of care summary are 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 and how to request a full copy of the plan of care.
 - (5) 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.
 - (6) The Managed Care Plan shall provide a copy of the plan of care to the enrollee or enrollee's authorized representative.
- c. Service Planning Standard

Section VI. Coverage and Authorization of Services

- (1) 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.
 - (2) 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.
 - (3) 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.
- d. Frequency and Type of Ongoing Minimum Contact Requirements

Section VI. Coverage and Authorization of Services

- (1) 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:
 - (a) 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.
 - (b) 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.
 - (c) Assess needs, including any changes to the enrollee's informal support system.
 - (d) Discuss the enrollee's perception of his/her progress toward established goals.
 - (e) Identify any barriers to the achievement of the enrollee's goals.
 - (f) Develop new goals as needed.
 - (g) Document the enrollee's current functional, medical, behavioral and social strengths.
- (2) The Managed Care Plan shall have an annual face-to-face visit with the enrollee to:
 - (a) Complete the annual reassessment.
 - (b) Determine the enrollee's functional status, satisfaction with services, and changes in service needs.
 - (c) Develop a new plan of care.
- (3) 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.
- (4) 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

Section VI. Coverage and Authorization of Services

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.

6. Monthly Contact

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

7. Freedom of Choice

In addition to the requirements specified in Attachment B., the Managed Care Plan shall review and have the enrollee or their authorized representative sign and date the Agency-approved Freedom of Choice Certification Form upon a change in the enrollee's living arrangement.

8. Pre-Admission Screening and Resident Review

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

9. Transition of Care

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

10. Disease Management Program

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

- a. Dementia and Alzheimer's issues.

F. Quality Enhancements

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

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

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 frequency and duration necessary to support the enrollee adequately and safely in the setting of his or her choice.

Section VI. Coverage and Authorization of Services

- b. The Managed Care Plan shall not deny covered services based on an incomplete plan of care.
- c. The Managed Care Plan shall authorize ongoing services within the timeframes specified in the enrollee's plan of care.
- d. The Managed Care Plan shall process service authorization requests for respite services requested on an emergent basis within the expedited timeframes specified in Attachment B., Section VI.G., Authorization of Services.
- e. 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.
- f. 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.
- g. The Managed Care Plan shall not deny medically necessary services required for the enrollee to remain safely in the community because of cost.
- h. 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.
- i. In addition to the requirements specified in Attachment B., the Managed Care Plan shall ensure a notice of action 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 B., Section VI.G., Coverage and Authorization of

Section VI. Coverage and Authorization of Services

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.

3. Service Authorization System

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

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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.

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 Table 1: LTC Provider Network Standards table. 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 1.
- 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 Table 2: PDO Provider Qualifications table 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.

2. Annual Network Development Plan

Section VIII. Provider Services

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 B., 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/>:
 - (1) If the nursing facility has an overall rating of two (2) or more stars, the nursing facility has met this measure. If the nursing facility has less than two (2) overall stars, proceed with the review.
 - (2) If the nursing facility has a rating of less than two (2) stars in the Quality Measures category within the Long-Stay Residents section, the nursing facility has not met this measure. If the nursing facility has a rating of two (2) or more stars in the Quality Measures category within the Long-Stay Residents section, proceed with the review.
 - (3) Determine under the Quality Measures category within the Long-Stay Residents section, if the percentage of long-stay residents who receive an antipsychotic medication at the nursing facility is the same as the statewide average or less. If the percentage is more than the statewide average percentage, the nursing

Section VIII. Provider Services

facility has not met this measure. If the percentage is the same or less than the statewide average percentage, the facility has met this measure. If the facility does not meet these quality criteria, 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 2 – PDO Provider Qualifications. Network adequacy requirements for LTC are listed in Table 1 - LTC Provider Network Standards Table below.
- d. 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.
- (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

Section VIII. Provider Services

- (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 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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Table 1

LTC Provider Network Standards Table				
	Urban County		Rural County	
Required Providers	Maximum Time (minutes) or Provider Ratio	Maximum Distance (miles) or Provider Ratio	Maximum Time (minutes) or Provider Ratio	Maximum Distance (miles) or Provider Ratio
Adult Companion	At least two (2) providers serving each county of the region.			
Adult Day Care (Adult Day Health Care)	30	20	60	45
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.			
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.			
Attendant Nursing Care	At least two (2) providers serving each county of the region.			
Behavior Management	30	20	60	45
Caregiver Training	30	20	60	45
Case Management	Each case manager's caseload may not exceed caseload ratios as described in Section X.A.4.b. of this Exhibit.			
Home Accessibility Adaptation	At least two (2) providers serving each county of the region.			
Home Delivered Meals	At least two (2) providers serving each county of the region.			
Homemaker	At least two (2) providers serving each county of the region.			
Hospice	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.			

