

ATTACHMENT II
CORE CONTRACT PROVISIONS – Effective July 1, 2014

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Section I. Definitions and Acronyms

A. Definitions

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

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

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

Abuse, Neglect and Exploitation — In accordance with Chapter 415, F.S., and Chapter 39, F.S.:

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

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

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

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

“Neglect” of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child’s physical, behavioral, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

Accountable Care Organization (ACO) — An entity qualified as an accountable care organization in accordance with federal regulations (see 42 CFR Part 425), and which

meets the requirements of a provider service network (PSN) as described in s. 409.912(4)(d), F.S., as determined by the Agency.

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

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

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

Adjudicated Claim — A claim for which a determination has been made to pay or deny the claim.

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

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

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

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) 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 DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older and disabled persons.

Aging Network Service Provider — A system of essential community providers including all providers that have previously participated in home and community-based waivers serving elders or community service programs administered by the Department of Elder Affairs (DOEA) pursuant to s. 409.982(1)(c), F.S., or s. 430.205, F.S., and to whom the

Agency or DOEA has made payments in the six months prior to the release of the long-term managed care ITN.

Ancillary Provider — A provider of ancillary medical services who has contracted with a Managed Care Plan to serve the Managed Care Plan's enrollees.

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

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

Assistive Care Services — A Medicaid service as defined in the Assistive Care Services Coverage and Limitations Handbook.

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

Baker Act — The Florida Mental Health Act, pursuant to ss. 394.451 through 394.47891, F.S.

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

Behavioral Health Care Provider — A licensed or certified behavioral health professional, such as a clinical psychologist under Chapter 490, F.S., clinical social worker, mental health professional under Chapter 491, F.S.; certified addictions professional; or registered nurse qualified due to training or competency in behavioral health care, who is responsible for the provision of behavioral health care to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide behavioral health services to enrollees.

Behavioral Health Services — Services listed in the Community Behavioral Health Services Handbook and the Mental Health Targeted Case Management Coverage and Limitations Handbook as specified in Section V, Covered Services and the MMA or LTC Exhibit, respectively.

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

Benefits — A schedule of health care services to be delivered to enrollees covered by the Managed Care Plan as set forth in Section V, Covered Services and the MMA or LTC Exhibit, respectively.

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

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

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

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

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

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

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

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

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

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

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

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

Children/Adolescents — Enrollees under the age of 21.

Children’s Medical Services Network — A primary care case management program for children from birth through age twenty (20) with special health care needs, administered by the Department of Health for physical health services and the Department of Children and Families for behavioral health.

Children’s Medical Services Network (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 who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

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

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

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

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

Community Outreach — The provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. Community outreach also includes the provision of information about health care services, preventive techniques, and other health care projects and the provision of information related to health, welfare, and social services or social assistance programs offered by the State of Florida or local communities.

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

Community Outreach Representative — A person who provides health information, information that promotes healthy lifestyles, information that provides guidance about social

assistance programs, and information that provides culturally and linguistically appropriate health or nutritional education. Such representatives must be appropriately trained, certified, and/or licensed, including but not limited to, social workers, nutritionists, physical therapists, and other health care professionals.

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

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

Comprehensive Long-Term Care Plan — A Managed Care Plan that provides services described in s. 409.973, F.S., and also provides the services described in s. 409.98, F.S. Also referred to as Comprehensive LTC Managed Care Plan. For purposes of this Contract, Comprehensive LTC Managed Care Plans must comply with all general requirements of Managed Care Plans, LTC Managed Care Plans and MMA Managed Care Plans unless otherwise indicated.

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

Contract, Comprehensive Long-Term Care Plan — As a result of receiving a regional award from the Agency pursuant to s. 409.966(2), F.S., and/or s. 409.974, F.S., and s. 409.981, F.S., and successfully meeting all plan readiness requirements, the agreement between the Managed Care Plan and the Agency where the Managed Care Plan will provide Medicaid-covered services to enrollees, comprising the Contract and any addenda, appendices, attachments, or amendments thereto, and be paid by the Agency as described in the terms of the agreement. Also referred to as the "Contract".

Contract, Long-Term Care — As a result of receiving a regional award from the Agency pursuant to s. 409.966(2), F.S., and/or s. 409.981, F.S., and successfully meeting all plan readiness requirements, the agreement between the Managed Care Plan and the Agency where the Managed Care Plan will provide Medicaid-covered services to enrollees, comprising the Contract and any addenda, appendices, attachments, or amendments thereto, and be paid by the Agency as described in the terms of the agreement. Also referred to as the "Contract".

Contract, Medical Assistance — As a result of receiving a regional award from the Agency pursuant to s. 409.966(2), F.S., and/or s. 409.974, F.S., and successfully meeting all plan readiness requirements, the agreement between the Managed Care Plan and the Agency where the Managed Care Plan will provide Medicaid-covered services to enrollees,

comprising the Contract and any addenda, appendices, attachments, or amendments thereto, and be paid by the Agency as described in the terms of the agreement. Also referred to as the “Contract”.

Contracting Officer — The Secretary of the Agency or designee.

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

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

Covered Services — Those services provided by the Managed Care Plan in accordance with this Contract, and as outlined in Section V, Covered Services, and the MMA or LTC Exhibit, respectively.

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

Customized Benefit Package (CBP) — Covered services, which may vary in amount, scope, and/or duration from those listed in Section V, Covered Services and the 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.”

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

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

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

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

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

Direct Service Behavioral Health Care Provider — An individual qualified by training or experience to provide direct behavioral health services.

Direct Service Provider, Long-Term Care — A person eighteen (18) years of age or older who, pursuant to a program to provide services to the elderly or disabled, has direct, face-to-face contact with a client while providing services to the client and has access to the client’s living areas, funds, personal property, or personal identification information as defined in s.

817.568, F.S. The term includes coordinators, managers, and supervisors of residential facilities and volunteers. (See s. 430.0402(1)(b), F.S.)

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

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

Disenrollment — The Agency-approved discontinuance of an enrollee's participation in a Managed Care Plan.

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

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

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

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

Early Intervention Services (EIS) — A Medicaid program designed for children receiving services through the Department of Health's Early Steps program. Early Steps serves eligible infants and toddlers from birth to thirty-six (36) months who have development delays or a condition likely to result in a developmental delay. EIS services are authorized in the child's Early Steps Individualized Family Support Plan and are delivered by Medicaid-enrolled EIS providers throughout the state.

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

Emergency Behavioral Health Services — Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination (see s. 394.463, F.S.), and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

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

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

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

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

Enrollee — A Medicaid recipient enrolled in a Managed Care Plan.

Enrollees with Special Health Care Needs — Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. This includes individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and all enrollees in LTC Managed Care Plans.

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 fiscal agent to the Managed Care Plans to provide the Managed Care Plans with their official Medicaid recipient enrollment. Supplemental enrollment files are provided by the Agency's Medicaid enrollment broker; these files contain additional demographic data and provider choice data not available on the X-12 834 enrollment files.

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

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

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

Expanded Benefit — A benefit offered to all enrollees in specific population groups, covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency. These specific population groups are as follows: TANF; SSI No Medicare, non-LTC eligible; SSI with Medicare, non-LTC eligible; Dual Eligible, LTC eligible; Medicaid Only, LTC eligible; HIV/AIDS Specialty Population, with Medicare; HIV/AIDS Specialty Population, No Medicare; and Child Welfare Specialty Population.

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

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

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

Facility-Based— 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.) FQHCs provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

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

Fee Schedule — A list of medical, dental or mental health services or products covered by the Florida Medicaid program which provide the associated reimbursement rates for each covered service or product and are promulgated into rule.

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

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

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

Florida Medical School Quality Network — The network as specified in s. 409.975(2), F.S.

Florida Mental Health Act — Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others) as specified in ss. 394.451 through 394.47891, F.S.

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

Full-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.

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

Good Cause — See Cause.

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

Grievance Process — The procedures for addressing enrollees' grievances.

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

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

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

Health Care-Acquired Condition (HCAC) — A condition, occurring in any inpatient hospital or inpatient psychiatric hospital setting, including crisis stabilization units (CSUs), identified as a hospital-acquired condition (HAC) by the Secretary of Health and Human Services under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program as specified in the Florida Medicaid State Plan. By federal law, Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE), 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.

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

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

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

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

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

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

Healthy Behaviors (MMA Managed Care Plans Only) — A program offered by Managed Care Plans 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.

Health Insurance Portability and Accountability Act (HIPAA) — Enacted in 1996. Public Law 104-191.

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

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

Home and Community Based Services — (HCBS) Services offered in the community setting designed to prevent or delay nursing facility placement of elderly or disabled adults.

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

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

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.

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

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

Instrumental Activities of Daily Living (IADL) — Activities related to independent living which include, but are not limited to, preparing meals, taking medications, using

transportation, managing money, shopping for groceries or personal items, performing light or heavy housework and using a telephone.

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

Level of Care (LOC) — Related to the MMA/LTC Comprehensive substitution of services or service level provisions, the type of care required by an enrollee.

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

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

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

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

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

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

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

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

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

Managed Care Plan Report Guide — A companion guide to the SMMC LTC and MMA Managed Care Plan Contracts that provides detailed information about standard reports required by the 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 — Any activity or communication conducted by or on behalf of any Managed Care Plan with a Medicaid recipient who is not enrolled with the Managed Care Plan or an individual potentially eligible for Medicaid that can reasonably be interpreted as intended to influence such individual to enroll in the particular Managed Care Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mixed Services — Medicaid services listed in statute as covered by the LTC Managed Care Plan under s. 409.98, F.S., and the MMA Managed Care Plan under s. 409.973, F.S. These include the following services: home health and nursing care (intermittent and skilled nursing), hospice services, medical equipment and supplies (including durable medical equipment), therapy services (physical, occupational, respiratory and speech) and non-emergency transportation services.

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

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 policies and 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.

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

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

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. In order to receive payment for covered services, non-participating providers must be eligible for a Medicaid provider agreement and recognized in the Medicaid system (FMMIS) as either actively enrolled Medicaid providers or as Managed Care Plan registered providers.

Normal Business Hours — The hours between eight AM (8am) and five PM (5pm) local time, Monday through Friday inclusive. State holidays are excluded.

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

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 Provider-Preventable Condition (OPPC) — A condition occurring in any health care setting that:

- Is identified in the Florida Medicaid State Plan,
- Is reasonably preventable through the application of procedures supported by evidence-based guidelines,
- Has a negative consequence for the beneficiary,
- Is auditable, and
- Includes, at a minimum, the following:
 - Wrong surgical or other invasive procedure performed on a patient,
 - Surgical or other invasive procedure performed on the wrong body part, and
 - Surgical or other invasive procedure performed on the wrong patient.

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

Overpayment — Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of

inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Participant Direction Option (PDO) — A service delivery enrollee option that enables long-term care 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) — The services an enrollee may choose for the participant direction option. They include: 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.

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

Patient Responsibility — The cost of Medicaid long-term care services not paid for by the Medicaid program, for which the enrollee is responsible. Patient responsibility is the amount enrollees must contribute toward the cost of their care. This is determined by the Department of Children and Families' Economic Self Sufficiency only and is based on income and type of placement.

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

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

Person (entity) — Any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care. (See Florida Medicaid Provider General Handbook.)

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

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

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

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

Plan Factor (MMA Only) — A budget-neutral calculation using a Managed Care Plan's available historical enrollee diagnosis data grouped by a health-based risk assessment

model. A Managed Care Plan's plan factor is developed from the aggregated individual risk scores of the Managed Care Plan's prior month's enrollment. The plan factor modifies a Managed Care Plan's monthly capitation payment to reflect the health status of its enrollees.

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

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

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

Potential Enrollee — Pursuant to 42 CFR 438.10(a), an eligible Medicaid recipient who is subject to mandatory assignment or who may voluntarily elect to enroll in a given Managed Care Plan, but is not yet an enrollee of a specific Managed Care Plan.

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

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

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

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

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

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

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

Primary Dental Provider (PDP) — A Managed Care Plan staff or subcontracted dentist practicing as a general dentist or pediatric dentist who furnishes primary dental care and patient management services to an enrollee.

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

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

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

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

Provider — A person or entity eligible for a Medicaid provider agreement.

Provider-Preventable Condition (PPC) — A condition that meets the definition of a health care-acquired condition or other provider-preventable condition as defined in 42 CFR 447.26(b). PPCs include health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs) in inpatient hospital and inpatient psychiatric hospital settings, including crisis stabilization units (CSUs).

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

Provider Service Network (MMA Only) — A network established or organized and operated by a health care provider, or group of affiliated health care providers, that provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers. The PSN may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization. PSNs are paid by the Agency on a capitated/prepaid basis.. Also refer to the definition for LTC PSN. (See s. 409.912(4)(d), F.S.)

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

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

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

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

Region — The designated geographical area within which the Managed Care Plan is authorized by the Contract to furnish covered services to enrollees. The 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. May also be referred to as “service area.”

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

Registered Provider — A provider that is registered with FMMIS via the Managed Care Plan. Such providers cannot bill Medicaid through fee-for-service claims submissions. Registered providers are assigned a Medicaid provider identification number for encounter data purposes only.

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.

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

Risk Adjustment (also Risk-Adjusted) — In a managed health care setting, risk adjustment of capitation payments is the process used to distribute capitation payments across Managed Care Plans based on the expected health risk 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).

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

Sanctions — In relation to Section VIII.F: 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). A monetary sanction under Rule 59G-9.070, F.A.C. may be referred to as a “fine.” A sanction may also be referred to as a disincentive.

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

Serious Injury - Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else as defined in 42 CFR. 483.352.

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

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

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

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

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

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

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

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

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

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. Marketing scripts are intended to influence such individual to enroll in the particular Managed Care Plan.

State — State of Florida.

Statewide Inpatient Psychiatric Program (SIPP) — A twenty-four (24) hour inpatient residential treatment program funded by Medicaid that provides mental health services to children under twenty-one (21) years of age.

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

Subcontract — An agreement entered into by the Managed Care Plan for the delegation of some of its functions, services or responsibilities for providing services under this Contract.

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

Substitute Service (MMA only) — In relation to behavioral health, a service covered by the Managed Care Plan as a downward substitution for a covered behavioral health service for which the Managed Care Plan receives no direct payment from the Agency.

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

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

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

Systems — See Information Systems.

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

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

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

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

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

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.

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

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

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

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

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

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

Vendor — An entity submitting a proposal to become a Managed Care Plan.

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

Voluntary Enrollee — A Medicaid recipient who is not mandated to enroll in a Managed Care Plan, but chooses to do so.

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

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

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B. Acronyms

AAA — Area Agencies on Aging

ACCESS — Automated Community Connection to Economic Self-Sufficiency, the Department of Children and Families' public assistance service delivery system

ADL — Activities of Daily Living

ADRC — Aging and Disability Resource Center

AFCH — Adult Family Care Home

AHCA — Agency for Health Care Administration (Agency)

ALF — Assisted Living Facility

APD — Agency for Persons with Disabilities

ARNP — Advanced Registered Nurse Practitioner

BAP — Beneficiary Assistance Program

BMHC — Bureau of Managed Health Care

CAHPS — Consumer Assessment of Healthcare Providers and Systems

CAP — Corrective Action Plan

CARES — Comprehensive Assessment and Review for Long-Term Care Services

CBP — Customized Benefit Package

CCE — Community Care for the Elderly

CCP — Cultural Competency Program

CDC — Centers for Disease Control and Prevention

CFARS — Children's Functional Assessment Rating Scales

CEO — Chief Executive Officer

CFO — Chief Financial Officer

CFR — Code of Federal Regulations (cites may be searched online at: <http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR>)

CHCUP — Child Health Check-Up Program

CHD — County Health Department

CMS — Centers for Medicare & Medicaid Services

COPD — Chronic Obstructive Pulmonary Disease

CPR — Cardiopulmonary Resuscitation

CPT® — Physicians' Current Procedural Terminology

CSU — Crisis Stabilization Unit

CTD — Commission for the Transportation Disadvantaged

DCF — Department of Children and Families

DD — Developmental Disability or Developmental Disabilities

DEA — Drug Enforcement Administration
DFS — Department of Financial Services
DHHS — United States Department of Health & Human Services
DJJ — Department of Juvenile Justice
DME — Durable Medical Equipment
DOEA — Department of Elder Affairs
DOH — Department of Health
DSM — Direct Secure Messaging
EDI — Electronic Data Interchange
EH — Emotionally Handicapped
EIS — Early Intervention Services
EOMB — Explanation of Medicaid Benefits
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
ET — Eastern Time
F.A.C. — Florida Administrative Code
FARS — Functional Assessment Rating Scales
FAR — Florida Administrative Register
FFS — Fee-for-Service
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
HCBS — Home and Community-Based Services
HEDIS — Healthcare Effectiveness Data and Information Set
HIPAA — Health Insurance Portability and Accountability Act
HIPP — Health Insurance Premium Payment
HITECH Act — Health Information Technology for Economic and Clinical Health Act
HMO — Health Maintenance Organization

HSA — Hernandez Settlement Agreement
HSD — Bureau of Medicaid Health Systems Development
IADL — Instrumental Activities of Daily Living
ICP — Institutional Care Program
IBNR — Incurred But Not Reported
ITN — Invitation to Negotiate
LEIE — List of Excluded Individuals & Entities
LTC — Long-Term Care
LOC — Level of Care
MBHO — Managed Behavioral Health Organization
MCP — Managed Care Plan
MEDS — Medicaid Encounter Data System
MFCU — Medicaid Fraud Control Unit, Office of the Attorney General
MMA — Managed Medical Assistance
MPI — Medicaid Program Integrity Bureau, Office of the AHCA Inspector General
MPO — Medicaid Program Oversight
NCPDP — National Council for Prescribed Drug Programs
NCQA — National Committee for Quality Assurance
NMHPA — Newborns and Mothers Health Protection Act
NPI — National Provider Identifier
ODBC — Open Database Connectivity
OIG — Office of the Inspector General
OIR — Office of Insurance Regulation
PA — Physician Assistant
PACE — Program of All-Inclusive Care for the Elderly
PASRR — Preadmission Screening and Resident Review
PCCB — Per Capita Capitation Benchmark
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, as defined in 45 CFR 160 and 164, and 42 CFR 431.305(b)
PIP — Performance Improvement Project

PM — Performance Measure

PMAP — Performance Measures Action Plan

PPEC — Prescribed Pediatric Extended Care

PSN — Provider Service Network

QE — Quality Enhancement

QI — Quality Improvement

RFP — Request for Proposal

RHC — Rural Health Clinic

SACWIS — Statewide Automated Child Welfare Information System, also known as Florida Safe Families Network (FSFN, formerly HomeSafeNet)

SAM — System for Award Management

SAMH — Substance Abuse & Mental Health Office of the Florida Department of Children and Families

SFTP — Secure File Transfer Protocol

SIPP — Statewide Inpatient Psychiatric Program

SMMC — Statewide Medicaid Managed Care Program

SNIP — Strategic National Implementation Process

SOBRA — Sixth Omnibus Budget Reconciliation Act

SQL — Structured Query Language

SSI — Supplemental Security Income

TANF — Temporary Assistance for Needy Families

TGCS — Therapeutic Group Care Services

UM — Utilization Management

USDA — United States Department of Agriculture

WEDI — Workgroup for Electronic Data Interchange

WIC — Special Supplemental Nutrition Program for Women, Infants & Children

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Section II. General Overview

A. Background

Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC) and includes two programs: one for medical assistance (MMA) and one for long-term care (LTC).

B. Purpose

Under the SMMC program, the Agency contracts with Managed Care Plans, as defined in Section I, Definitions and Acronyms, to provide services to recipients.

The provisions in this Contract apply to all Managed Care Plans 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.

C. Responsibilities of the State of Florida

1. The Agency for Health Care Administration (Agency) is responsible for administering the Medicaid program. The Agency will administer contracts, monitor Managed Care Plan performance, and provide oversight in all aspects of Managed Care Plan operations. The Agency shall be responsible for imposing liquidated damages as a result of failure to meet any aspect of the responsibilities of the Contract, sanctions for Contract violations or other non-compliance, requiring corrective actions for a violation of or any other non-compliance with this Contract
2. The state has sole authority for determining eligibility for Medicaid. The Department of Children and Families acts as the Agency's agent by enrolling recipient in Medicaid. 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 agent(s) shall be responsible for enrollment, including algorithms to assign mandatory potential enrollees, and disenrollment, including determinations regarding involuntary disenrollment, in accordance with this Contract.
3. The Department of Elder Affairs shall assist the Agency in determining clinical eligibility for enrollment in LTC managed care plans, monitor LTC managed care plan performance and measure quality of service delivery, assist enrollees and their families to address complaints with the LTC managed care plans, facilitate working relationships between LTC managed care plans and providers serving elders and adults with disabilities, and perform other functions specified in a memorandum of agreement between the Agency and DOEA.

4. The state shall be responsible for accepting complaints directly from Medicaid recipients and providers, operating the Beneficiary Assistance Panel, conducting Medicaid Fair Hearings, as well as reviewing complaints, grievances and appeals reported by Managed Care Plans to ensure appropriate resolution and monitor for contractual compliance, plan performance and trends that may reflect policy changes or operational changes needed.
5. The Agency shall be responsible for promulgating coverage requirements applicable to Managed Care Plan through the Florida Medicaid Coverage and Limitations Handbooks, Provider General Handbook, Medicaid fee schedules and the Florida Medicaid State Plan, as well as policy transmittals specific to changes in federal and state law, rules or regulations and federal Centers for Medicare and Medicaid Services waivers applicable to this Contract.
6. The Agency shall be responsible for providing Managed Care Plans with instructions for customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services, as well as evaluating the Managed Care Plan's customized benefits packages for actuarial equivalency and sufficiency of benefits.
7. 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 meet the enrollment levels in this Contract.
8. The Agency shall be responsible for establishing standards and requirements for quality improvement (QI), including performance measures, targets, improvement plans, satisfaction surveys and medical/case record reviews, and providing instructions to Managed Care Plans through the Managed Care Plan Report Guide and Performance Measures Specifications Manual.
9. The Agency shall be responsible for contracting with an external quality review organization (EQRO) and conducting other QI activities, to include but not limited to audits of medical/case 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. The Agency shall be responsible for establishing incentives to high-performing Managed Care Plans and restricting enrollment activities if the Managed Care Plans do not meet acceptable quality improvement and performance indicators.
10. The Agency shall be responsible for the operations of the Florida Medicaid Management Information System (FMMIS) and contracting with the state's fiscal agent to exchange data with Managed Care plans, enroll Medicaid providers, process Medicaid claims, distribute Medicaid forms and publications, and send written notification and information to all potential enrollees. 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 Health Information Technology (HIT) and Health Information Exchange (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 www.FloridaHealthFinder.gov.

11. 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, Florida Statutes, and to determine Managed Care Plan compliance with contractual requirements and to measure health outcomes of Medicaid recipients. 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, Pharmacy Payer Specifications.
12. 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 Medicaid program integrity program, which includes but is not limited to such monitoring as may be done as desk reviews or on site as determined by the Agency. These reviews may be conducted by various Agency bureaus and the Agency will 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 Medicaid Program Integrity (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 Medicaid Fraud Control Unit (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.
13. The Agency shall be responsible for administration of the Medicaid prescribed drug program, including negotiating supplemental rebates and favorable net pricing, and maintaining the Medicaid Pharmaceutical and Therapeutics (P&T) Committee reviews drug options within to maintain an array of choices for prescribers within each therapeutic class on the Medicaid Preferred Drug List (PDL). In order to promote an effective transition of recipients during implementation of the SMMC, the Agency will require Managed Care Plans use the Medicaid PDL for at least the first year of operation.
14. The Agency shall be responsible for making payment to the Managed Care Plan as specified in Section IX, Method of Payment, adjusting applicable capitation rates to reflect budgetary changes in the Medicaid program, and reconciling payments for SIPPs, nursing facilities and hospices pursuant to ss. 409.9876(2), F.S., 409.983(6) and 409.983(7), F.S.
15. In accordance with s. 409.967(3), F.S., the Agency shall be responsible for verifying the Managed Care Plan's achieved savings rebate as specified in this Contract. The Agency will contract with independent certified public accountants to conduct compliance audits for the purpose of auditing Managed Care Plan financial information in order to determine and validate the Managed Care Plan's achieved savings rebate.

D. General Responsibilities of the Managed Care Plan

1. The Managed Care Plan shall comply with all provisions of this Contract, including all attachments, applicable exhibits, and any amendments and shall act in good faith in the performance of the Contract provisions. The Managed Care Plan agrees that failure to comply with all provisions of this Contract may result in the assessment of sanctions and/or termination of the Contract, in whole or in part, in accordance with Section XI, Sanctions. The Managed Care Plan agrees that failure to meet any aspect of the responsibilities of the Contract may result in the assessment of damages in accordance with Section XIII, Liquidated Damages.
2. The Managed Care Plan shall comply with all requirements of the Managed Care Plan Report Guide referenced in Section XIV, Reporting Requirements, and other applicable requirements of this Contract. The Managed Care Plan may be required to provide to the Agency or its agents information or data relative to this Contract. In such instances, and at the direction of the Agency, the Managed Care Plan shall fully cooperate with such requests and furnish all 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 verify that data and information it submits to the Agency is accurate.
3. The Managed Care Plan shall develop and maintain written policies and procedures to implement and comply with all the provisions of this Contract.
4. The Managed Care Plan shall submit all policies and procedures to the Agency as required by this Contract. Unless specified elsewhere in the Contract, policies and 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 policies and procedures related to this Contract shall be submitted to the Agency upon request. If the Agency has requested policies and procedures, the Managed Care Plan shall notify the Agency of any subsequent changes in such materials. Comprehensive LTC managed care plans shall submit one (1) set of policies and procedures that include all MMA and LTC contractually required provisions.
5. The Managed Care Plan shall submit model provider contract templates to the Agency for review as specified in Section VII, Provider Network.
6. The Managed Care Plan shall submit any proposed delegation of responsibility to the Agency for prior written approval as required in Section VIII.B., Subcontracts. Except as otherwise provided in this Contract, the Managed Care Plan shall submit subcontracts, to the Agency for review as specified in Section VIII.B., Subcontracts. Unless specified elsewhere in the Contract, subcontracts shall be submitted to the Agency at least forty-five (45) days before the proposed effective date of the subcontract or change.
7. The Managed Care Plan shall submit enrollee, community outreach and marketing materials related to this Contract to the Agency for review and approval before implementation. Any changes in such materials must be prior approved by the Agency before they take effect.

- a. The Managed Care Plan shall submit written materials for Agency review as follows unless specified elsewhere in the Contract:
 - (1) Enrollee material shall be submitted to the Agency at least seventy-five (75) days before the proposed use of the enrollee material or revised material.
 - (2) Marketing and community outreach material shall be submitted to the Agency at least forty-five (45) days before the proposed use of the marketing material or revised material.
 - (3) Other written materials shall be submitted to the Agency upon request.
 - 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 marketing materials inaccurate or misleading.
 - c. To expedite the review of previously disapproved material, the Managed Care Plan shall clearly indicate all changes/updates made to a material when it is resubmitted. The Managed Care Plan may meet this requirement by highlighting any text changes and/or inserting notes to altered areas on the material. The Managed Care Plan may develop an alternative process for identifying changes, provided the Managed Care Plan discusses the alternative with and receives approval from the Agency.
 - d. The Managed Care Plan shall ensure that non-English enrollee and marketing materials are based on previously approved English versions of the same material. The Managed Care Plan shall ensure that any changes or revisions that are made to the English version are accurately reflected in non-English materials and re-submitted to the Agency as required.
 - e. The Managed Care Plan shall provide written notice of such any changes affecting enrollees to those enrollees at least thirty (30) days before the effective date of change.
8. 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.
 9. The Managed Care Plan shall accept Medicaid recipients without restriction and in the order in which they enroll. The Managed Care Plan shall not discriminate on the basis of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services and shall not use any policy or practice that has the effect of such discrimination.
 10. 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 through written materials, telephone, electronic and face-to-face communication.

11. The Managed Care Plan shall establish and maintain a grievance system for reviewing and resolving enrollee complaints, grievances and appeals. Components must include a complaint process, a grievance process, an appeal process, access to an applicable review outside the Managed Care Plan (Beneficiary Assistance Program), and access to a Medicaid Fair Hearing through the Department of Children and Families.
12. The Managed Care Plan shall ensure the provision of services in sufficient amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services defined and specified in this Contract.
13. The Managed Care Plan shall comply with all current promulgated Florida Medicaid handbooks (Handbooks) as noticed in the Florida Administrative Register (FAR), and incorporated by reference in rules relating to the provision of services, except where the provisions of the Contract alter the requirements set forth in the Handbooks and Medicaid fee schedules.
14. MMA Managed Care Plans and Comprehensive Managed Care Plans shall provide all prescription drugs listed in the Agency's Medicaid Preferred Drug List (PDL) in accordance with the following:
 - a. Prior authorization, step-edit therapy and protocols for PDL drugs may be no more restrictive than those posted on the Agency website.
 - b. Certain drugs that are required to be covered by Medicaid are not listed on the PDL, and the AHCA fee-for-service program requires prior authorization because of clinical concerns or the risk of fraud or misuse. Plans may use the same prior authorization criteria that are posted to the AHCA website, or may develop their own criteria that are no more restrictive.
 - c. No sooner than the end of the first year of operation, the Managed Care Plan may develop a Managed Care Plan-specific PDL for the Agency's consideration, if requested by the Agency at that time. During the time that the Managed Care Plan is utilizing the Agency's PDL, the Managed Care Plan shall participate in the Agency's Pharmaceutical and Therapeutics Committee, as requested by the Agency.
15. The Managed Care Plan shall provide care coordination/case management services offer and coordinate access to quality enhancements (QEs), and provide approved expanded benefits as specified under this Contract.
16. Managed Care Plan shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements of this Contract, including contracting with a sufficient number of credentialed providers to provide all covered services to enrollees and ensuring that each covered service is provided promptly and is reasonably accessible and that each enrollee is afforded choice of participating providers in accordance with 42 CFR 431.51.

17. 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, including provider complaints and disputes proposed actions, billing, payment and service authorizations.
18. The Managed Care Plan shall have a quality improvement program that ensures enhancement of quality of care and emphasizes improving the quality of patient outcomes, including establishing metrics for monitoring the quality and performance of each participating provider. evaluating the provider's performance and determining continued participation in the network.
19. The Managed Care Plan shall cooperate with the Agency and the EQRO and shall have a cooperative agreement with the Florida Medical School Quality Network when the network becomes operational, in accordance with s. 409.975(2), F.S.
20. The Managed Care Plan shall established and maintain a utilization management system to monitor utilization of services, including an automated service authorization systems 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 solely because of the enrollee's diagnosis, type of illness or condition.
21. The Managed Care Plan shall meet all requirements for doing business in the State of Florida, and 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. The Managed Care Plan shall comply with all pertinent Agency rules in effect throughout the duration of the Contract.
22. 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.
23. 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.
24. The Managed Care Plan shall encourage its providers to connect to the Florida Health Information Exchange (HIE) and promote provider use of the HIE, including educating providers on the benefits of using the HIE and the availability of incentive funding. The Managed Care Plan shall encourage network providers to participate in the Agency's Direct Secure Messaging (DSM) service when it is implemented.

25. The Managed Care Plan shall collect and submit encounter data in accordance with generally accepted industry best practices and the requirements of this Contract. The Managed Care Plan shall ensure that its provision of provider information to the Agency is sufficient to ensure that its providers are recognized as participating providers of the Managed Care Plan for plan selection and encounter data acceptance purposes, and shall participate in Agency-sponsored workgroups directed at continuous improvements in encounter data quality and operations.
26. 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 standards and timeframes specified by the Agency within 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.
27. The Managed Care Plan shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall have adequate staffing, resources, internal controls, and policies and procedures to prevent, reduce, detect, correct and report known or suspected fraud and abuse and overpayment activities. The Managed Care Plan shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect and overpayment issues.
28. 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 XIV, Reporting Requirements, the Managed Care Plan Report Guide and other Agency instructions. The Managed Care Plan shall verify that information it submits to the Agency is accurate.
29. Prior to enrolling recipients in the Managed Care Plan in each authorized Region, the Agency will conduct a plan-specific readiness review to assess the Managed Care Plan's readiness and ability to provide services to recipients. The plan readiness review may include, but is not limited to, desk and onsite review of plan policies and procedures and corresponding documents, the plan's provider network and corresponding Contracts, a walk-through of the plan's operations, 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. The Agency will not enroll recipients into the Managed Care Plan until the Agency has determined that the Managed Care Plan meets all Contract requirements.
- a. The Managed Care Plan shall provide the Agency, 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:
- (1) 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 Section 409.967(2)(c)(1), Florida Statutes; and

- (2) 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.
- b. If the Managed Care Plan does not meet the plan readiness review deadlines established by the Agency for its respective Region, the following options may be exercised by the Agency:
 - (1) The Agency may grant an extension for the Managed Care Plan to correct deficiencies; however the Managed Care Plan will lose the initial enrollment of eligible recipients into the affected region(s) and will lose its transition enrollment, if applicable; and /or
 - (2) The Agency will impose liquidated damages for failure to meet plan readiness review deadlines and/or specific plan readiness goals set by the Agency.
- c. After an extension is granted by the Agency, the Managed Care Plan will have until the penultimate Saturday before the respective Region's enrollment effective date, as established by the Agency, to be deemed ready for recipient enrollment. If a Managed Care Plan is not deemed ready for recipient enrollment by the Agency by the penultimate Saturday before the respective Region enrollment effective date, the Contract between the Managed Care Plan and the Agency will be terminated.

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Section III. Eligibility and Enrollment

A. Eligibility

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

1. Mandatory Populations

- a. Recipients in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan:
 - (1) Temporary Assistance to Needy Families (TANF);
 - (2) SSI (Aged, Blind and Disabled);
 - (3) Hospice;
 - (4) Low Income Families and Children;
 - (5) Institutional Care;
 - (6) Medicaid (MEDS) - Sixth Omnibus Budget Reconciliation Act (SOBRA) for children born after 9/30/83 (age 18 to 19);
 - (7) MEDS AD (SOBRA) for aged and disabled;
 - (8) Protected Medicaid (aged and disabled);
 - (9) Full Benefit Dual Eligibles (Medicare and Medicaid -FFS);
 - (10) Full Benefit Dual Eligibles - Part C – Medicare Advantage Plans Only; and
 - (11) The Florida Assertive Community Treatment Team (FACT Team).
- b. Additional mandatory recipient eligibility criteria for MMA and Comprehensive LTC managed care plans are specified in the MMA Exhibit.
- c. Additional mandatory recipient eligibility criteria for LTC and Comprehensive LTC managed care plans are specified in the LTC Exhibit.

2. Voluntary Populations

Certain recipients may voluntarily enroll in a Managed Care Plan to receive services. These recipients are not subject to mandatory open enrollment periods.

- a. Voluntary recipients for MMA and Comprehensive LTC managed care plans are specified in the MMA Exhibit.
- b. Voluntary recipients for LTC and Comprehensive LTC managed care plans are specified in the LTC Exhibit.