Section VIII. Provider Services

LTC Provider Network Standards Table				
	Urban County		Rural County	
Required Providers	<i>Maximum Time (minutes) or Provider Ratio</i>	<i>Maximum Distance (miles) or Provider Ratio</i>	<i>Maximum Time (minutes) or Provider Ratio</i>	<i>Maximum Distance (miles) or Provider Ratio</i>
Medication Administration	30	20	60	45
Medication Management	30	20	60	45
Medical Equipment & Supplies	At least two (2) providers serving each county of the region.			
Nutritional Assessment and Risk Reduction	30	20	30	20
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.			
Personal Care	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.			
Respite Care	30	20	60	45
Transportation	At least two (2) providers serving each county of the region.			
Occupational Therapy	30	20	60	45
Physical Therapy	30	20	60	45
Respiratory Therapy	30	20	60	45
Speech Therapy	30	20	60	45

Table 2
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:

(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.

Section VIII. Provider Services

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.

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;*

Section VIII. Provider Services

- *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 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,

Section VIII. Provider Services

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

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

- (1) The role of case managers; and
- (2) 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

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

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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

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

6. EQRO Coordination Requirements

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

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

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

Centers for Medicare and Medicaid Services and Mathematica Managed Long-Term Services and Supports (LTSS) Measures	
1.	Comprehensive LTSS 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.	Comprehensive LTSS Care Plan: 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.	Shared Care Plan: 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.	Reassessment and Care Plan Update after 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.	Falls: 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: <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.	Admission to an Institution from the Community among LTSS beneficiaries: the number of LTSS enrollee admissions to an institution

Section IX. Quality

	(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).

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

The Managed Care Plan shall report the following performance measures to the Agency in a manner prescribed by the Agency.

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	

Section IX. Quality

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 Freedom of Choice 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.
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 every thirty (30) days 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. Annual Report of Performance

There are no additional annual report of performance provisions unique to the LTC managed care program.

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 perform two (2) Agency-approved statewide performance improvement projects (PIPs), one (1) clinical PIP, and one (1) non-clinical PIP.
- b. One PIP may be a 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.
- 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 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 report on a quarterly basis on activities pertaining to improving member satisfaction resulting from the annual enrollee satisfaction survey.

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.

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 B., 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;
- (6) Needs assessments;
- (7) Plan of care;
- (8) Documentation of enrollee's responses to HCB Settings Requirements queries;

Section IX. Quality

- (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.
- 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. Per 42 CFR 441.303(c)(3), written and electronically retrievable documentation of all evaluations and re-evaluations shall be maintained as required in 45 CFR 92.42. The Managed Care Plan shall specify in policy where records of evaluation and re-evaluations of 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 case management enrollee record audit report template used by the Managed Care Plan shall be approved by the Agency prior to implementation and revision.
- 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;
- (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.

Section IX. Quality

- 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.

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 B., 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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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

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

1. 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.
 - (3) 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.
- 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

Section X. Administration and Management

case managers with up-to-date information designed to aid enrollees in making informed decisions about their independent living options.

2. 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. A system of internal monitoring of the case management program, using, at a minimum, the Enrollee Record Audit Report and results, shall be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including enrollee record audits, reviews of the consistency of enrollee assessments and service authorizations, and the development and implementation of continuous improvement strategies to address identified deficiencies, shall be documented and made available to the Agency upon request.

b. Case management supervisor qualifications

- (1) Successful completion of a Level II criminal history and/or background investigation; and
- (2) Master's degree in a human service, social science or health field and has a minimum of two (2) years' experience in case management, at least one (1) year of which 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).

3. 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 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 annually as directed by the Agency for the upcoming year.

Section X. Administration and Management

- 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 a person-centered approach to LTC case management, 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;
 - (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:

Section X. Administration and Management

- (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.
- 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.

4. 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:

Section X. Administration and Management

- (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.
 - (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.