3. Excluded Populations

- a. Recipients in any eligibility category not listed in sub-items A.1. or A.2. above are excluded from enrollment in a managed care plan. This includes, but is not limited to, recipients in the following eligibility categories:
 - (1) Presumptively eligible pregnant women;
 - (2) Family planning waiver;
 - (3) Women enrolled through the Breast and Cervical Cancer Program;
 - (4) Emergency shelter/Department of Juvenile Justice (DJJ) residential;
 - (5) Emergency assistance for aliens;
 - (6) Qualified Individual (QI);
 - (7) Qualified Medicare beneficiary (QMB) without other full Medicaid coverage;
 - (8) Special low-income beneficiaries (SLMB) without other full Medicaid coverage;
 - (9) Working disabled; and
 - (10) Recipients eligible for the Medically Needy program.
- b. In addition, regardless of eligibility category, the following recipients are excluded from enrollment in a Managed Care Plan:
 - (1) Recipients in the Health Insurance Premium Payment (HIPP) program.
- c. Additional excluded populations for LTC and Comprehensive LTC managed care plans are specified in the LTC Exhibit.

4. Medicaid Pending for Home and Community-Based Services

- a. Medicaid pending for HCBS is specified in the LTC Exhibit.

B. Enrollment

1. General Provisions

- a. Only Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to enroll and receive services from the Managed Care Plan.
- b. Each recipient shall have a choice of Managed Care Plans and may select any authorized Managed Care Plan unless the Managed Care Plan is restricted by this Contract to a specific population that does not include the recipient.
- c. 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 will use an established algorithm to assign mandatory potential enrollees who do not select a Managed Care Plan during their thirty- (30) day choice period. The process may differ for MMA Managed Care Plans, LTC Managed Care Plans and Comprehensive LTC Managed Care Plans as required by 409.977, F.S. and s. 409.984, F.S. and any other state law and federally approved State Plan amendments and/or waivers. The Managed Care Plan shall coordinate with the Agency and its enrollment broker as necessary for all enrollment and disenrollment functions.
- d. The Agency or its agents will notify the Managed Care Plan of an enrollee's selection or assignment to the Managed Care Plan. The Agency or its enrollment broker will send written confirmation to enrollees of the chosen or assigned Managed Care Plan. Notice to the enrollee will be sent by surface mail. Notice to the Managed Care Plan will be by file transfer.

For MMA Managed Care Plans, if the enrollee has not chosen a PCP, the Agency's confirmation notice will advise the enrollee that a PCP will be assigned by the Managed Care Plan.

- e. Enrollment in a Managed Care Plan, whether chosen or assigned, will be effective at 12:01 a.m. on the first calendar day of the month following a selection or assignment that occurs between the first calendar day of the month and the penultimate Saturday of the month. For those enrollees who choose or are assigned a Managed Care Plan between the Sunday after the penultimate Saturday and before the last calendar day of the month, enrollment in a Managed Care Plan will be effective on the first calendar day of the second month after choice or assignment.
- f. Conditioned on continued eligibility, mandatory enrollees have a lock-in period of up to twelve (12) consecutive months. After an initial ninety- (90) day change period, mandatory enrollees may disenroll from the Managed Care Plan only for cause. The Agency or its enrollment broker will notify enrollees at least once every twelve (12) months, and for mandatory enrollees at least sixty (60) days before the lock-in period ends that an open enrollment period exists giving them an opportunity to change Managed Care Plans. Mandatory enrollees who do not make a change during open enrollment will be deemed to have chosen to remain with the current Managed Care Plan, unless that Managed Care Plan no longer participates. In that case, the enrollee will be transitioned to a new Managed Care Plan.

- g. The Agency will automatically reinstate an enrollee into the Managed Care Plan in which the person was most recently enrolled if the enrollee has a temporary loss of eligibility. In this instance, for mandatory enrollees, the lock-in period will continue as though there had been no break in eligibility, keeping the original twelve- (12) month period.
 - (1) For LTC managed care plans, the “temporary loss period” is defined as no more than sixty (60) days.
 - (2) For MMA managed care plans, the “temporary loss period” is defined as no more than one hundred eighty (180) days.
 - (3) For Comprehensive LTC managed care plans, the “temporary loss period” is defined as no more than sixty (60) days for recipients with LTC benefits and one hundred eighty (180) days for recipients without LTC benefits.
- h. If a temporary loss of eligibility causes the enrollee to miss the open enrollment period, the Agency will enroll the person in the Managed Care Plan in which he or she was enrolled before loss of eligibility. The enrollee will have ninety (90) days to disenroll without cause.

2. Enrollment in an MMA Specialty Plan

- a. In addition to meeting the eligibility requirements listed in this section, a Specialty Plan may enroll eligible recipients who meet specific criteria by age, medical condition and/or diagnoses as defined in the Section III.A of the applicable Specialty Plan Exhibit.
- b. The Agency or its agent will be responsible for identifying the defined specialty population and enrollment of such recipients in a Specialty Plan in accordance with this section. Clinical assessment and/or referral may be required to determine eligibility for Specialty Plan enrollment, as defined in Section III.B of the applicable Specialty Plan Exhibit.
 - (1) If clinical assessment and/or referral are required to be conducted by the Specialty Plan to determine eligibility for Specialty Plan enrollment, as defined in this Contract, the Specialty Plan shall establish and maintain policies and procedures to accomplish such assessments and /or referrals.
 - (2) The Specialty Plan shall submit clinical assessments and/or referral policies and procedures for approval by the Agency on an annual basis, at a date determined by the Agency.
 - (3) The Agency reserves the right to make adjustments to administrative data or other mechanisms used to identify recipients eligible to enroll in a Specialty Plan.
- c. In addition to benefits required in Section V, Covered Services and the MMA Exhibit, the Specialty Plan shall provide such other services and care coordination and/or

case management services to eligible recipients enrolled in a Specialty Plan as defined in Section V.E of the applicable Specialty Plan Exhibit.

- d. In addition to the provider network standards required in Section VI, Provider Network and the MMA Exhibit, the Specialty Plan shall comply with such other provider network standards as defined in Section VI.A of the applicable Specialty Plan Exhibit.
- e. In addition to the quality management activities required in Section VII, Quality and Utilization Management and the MMA Exhibit, the Specialty Plan shall comply with such other requirements for quality management as defined in Section VII of the applicable Specialty Plan Exhibit.

3. Verification of Enrollment

- a. The Managed Care Plan shall review its X12-834 enrollment files in accordance with the schedule specified in the file exchange calendar posted on the Florida Medicaid provider portal to ensure that all enrollees are eligible to receive services from the Managed Care Plan, including that:
 - (1) Each enrollee of the Managed Care Plan is residing in the same region in which they were enrolled; and
 - (2) Each enrollee of the Managed Care Plan is not ineligible for services under the MMA, Specialty, Comprehensive LTC or LTC Managed Care Plan, respectively, in accordance with this section and the applicable Exhibits.
- 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) days of receipt of the enrollment file.

4. Notification of Enrollee Pregnancy

- a. Upon notification that an enrollee is pregnant or has given birth to a newborn, the Managed Care Plan shall notify DCF in a manner prescribed by the Agency.
- b. MMA and Comprehensive LTC Managed Care Plans shall notify DCF and follow the unborn activation and newborn enrollment processes in accordance with the MMA Exhibit.

5. Maximum Enrollment Levels

- a. The Agency assigns the Managed Care Plan an authorized maximum enrollment level for the region(s), which cannot be exceeded by the Managed Care Plan. Any increases requested by the Managed Care Plan must be approved by the Agency.
- b. The Agency does not guarantee that the Managed Care Plan will receive any particular enrollment level; however, the enrollment level may not be exceeded unless a plan-specific enrollment level increase has been approved by the Agency.

- c. The Agency must approve in writing any increase or decrease in the Managed Care Plan's maximum enrollment level for the region(s) to be served as specified in this Contract.

6. Temporarily Stopping or Limiting Enrollment

- a. The Managed Care Plan may ask the Agency to halt or reduce enrollment temporarily for any enrollment amount above the Agency's set regional enrollment limit if continued full enrollment would exceed the Managed Care Plan's capacity to provide required services under the Contract. The Agency may not approve or may also limit Managed Care Plan enrollments when such action is considered to be in the Agency's best interest in accordance with the provisions of this Contract.
- b. For MMA Managed Care Plans, if a request to halt or reduce enrollment temporarily is received and approved by the Agency, it shall not affect the enrollment of newborns as specified in the MMA Exhibit.

7. Increasing Enrollment Levels

- a. The Managed Care Plan may request a higher regional enrollment level, in writing, to the Agency; however, the Managed Care Plan must be able to serve the enrollment level.
- b. If the Managed Care Plan requests an increase in the regional enrollment level, the Agency will review such request and approve it in writing if the Agency determines the Managed Care Plan's regional provider network is sufficient to meet the increased enrollment level requested and the Managed Care Plan has satisfactorily performed the terms of the Contract, and the Agency has approved the Managed Care Plan's administrative, financial and service resources, as specified in this Contract, in support of the requested enrollment level. If after an enrollment increase is approved by the Agency and a Managed Care Plan determines lower enrollment levels are desired, the Managed Care Plan may request an enrollment level decrease, as long as the decrease requested is not below the required enrollment levels for the region.
- c. If the Agency has approved the Managed Care Plan's regional enrollment level increase, the Managed Care Plan must then maintain a provider network, as specified in this Contract, sufficient to meet the increased recipient enrollment level, and this enrollment level shall become the Managed Care Plan's maximum enrollment level upon execution of a Contract amendment stating such.

C. Disenrollment

1. General Provisions

- a. The Agency will notify enrollees of their right to request disenrollment. The Agency will process all disenrollments from the Managed Care Plan. The Agency or its agent will make final determinations about granting disenrollment requests and will notify the Managed Care Plan by file transfer and the enrollee by surface mail of any

disenrollment decision. Enrollees dissatisfied with an Agency determination may request a Medicaid Fair Hearing.

- b. An enrollee may request disenrollment at any time. The Agency or its enrollment broker performs disenrollment as follows:
 - (1) For good cause, at any time.
 - (2) Without cause, for mandatory enrollees at the times specified in Section III. C.4.
 - (3) Without cause, for voluntary enrollees at any time.
- c. The Managed Care Plan shall ensure that it does not restrict the enrollee's right to disenroll voluntarily in any way.
- d. The Managed Care Plan or its subcontractors, providers or vendors shall not provide or assist in the completion of a disenrollment request or assist the Agency's enrollment broker in the disenrollment process.
- e. The Managed Care Plan shall ensure that enrollees who are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal on disenrollment except for the following reasons:
 - (1) Moving out of the region;
 - (2) Loss of Medicaid eligibility;
 - (3) Determination that an enrollee is in an excluded population, as defined in this Contract; or
 - (4) Enrollee death.

2. Disenrollment Due to Enrollee Change of Region

- a. On the first day of the month after receiving notice from FMMIS that the enrollee has moved to another region, the Agency will automatically disenroll the enrollee from the Managed Care Plan and treat the recipient as if the recipient is a new Medicaid recipient eligible to choose another Managed Care Plan pursuant to the Agency's enrollment process (see s. 409.969(2)d., F.S.) but without having to be placed on the long term care wait list if enrolled in a LTC Managed Care Plan.

3. Disenrollment for Good Cause

- a. A mandatory enrollee may request disenrollment from the Managed Care Plan for cause at any time. Such request shall be submitted to the Agency or its enrollment broker.
- b. The following reasons constitute cause for disenrollment from the Managed Care Plan:

- (1) The enrollee does not live in a region where the Managed Care Plan is authorized to provide services, as indicated in FMMIS.
- (2) The provider is no longer with the Managed Care Plan.
- (3) The enrollee is excluded from enrollment.
- (4) A substantiated marketing or community outreach violation has occurred.
- (5) The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
- (6) The enrollee has an active relationship with a provider who is not on the Managed Care Plan's panel, but is on the panel of another Managed Care Plan. "Active relationship" is defined as having received services from the provider within the six months preceding the disenrollment request.
- (7) The enrollee is in the wrong Managed Care Plan as determined by the Agency.
- (8) The Managed Care Plan no longer participates in the region.
- (9) The state has imposed intermediate sanctions upon the Managed Care Plan, as specified in 42 CFR 438.702(a)(3).
- (10) The enrollee needs related services to be performed concurrently, but not all related services are available within the Managed Care Plan network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
- (11) The Managed Care Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- (12) The enrollee missed open enrollment due to a temporary loss of eligibility.
- (13) Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers experienced in dealing with the enrollee's health care needs; or fraudulent enrollment.

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

4. Disenrollment without Cause

- a. A mandatory enrollee subject to open enrollment may submit to the Agency or its enrollment broker a request to disenroll from the Managed Care Plan. This may be done without cause at the following times:

- (1) During the ninety (90) days following the enrollee's initial enrollment, or the date the Agency or its enrollment broker sends the enrollee notice of the enrollment, whichever is later;
 - (2) At least every twelve (12) months during a recipient's annual open enrollment period;
 - (3) If the temporary loss of Medicaid eligibility has caused the enrollee to miss the open enrollment period;
 - (4) When the Agency or its enrollment broker grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); and
 - (5) During the thirty (30) days after the enrollee is referred for hospice services in order to enroll in another Managed Care Plan to access the enrollee's choice of hospice provider.
- b. Voluntary enrollees not subject to open enrollment may disenroll without cause at any time.

5. 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.
- b. The following are acceptable reasons for which the Managed Care Plan may submit involuntary disenrollment request:
 - (1) Fraudulent use of the enrollee identification (ID) card. In such cases the Managed Care Plan shall notify MPI of the event.
 - (2) Falsification of prescriptions by an enrollee. In such cases the Managed Care Plan shall notify MPI of the event.
 - (3) The enrollee's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the Managed Care Plan seriously impairs the organization's ability to furnish services to either the enrollee or other enrollees.
 - (a) This provision does not apply to enrollees with medical or mental health diagnoses if the enrollee's behavior is attributable to the diagnoses.
 - (b) An involuntary disenrollment request related to enrollee behavior must include documentation that the Managed Care Plan:
 - (i) Provided the enrollee at least one (1) oral warning and at least one (1) written warning of the full implications of the enrollee's actions;
 - (ii) Attempted to educate the enrollee regarding rights and responsibilities;

- (iii) Offered assistance through care coordination/case management that would enable the enrollee to comply; and
 - (iv) Determined that the enrollee's behavior is not related to the enrollee's medical or mental health condition.
 - (4) The enrollee will not relocate from an assisted living facility or adult family care home that does not, and will not, conform to HCB characteristics required by this Contract.
- 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) Uncooperative or disruptive behavior resulting from the enrollee's special needs (with the exception of Section III.C.5.b.(3)(b));
 - (7) Attempt to exercise rights under the Managed Care Plan's grievance system; or
 - (8) Request of a provider to have an enrollee assigned to a different provider out of the Managed Care Plan.
- d. The Managed Care Plan shall promptly submit such disenrollment requests to the Agency. In no event shall the Managed Care Plan submit a disenrollment request at such a date as would cause the disenrollment to be effective later than forty-five (45) days after the Managed Care Plan's receipt of the reason for involuntary disenrollment. The Managed Care Plan shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.
- e. When the Managed Care Plan requests an involuntary disenrollment, it shall notify the enrollee in writing that the Managed Care Plan is requesting disenrollment, the reason for the request, and an explanation that the Managed Care Plan is requesting that the enrollee be disenrolled in the next Contract month, or earlier if necessary. Until the enrollee is disenrolled, the Managed Care Plan shall be responsible for the provision of services to that enrollee.
- f. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the Agency. Any request not approved is final and not subject to Managed Care Plan dispute or appeal.

6. Effective Date of Disenrollment

- a. The effective date of an approved disenrollment shall be the last calendar day of the month in which disenrollment was made effective by the Agency or its enrollment broker. In no case shall disenrollment be later than the first calendar day of the second month following the month in which the enrollee or the Managed Care Plan files the disenrollment request. If the Agency or its enrollment broker fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved as of the date Agency action was required.
- b. When disenrollment is necessary because an enrollee loses Medicaid eligibility, disenrollment shall be at the end of the month in which eligibility was lost.

D. Marketing

1. General Provisions

- a. The Managed Care Plan shall not market nor distribute any marketing materials without first obtaining Agency approval.
- b. The Managed Care Plan shall ensure compliance with the Contract and 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 (see 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.; and s. 626.611, F.S.). If the Agency finds that the Managed Care Plan failed to comply with applicable contract, federal or state marketing requirements, the Agency may take compliance action, including sanctions (see Section XI, Sanctions).
- c. The Managed Care Plan shall document compliance with applicable marketing requirements.
- d. 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.
- e. 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.
- f. The Managed Care Plan shall not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, actual or perceived health status, claims experience, medical history, genetic information, evidence of insurability or geographic location.
- g. The Managed Care Plan may use social/electronic media (e.g., Facebook, Twitter, Scan Code, or QR Code). However, the Agency considers such tools to be marketing materials, and the Managed Care Plan shall ensure that the use of

social/electronic media complies with the requirements of this Contract and federal and state law.

- h. In accordance with s. 409.912, F.S., marketing to Medicaid recipients in State offices is prohibited unless approved in writing and approved by the affected state agency when solicitation occurs in the office of another state agency. The Agency shall ensure that marketing representatives stationed in state offices market to Medicaid recipients only in designated areas and in such a way as to not interfere with the Medicaid recipients' activities in the State office. The Managed Care Plan shall not use any other State facility, program, or procedure in the recruitment of Medicaid recipients 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.

2. Prohibited Statements and Claims

- a. The Managed Care Plan shall ensure that marketing materials are accurate and do not mislead, confuse, or defraud recipients. The Managed Care Plan shall not distribute marketing materials that are materially inaccurate, misleading, or otherwise make material misrepresentations.
- b. The Managed Care Plan shall not, either orally or in writing:
 - (1) Claim that the recipient must enroll in the Managed Care Plan in order to obtain benefits or in order to not lose benefits;
 - (2) Claim that it is recommended or endorsed by CMS, the federal or state government, or similar entity.
 - (3) Claim that the state or the county recommends that a Medicaid recipient enroll with the Managed Care Plan.
 - (4) Claim that marketing representatives 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.
 - (5) Claim that a Medicaid recipient will lose benefits under the Medicaid program or any other health or welfare benefits to which the recipient is legally entitled if the recipient does not enroll with the Managed Care Plan.