Section X. Administration and Management

- f. 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

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

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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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. Payment Provisions for FFS PSNs

a. Per Capita Service Benchmark (PCSB)

There are no additional Per Capita Service Benchmark requirements unique to the LTC program.

b. Annual Utilization Data

There are no additional annual utilization data requirements unique to the LTC program.

c. Annual Cost Reconciliation Process for Fee-for-Service Provider Service Networks

There are no additional reconciliation process for fee-for-services provider service networks unique to the LTC program.

d. Annual Reconciliation Review for Fee-for-Service Provider Service Networks

There are no additional annual reconciliation review provisions unique to the LTC program.

e. Reconciliation upon Termination for Fee-for-Service Provider Service Networks

There are no additional reconciliation upon termination requirements unique to the LTC program.

f. Capitation Payments for Transportation Services

There are no additional capitation payment for transportation services provisions unique to the LTC managed care program.

g. Enrollee Payment Liability Protection for Transportation Services

Section XI. Method of Payment

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

h. Rate Increases

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

2. Capitated Managed Care Plans

a. Capitation Rates

- (1) The Agency will prospectively adjust the base capitation rates included in the Contract to reflect the Managed Care Plan's enrolled risk.
- (2) 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.
- (3) 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.
- (4) 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.

b. Rate Adjustments and Reconciliations

- (1) 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:
- (2) 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

Section XI. Method of Payment

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.

- (3) The nursing facility rate reconciliation process required by 409.983(6), F.S., is as follows:
 - (a) 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.
 - (b) Participating nursing facilities shall maintain their active Medicaid enrollment and submit required cost reports to the Agency.
 - (c) For changes in nursing facility payment rates, the following process shall be used:
 - i. 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.
 - 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 nursing facility and hospice payments, 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 B., Section XV., Special Terms and Conditions, if it does not concur with the results.

Section XI. Method of Payment

- 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.
- (d) For retroactive changes in nursing facility payment rates, the following process shall be used:
- i. 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.
 - ii. 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.
- (4) 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.
 - (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.

Section XI. Method of Payment

- 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 B., 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.
- (5) Patient Responsibility Reconciliation. The Managed Care Plan shall have its annual patient responsibility collections and HCBS waiver service costs report reviewed annually by the Agency to verify the patient responsibility collections on a per capita basis did not exceed the cost of HCBS. If the per capita patient responsibility collections exceed the HCBS waiver costs, the Agency will adjust the capitation to correct the Managed Care Plan overpayment.
- (6) 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.
- (7) 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 Managed Care Plan in excess of the FFS amount shall be overpayments and shall be recouped.

c. Errors

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

d. Enrollee Payment Liability Protection

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

e. Achieved Savings Rebate

Section XI. Method of Payment

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 below:

Measure	Threshold
<u>Centers for Medicare & Medicaid Services and Mathematica Managed Long-Term Services and Supports (MLTSS) Measures</u>	
Comprehensive LTSS Assessment and Update	95%
Comprehensive LTSS Care Plan	95%
Shared Care Plan	95%
Re-Assessment and Care Plan Update after Discharge	95%

f. Community High Risk Pool (CHRP)

- (1) 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 B., Section X., Administration and Management. The Agency shall analyze the LTC encounter data submitted by the Managed Care Plan.
 - (a) Only HCBS will be used to evaluate the SMMC LTC risk pool for an enrolled recipient.
 - (b) Costs associated with nursing facility services and hospice services are explicitly excluded from the distribution of the risk pool.
- (2) The Agency will establish a withhold per-member-per-month (PMPM) on a quarterly basis.
 - (a) The withhold PMPM will use only State plan or waiver approved services and exclude nursing facility and hospice services.
 - (b) The CHRP will be established by SMMC LTC region.
 - (c) The Agency may adjust the PMPM withhold value on a quarterly basis as necessary.
 - (d) The Agency shall communicate the terms of the CHRP including the threshold and coinsurance amount each quarter.
 - (e) The established CHRP withhold will be applied to the pre-transition HCBS enrollment on a monthly basis.

Section XI. Method of Payment

- (3) 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.
 - (a) 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 B., Section X., Administration and Management.
 - (b) 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.
 - (c) 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
 - iv. February Disbursement – Claims incurred June – August, paid and submitted through November.
 - (d) 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.
 - (e) 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.
 - (f) 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.

Section XI. Method of Payment

- (4) 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.
- (5) The Agency retains the right to update the withhold percentage on a quarterly basis, if needed. Inclusion of this information in the LTC databook 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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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.

3. Patient Responsibility

The Managed Care Plan shall submit a Patient Responsibility Report annually, in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. If an enrollee's patient responsibility exceeds the reported Medicaid HCBS service expenditure, the Agency will employ the reconciliation process detailed in Section XI.C., Payment Provisions, to determine if a payment adjustment is required.

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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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 table below.

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
Comprehensive LTC Assessment and Update	Rate < 85%, \$10,000 monetary sanction
Comprehensive LTC Care Plan	Rate < 85%, \$10,000 monetary sanction
Shared Care Plan	Rate < 85%, \$10,000 monetary sanction
Reassessment and Care Plan Update after Discharge	Rate < 85%, \$10,000 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.

F. Dispute of Sanctions

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

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 Issues and Amounts Table below.

Liquidated Damages Issues and Amounts		
#	LTC PROGRAM ISSUE	DAMAGES
1	Failure to comply with the enrollee records documentation requirements pursuant to the Contract.	\$1,000 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.	\$500 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.	\$5,000 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.	\$500 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.	\$500 per occurrence.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	LTC PROGRAM ISSUE	DAMAGES
6	Failure to develop a person-centered plan of care for an enrollee that includes all of the required elements, and which has been reviewed with and signed and dated by the enrollee or enrollee's authorized representative, unless the enrollee or enrollee's authorized representative refuses to sign, which shall be documented in writing as described in the Contract.	\$500 per deficient plan of care. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the caseload and staffing requirements specified in the Contract.
7	Failure to meet any timeframe regarding care coordination for enrollees as described in the Contract.	\$250 per day, per occurrence.
8	Failure to follow-up within fourteen (14) days of initial plan of care development to ensure that services are in place as described in the Contract.	\$500 for each occurrence.
9	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.	\$500 per day.
10	Failure to report enrollees that do not receive any LTC services listed in the approved plan of care for a month, 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.
11	Failure to comply with obligations and time frames in the delivery of annual face-to-face LOC redeterminations as described in the Contract.	\$1,000 per occurrence.
12	Failure to ensure that for each enrollee all necessary paperwork is submitted to DCF within the timeframes included in the Contract.	\$100 assessed for each enrollee who temporarily loses eligibility (for less than sixty (60) days) pursuant to a redetermination.
13	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	\$5,000 per occurrence.
14	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.	\$5,000 per occurrence.

Section XIV. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	LTC PROGRAM ISSUE	DAMAGES
15	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.)	\$5,000 per occurrence.
16	Performance Measure: Comprehensive LTC Assessment and Update	Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.
17	Performance Measure: Comprehensive LTC Care Plan	Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.
18	Performance Measure: Shared Care Plan	Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.
19	Performance Measure: Reassessment and Care Plan Update after Discharge	Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.

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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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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 below and the Managed Care Plan Report Guide.

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	LTC Program	Immediately upon occurrence and no later than within twenty-four (24) hours after detection or notification
Denied or Suspended Nursing Facility Claims	LTC Program	Monthly
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
Patient Responsibility Report	LTC Program	Annually
Provider Network and Qualifications Report	LTC Program	Quarterly
Unable to Provide Case Management Report	LTC Program	Monthly

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**EXHIBIT B-3
[SPECIALTY CONDITION] SPECIALTY PLAN**

The provisions in Attachment B and Exhibit B-1 apply to this Specialty Plan, unless otherwise specified in this Exhibit.

Section I. Definitions and Acronyms

A. Definitions

In addition to the definitions required in Attachment B, Section I. and the Exhibit B-1, the Specialty Plan shall propose additional definitions with such other requirements for quality management as defined in the resulting Contract.

B. Acronyms

In addition to the acronyms required in Attachment B.I and Exhibit B-1, the Specialty Plan shall propose additional acronyms with such other requirements for quality management as defined in the resulting Contract.

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Section II. General Overview

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

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Section III. Eligibility and Enrollment

A. Eligibility

1. Specialty Population Eligibility Criteria

- a. The specialty population eligible to enroll in this Specialty Plan shall consist of only those mandatory and voluntary recipients specified in Attachment B and its Exhibits based upon negotiations.

B. Enrollment

1. Specialty Plan-Specific Claims-Based Population Identification

- a. The Agency shall identify the specialty population eligible for enrollment in the Specialty Plan based on eligibility criteria based upon negotiations.