3. Prohibited Activities

- a. The Managed Care Plan shall not enlist the assistance of any employee, officer, elected official or agency of the state including the state's enrollment broker in recruitment of Medicaid recipients except as authorized in writing by the Agency.
- b. 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.

4. Marketing of Multiple Lines of Business

- a. Pursuant to 42 CFR 438.104(b)(1)(iv), the Managed Care Plan shall not influence enrollment in conjunction with the sale or offering of any private insurance. However, the Managed Care Plan may market other lines of business (both health-related and non health-related), other than private insurance, provided that such materials are in compliance with applicable state law governing the other lines of business.
- b. The Managed Care Plan shall ensure that marketing materials sent to recipients or enrollees describing other health-related lines of business contain instructions that describe how recipients or enrollees may opt out of receiving such communications. The Managed Care Plan shall ensure that recipients and enrollees who ask to opt out of receiving future marketing communications are not sent such communications. In marketing multiple lines of business, the Managed Care Plan shall comply with HIPAA rules regarding use of enrollee information.
- c. If the Managed Care Plan advertises multiple lines of business within the same marketing document, it shall keep the Managed Care Plan's lines of business clearly and understandably distinct from the Medicaid Managed Care Plan.
- d. The Managed Care Plan shall not include enrollment applications for non-Medicaid lines of business in mailings that combine Medicaid Managed Care Plan information with other product information.

5. Compliance with State Licensure and Appointment Laws

- a. In order to use marketing agents to market, the Managed Care Plan shall comply with applicable state licensure and/or appointment laws.
- b. The Managed Care Plan shall register each marketing agent with the Agency within fifteen (15) days after the marketing agent's appointment to the Managed Care Plan. The registration shall consist of providing the Agency with the agent's name; address; telephone number; cellular telephone number; DFS license number; the names of all Managed Care Plans with which the marketing agent was previously employed; and the name of the Managed Care Plan with which the marketing agent is presently employed.
- c. The Managed Care Plan shall implement and maintain procedures to ensure the use of background and reference checks in its marketing agent hiring practices.
- d. The Managed Care Plan shall maintain and make available to the Agency upon request evidence of current licensure and contractual agreements with all marketing representatives used by the Managed Care Plan to recruit Medicaid recipients.
- e. The Managed Care Plan shall ensure that all marketing agents (including employed agents) are trained and tested annually on state and federal requirements and on details specific to the Managed Care Plan. The Managed Care Plan shall ensure that its training and testing programs are designed and implemented in a way that

maintains the integrity of the training and testing and shall provide this information to the Agency upon request.

- f. The Managed Care Plan shall report to DFS and the Agency any marketing agent who violates any requirements of this Contract, within fifteen (15) days of knowledge of such violation.
- g. The Managed Care Plan shall report the termination of any marketing agents and the reasons for the termination to the state in which the marketing agent has been appointed in accordance with the state appointment law. The Managed Care Plan shall submit reports to the Agency as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

6. Marketing through Unsolicited Contacts Prohibited

- a. 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, including but not limited to:
 - (1) Leaving information such as a leaflet or flyer at a residence or car.
 - (2) Approaching recipients in common areas (e.g., parking lots, hallways, lobbies, sidewalks, etc.).
 - (3) Telephonic or electronic solicitation, including leaving electronic voicemail messages or text messaging.
- b. If the Managed Care Plan has a pre-scheduled personal/individual marketing appointment that becomes a “no-show,” the Managed Care Plan may leave information at the no-show recipient’s residence.
- c. If the Managed Care Plan receives permission to call or otherwise contact a recipient, 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 recipient after the recipient’s inquiry or questions have been answered by the Managed Care Plan.

7. Telephonic Activities and Scripts

- a. The Managed Care Plan may contact enrollees at any time to discuss Managed Care Plan business. The Managed Care Plan shall not engage in the following telephonic activities:
 - (1) Bait-and-switch strategies - making unsolicited calls about other business as a means of generating leads for the Managed Care Plan.
 - (2) 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 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.

- (3) 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.
 - (4) Calls to recipients who attended a marketing event, unless the recipient gave express permission at the event for a follow-up call (including documentation of permission to be contacted).
 - (5) Calls to recipients to confirm receipt of mailed information.
- b. The Managed Care Plan may do the following:
- (1) Contact its enrollees to discuss educational events.
 - (2) Contact its enrollees to conduct normal business related to enrollment in the Managed Care Plan.
 - (3) Call former enrollees within one month after the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes. Such disenrollment surveys shall be approved by the Agency before Managed Care Plan implementation. Disenrollment surveys may be done by phone or sent by mail, but the Managed Care Plan shall ensure that neither calls nor mailings include marketing information.
 - (4) Call recipients who have expressly given permission for the Managed Care Plan to contact them, for example, by filling out a business reply card or asking an enrollee service representative to have a marketing representative contact them.
 - (5) Return phone calls or messages, as these are not unsolicited.
 - (6) Contact its enrollees via an automated telephone notification to inform them about general information such as the availability of flu shots, upcoming Managed Care Plan changes, and other important information.
- c. The Managed Care Plan's informational scripts (scripts designed to respond to recipient questions and requests and provide objective information about the Managed Care Plan and SMMC) shall not ask the recipient if he or she wants to be transferred to the marketing department, and the Managed Care Plan shall not automatically transfer calls to the enrollee services lines to the marketing department. The Managed Care Plan shall only transfer calls to the marketing department at the proactive request of the recipient.
- d. The Managed Care Plan shall clearly inform the recipient 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 recipient, ideally with a yes/no question.

- e. The Managed Care Plan may not:
 - (1) Include information about other lines of business in scripts.
 - (2) Request recipient identification numbers (e.g., Social Security number, bank account numbers, credit card number) except as required to verify enrollment or determine enrollment eligibility.
 - (3) Use language in scripts that implies 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.
- f. Any telephone marketing scripts (scripts designed to steer a recipient to the Managed Care Plan) must be prior approved by the Agency. The Managed Care Plan shall submit all telephone marketing scripts verbatim (bullets or talking points are unacceptable).

8. Standards for Written Materials

- a. The Managed Care Plan shall ensure that all marketing materials comply with the standards for written materials specified in Section IV.A.
- b. The Managed Care Plan shall ensure that all marketing materials include the statement that the Managed Care Plan contracts with the Agency. The Managed Care Plan shall use the following statement as the contracting statement: “[insert Managed Care Plan’s legal or marketing name] is a Managed Care Plan with a Florida Medicaid contract.” The Managed Care Plan shall not modify the statement and shall include the statement either in the text of the piece or at the end/bottom of the piece.
- c. The Managed Care Plan shall include the following disclaimers in any marketing materials that include information on benefits:
 - (1) “The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the Managed Care Plan.”
 - (2) “Limitations, copayments, and restrictions may apply.”
 - (3) “[Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance] may change.”
- d. If there are any changes or corrections made to materials, the Managed Care Plan shall correct those materials for prospective enrollees and may be required by the Agency to send errata sheets/addenda/reprints to current enrollees.
- e. The Managed Care Plan shall include a TTY number in conjunction with the Managed Care Plan’s toll-free enrollee help line number. This requirement in does not apply to outdoor advertising or banner/banner-like ads or radio ads.

9. Regional Distribution of Marketing Materials

- a. If the Managed Care Plan markets, it shall distribute marketing materials to the entire region served by the Managed Care Plan.
- b. The Managed Care Plan shall not advertise outside of its service area 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 service area.
- c. If the Managed Care plan is a joint enterprise, it shall market the Managed Care Plan under a single name throughout the region.

10. Use of Superlatives in Marketing Materials

- a. 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.
- b. The Managed Care Plan may use statements in its logos and in its product tag lines (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 tag lines (e.g., “XYZ plan means the first in quality care” or “XYZ Plus means the best in managed care”).

11. References to Studies

- a. 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 a marketing piece, it must provide the following information, either in the text or as a footnote, on the market piece:
 - (1) The source and date of the study.
 - (2) Information about the Managed Care Plan’s relationship with the entity that conducted the study including funding source.
 - (3) The study sample size and number of Managed Care Plans surveyed (unless the study that is referenced is a CMS or Agency study).
 - (4) Reference information (e.g., publication, date, page number).
- b. The Managed Care Plan shall not compare itself to another Managed Care Plan by name unless it has written concurrence from all Managed Care Plans being compared. The Managed Care Plan shall include this documentation when the material is submitted to the Agency as part of the marketing review process.

12. Product Endorsements/Testimonials

- a. The Managed Care Plan shall not pay or compensate enrollees in any way to endorse or promote the Managed Care Plan. A Medicaid recipient may offer endorsement of the Managed Care Plan, provided the recipient is a current enrollee and voluntarily chooses to endorse the Managed Care Plan.
- b. The Managed Care Plan shall ensure that all product endorsements and testimonials adhere to the following:
 - (1) The speaker must identify the Managed Care Plan by name.
 - (2) If an individual, such as an actor, is paid to portray a real or fictitious situation, the ad must clearly state it is a "Paid Actor Portrayal."
- c. The endorsement or testimonial cannot use any quotes by physicians, health care providers, and/or by Medicaid recipients not enrolled in the Managed Care Plan.
- d. The endorsement or testimonial cannot use negative testimonials about other Managed Care Plans.

13. Promotional Activities and Nominal Gifts

- a. The Managed Care Plan may use nominal gifts to attract the attention of potential enrollees as long as the gifts are of nominal value and provided regardless of enrollment.
- b. Nominal value is defined as an individual item/service worth fifteen dollars (\$15) or less (based on the retail value of the item).
- c. The Managed Care Plan shall follow the following rules when providing gifts:
 - (1) If a nominal gift is one large gift that is enjoyed by all in attendance (e.g., a concert), the total retail cost must be fifteen dollars (\$15) or less 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.
 - (2) Nominal gifts may not be in the form of cash or other monetary rebates. Cash gifts are prohibited even if their worth is less than fifteen dollars (\$15). Cash gifts include charitable contributions made on behalf of potential enrollees, and those gift certificates and gift cards that can be readily converted to cash, regardless of dollar amount.
- d. The Managed Care Plan may use promotional activities to attract the attention of prospective enrollees and/or encourage retention of current enrollees.
- e. The Managed Care Plan shall ensure that any promotional activities or items offered by the Managed Care Plan:

- (1) Are worth fifteen dollars (\$15) or less with a maximum aggregate of fifty dollars (\$50) per person, per year;
 - (2) Are offered to all individuals regardless of enrollment and without discrimination;
 - (3) Are not items that are considered a health benefit (e.g., a free checkup);
 - (4) Do not consist of lowering or waiving co-payments;
 - (5) Are not used or included with the enrollee handbook;
 - (6) Do not inappropriately influence the enrollee's selection of a provider, practitioner, or supplier of any item or service;
 - (7) Are tracked and documented during the contract year; and
 - (8) Are not tied directly or indirectly to the provision of any other covered item or service.
- f. The Managed Care Plan shall track and document items given to enrollees. The Managed Care Plan is not required to track pre-enrollment promotional items on a per person basis; however, the Managed Care Plan shall not structure pre-enrollment activities with the intent to give recipients or enrollees more than fifty dollars (\$50) per year.
 - g. The Managed Care Plan shall not provide meals (or have meals subsidized) at marketing or educational events.
 - h. 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."

14. Marketing Events

- a. Marketing events are events designed to steer, or attempt to steer, potential enrollees toward the Managed Care Plan. At marketing events, the Managed Care Plan may discuss Managed Care Plan-specific information. All marketing events must be kept in a log and reported to the Agency, as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.
- b. There are two main types of marketing events – formal and informal.
 - (1) Formal marketing events are typically structured in an audience/presenter style with the Managed Care Plan formally providing specific Managed Care Plan information via a presentation on the products being offered.
 - (2) Informal marketing events are conducted with a less structured presentation or in a less formal environment. They typically utilize a table, kiosk or a recreational vehicle (RV) that is staffed by a representative of the Managed Care Plan who can discuss the merits of the Managed Care Plan.

- c. The Managed Care Plan shall submit all marketing scripts and presentations for approval to the Agency prior to their use during a marketing event.
- d. The Managed Care Plan shall obtain Agency approval prior to conducting any marketing events.
- e. The Managed Care Plan shall ensure that advertisements and invitations to marketing events (in any form of media) used to invite recipients to attend a group session include the following two statements on marketing materials:
 - (1) "A health plan representative will be present with information."
 - (2) "For accommodation of persons with special needs at marketing events call <insert phone and TTY number>."
- f. At a marketing event, the Managed Care Plan shall not:
 - (1) Conduct health screening or other like activities that could give the impression of "cherry picking."
 - (2) Require recipients to provide any contact information as a prerequisite for attending the event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through mail. The Managed Care Plan shall clearly indicate on any sign-in sheets that completion of any contact information is optional.
 - (3) Use personal contact information obtained to notify recipients of raffle or drawing winnings for any other purpose.
- g. The Managed Care Plan shall notify the Agency of cancelled marketing events in advance of the scheduled event. In addition the Managed Care plan shall take the following actions to notify potential attendees:
 - (1) If a marketing event is cancelled less than forty-eight (48) hours before its originally scheduled date and time, the Managed Care Plan shall ensure a Managed Care Plan representative is present at the site of the cancelled event, at the time that the event was scheduled to occur, to inform attendees of the cancellation and distribute information about the Managed Care Plan. The representative should remain 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 representative is not required to be present at the site.
 - (2) If a marketing event is cancelled more than forty-eight (48) hours before the originally scheduled date and time, the Managed Care Plan shall notify recipients of the cancellation by the same means the Managed Care Plan used to advertise the event. A representative is not required to be present at the site.

15. Personal/Individual Marketing Appointments

- a. Personal/individual marketing appointments are one-on-one appointments that typically take place in the recipient's home; however, these appointments can also take place in other venues such as a library or coffee shop.
- b. All personal/individual appointments with recipients are considered marketing events, and all marketing materials used for personal/individual appointments must be kept in a log and reported to the Agency, as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.
- c. During a personal/individual marketing appointment, the Managed Care Plan shall not:
 - (1) Discuss products that were not agreed to by the recipient.
 - (2) Market any health care related product beyond the scope agreed upon by the recipient, and documented by the Managed Care Plan, prior to the appointment.
 - (3) Market non-health care related products (such as annuities or life insurance).
 - (4) Ask a recipient for referrals.
- d. During a personal/individual marketing appointment, the Managed Care Plan shall only discuss those products that have been agreed upon by the recipient for that appointment. If other products need to be discussed at the request of the recipient, the Managed Care Plan shall document a second scope of appointment for the new product type and then the marketing appointment may be continued.
- e. The documentation of appointment scope can be in writing, in the form of a signed agreement by the recipient, or a recorded oral agreement. The Managed Care Plan is allowed and encouraged to use a variety of technological means to fulfill the scope of appointment requirement, including conference calls, fax machines, designated recording line, pre-paid envelopes, and email, etc.
- f. A recipient may set a scope of appointment at a marketing event for a future personal/individual marketing appointment.
- g. The Managed Care Plan shall submit all business reply cards for documenting recipient scope of appointment or agreement to be contacted to the Agency. The Managed Care Plan should include a statement on the business reply card informing the recipient that a marketing representative may call as a result of the recipient returning a business reply card.
- h. In instances where a recipient visits the Managed Care Plan on his/her own accord, the Managed Care Plan shall document the scope of appointment prior to discussing the Managed Care Plan.

16. Marketing in the Health Care Setting

- a. 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.
- b. The Managed Care Plan shall not conduct marketing presentations or solicit recipients 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.
- c. The Managed Care Plan shall only schedule appointments with recipients residing in long-term care facilities (including nursing facilities and assisted living facilities) upon request by the recipient.

17. Provider-Based Marketing Activities

- a. The Managed Care Plan shall ensure, through provider education, outreach and monitoring that its providers are aware of and comply with the following: Providers are permitted to make available and/or distribute Managed Care Plan marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates. The Agency does not expect providers to proactively contact all Managed Care Plans; rather, if a provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates. Providers are also permitted to display posters or other materials in common areas such as the provider's waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.
- b. The Managed Care Plan shall ensure, through provider education, outreach and monitoring that its providers are aware of and comply with the following:
 - (1) To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
 - (2) Providers may not:
 - (a) Offer marketing/appointment forms.

- (b) Make phone calls or direct, urge or attempt to persuade recipients 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 induce recipients/enrollees to select them as their provider.
- (e) Offer inducements to persuade recipients to enroll in the Managed Care Plan.
- (f) Conduct health screening as a marketing activity.
- (g) Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
- (h) Distribute marketing materials within an exam room setting.
- (i) Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

(3) Providers may:

- (a) Provide the names of the Managed Care Plans with which they participate.
- (b) Make available and/or distribute Managed Care Plan marketing materials.
- (c) Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.
- (d) Share information with patients from the Agency's website or CMS' website.

(4) 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 contract.
 - (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 contracts.
 - (e) Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.
- c. Multiple Managed Care Plans can either have one Managed Care Plan submit the material on behalf of all the other Managed Care Plans, or have the piece submitted and approved by the Agency prior to use for each Managed Care Plan. Materials that indicate the provider has an affiliation with certain Managed Care Plans and that only list Managed Care Plan names and/or contact information do not require Agency approval.
- d. Providers may distribute printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the providers contract. The Managed Care Plan shall ensure that:
- (1) Materials do not "rank order" or highlight specific Managed Care Plans and include only objective information.

- (2) Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution.
- (3) The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials.

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Section IV. Enrollee Services and Grievance Procedures

A. Enrollee Material

1. General Provision

The Managed Care Plan shall ensure that enrollees are notified of their rights and responsibilities; the role of PCPs; how to obtain care; what to do in an emergency or urgent medical situation; how to pursue a complaint, a grievance, appeal or Medicaid Fair Hearing; how to report suspected fraud and abuse; how to report abuse, neglect and exploitation; and all other requirements and benefits of the Managed Care Plan.

2. Requirements for Written Material

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

Managed Care Plan shall notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats.

3. Requirements for Mailing Material to Enrollees

- a. The Managed Care Plan shall mail all enrollee materials to the enrollee's payee address provided by the Agency on the Managed Care Plan's monthly enrollment file.
- b. When enrollee materials are returned to the Managed Care Plan as undeliverable, the Managed Care Plan shall re-mail the materials to the enrollee residence address provided by the Agency if that address is different from the payee address. The Managed Care Plan shall use and maintain in a file a record of all of the following methods to contact the enrollee:
 - (1) Routine checks of the Agency enrollment files for changes of address and/or presence of the enrollee's residence address, maintaining a record of returned mail and attempts to re-mail to either a new payee address or residence address as provided by the Agency;
 - (2) Telephone contact at the number obtained from Agency enrollment files, the local telephone directory, directory assistance, city directory or other directory; and
 - (3) Routine checks (at least once a month for the first three (3) months of enrollment) on services or claims authorized or denied by the Managed Care Plan to determine if the enrollee has received services, and to locate updated address and telephone number information.
- c. In order to ensure that recipients and enrollees can quickly and easily identify the contents of the Managed Care Plan's mailing, the Managed Care Plan shall prominently display one of the following four statements 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 or wellness or prevention information"
 - (4) Non-health or non-managed care plan information - "Non-health or non-managed care plan related information"

The Managed Care Plan shall ensure that all mailings include one of these four mailing statements. The Managed Care Plan shall not modify these mailing statements and shall use them verbatim. The Managed Care Plan may meet this requirement through the use of ink stamps or stickers, in lieu of pre-printed statements. The Agency does not require resubmission of envelopes based only on a change in the envelope size. If the Managed Care Plan uses the same mailing statement on three different mailing packages (e.g., 8 x 12 envelope, letter size

envelope, and box) the Managed Care Plan is only required to submit the envelope once as part of the material submission, provided the required mailing statement remains unchanged and additional information is not included.

- d. The Managed Care Plan shall ensure that its Managed Care Plan name or logo is included in every mailing to current and prospective enrollees (either on the front envelope or on the mailing when no envelope accompanies the mailer).
- e. Mailing envelopes for enrollee materials shall contain a request for address correction.
- f. The Managed Care Plan shall not send emails unless the enrollee or potential recipient has agreed to receive those emails.
- g. 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.
- h. The Managed Care Plan shall not email enrollees or potential recipients at email addresses obtained through friends or referrals.
- i. The Managed Care Plan shall provide an opt-out process for enrollees and potential recipients to no longer receive email communications.

4. Required Enrollment Notice

- a. The Managed Care Plan shall notify, in writing, each person who is to be enrolled with the Managed Care Plan.
- b. The Managed Care Plan's enrollment notification shall include, at a minimum, the following information:
 - (1) The effective date of enrollment;
 - (2) 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 toll-free enrollment broker telephone number as appropriate;
 - (3) 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;
 - (4) 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
 - (5) A postage-paid, pre-addressed return envelope.

- c. The Managed Care Plan shall notify, in writing, each person who is to be reinstated, of the effective date of the reinstatement. The notification shall also instruct the enrollee to contact the Managed Care Plan if a new enrollee card, new enrollee handbook, and/or a new provider directory are needed.
- d. The Managed Care Plan shall provide such notice to each affected enrollee by the first calendar day of the month following the Managed Care Plan's receipt of the notice of enrollment or reinstatement or within five (5) days from receiving the enrollment file, whichever is later.
- e. MMA Managed Care Plan's new enrollment and reinstatement notifications shall include the enrollee's assigned primary care provider.

5. New Enrollee Procedures and Materials

- a. By the first day of the assigned enrollee's enrollment or within five (5) days following receipt of the X12-834 enrollment file from the Agency or its fiscal agent, whichever is later, the Managed Care Plan shall mail or hand deliver to the new enrollee:
 - (1) An enrollee identification (ID) card;
 - (2) An enrollee handbook;
 - (3) A printed provider directory; and
 - (4) For MMA Managed Care Plans and Comprehensive LTC Plans, the following information:
 - (a) Name, telephone number and address of the MMA enrollee's PCP assignment;
 - (b) An explanation that enrollees may choose to have all family members served by the same PCP or may choose different PCPs; and
 - (c) A postage-paid, pre-addressed return envelope.
- b. For enrollees with LTC benefits, as long as the materials are provided within five (5) days, the LTC Managed Care Plan or Comprehensive LTC Managed Care Plan may provide new enrollee materials to enrollees as part of the initial case management visit.
- c. New enrollee materials are not required for a former enrollee who was disenrolled because of the loss of Medicaid eligibility and who regains eligibility within their temporary loss period, as specified in Section III.B.1.g., and is automatically reinstated in the Managed Care Plan, unless there was change in enrollee materials or the provider directory during the timeframe in which the recipient was disenrolled.
- d. A notation of the effective date of the reinstatement is to be made on the most recent application or conspicuously identified in the enrollee's administrative file.

- e. Enrollees who were previously enrolled in the Managed Care Plan, and who lose and regain eligibility in a number of days in excess of the temporary loss period, as specified in Section III.B.1.g., will be treated as new enrollees.
- f. The Managed Care Plan may send new enrollment material in separate mailings. Each mailing/provision of materials shall be documented in the Managed Care Plan's records.

6. Enrollee ID Card Requirements

- a. The Managed Care Plan shall furnish each enrollee an enrollee ID card that shall include, at a minimum, the following information:
 - (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.

7. Enrollee Handbook Requirements

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

Enrollment:

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

Open Enrollment:

If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you

want to. This is called “open enrollment.” You do not have to change Managed Care Plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next 12 months. Every year you may change Managed Care Plans during your 60 day open enrollment period.

Disenrollment:

If you are a mandatory enrollee and you want to change plans after the initial 90-day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state-approved cause reasons to change Managed Care Plans: [INSERT CAUSE LIST FROM THIS SECTION].

- (4) Procedures for filing a request for disenrollment for cause. As noted in the section, the state-approved for-cause reasons listed shall be listed verbatim in the disenrollment section of the enrollee handbook. In addition, the Managed Care Plan shall include the following language verbatim in the disenrollment section of the enrollee handbook:

Some Medicaid recipients may change Managed Care Plans whenever they choose, for any reason. To find out if you may change plans, call the Enrollment Broker [INSERT APPROPRIATE TELEPHONE NUMBER].

- (5) Information regarding newborn enrollment, including the mother’s responsibility to notify the Managed Care Plan and DCF of the pregnancy and the newborn’s birth;
- (6) Enrollee rights and responsibilities, including the extent to which and how enrollees may obtain services from non-participating providers and other provisions in accordance with 42 CFR 438.100;
- (7) Description of services provided, including limitations and general restrictions on provider access, exclusions and out-of-network use, and any restrictions on enrollee freedom of choice among participating providers;
- (8) Procedures for obtaining required services, including second opinions at no expense to the enrollee (in accordance with 42 CFR 438.206(3) and s. 641.51, F.S.), and authorization requirements, including any services available without prior authorization;
- (9) The extent to which, and how, After Hours and emergency coverage is provided, and that the enrollee has a right to use any hospital or other setting for emergency care;
- (10) Cost sharing for the enrollee, if any;
- (11) Information that interpretation services and alternative communication systems are available, free of charge, including for all foreign languages and vision and hearing impairment, and how to access these services;

- (12) How and where to access any benefits that are available under the Medicaid State Plan but are not covered under this Contract, including any cost sharing;
- (13) Procedures for reporting fraud, abuse and overpayment that includes the following language verbatim:

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx;

If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of \$500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

- (14) Clear specifics on the required procedural steps in the grievance process, including the address, telephone number and office hours of the grievance staff. The Managed Care Plan shall specify telephone numbers to call to present a complaint, grievance, or appeal. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the Managed Care Plan without undue delays;
- (15) Fair Hearing procedures;
- (16) Information that services will continue upon appeal of a denied authorization and that the enrollee may have to pay in case of an adverse ruling;
- (17) Information about the Beneficiary Assistance Program (BAP) process, including an explanation that a review by the BAP must be requested within one (1) year after the date of the occurrence that initiated the appeal, how to initiate a review by the BAP and the BAP address and telephone number:

Agency for Health Care Administration
Beneficiary Assistance Program
Building 3, MS #26
2727 Mahan Drive, Tallahassee, FL 32308
(850) 412-4502
(888) 419-3456 (toll-free)

- (18) Information regarding HIPAA relative to the enrollee's personal health information (PHI);
- (19) Information to help the enrollee assess a potential behavioral health problem;
- (20) Procedures for reporting abuse, neglect, and exploitation, including the abuse hotline number: 1-800-96-ABUSE;

- (21) Information regarding health care advance directives pursuant to ss. 765.302 through 765.309, F.S., 42 CFR 438.6(i)(1)-(4) and 42 CFR 422.128, as follows:
 - (a) The Managed Care Plan's information shall include a description of state law and must reflect changes in state law as soon as possible, but no later than ninety (90) days after the effective change.
 - (b) The Managed Care Plan shall provide these policies and procedures to all enrollee's age 18 and older and shall advise enrollees of the enrollee's rights under state law, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
 - (c) The Managed Care Plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
 - (d) The Managed Care Plan's information shall inform enrollees that complaints about non-compliance with advance directive laws and regulations may be filed with the state's complaint hotline.
 - (e) The Managed Care Plan shall educate enrollees about their ability to direct their care using this mechanism and shall specifically designate which staff and/or participating providers are responsible for providing this education.
- (22) How to get information about the structure and operation of the Managed Care Plan and any physician incentive plans, as set forth in 42 CFR 438.10(g)(3);
- (23) Instructions explaining how enrollees may obtain information from the Managed Care Plan about how it rates on performance measures in specific areas of service;
- (24) How to obtain information from the Managed Care Plan about quality enhancements (QEs) as specified in Section V.F.; and
- (25) Toll-free telephone number of the appropriate Medicaid Area Office and Aging and Disability Resource Centers.
- b. In accordance with 42 CFR 438.10, for a counseling or referral service that the Managed Care Plan does not cover because of moral or religious objections, the Managed Care Plan need not furnish information on how and where to obtain the service.
- c. The Managed Care Plan shall include additional information in its handbooks with respect to the applicable SMMC program, as follows:
 - (1) MMA Managed Care Plans shall include the additional information specified in the MMA Exhibit.

- (2) LTC Managed Care Plans shall include the additional information specified in the LTC Exhibit.
- (3) Comprehensive LTC Managed Care Plans shall include additional information as specified in both the MMA Exhibit and the LTC Exhibit.

8. Printed Provider Directory

- a. The Managed Care Plan shall ensure its initial provider directory printed prior to enrolling recipients in the Managed Care Plan in each authorized Region matches the provider network submission used by the Agency to determine the Managed Care Plan has the capacity to provide covered services to all enrollees up to the maximum enrollment level. After the Agency's initial provider directory approval as part of the plan-specific readiness review specified in Section II, Responsibilities of the State of Florida, the Managed Care Plan shall ensure its provider directory (either printed or online) matches the most recent provider network file that the Managed Care Plan submitted to the Agency as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.
- b. The Managed Care Plan shall furnish a printed provider directory to all enrollees. The Managed Care Plan shall update the printed provider directory at least every six months and provide the most recently printed provider directory to new enrollees. Comprehensive LTC Managed Care Plans shall distribute a separate LTC and MMA printed provider directory to enrollees with both LTC and MMA benefits.
- c. When distributing printed provider directories, the Managed Care Plan must append to the provider directory a list of the providers who have left the network and those who have been added since the directory was printed or, in lieu of the appendix to the provider directory, enclose a letter stating that the most current listing of providers is available by calling the Managed Care Plan at its toll-free telephone number and at the Managed Care Plan's website. The letter shall include the telephone number and the Internet address that will take the enrollee directly to the online provider directory.
- d. The provider directory shall include the names, locations, office hours, telephone numbers of, and non-English languages spoken by current Managed Care Plan providers. The provider directory also shall identify providers that are not accepting new patients.
- e. 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.
- f. In accordance with s. 1932(b)(3) of the Social Security Act, the provider directory shall include a statement that some providers may choose not to perform certain services based on religious or moral beliefs.

- g. The Managed Care Plan is not required to include outpatient-based specialty providers in ambulatory surgical centers and hospital-based providers in the online or printed provider directory. However, the Managed Care Plan shall include these providers in the provider network file it submits to the Agency.
- h. In addition to the provision of a printed provider directory to new enrollees, the Managed Care Plan shall provide a printed provider directory to those enrollees who were reinstated after the open enrollment period.

9. Online Enrollee Materials

- a. The Managed Care Plan shall make enrollee materials, including the provider directory and enrollee handbook(s), available online at the Managed Care Plan's website without requiring enrollee log-in. The Managed Care Plan may provide a link to applications (smartphone applications) for enrollee use that will take enrollees directly to existing Agency-approved materials on the Managed Care Plan's website, such as the Managed Care Plan's enrollee handbook and provider directory. Smartphone applications may also be known as "apps." See Section VIII.C.
- b. The Managed Care Plan shall maintain an accurate and complete online provider directory containing all the information required in the printed provider directory as well as information about licensure or registration, specialty credentials and other certifications, and specific performance indicators. The online provider directory must be searchable by:
 - (1) Name,
 - (2) Provider type,
 - (3) Distance from the enrollee's address,
 - (4) Zip code, and
 - (5) Whether the provider is accepting new patients.
- c. The online provider directory shall also have the capability to compare the availability of providers to network adequacy standards and accept and display feedback from each provider's patients.
- d. The Managed Care Plan shall update the online provider directory at least weekly to match the most recent provider network file submitted to the Agency and shall file an attestation to this effect with the Agency each week, even if no changes have occurred. (See s. 409.967(2)(c), F.S.)
- e. MMA Managed Care Plans and Comprehensive Managed Care Plans shall provide a link to the Agency's Medicaid preferred drug list (PDL) on the Managed Care Plan's website without requiring enrollee log-in. Such Managed Care Plans shall also post prior authorization, step-edit criteria and protocol, and updates to the list of non-Medicaid PDL drugs that are subject to prior authorization within twenty one (21) days after the prior authorization and step-edit criteria and protocol and updates

have been approved by the Managed Care Plan's Pharmaceutical and Therapeutics Committee.

10. 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.
- b. The Managed Care Plan shall have procedures to inform enrollees of adverse changes to its provider network.

B. Enrollee Services

1. General Provisions

The Managed Care Plan shall have the capability to answer enrollee inquiries through written materials, telephone, electronic transmission and face-to-face communication.

- a. The enrollee's guardian or legally authorized responsible person, as provided in s. 765.401, F.S., is permitted to act on the enrollee's behalf in matters relating to the enrollee's enrollment, plan of care, and/or provision of services, if the enrollee:
 - (1) Was adjudicated incompetent in accordance with the law;
 - (2) Is found by the provider to be medically incapable of understanding his or her rights; or
 - (3) Exhibits a significant communication barrier.
- b. Notices may be sent to the enrollee's guardian or legally authorized responsible person as applicable.
- c. 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.

2. 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 may use an automated telephone triage system. The toll-free enrollee help line shall respond to all areas of enrollee inquiry.

- b. The Managed Care Plan shall develop and implement an administrative policies and procedures manual relevant to the call center that includes the specifications of operation of all call center activities. The administrative policies and procedures shall address:
 - (1) Covered services, referrals, provider network and transportation;
 - (2) Data entry;
 - (3) Internal quality control of telephone staff; and
 - (4) Reporting.
- c. The Managed Care Plan shall have telephone call policies and procedures that shall include requirements for staffing, personnel, hours of operation, call response times, maximum hold times and maximum abandonment rates, monitoring of calls via recording or other means and compliance with performance standards.
- d. 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. The enrollee help line staff shall be trained to respond to enrollee questions in all areas.
- e. The Managed Care Plan may have an automated system available between the hours of 7:00 p.m. and 8:00 a.m., in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays. This automated system must provide, at a minimum, callers with clear instructions on what to do in case of an emergency, a voice mailbox option for callers to leave messages, and an option to speak to a Managed Care Plan representative.
- f. If the Managed Care Plan utilizes a voice mail 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 messages on the next business day.
- g. If the Managed Care Plan utilizes an automated system, the Managed Care Plan's enrollee help line must include the option for enrollees to bypass the automated attendant/IVR and speak with an enrollee help line staff member.
- h. The Managed Care Plan shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by the Agency before the Managed Care Plan begins operation, and the Managed Care Plan shall report its performance on these standards as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. At a minimum, the standards shall require that, measured on a monthly basis:
 - (1) The average speed of answer (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 wait time in the queue shall not exceed sixty (60) seconds.
- i. The Managed Care Plan shall ensure that hold time messages do not include non-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.

3. Translation Services and Availability of Translated Materials

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

4. Cultural Competency Plan

- a. In accordance with 42 CFR 438.206, the Managed Care Plan shall have a comprehensive written cultural competency plan (CCP) describing the Managed Care Plan's program to ensure that services are provided in a culturally competent manner to all enrollees, including all services and settings and including those with limited English proficiency. The CCP must describe how providers, Managed Care Plan employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of the individual enrollees and protects and preserves the dignity of each. The CCP shall be updated annually and submitted to the Agency by June 1 for approval for implementation by September 1 of each Contract year.

- b. The Managed Care Plan may distribute a summary of the CCP to participating providers if the summary includes information about how the provider may access the full CCP on the website. This summary shall also detail how the provider can request a hard copy of the cultural competency plan from the Managed Care Plan at no charge to the provider.
- c. The Managed Care Plan shall complete an annual evaluation of the effectiveness of its CCP. This evaluation may include results from the CAHPS or other comparative member satisfaction surveys, outcomes for certain cultural groups, member grievances, member appeals, provider feedback and Managed Care Plan employee surveys. The Managed Care Plan shall track and trend any issues identified in the evaluation and shall implement interventions to improve the provision of services. A description of the evaluation, its results, the analysis of the results and interventions to be implemented shall be described in the CCP submitted to the Agency annually by June 1 of each Contract year.