2. Specialty Plan-Specific Verification of Eligibility

- a. The Specialty Plan shall have policies and procedures, subject to Agency approval, to verify the specialty population eligibility criteria of each enrolled recipient. The Specialty Plan shall submit policies and procedures regarding screening for specialty population eligibility prior to implementation of such policies and procedures.
- b. Policies and procedures regarding screening for specialty population eligibility must include:
 - (1) Timeframes for verification of specialty population eligibility criteria;
 - (2) Mechanisms for reporting the results of specialty population eligibility screening to the Agency;
 - (3) Mechanisms for submitting disenrollment requests for enrollees that do not meet specialty population eligibility criteria; and
 - (4) Such other verifications, protocols, or mechanisms as may be required by the Agency to ensure enrolled recipients meet defined specialty population eligibility criteria.
- c. The Specialty Plan may develop and implement, subject to Agency approval, policies and procedures to identify recipients meeting the Specialty Plan eligibility criteria and who have not been identified by Agency. The Agency may enroll such recipients upon receipt of verification pursuant to the screening requirements specified above.

C. Disenrollment

The Specialty Plan shall submit involuntary disenrollment requests to the Agency or its designee, in a format and timeframe prescribed by the Agency, for each enrollee that does not meet the Specialty Plan eligibility criteria, pursuant to the specialty population screening requirements specified above.

D. Medicaid Redetermination Assistance

The Specialty Plan may develop and implement, subject to Agency approval, policies and procedures to provide assistance with Medicaid eligibility redetermination to enrollees in order to promote continuous Medicaid eligibility.

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Section IV. Marketing

The Specialty Plan shall develop and implement, subject to Agency approval, policies and procedures that ensure the confidentiality of recipients diagnosed with an [Specialty condition] in the conduct of any marketing activities pursuant to Attachment B and its Exhibits.

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Section V. Enrollee Services

A. General Provisions

There are no additional general provisions unique to the Specialty Plan.

B. Enrollee Material

The Specialty Plan shall develop and implement, subject to Agency approval, policies and procedures that ensure the confidentiality of enrollees diagnosed with [Specialty condition] in the distribution of all enrollee materials pursuant to Attachment B and its Exhibits.

C. Enrollee Services

There are no additional enrollee services provisions unique to the Specialty Plan.

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Section VI. Coverage and Authorization of Services

A. Required Benefits

There are no additional required benefits provisions unique to the Specialty Plan.

B. Expanded Benefits

1. Specialty Plan-Specific Expanded Benefits

- a. In addition to the minimum covered services set forth in Attachment B and Exhibits, the Agency shall identify the additional expanded benefits for the Specialty Plan based upon negotiations:

C. Excluded Services

There are no additional excluded services provisions unique to the Specialty Plan.

D. Coverage Provisions

There are no additional coverage provisions unique to the Specialty Plan.

E. Care Coordination/Case Management

1. Care Coordination/Case Management Program Description

- a. In addition to the provisions set forth in Attachment B and Exhibits, the Specialty Plan shall provide care coordination/case management to enrollees appropriate to the needs of persons meeting the Specialty Plan eligibility criteria. The Specialty Plan shall develop, implement and maintain an Agency-approved care coordination/case management program specific to the specialty population.
- b. The Specialty Plan shall submit a care coordination/case management program description annually to the Agency, at a date specified by the Agency. The care coordination/case management program description shall, at a minimum, address:
 - (1) The organization of care coordination/case management staff, including the role of qualified and trained nursing, social work, pharmacy, and specialty health personnel in case management processes;
 - (2) Maximum caseload for case managers with an adequate number of qualified and trained case managers to meet the needs of enrollees;
 - (3) Case manager selection and assignment, including protocols to ensure new enrollees are assigned to a case manager immediately;
 - (4) Protocols for initial contact with enrollees, as well as requirements for the frequency and type of ongoing minimum contacts with enrollees;

Section VI. Covered and Authorization of Services

- (5) Surrogate decision-making, including protocols if the enrollee is not capable of making his/her own decisions, but does not have a legal representative or authorized representative available;
- (6) Outreach programs that make a reasonable effort to locate and/or re-engage enrollees who have not received follow-up care for ninety (90) days or more;
- (7) Enrollee access to case managers, including provisions for access to back-up case managers as needed;
- (8) Assessment and reassessment of the acuity level and service needs of each enrollee;
- (9) Care planning for [Specialty condition] treatment that is tailored to the individual enrollee and is in agreement with evidenced based guidelines for [Specialty condition] treatment;
- (10) Coordination of care through all levels of practitioner care (primary care to specialist);
- (11) Monitoring compliance with scheduled appointments, laboratory results and medication adherence;
- (12) Coordination with and referrals to providers of other related services for enrollees with [Specialty condition];
- (13) Interventions to avoid unnecessary use of emergency departments, inpatient care, and other acute care services;
- (14) Patient education to assist enrollees in better management of their health issues including the principles of recovery and resiliency.
- (15) Linking enrollees to community or other support services.

2. Care Coordination/Case Management Staff Qualifications

- a. The Specialty Plan shall have sufficient care coordination/case management staff, qualified by training, experience and certification/licensure applicable to the Specialty Plan population.
- b. The Specialty Plan shall establish, subject to Agency approval, qualifications for all care coordination/case management staff that include clinical training, licensure and a minimum number of years of relevant experience. The Specialty Plan may request a waiver for staff without the aforementioned qualifications on a case-by-case basis. All such waivers must be approved in advance, in writing by the Agency.

3. Case Management Supervision

The Specialty Plan shall establish a supervisor-to-case-manager ratio that is conducive to a sound support structure for case managers. Supervisors must have adequate time to

Section VI. Covered and Authorization of Services

train and review the work of newly hired case managers as well as provide support and guidance to established case managers. A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of enrollee assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, must be documented and made available to the Agency upon request.

4. Care Coordination/Case Management and Staff Training

- a. The Specialty Plan shall provide all care coordination/case managers with adequate orientation and ongoing training on subjects relevant to enrollees diagnosed with [Specialty condition]. The Specialty Plan shall develop a training plan to provide uniform training to all care coordination/case management. This plan should include formal training classes as well as practicum observation and instruction for newly hired staff.
- b. The Specialty Plan shall provide all newly hired care coordination/case management staff orientation and pre-service training covering areas applicable to responsibilities and duties performed.
- c. In addition to review of areas covered in orientation, the Specialty Plan shall also provide all care coordination/case management staff with regular ongoing in-service training on topics relevant to enrollees diagnosed with [Specialty condition].
- d. The Specialty Plan shall maintain documentation of training dates and staff attendance as well as copies of materials used for orientation, pre-service and in-service training for care coordination/case management staff.

F. Quality Enhancements

There are no additional quality enhancements provisions unique to the Specialty Plan.

G. Authorization of Services

The Specialty Plan shall ensure its Utilization Management Program Description, service authorization systems, practice guidelines and clinical decision-making required pursuant to Attachment B and its Exhibits are consistent with prevailing standards of professional medical practice and with standards regarding the most recent clinical practice guidelines in [Specialty condition] treatment. The Specialty Plan shall develop and implement, subject to Agency approval, policies and procedures to notify the Agency of clinical practice guidelines for [Specialty condition] treatment.

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Section VII. Grievance and Appeal System

There are no additional grievance and appeal system provisions unique to the Specialty Plan.

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Section VIII. Provider Services

A. Network Adequacy Standards

1. Specialty Plan-Specific Network Capacity Enhancements

- a. The Specialty Plan shall select and approve its Primary Care Providers (PCPs) that practice in one of the following areas: general practice, family practice, pediatrics, obstetricians, and internal medicine. The Specialty Plan shall ensure that physicians with training and demonstrated experience in treating persons diagnosed with [diagnosis] are members of the provider network and can be designated as PCPs. The Specialty Plan may designate [specialist] with training and demonstrated experience in primary care as PCPs.
- b. Notwithstanding the Provider Network Standards established in Attachment B, Section VIII, Provider Services, the Specialty Plan shall, at a minimum, maintain enhanced provider ratios as indicated in the table (below) for the Specialty Plan. The Agency shall determine regional provider ratios based upon one hundred and twenty percent (120%) of the Specialty Plan's actual monthly enrollment measured at the first of each month, by region.

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Section VIII. Provider Services

Managed Medical Assistance Provider Network Standards Table [Specialty Condition] Specialty Plan Enhancements					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	<i>Maximum Time (minutes)</i>	<i>Maximum Distance (miles)</i>	<i>Maximum Time (minutes)</i>	<i>Maximum Distance (miles)</i>	<i>Providers per Recipient</i>
Primary Care Provider	30	20	30	20	1:750
Specialists					
24 Hour Pharmacy	60	45	75	60	2:County

2. Specialty Plan Network Adequacy Measures

- a. Notwithstanding the Provider Network Standards established in Attachment B, Section VIII., Provider Services, the Specialty Plan shall comply with the regional standards for each measure as specified in the Provider Network Adequacy Standards Table below.