5. Educational Events

- a. An educational event is an event designed to inform recipients about Medicaid programs and does not include marketing (i.e., the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific Managed Care Plan or limited number of Managed Care Plans). All educational events must be kept in a log and reported to the Agency, as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.
- b. 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 in-home or one-on-one settings.
- c. Educational events may not include any marketing activities such as the distribution of marketing materials. The Managed Care shall explicitly advertise educational events as “educational;” otherwise, the Agency will consider the event to be a marketing event.
- d. The Managed Care Plan shall ensure that materials distributed or made available at an educational event are free of Managed Care Plan-specific information (including Managed Care Plan-specific benefits, co-payments, or contact information), and any bias toward one Managed Care Plan over another.
- e. The following are examples of acceptable materials and activities by the Managed Care Plan at an educational event:
 - (1) A banner with the Managed Care Plan name and/or logo displayed.
 - (2) Promotional items, including those with Managed Care Plan name, logo, and toll-free enrollee help line number and/or website. The Managed Care Plan shall ensure that promotional items are free of benefit information and consistent with the definition of nominal gift specified in Section III.D.5.a.
 - (3) Respond to questions asked at an educational event.

- f. At educational events, the Managed Care Plan shall not:
 - (1) Discuss Managed Care Plan-specific benefits.
 - (2) Distribute Managed Care Plan-specific materials.
 - (3) Distribute or display business reply cards, scope of appointment forms or sign-up sheets.
 - (4) Set up individual marketing appointments or get permission for an outbound call to the recipient.
 - (5) Attach business cards or Managed Care Plan contact information to educational materials, unless requested by the recipient.
 - (6) Advertise an educational event and then have a marketing event immediately following in the same general location (e.g., same hotel).
- g. If the Managed Care Plan holds enrollee-only events, the Managed Care Plan shall not conduct marketing activities at these events. In addition, the Managed Care Plan shall advertise these events in a way that reasonably targets only current enrollees (e.g., direct mail flyers) and not the mass marketplace (e.g., radio or newspaper ad).
- h. The Managed Care Plan shall submit information on educational events to the Agency for prior approval.

6. Medicaid Redetermination Assistance

- a. The Agency will provide Medicaid recipient redetermination date information to the Managed Care Plan. This information shall be used by the Managed Care Plan only as indicated in this section.
- b. MMA Managed Care Plans shall notify the Agency, in writing, if it wants to provide assistance with Medicaid eligibility redetermination to enrollees in order to promote continuous Medicaid eligibility. The Managed Care Plan's participation in using this information is voluntary. If requested and approved by the Agency, the MMA Managed Care Plan shall participate as specified in the MMA Exhibit.
- c. LTC Managed Care Plans shall develop a process for providing assistance with Medicaid eligibility redetermination to in order to ensure continuous Medicaid eligibility, including both financial and medical/functional eligibility, as specified in the LTC Exhibit.
- d. Comprehensive LTC Managed Care Plans shall develop a process for providing assistance with Medicaid eligibility redetermination for enrollees with both LTC and MMA benefits as specified in the LTC Exhibit. Comprehensive LTC Managed Care Plans may provide assistance, subject to Agency approval, for enrollees with MMA benefits only as specified in the MMA Exhibit.

C. Grievance System

1. General Provisions

- a. Federal law requires Medicaid managed care organizations to have internal grievance procedures under which Medicaid enrollees, or providers acting as authorized representatives, may challenge denial of coverage of, or payment for, medical assistance. The Managed Care Plan's grievance system shall comply with the requirements set forth in s. 641.511, F.S., if applicable, and with all applicable federal and state laws and regulations, including 42 CFR 431.200 and 42 CFR Part 438, Subpart F, "Grievance System".
- b. For purposes of this Contract, these procedures must include an opportunity to file a complaint, a grievance and/or an appeal and to seek a Medicaid Fair Hearing through DCF.
- c. A Managed Care Plan that covers services through a subcontractor shall ensure that the subcontractor meets the complaint and grievance system requirements for all delegated services.

2. Use of Independent Review Organization

- a. The Managed Care Plan may elect to have all of its grievance and appeal issues subject to external review processes by an independent review organization.
- b. The Managed Care Plan must notify the Agency in writing if it elects to have all its contracts subject to such external review.

3. Information to be Provided

- a. The Managed Care Plan shall include all necessary procedural steps for filing complaints, grievances, appeals and requests for a Medicaid Fair Hearing in the enrollee handbook.
- b. Where applicable, the Managed Care Plan's grievance system must include information for enrollees on seeking a state level appeal through the Beneficiary Assistance Program.
- c. The Managed Care Plan shall provide information about the grievance system to all providers and subcontractors in the provider handbook when they enter into a contract.
- d. Types of Issues
 - (1) A complaint is the lowest level of challenge and provides the Managed Care Plan an opportunity to resolve a problem without it becoming a formal grievance. Complaints shall be resolved by close of business the day following receipt or be moved into the grievance system within twenty-four (24) hours.
 - (2) A grievance expresses dissatisfaction about any matter other than an action.

- (3) An action is any denial, limitation, reduction, suspension or termination of service, denial of payment, or failure to act in a timely manner.
- (4) An appeal is a request for review of an action.

4. Process for Grievances and Appeals

- a. The Managed Care Plan shall adhere to the following timeframes for filing of grievances and appeals:
 - (1) A grievance may be filed orally or in writing within one (1) year of the occurrence.
 - (2) An appeal may be filed orally or in writing within thirty (30) days from the date on the notice of action and, except when expedited resolution is required, must be followed with a written notice within ten (10) days of the oral filing. The date of oral notice shall constitute the date of receipt.
- b. The Managed Care Plan shall refer all enrollees and/or providers on behalf of the enrollee (whether participating or non-participating) who are dissatisfied with the Managed Care Plan or its activities to the Managed Care Plan's grievance/appeal coordinator for processing and documentation of the issue.
- c. The Managed Care Plan shall provide any reasonable help to the enrollee in completing forms and following the procedures for filing a grievance or appeal or requesting a Medicaid Fair Hearing. This includes interpreter services, toll-free calling, and TTY/TTD capability.
- d. The Managed Care Plan shall acknowledge in writing within five (5) business days of receipt of each grievance and appeal unless the enrollee requests an expedited resolution. The Managed Care Plan shall notify enrollees in their primary language of grievance and appeal resolutions.
- e. The Managed Care Plan shall handle grievances and appeals as follows:
 - (1) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.
 - (2) Ensure the enrollee understands any time limits that may apply.
 - (3) Provide opportunity before and during the process for the enrollee or an authorized representative to examine the case file, including medical/case records, and any other material to be considered during the process.
 - (4) Consider as parties to the appeal the enrollee or an authorized representative or, if the enrollee is deceased, the legal representative of the estate.
- f. The Managed Care Plan shall ensure that all decision makers are health care professionals with clinical expertise in treating the enrollee's condition when deciding the following:

- (1) Appeal of denial based on lack of medical necessity;
 - (2) Grievance of denial of expedited resolution of an appeal; and
 - (3) Grievance or appeal involving clinical issues.
- g. The Managed Care Plan shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision

5. Standard Timeframes

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

6. Expedited Appeals

- a. The Managed Care Plan shall have an expedited review process for appeals for use when taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function.
- b. The Managed Care Plan shall resolve each expedited appeal and provide notice to the enrollee, as quickly as the enrollee's health condition requires, within state established timeframes not to exceed three (3) business days after the Managed Care Plan receives the appeal request, whether the appeal was made orally or in writing.
- c. The Managed Care Plan shall ensure that no punitive action is taken against a provider who requests or supports a request for an expedited appeal.

- d. If the Managed Care Plan denies the request for expedited appeal, it shall immediately transfer the appeal to the timeframe for standard resolution and so notify the enrollee.

7. Disposition Notice Requirements

- a. The Managed Care Plan shall provide written notice of disposition of an appeal. In the case of an expedited appeal denial, the Managed Care Plan shall also provide oral notice by close of business on the day of disposition, and written notice within two (2) days of the disposition.
- b. Content of notice — The written notice of resolution must include:
 - (1) The results of the resolution process and the date it was completed;
 - (2) If not decided in the enrollee's favor, information on the right to request a Medicaid Fair Hearing and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request;
 - (3) If the Managed Care Plan does not have an independent external review organization for its grievance process, the right to appeal an adverse decision on an appeal to the Beneficiary Assistance Program (BAP), including how to initiate such a review and the following:
 - (a) Before filing with the BAP, the enrollee must complete the Managed Care Plan's appeal process;
 - (b) The enrollee must submit the appeal to the BAP within one (1) year after receipt of the final decision letter from the Managed Care Plan;
 - (c) The BAP will not consider an enrollee appeal that has already been to a Medicaid Fair Hearing;
 - (d) The address and toll-free telephone number for enrollee appeals to the BAP are:

Agency for Health Care Administration
Beneficiary Assistance Program
Building 3, MS #26
2727 Mahan Drive
Tallahassee, Florida 32308
(850) 412-4502
(888) 419-3456 (toll-free)
 - (e) That the enrollee may have to pay for the cost of those benefits if the Medicaid Fair Hearing upholds the Managed Care Plan's action.

8. Documentation and Reporting

- a. The Managed Care Plan must maintain a record of all complaints, grievances and appeals.

- b. 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.
- c. The log of complaints that do not become grievances must include date, complainant and enrollee name(s), Medicaid ID number, nature of complaint, description of resolution and final disposition. The Managed Care Plan shall submit this complaint log upon request of the Agency.
- d. The Managed Care Plan shall report on complaints, grievances and appeals to the Agency as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.

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

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

Department of Children and Families
 Office of Appeal Hearings
 Building 5, Room 255
 1317 Winewood Boulevard
 Tallahassee, FL 32399-0700
 (850) 488-1429
 (850) 487-0662 (fax)
 Appeal_Hearings@dcf.state.fl.us (email)
<http://www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings>

10. Continuation of Benefits

- a. The Managed Care Plan shall continue the enrollee's benefits if:
 - (1) The enrollee or the enrollee's authorized representative files an appeal with the Managed Care Plan regarding the Managed Care Plan's decision:
 - (a) Within ten (10) days after the notice of the adverse action is mailed; or

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

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Section V. Covered Services

A. Required Benefits

1. General Provisions

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

2. Specific Services to be Provided

- a. MMA Managed Care Plans and Comprehensive LTC Managed Care Plans shall ensure the provision of the covered services specified in the MMA Exhibit, including those covered under s. 409.973(1)(a) through (cc), F.S.
- b. LTC Managed Care Plans and Comprehensive LTC Managed Care Plans shall ensure the provision of the covered services specified in the LTC Exhibit, including those covered under s. 409.98(1) through (19), F.S.
- c. LTC Managed Care Plans and Comprehensive LTC Managed Care Plans are responsible for implementing and managing the Participant Direction Option (PDO) for enrollees with LTC benefits, as defined in Section I, Definitions and Acronyms, and as specified in the LTC Exhibit.

- d. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those specified in the Handbooks and Medicaid fee schedules except that, pursuant to s. 409.973(2), F.S., the Managed Care Plan may customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional MMA services as specified in the MMA Exhibit.

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 all enrollees in the applicable Managed Care program, subject to any Agency-agreed service limitations set forth in Attachment I of this Contract as follows:
 - (1) MMA enrollees shall receive MMA expanded benefits;
 - (2) LTC enrollees shall receive LTC expanded benefits;
 - (3) Specialty Plan enrollees shall receive both Specialty Plan and MMA expanded benefits; and
 - (4) Comprehensive LTC enrollees shall receive both MMA and LTC expanded benefits.
- c. In instances where an expanded benefit is also a Medicaid covered service, the Managed Care Plan shall administer the benefit in accordance with any applicable service standards pursuant to this Contract, the Florida Medicaid State Plan and any Medicaid Coverage and Limitations Handbooks.

2. Types of Expanded Benefits

- a. The Managed Care Plan may offer services in excess of the amount, duration and scope of those listed in the MMA Exhibit for MMA Managed Care Plans and Comprehensive LTC Plans, and the LTC Exhibit for Comprehensive LTC Managed Care Plans and LTC Managed Care Plans.
- b. The Managed Care Plan may offer other services and benefits not listed in the MMA Exhibit and the LTC Exhibit upon approval of the Agency. The Managed Care Plan shall define such expanded benefits specifically in writing and submit them to the Agency for approval before implementation. Such expanded benefits are those services or benefits not otherwise covered or that exceed limits outlined in the in the Medicaid State Plan and the Florida Medicaid Coverage and Limitations Handbooks and the Florida Medicaid Fee Schedules.
- c. The Managed Care Plan may offer an over-the-counter expanded drug benefit. Such benefits shall be limited to nonprescription drugs containing a national drug code (NDC) number, first aid supplies, vitamins and birth control supplies. Such benefits must be offered directly through the Managed Care Plan's fulfillment house or through a subcontractor, in which a debit card system may be used. The Managed Care Plan shall make payments for the over-the-counter drug benefit directly to the subcontractor, if applicable. Over-the-counter expanded drug benefits shall not exceed the following limits:
 - (1) For MMA Managed Care Plans, such benefits shall not to exceed twenty-five dollars (\$25) per household per month for enrollees with MMA benefits.
 - (2) In addition to MMA Managed Care Plan benefits, LTC Managed Care Plan benefits shall not to exceed fifteen dollars (\$15) per individual per month for enrollees with LTC benefits.

3. Changes to Expanded Benefits Offered

- a. The Managed Care Plan shall submit to the Agency for approval, by the date specified by the Agency, of each Contract year, a Plan Evaluation Tool (PET) for a CBP.
- b. Such changes in the Managed Care Plan's expanded benefits shall only be for additional expanded benefits or if the Managed Care Plan is proposing to exchange an expanded benefit for another, the proposed expanded benefit must be determined to be actuarially equivalent, by the Agency, to the expanded benefit being proposed to be removed. In no instance may the Managed Care Plan reduce or remove an expanded benefit if supplemental expanded benefit(s) are not proposed by the Managed Care Plan and approved by the Agency.
- c. The Managed Care Plan's expanded benefits may be changed on a Contract year basis and only as approved in writing by the Agency.

C. Excluded Services

1. General Provisions

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

2. Moral or Religious Objections

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

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

D. Coverage Provisions

1. Service-Specific Requirements

The Managed Care Plan shall provide the services listed in this Contract in accordance with the provisions herein, and shall comply with all state and federal laws pertaining to the provision of such services. The Managed Care Plan shall provide coverage in accordance with the Florida Medicaid Coverage and Limitations Handbooks, Medicaid fee schedules and the Florida Medicaid State Plan, as well as specific coverage requirements with respect to the applicable SMMC program, as follows:

- a. MMA Managed Care Plans must comply with additional provisions for covered services specified in the MMA Exhibit.
- b. LTC Managed Care Plans must comply with additional provisions for covered services specified in the LTC Exhibit.
- c. Comprehensive LTC Managed Care Plans must comply with additional provisions for covered services specified in both the MMA Exhibit and the LTC Exhibit.

2. Behavioral Health

- a. For SMMC enrollees, behavioral health services will be provided to enrollees by other sources, including Medicare, and state-funded programs and services. The Managed Care Plan shall coordinate with other entities, including MMA Managed Care Plans, Medicare plans, Medicare providers, and state-funded programs and services.
- b. LTC Managed Care Plans shall be responsible for coordinating with other entities' MMA Managed Care Plans available to provide behavioral health services for these enrollees as specified in the LTC Exhibit.
- c. MMA Managed Care Plans and Comprehensive LTC Managed Care Plans shall provide a full range of medically necessary behavioral health services for enrollees as authorized under the Medicaid State Plan and specified in the MMA Exhibit.

3. Managing Mixed Services

- a. The Managed Care Plan shall provide case management and care coordination with other Managed Care Plans for enrollees with both MMA benefits and LTC benefits to ensure mixed services are not duplicative but rather support the enrollee in an efficient and effective manner. Mixed Services include:
 - (1) Assistive Care Services;
 - (2) Home health and nursing care (intermittent and skilled nursing);
 - (3) Hospice services;
 - (4) Medical equipment and supplies (including durable medical equipment); and
 - (5) Therapy services (physical, occupational, respiratory and speech).
- b. MMA Managed Care Plans shall provide mixed services to enrollees with only MMA benefits.
- c. The Managed Care Plan, if a Comprehensive LTC Plan, shall provide mixed services to enrollees receiving LTC benefits from the Managed Care Plan.
- d. LTC Managed Care Plans shall provide mixed services to enrollees with LTC benefits, regardless of an enrollee's enrollment in an MMA Managed Care Plan.
- e. Comprehensive LTC Plans shall provide mixed services to enrollees with both MMA benefits and LTC benefits enrolled in the Comprehensive LTC Plan for both MMA benefits and LTC benefits.
- f. Managed Care Plans shall provide non-emergency transportation (NET) services to enrollees with both MMA benefits and LTC benefits as follows:
 - (1) MMA Managed Care Plans shall provide NET to all MMA benefits.

- (2) LTC Managed Care Plans shall provide NET to all LTC benefits.
- (3) Comprehensive LTC Managed Care Plans shall provide NET to enrollees with both MMA and LTC benefits, and provide NET to all MMA benefits for enrollees with only MMA benefits.
- g. The Managed Care Plan shall also provide case management and care coordination with other service delivery systems serving enrollees in the Managed Care Plan to ensure services are not duplicative but rather support the enrollee in an efficient and effective manner.