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Provider Network Adequacy Measures Table [Specialty Condition] Specialty Plan								
Measure	Standard	Region						
		2	4	5	6	7	9	10
The Managed Care Plan agrees that no more than ___ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in Subsection VII. H., Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.	10	10	6	10	10	10	10	10
The Managed Care Plan agrees that no more than ___ percent of enrollee specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in Subsection VII. H., Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.	15	15	15	10	15	15	10	15

B. Network Management

The Specialty Plan shall address the availability and accessibility of specialty providers relevant to the specialty population in its annual network plan submitted to the Agency in

Section VIII. Provider Services

accordance with Attachment B and its Exhibits. The Agency will identify additional specialty provider network standards for the Specialty Plan based upon negotiations.

C. Provider Credentialing and Contracting

1. Provider Training Verification

The Specialty Plan shall require formal training or verification of completed training for network providers in the use of assessment tools, assessment instruments and in techniques for identifying individuals with unmet health needs and evidence-based.

D. Provider Services

1. General Provisions

The Specialty Plan shall develop and implement, subject to Agency approval, a continuing education program that provides ongoing education with continuing education (medical and non-medical) to network providers, at no cost to such providers, on topics including, but not limited to, evidence-based practice.

2. Additional Provider Handbook Requirements

- a. In addition to the provisions set forth in Attachment B, Section VIII., Provider Services, the Specialty Plan shall include Specialty Plan-specific information regarding proposed policies and procedures, to include information such as:
 - (1) Specialized provider education requirements;
 - (2) Requirements for care in accordance with the most recent clinical practice guidelines for [Specialty condition] treatment;
 - (3) Treatment adherence services available from the Specialty Plan;
 - (4) PCP criteria including procedures for required use of approved assessment instruments for [Specialty condition];
 - (5) Specialist Case Management policies and procedures including role of the provider in the Specialty Plan's medical case management/care coordination services;
 - (6) Referral to services including services outside of the Specialty Plan's covered services and services provided through interagency agreements; and
 - (7) Quality measurement standards for providers and requirements for exchange of data.

E. Claims and Provider Payment

There are no additional claims and provider payment provisions unique to the Specialty Plan.

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Section IX. Quality

A. Quality Improvement

1. Specialty Plan-Specific Quality Improvement Plan Requirements

- a. In addition to the requirements set forth in Attachment B and its Exhibits, the Specialty Plan's Quality Improvement (QI) Plan shall include measurement of adherence to clinical and preventive health guidelines consistent with prevailing standards of professional medical practice and with standards regarding the most recent clinical and evidence-based practice guidelines for [Specialty condition] treatment.

B. Performance Measures (PMs)

1. Specialty Plan-Specific Performance Measure Requirements

- a. The Agency shall identify additional performance measures for the Specialty Plan based upon negotiations.
- b. In addition to the provisions set forth in Attachment B and its Exhibits, the Specialty Plan shall collect data, and report on, additional performance measures that are germane to the Specialty Plan population, as identified by the Agency based upon negotiations.
- c. The Specialty Plan shall collect data and report on the additional Healthcare Effectiveness Data and Information Set performance measures in accordance with Attachment B and Exhibits.

C. Performance Improvement Projects

There are no additional performance improvement projects provisions unique to the Specialty Plan.

D. Satisfaction and Experience Surveys

There are no additional satisfaction and experience surveys provisions unique to the Specialty Plan.

E. Enrollee Record Requirements

There are no additional enrollee record requirements provisions unique to the Specialty Plan.

F. Provider- Specific Performance Monitoring

There are no additional provider-specific performance monitoring provisions unique to the Specialty Plan.

G. Additional Quality Management Requirements

There are no additional quality management provisions unique to the Specialty Plan.

H. Continuity of Care in Enrollment

There are no additional continuity of care in enrollment provisions unique to the Specialty Plan.

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Section X. Administration and Management

A. Organizational Governance and Staffing

There are no additional organizational governance and staffing provisions unique to the Specialty Plan.

B. Subcontracts

There are no additional subcontracts provisions unique to the Specialty Plan.

C. Information Management and Systems

There are no additional information management and systems provisions unique to the Specialty Plan.

D. Encounter Data Requirements

There are no additional encounter data provisions unique to the Specialty Plan.

E. Fraud and Abuse Prevention

There are no additional fraud and abuse prevention provisions unique to the Specialty Plan.

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Section XI. Method of Payment

A. General Provisions

There are no additional general provisions unique to the Specialty Plan.

B. Fixed Price Unit Contract

There are no additional fixed price unit provisions unique to the Specialty Plan.

C. Payment Provisions

There are no additional payment provisions unique to the Specialty Plan.

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Section XII. Financial Requirements

A. Insolvency Protection

There are no additional insolvency protection provisions unique to the Specialty Plan.

B. Surplus

There are no additional surplus provisions unique to the Specialty Plan.

C. Interest

There are no additional interest provisions unique to the Specialty Plan.

D. Third Party Resources

There are no additional third party resources provisions unique to the Specialty Plan.

E. Assignment

There are no additional assignment provisions unique to the Specialty Plan.

F. Financial Reporting

There are no additional financial reporting provisions unique to the Specialty Plan.

G. Inspection and Audit of Financial Records

There are no additional inspection and audit provisions unique to the Specialty Plan.

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Section XIII. Sanctions

A. Contract Violations and Non-Compliance

There are no additional provisions unique to the Specialty Plan.

B. Corrective Action Plans (CAP)

There are no additional CAP provisions unique to the Specialty Plan.

C. Performance Measure Sanctions

In addition to the provisions set forth in the MMA Exhibit, the Agency will review the Specialty Plan's data related to the performance measures specified heretofore to determine acceptable performance levels and may establish sanctions for these measures based on those levels after the first year of the Contract. In addition to the provisions set forth in the MMA Exhibits, the Agency reserves the right to determine performance measure groups which shall be subject to the sanction provisions for the Specialty Plan performance measures.

D. Other Sanctions

There are no additional other sanction provisions unique to the Specialty Plan.

E. Notice of Sanctions

There are no additional notice provisions unique to the Specialty Plan.

F. Dispute of Sanctions

There are no additional dispute provisions unique to the Specialty Plan.

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Section XIV. Liquidated Damages

A. Damages

Additional damages issues and amounts unique to this Specialty Plan are specified below.

B. Issues and Amounts

1. Specialty Plan-Specific Liquidated Damages

- a. In addition to the provisions set forth in Attachment B and its Exhibits, if the Specialty 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 Issues and Amounts Table below.

Liquidated Damages Issues and Amounts		
#	MMA PROGRAM ISSUES	DAMAGES
1.	Failure to verify specialty population eligibility criteria of an enrolled recipient within the timeframes in the Specialty Plan’s policies and procedures.	\$150 per day for every day beyond the enrollment date.
2.	Failure to comply with required Specialty Plan policies and procedures subject to Agency approval pursuant to the Contract.	\$1,000 per occurrence.

- b. In addition to the provisions set forth in Attachment B and its Exhibits, the Agency will review the Specialty Plan’s performance related to the performance measures specified heretofore to determine acceptable performance levels and may set liquidated damages for these measures based on those levels after the first year of the Contract.

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Section XV. Special Terms and Conditions

The Special Terms and Conditions in Section XV, Special Terms and Conditions apply to the Specialty Plan unless specifically noted otherwise in this Exhibit.

Section XVI. Reporting Requirements

There are no additional reporting requirements unique to the Specialty Plan.

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**ATTACHMENT C
COST PROPOSAL INSTRUCTIONS AND RATE METHODOLOGY
NARRATIVE**

Attachment C, Cost Proposal Instructions and Rate Methodology Narrative is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>

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**EXHIBIT C-1
CAPITATED PLAN COST PROPOSAL TEMPLATE**

Exhibit C-1, Capitated Plan Cost Proposal Template is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>.

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**EXHIBIT C-2
FFS PSN COST PROPOSAL TEMPLATE**

Exhibit C-2, FFS PSN Cost Proposal Template is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>.

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EXHIBIT C-3 TO EXHIBIT C-6

Exhibit C-3, Preliminary Managed Medical Assistance Program Rate Cell Factors; **Exhibit C-4**, Managed Medical Assistance Program Expanded Benefit Adjustment Factors; **Exhibit C-5**, Managed Medical Assistance Program IBNR Adjustment Factors; and **Exhibit C-6**, Managed Medical Assistance Program Historical Capitated Plan Provider Contracting Levels During SFY 15/16 Time Period is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>.

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**EXHIBIT C-7
STATEWIDE MEDICAID MANAGED CARE DATA BOOK**

Exhibit C-7, Statewide Medicaid Managed Care Data Book is available for respondents to download at:

<http://ahca.myflorida.com/procurements/index.shtml>.

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**EXHIBIT C-8
STATEWIDE MEDICAID MANAGED CARE DATA BOOK
QUESTIONS AND ANSWERS**

Exhibit C-8, Statewide Medicaid Managed Care Data Book Questions and Answers is available for respondents to download at:

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