E. Care Coordination/Case Management

1. General Provisions

- a. The Managed Care Plan shall be responsible for care coordination and case management for all enrollees.
- b. The Managed Care Plan shall provide care coordination and case management to enrollees as specified in this Contract and with respect to the applicable SMMC program as follows:
 - (1) MMA Managed Care Plans shall comply with care coordination and case management requirements specified in the MMA Exhibit.
 - (2) LTC Managed Care Plans shall comply with care coordination and case management requirements specified in the LTC Exhibit.
 - (3) Comprehensive LTC Managed Care Plans shall comply with care coordination and case management requirements specified in the MMA Exhibit and the LTC Exhibit.
- c. The Managed Care Plan shall provide disease management programs as follows:
 - (1) MMA Managed Care Plans shall provide disease management programs specified in Attachment I of this Contract.
 - (2) LTC Managed Care Plans shall provide disease management programs specified in the LTC Exhibit.
 - (3) Comprehensive LTC Managed Care Plans shall provide disease management programs specified in Attachment I of this Contract and the LTC Exhibit.

2. Transition of Care

- a. The Managed Care Plan shall develop and maintain transition of care policies and procedures that address all transitional care coordination/care management requirements and submit these policies and procedures for review and approval to

the Agency. Transition of care policies and procedures shall include the following minimum functions:

- (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;
 - (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. Transfer of medical/case records in compliance with HIPAA privacy and security rules;
 - (3) Documentation of referral services in enrollee medical/case 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;
 - (5) Identification of enrollees with hospitalizations, including emergency care encounters and documentation in enrollee medical/case records of appropriate follow-up to assess contributing reasons for emergency visits and develop actions to reduce avoidable emergency room visits and potentially avoidable hospital admissions;
 - (6) Transitional care coordination/care management that includes coordination of hospital/institutional discharge planning and post-discharge care, including conducting a comprehensive assessment of enrollee and family caregiver needs, coordinating the patient's discharge plan with the family and hospital provider team, collaborating with the hospital or institution's care coordinator/case manager to implement the plan in the patient's home and facilitating communication and the transition to community providers and services. The policy and procedures shall define reporting requirements for nursing facility transition, including reporting schedules for case management and submission to the Agency on a quarterly basis; and
 - (7) Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describing the requirements regarding the privacy of individually identifiable health information.
- 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 shall assist the new Managed Care Plan with obtaining the enrollee's medical/case records.
 - d. The Managed Care Plan shall implement a process determined by the Agency to ensure records and information are shared and passed to the new Managed Care Plan within thirty (30) days.

3. Health Management

- a. The Managed Care Plan shall develop and maintain written policies and procedures that address components of effective health management including, but not limited to, anticipation, identification, monitoring, measurement, evaluation of enrollee's health care needs and effective action to promote quality of care.
- b. The Managed Care Plan shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization and focus on improved outcome management achieving the highest level of success.
- c. The Managed Care Plan, through its QI plan, shall demonstrate specific interventions in its health management to better manage the care and promote healthier enrollee outcomes.

4. Disease Management Program

- a. Disease management programs provided by the Managed Care Plan shall address co-morbid conditions and consider the whole health of the enrollee.
- b. 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..
- c. The Managed Care Plan shall have policies and procedures regarding disease management programs provided 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.
- d. The Managed Care Plan shall submit a copy of its policies and procedures and program description for each of its disease management programs to the Agency by April 1 of each Contract year. If no changes, the Managed Care Plan shall attest to such.
 - e. The Managed Care Plan shall develop and use a plan of treatment for each disease management program participant that is tailored to the individual enrollee. The plan of treatment 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 treatment 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 reimbursed by the Agency for these services, nor may the Managed Care Plan offer these services as expanded benefits. The Managed Care Plan must offer QEs to as follows:
 - (a) MMA Managed Care Plans shall offer additional quality enhancements as specified in the MMA Exhibit.
 - (b) LTC Managed Care Plans shall offer additional quality enhancements as specified in the LTC Exhibit.
 - (c) Comprehensive LTC Managed Care Plans shall offer additional quality enhancements as specified in the MMA Exhibit for enrollees with MMA benefits only and the LTC Exhibit for enrollees with LTC benefits.
- 2. The Managed Care Plan shall develop and maintain written policies and 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 actively collaborate 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's medical/case record of referrals to the community program and follow up on the enrollee's receipt of services from the community program.

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Section VI. Provider Network

A. Network Adequacy Standards

1. General Provisions

- a. The Managed Care Plan shall enter into provider contracts with a sufficient number of providers to provide all covered services to enrollees and ensure that each covered service is provided promptly and is reasonably accessible.
- b. The Managed Care Plan shall develop and maintain a provider network that meets the needs of enrollees in accordance with the requirements of this Contract.
- c. When establishing and maintaining the provider network or requesting enrollment level increases, the Managed Care Plan shall take the following into consideration as required by 42 CFR 438.206:
 - (1) The anticipated number of enrollees;
 - (2) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented;
 - (3) The numbers and types (in terms of training, experience and specialization) of providers required to furnish the covered services;
 - (4) The numbers of participating providers who are not accepting new enrollees; and
 - (5) The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees and whether the location provides physical access for Medicaid enrollees with disabilities.
- d. Except as otherwise provided in the Contract, the Managed Care Plan may limit the providers in its network based on credentials, quality indicators, and price.
- e. The Managed Care Plan shall allow each enrollee to choose among participating providers in accordance with 42 CFR 431.51.

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 capacity to provide covered services to all enrollees up to the maximum enrollment level, by region, as indicated in this Contract.

- c. 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, as follows:
 - (1) MMA Managed Care Plans shall meet the network capacity and geographic access standards specified in the MMA Exhibit.
 - (2) LTC Managed Care Plans shall meet the network capacity and geographic access standards specified in the LTC Exhibit.
 - (3) Comprehensive LTC Managed Care Plans shall meet the network capacity and geographic access standards specified in the both the MMA Exhibit and the LTC Exhibit.

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) as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

4. Timely Access Standards

- a. The Managed Care Plan shall contract with and maintain a provider network sufficient to comply with timely and geographic access standards as specified in this Contract with respect to the applicable SMMC program as follows:
 - (1) MMA Managed Care Plans and Comprehensive LTC Managed Care Plans shall comply with timely access standards specified in the MMA Exhibit.
- b. In accordance with 42 CFR 438.206 (c), the Managed Care Plan shall establish mechanisms to ensure network providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.

B. Network Development and Management Plan

1. General Provisions

- a. The Managed Care Plan shall develop and maintain an annual network development and management plan (annual network plan). The Managed Care Plan shall submit this plan annually by September 1, to the Agency.
- b. The Managed Care Plan shall develop and maintain policies and procedures to evaluate the Managed Care Plan's provider network to ensure that covered services are:
 - (1) Available and accessible, at a minimum, in accordance with the access standards in the Contract;

- (2) Provided promptly and are reasonably accessible in terms of location and hours of operation; and
 - (3) For LTC Managed Care Plans and Comprehensive LTC Managed Care Plans, home and community-based services (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.
- c. The methodology(ies) the Managed Care Plan uses to collect and analyze enrollee, provider and staff feedback about the network designs and performance, and, when specific issues are identified, the protocols for handling them.

2. Annual Network Plan Content

- a. The Managed Care Plan's annual network plan shall include the Managed Care Plan's processes to develop, maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.
- b. The Managed Care Plan's annual network plan must include a description of network design by region and county for the general population, including details regarding special populations as identified by the Managed Care Plan (e.g., medically complex). The description shall also cover:
 - (1) How enrollees access the system;
 - (2) Analysis of timely access to services; and
 - (3) Relationships among various levels of the system.
- c. The Managed Care Plan's annual network plan must 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.
- d. Managed Care Plan's annual network plan must include a description or explanation of the current status of the network by each covered service at all levels including:
 - (1) How enrollees access services;
 - (2) Analysis of timely access to services;
 - (3) Relationships between the various levels, focusing on provider-to-provider contact and facilitation of such by the Managed Care Plan (e.g., PCP, specialists, hospitals, behavioral health, ALFs, home health agencies); and
 - (4) For MMA and Comprehensive LTC Managed Care Plans, 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.

- e. The Managed Care Plan's annual network plan must address any current barriers and/or network gaps and include the following:
 - (1) The methodology used to identify barriers and network gaps;
 - (2) Immediate short-term interventions to address network gaps;
 - (3) Longer-term interventions to fill network gaps and resolve barriers;
 - (4) Outcome measures/evaluation of interventions to fill network gaps and resolve barriers;
 - (5) Projection of changes in future capacity needs, by covered service; and
 - (6) Ongoing activities for network development based on identified gaps and future needs projection.
- f. The Managed Care Plan's annual network plan must include a description of coordination between internal departments, including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (e.g., quality management, medical management/utilization management, grievances, finance, claims) that they represent on the committee.
- g. The Managed Care Plan's annual network plan must include a description of coordination with outside organizations.

3. Waiver

- a. If the Managed Care Plan is able to demonstrate to the Agency's satisfaction that a region as a whole is unable to meet network requirements, the Agency may waive the requirement at its discretion in writing. As soon as additional service providers become available, however, the Managed Care Plan shall augment its network to include such providers in order to meet the network adequacy requirements. Such a written waiver shall require attestation by the Managed Care Plan that it agrees to modify its network to include such providers as they become available.
- b. If the Managed Care Plan is unable to provide medically necessary services to an enrollee through its network, the Managed Care Plan shall cover these services in an adequate and timely manner by using providers and services that are not in the Managed Care Plan's network for as long as the Managed Care Plan is unable to provide the medically necessary services within its network.

4. 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 operations that would affect adequate capacity and services, including, but not limited to, the following:
 - (1) Changes in Managed Care Plan services; and
 - (2) Enrollment of a new population in the Managed Care Plan.
- c. The Managed Care Plan shall notify the Agency within seven (7) business days of any adverse changes to its regional provider network. An adverse change is defined as follows:
 - (1) For MMA Managed Care Plans, adverse changes to the composition of the network that impair access standards as specified in the MMA Exhibit;
 - (2) For LTC Managed Care Plans, adverse changes to the composition of the network that impair access standards as specified in the LTC Exhibit; or
 - (3) For Comprehensive LTC Managed Care Plans, adverse changes to the composition of the network that impair access standards as specified in both the MMA Exhibit and the LTC Exhibit.
- d. Significant changes in regional network composition that the Agency determines negatively impact enrollee access to services may be grounds for Contract termination or sanctions as determined by the Agency and in accordance with Section XI, Sanctions.

C. Provider Credentialing and Contracting

1. General Provision

The Managed Care Plan shall be responsible for the credentialing and recredentialing of its provider network.

2. Credentialing and Recredentialing

- a. The Managed Care Plan's credentialing and recredentialing policies and 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.
- b. The Managed Care Plan shall establish and verify credentialing and recredentialing criteria for all providers that, at a minimum, meet the Agency's Medicaid participation standards. The Agency's criteria include:
 - (1) A copy of each provider's current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualifications; 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 state license by the Agency or the Department of Health, if applicable;
 - (3) Evidence of the provider's professional liability claims history;
 - (4) Any sanctions imposed on the provider by Medicare or Medicaid;
 - (5) 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
 - (6) A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program, in accordance with the following:
 - (a) The Managed Care Plan shall verify the provider's Medicaid eligibility through the Agency's electronic background screening system; if the provider's fingerprints are not retained in the Care Provider Background Screening Clearinghouse (Clearinghouse, see s. 435.12, F.S.) and/or eligibility results are not found, the Managed Care Plan shall submit complete sets of the provider's fingerprints electronically for Medicaid Level II screening following the appropriate process described on the Agency's background screening website;
 - (b) The Managed Care Plan shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.; and
 - (c) For Individuals listed in s. 409.907(8)(a), F.S., for whom criminal history background screening cannot be documented, the Managed Care Plan must provide fingerprints electronically following the process described on the Agency's background screening website.
- c. The Managed Care Plan's credentialing and recredentialing files must document the education, experience, prior training and ongoing service training for each staff member or provider rendering services.

- d. The Managed Care Plan shall collect and verify each provider's National Provider Identifier (NPI) and taxonomy as part of the credentialing and recredentialing process, as applicable.
- e. The Managed Care Plan shall establish and verify additional provider credentialing and recredentialing criteria with respect to the applicable SMMC program as follows:
 - (1) MMA Managed Care Plans shall verify the additional criteria specified in the MMA Exhibit.
 - (2) LTC Managed Care Plans shall verify the additional criteria specified in the LTC Exhibit.
 - (3) Comprehensive LTC Managed Care Plans shall verify the additional criteria specified in the MMA Exhibit for MMA providers and the LTC Exhibit for LTC providers. Comprehensive LTC Managed Care Plans shall verify the additional criteria for all mixed service providers specified in the MMA Exhibit.
- f. The Managed Care Plan must submit disclosures and notifications to the federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) and to MPI in accordance with s. 1128, s. 1156, and s. 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in Section VIII.F.
- g. The Managed Care Plan shall not pay, employ or contract with individuals on the state or federal exclusions lists.
- h. If the Managed Care Plan declines to include individual providers or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

3. Provider Registration

- a. The Managed Care Plan shall ensure that all providers are eligible for participation in the Medicaid program. 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.
- b. The Managed Care Plan shall require each provider to have a unique Florida Medicaid provider number, Medicaid provider registration number or documentation of submission of the Medicaid provider registration form.
- c. The Managed Care Plan shall require each provider to have a National Provider Identifier (NPI) in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The provider contract shall require providers to submit all NPIs to the Managed Care Plan. The Managed Care Plan shall file the providers' NPIs as part of its provider network file to the Agency or its agent, as set forth in Section XIV, 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:

- (1) Individuals or organizations that furnish atypical or nontraditional services that are only indirectly related to the provision of health care (examples include taxis, home modifications, home delivered meals and homemaker services); and
- (2) Individuals or businesses that only bill or receive payment for, but do not furnish, health care services or supplies (examples include billing services and repricers).

4. Minority Recruitment and Retention Plan

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

5. 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, solely on the basis of such license or certification, in accordance with s. 1932(b) (7) of the Social Security Act (as enacted by s. 4704[a] of the Balanced Budget Act of 1997).
- b. The Managed Care Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments.

6. Provider Contract Requirements

- a. The Managed Care Plan shall submit all provider contract templates for Agency review to determine compliance with Contract requirements. The Managed Care Plan shall submit to the Agency, upon request, individual provider contracts as required by the Agency. If the Agency determines, at any time, that a provider contract is not in compliance with a Contract requirement, the Managed Care Plan shall promptly revise the provider contract to bring it into compliance. In addition, the Managed Care Plan may be subject to sanctions pursuant to Section XIV, Sanctions, and/or liquidated damages pursuant to Section XIII, Liquidated Damages.
- b. The Managed Care Plan shall ensure all provider contracts comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.
- c. All provider contracts and amendments executed by the Managed Care Plan shall be in writing, signed and dated by the Managed Care Plan and the provider, and shall meet the following requirements:

- (1) Contain no provision that in any way prohibits or restricts the provider from entering into a commercial contract with any other Managed Care Plan (see s. 641.315, F.S.);
- (2) Contain no provision requiring the provider to contract for more than one (1) Managed Care Plan product or otherwise be excluded (see s. 641.315, F.S.);
- (3) Not prohibit a provider from acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee for the enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
- (4) Not prohibit a provider from discussing treatment or non-treatment options with enrollees that may not reflect the Managed Care Plan's position or may not be covered by the Managed Care Plan;
- (5) Not prohibit a provider from advocating on behalf of the enrollee in any grievance system or UM process, or individual authorization process to obtain necessary services;
- (6) Require providers to offer hours of operation that are no less than the hours of operation offered to commercial Managed Care Plan members or comparable Medicaid fee-for-service recipients if the provider serves only Medicaid recipients;
- (7) Specify covered services and populations to be served under the provider contract;
- (8) Require providers to immediately notify the Managed Care Plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims or otherwise;
- (9) For nursing facility and hospice, include a bed hold days provision that comports with Medicaid FFS bed hold days policies and procedures;
- (10) Require all direct service providers to complete abuse, neglect and exploitation training;
- (11) Include provisions for the immediate transfer to another provider if the enrollee's health or safety is in jeopardy;
- (12) Require providers of transitioning enrollees to cooperate in all respects with providers of other Managed Care Plans to assure maximum health outcomes for enrollees;
- (13) Provide for continuity of treatment in the event a provider contract terminates during the course of an enrollee's treatment by that provider;
- (14) Prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of this Contract;

- (15) Require the provider to look solely to the Managed Care Plan for compensation for services rendered, with the exception of nominal cost sharing and patient responsibility, pursuant to the Medicaid State Plan and the Medicaid Provider General and Coverage and Limitations Handbooks
- (16) Specify that any claims payment be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the service units, the amount of reimbursement and the identification of the Managed Care Plan;
- (17) Require the provider to cooperate with the Managed Care Plan's peer review, grievance, QI and UM activities, provide for monitoring and oversight, including monitoring of services rendered to enrollees, by the Managed Care Plan (or its subcontractor), and identify the measures that will be used by the Managed Care Plan to monitor the quality and performance of the provider. If the Managed Care Plan has delegated the credentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with the Managed Care Plan's and the Agency's credentialing requirements as found in Section VI. C.2.;
- (18) Require that providers and subcontractors comply with the Managed Care Plan's cultural competency plan;
- (19) 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;
- (20) Specify that the provider shall comply with the marketing requirements specified in Section III.D.;
- (21) 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;
- (22) Require that records be maintained for a period not less than six (6) years from the close of the Contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the provider contract is continuous;
- (23) Specify that DHHS, the Agency, DOEA, MPI and MFCU shall have the right to inspect, evaluate, and audit all of the following related to this Contract:
 - (a) Pertinent books;
 - (b) Financial records;
 - (c) Medical/case records; and
 - (d) Documents, papers and records of any provider involving financial transactions;

- (24) Provide for submission of all reports and clinical information required by the Managed Care Plan, including Child Health Check-Up reporting (if applicable);
- (25) Require providers to submit timely, complete and accurate encounter data to the Managed Care Plan in accordance with the requirements of Section VIII.E.;
- (26) 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;
- (27) Require compliance with the background screening requirements of this Contract;
- (28) Require safeguarding of information about enrollees according to 42 CFR 438.224;
- (29) Require compliance with HIPAA privacy and security provisions;
- (30) Require providers to submit notice of withdrawal from the network at least ninety (90) days before the effective date of such withdrawal;
- (31) Specify that in addition to any other right to terminate the provider contract, and notwithstanding any other provision of this Contract, the Agency or the Managed Care Plan may request immediate termination of a provider contract if, as determined by the Agency, a provider fails to abide by the terms and conditions of the provider contract, or in the sole discretion of the Agency, the provider fails to come into compliance with the provider contract within fifteen (15) days after receipt of notice from the Managed Care Plan specifying such failure and requesting such provider abide by the terms and conditions thereof;
- (32) Specify that any provider whose participation is terminated pursuant to the provider contract for any reason shall utilize the applicable appeals procedures outlined in the provider contract. No additional or separate right of appeal to the Agency or the Managed Care Plan is created as a result of the Managed Care Plan's act of terminating, or decision to terminate, any provider under this Contract. Notwithstanding the termination of the provider contract with respect to any particular provider, this Contract shall remain in full force and effect with respect to all other providers;
- (33) Require an exculpatory clause, which survives provider contract termination, including breach of provider contract due to insolvency, which assures that neither Medicaid recipients nor the Agency shall be held liable for any debts of the provider;
- (34) Require that the provider secure and maintain during the life of the provider contract workers' compensation insurance (complying with the Florida workers' compensation law) for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Managed Care Plan;

- (35) 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;
 - (36) 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 contract. This clause must survive the termination of the provider contract, 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;
 - (37) Make provisions for a waiver of those terms of the provider contract that, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract; and
 - (38) Specify that any contracts, agreements or subcontracts entered into by the provider for purposes of carrying out any aspect of this Contract shall include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of this Contract.
- d. The Managed Care Plan shall include additional provisions in its provider contracts with respect to the applicable SMMC program as follows:
 - (1) MMA Managed Care Plans shall include the additional provisions specified in the MMA Exhibit.
 - (2) LTC Managed Care Plans shall include the additional provisions specified in the LTC Exhibit.
 - (3) Comprehensive LTC Managed Care Plans shall include additional provisions specified in the MMA Exhibit for MMA only providers, the LTC Exhibit for LTC only providers and the MMA Exhibit for mixed service providers.
 - e. No provider contract that the Managed Care Plan enters into with respect to performance under this Contract shall in any way relieve the Managed Care Plan of any responsibility for the provision of services or duties under this Contract. The Managed Care Plan shall assure that all services and tasks related to the provider contract are performed in accordance with the terms of this Contract. The Managed Care Plan shall identify in its provider contract any aspect of service that may be subcontracted by the provider.
 - f. The Managed Care Plan shall prohibit discrimination with respect to participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of such license or certification. This provision shall not be construed as an any willing

provider law, as it does not prohibit the Managed Care Plan from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision does not interfere with measures established by the Managed Care Plan that are designed to maintain quality and control costs;

7. Network Performance Management

- a. The Managed Care Plan shall monitor the quality and performance of each participating provider.
- b. The Managed Care Plan shall include using performance measures specified and collected by the Agency, as well as additional measures agreed upon by the provider and the Managed Care Plan.
- c. The Managed Care Plan is not prohibited from including providers only to the extent necessary to meet the needs of the Managed Care Plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Managed Care Plan.
- d. The Managed Care Plan shall have policies and 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.

8. 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 notify enrollees in accordance with the provisions of this Contract and state and federal law regarding provider termination. Additionally, the Managed Care Plan shall provide notice to enrollees as follows:
 - (1) Pursuant to s. 409.982(1), F.S., if a LTC Managed Care Plan or Comprehensive LTC Managed Care Plan excludes an aging network provider for failure to meet quality or performance criteria specified in s. 409.967, F.S., the Managed Care Plan must provide written notice to all enrollees who have chosen that provider for care, and the notice must be provided at least thirty (30) days before the effective date of the exclusion.
 - (2) For MMA Managed Care Plans and Comprehensive LTC Managed Care Plans, if a PCP ceases participation in the Managed Care Plan's network, the Managed Care Plan shall send written notice to the enrollees who have chosen the provider as their PCP. This notice must be provided at least thirty (30) days before the effective date of the termination notice. The requirement 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.

- (3) Pursuant to s. 409.975(1)(c), F.S., if a MMA or Comprehensive LTC Managed Care Plan excludes any essential provider from its network for failure to meet quality or performance criteria, the Managed Care Plan must provide written notice to all enrollees who have chosen that provider for care. The notice shall be provided at least thirty (30) days before the effective date of the exclusion.
- c. The Managed Care Plan shall notify the provider and enrollees in active care at least sixty (60) days before the effective date of the suspension or termination of a provider from the network. If the termination was for "cause," the Managed Care Plan shall provide to the Agency the reasons for termination.
- d. If an enrollee is receiving prior authorized care from any provider who becomes unavailable to continue to provide services, the Managed Care Plan shall notify the enrollee in writing within ten (10) days from the date the Managed Care Plan becomes aware of such unavailability. These requirements to provide notice prior to the effective dates of termination shall be waived in instances where a provider becomes physically unable to care for enrollees due to illness, death or leaving the Managed Care Plan's region(s) and fails to notify the Managed Care Plan, or when a provider fails credentialing. Under these circumstances, notice shall be issued immediately upon the Managed Care Plan's becoming aware of the circumstances.
- e. In a case in which a patient's health is subject to imminent danger or a provider's ability to practice medicine or otherwise provide services is effectively impaired by an action by the Board of Medicine or other governmental agency, notice to the provider, the enrollee and the Agency shall be immediate. The Managed Care Plan shall work cooperatively with the Agency to develop and implement a plan for transitioning enrollees to another provider.
- 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 recipients until the enrollee selects another provider as specified below:
 - (1) For MMA and LTC services, continuation shall be provided for a minimum of sixty (60) days after the termination of the provider's contract for the provision of services;
 - (2) For MMA services, continuation shall not exceed six (6) months after the termination of the provider's contract for the provision of MMA services; and
 - (3) For any pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, continuation shall be provided until the completion of postpartum care.
- g. Notwithstanding the provisions in this section, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

- h. For continued 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.
- i. The requirements set forth in this section, shall not apply to providers who have been terminated from the Managed Care Plan for cause.
- j. The Managed Care Plan shall report provider terminations, including documentation of enrollee notification, and additions as specified in Section XIV, 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 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 corrective action when needed to ensure compliance.

2. Provider Handbook and Bulletin Requirements

- a. The Managed Care Plan shall issue a provider handbook to all providers at the time the provider credentialing is complete.
- b. The Managed Care Plan may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the handbook from the Managed Care Plan's website. This notification shall also detail how the provider can request a hard copy from the Managed Care Plan at no charge.
- 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, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are met.
- d. The Managed Care Plan's provider handbook must, at a minimum, include the following information:
 - (1) Description of the Medicaid program and the SMMC program;
 - (2) Listing of covered services;
 - (3) Emergency service responsibilities;

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

- e. The Managed Care Plan shall include information in provider handbooks with respect to the applicable SMMC program as follows:
 - (1) MMA Managed Care Plans shall provide the additional information specified in the MMA Exhibit.
 - (2) LTC Managed Care Plans shall provide the additional information specified in the LTC Exhibit.
 - (3) Comprehensive LTC Managed Care Plans shall issue one (1) provider handbook to all network providers and shall provide additional information as specified in the both the MMA Exhibit and the LTC Exhibit.
- f. 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 offer training to all providers and their staff regarding the requirements of this Contract 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 program standards and this Contract.
- c. The Managed Care Plan shall provide training and education to providers regarding the Managed Care Plan's enrollment and credentialing requirements and processes.
- d. For a period of at least twelve (12) months following the implementation of this Contract, the Managed Care Plan shall conduct monthly education and training for providers regarding claims submission and payment processes, which shall include, but not be limited to, an explanation of common claims submission errors and how to avoid those errors. Such period may be extended as determined necessary by the Agency.
- e. 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. If the Managed Care Plan provides such training to its participating and direct service providers, training materials must, at minimum, include the Agency's specified standards.

4. Toll-Free Provider Help Line

- a. The Managed Care Plan shall operate a toll-free telephone help line to respond to provider questions, comments and inquiries.
- b. The Managed Care Plan shall develop provider help line policies and procedures that address staffing, personnel, hours of operation, access and response standards,

monitoring of calls via recording or other means and compliance with Managed Care Plan standards.

- c. The help line must be staffed twenty-four hours a day, seven days a week (24/7) to respond to prior authorization requests.
- d. This help line shall have staff to respond to provider questions in all other areas, including but not limited to the provider complaint system and provider responsibilities, between the hours of 8 a.m. and 7 p.m. in the provider's time zone, Monday through Friday, excluding state holidays.
- e. The Managed Care Plan shall ensure that after regular business hours the provider services line (not the prior authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for an enrollee with an emergency or urgent medical condition. This requirement shall not be construed to mean that the provider must obtain verification before providing emergency services and care.
- f. The Managed Care Plan's call center systems shall have the capability to track call management metrics identified in Section IV, Enrollee Services and Grievance Procedures.

5. Provider Complaint System

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

- (3) Allow providers forty-five (45) days to file a written complaint for issues that are not about claims;
 - (4) Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
 - (5) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the Managed Care Plan's written policies and procedures;
 - (6) Document why a complaint is unresolved after fifteen (15) days of receipt and provide written notice of the status to the provider every fifteen (15) days thereafter;
 - (7) 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; and
 - (8) Ensure that Managed Care Plan executives with the authority to require corrective action are involved in the provider complaint process.
- e. The Managed Care Plan shall report provider complaints as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

E. Medical/Case Records Requirements

1. General Provisions

- a. The Managed Care Plan shall ensure maintenance of medical/case records for each enrollee in accordance with this section and with 42 CFR 431 and 42 CFR 456. Medical/case records shall include the quality, quantity, appropriateness and timeliness of services performed under this Contract.
- b. The Managed Care Plan shall comply with additional documentation requirements with respect to the applicable SMMC program as follows:
 - (1) MMA Managed Care Plans shall comply with the additional requirements specified in the MMA Exhibit.
 - (2) LTC Managed Care Plans shall comply with the additional requirements specified in the LTC Exhibit.
 - (3) Comprehensive LTC Managed Care Plans shall comply with the additional requirement as specified in the both the MMA Exhibit and the LTC Exhibit.

2. Confidentiality of Medical/Case Records

- a. The Managed Care Plan shall have a policy to ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- b. The Managed Care Plan shall have a policy to ensure the confidentiality of medical/case records in accordance with 42 CFR, Part 431, Subpart F.
- c. The enrollee or authorized representative shall sign and date a release form before any clinical/case records can be released to another party. Clinical/case record release shall occur consistent with state and federal law.

3. Standards for Medical/Case Records

- a. The Managed Care Plan shall follow the medical/case record standards set forth below for each enrollee's medical/case records, as appropriate:
 - (1) Include the enrollee's identifying information, including name, enrollee identification number, date of birth, sex and legal guardianship (if any);
 - (2) Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications;
 - (3) Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases;
 - (4) Document referral services in enrollees' medical/case records;
 - (5) Each record shall be legible and maintained in detail;
 - (6) All records shall contain an immunization history;
 - (7) All records shall contain information relating to the enrollee's use of tobacco, alcohol, and drugs/substances;
 - (8) All records shall contain summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up;
 - (9) All records shall reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
 - (10) All records shall identify enrollees needing communication assistance in the delivery of health care services;
 - (11) All entries shall be dated and signed by the appropriate party;

- (12) All entries shall indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider;
 - (13) All entries shall indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports;
 - (14) All entries shall indicate therapies administered and prescribed;
 - (15) All entries shall include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider;
 - (16) All entries shall include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services; and
 - (17) Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13).
- b. The Managed Care Plan shall maintain written policies and procedures for enrollee advance directives which address how the Managed Care Plan will access copies of any advance directives executed by the enrollee. All medical/case 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) and whether or not the enrollee has executed an advance directive. 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.

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Section VII. Quality and Utilization Management

A. Quality Improvement

1. General Provisions

- a. The Managed Care Plan shall have an ongoing quality improvement program (QI program) that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. (See 42 CFR 438.204 and 438.240.)
- b. The Managed Care Plan shall cooperate with the Agency and the external quality review organization (EQRO). The Agency will set methodology and standards for quality improvement (QI) with advice from the EQRO.
- c. The Managed Care Plan shall have a cooperative agreement with the Florida Medical School Quality Network when the network becomes operational, in accordance with s. 409.975(2), F.S.
- d. The Managed Care Plan shall monitor, evaluate and improve the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees through peer review, performance improvement projects (PIP), medical/case record audits, performance measures, surveys and related activities.
- e. The Managed Care Plan shall identify and track critical incidents and shall review and analyze critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues.

2. Performance Incentives

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

3. Accreditation

Pursuant to s. 409.967(2)(e)3., F.S., the Managed Care Plan must be accredited by a nationally recognized accrediting body, or have initiated the accreditation process within one (1) year after this Contract was executed. If the Managed Care Plan is not accredited within eighteen (18) months after executing this Contract the Agency may

terminate the Contract for failure to comply with the Contract. The Agency shall suspend all assignments until the Managed Care Plan is accredited by a nationally recognized body.

For managed Behavioral Health Organization subcontracts:

- a. If the Managed Care Plan subcontracts with a managed behavioral health organization (MBHO) for the provision of behavioral health services, the MBHO must be accredited in the same manner as specified in s. 641.512, F.S., and Rule 59A-12.0072, F.A.C., as follows:
 - (1) If the MBHO has been in operation for less than two (2) years, it must apply for accreditation from a recognized national accreditation organization within one (1) year of start-up and achieve full accreditation within two (2) years of beginning operations.
 - (2) If the MBHO has been in operation for at least two (2) years, it must be fully accredited by at least one of the recognized national accreditation organizations.
- b. All MBHOs must undergo reaccreditation not less than once every three (3) years.

4. Oversight of Quality Improvement

- a. The Managed Care Plan's governing body shall oversee and evaluate the QI program. The role of the Managed Care Plan's governing body shall include providing strategic direction to the QI program, as well as ensuring the quality improvement plan (QI plan) is incorporated into operations throughout the Managed Care Plan.
- b. The Managed Care Plan shall have a QI program committee. The Managed Care Plan's medical director shall either chair or co-chair the committee. Other committee representatives shall be selected to meet the needs of the Managed Care Plan but must include: 1) the quality director; 2) the grievance coordinator; 3) the care coordination/case management manager; 4) the utilization review manager; 5) the credentialing manager; 6) the risk manager/infection control nurse; 7) an enrollee advocate representative (the Managed Care Plan is encouraged to include multiple advocate representatives on the QI program committee); and 8) provider representation (either through providers serving on the committee or through a provider liaison position, such as a representative from the network management department). Individual staff members may serve in multiple roles on the committee if they also serve in multiple positions within the Managed Care Plan.
- c. Comprehensive LTC Managed Care Plans and LTC Managed Care Plans shall appoint a Geriatrician to the QI program committee. The Geriatrician shall be a qualified geriatrician, with a current active unencumbered Florida license under Chapter 458 or 459, F.S., and further certified in Geriatric Medicine. The Geriatrician shall be responsible for establishing and monitoring the implementation and administration of geriatric management protocols to support long-term care requiring geriatric practice.

- d. The committee must meet no less than quarterly. Its responsibilities shall include the development and implementation of a written QI plan, which incorporates the strategic direction provided by the governing body.
- e. The Managed Care Plan shall maintain minutes of all QI committee and sub-committee meetings and make the minutes available for Agency review on request. The minutes shall demonstrate resolution of items or be brought forward to the next meeting.

5. Quality Improvement Plan

- a. The Managed Care Plan shall develop and maintain a written quality improvement plan (QI plan) and submit its QI plan to the Agency within thirty (30) days from execution of the initial Contract. The Managed Care Plan shall make the QI Plan available to the Agency as requested.
- b. The written QI plan must clearly describe the mechanism within the Managed Care Plan for strategic direction from the governing body to be provided to the QI program and for the QI program committee to communicate with the governing body.
- c. The QI plan must describe the QI program and committee structure and the committee's role in monitoring and evaluation of quality and appropriateness of care provided to enrollees including, but not limited to, review of quality of care and service concerns, grievances, enrollee rights, adverse events, patient safety and utilization review processes, including:
 - (1) The process for selecting and directing task forces, committees or other Managed Care Plan activities to review areas of concern in the provision of health care services to enrollees;
 - (2) The role of its providers in giving input to the QI program, whether that is by membership on the committee, its sub-committees or other means;
 - (3) A description of the Managed Care Plan positions assigned to the QI program, including a description of why each position was chosen to serve on the committee and the roles each position is expected to fulfill. The resumes of QI program committee members shall be made available upon the Agency's request;
 - (4) Specific training about quality that will be provided by the Managed Care Plan to staff serving in the QI program. At a minimum, the training shall include protocols developed by CMS regarding quality. CMS protocols may be obtained from:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>; and
www.cms.hhs.gov/MedicaidManaqCare
 - (5) A standard for how the Managed Care Plan shall assure that QI program activities take place throughout the Managed Care Plan and document results

of QI program activities for reviewers. Protocols for assigning tasks to individual staff persons and selection of time standards for completion shall be included.

- d. The QI plan must describe Managed Care Plan's guiding philosophy for quality management. The Managed Care Plan should identify any nationally recognized, standardized approach that is used (e.g., PDCA, Rapid Cycle Improvement, FOCUS-PDCA, Six Sigma). Selection of performance indicators and sources for benchmarking also shall be included in addressing the following specific components of the QI plan:
 - (1) 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:
 - (a) Service availability and accessibility;
 - (b) Quality of services;
 - (c) Network quality;
 - (d) Care planning and implementation;
 - (e) Coordination and continuity of care; and
 - (f) Member safety;
 - (2) The process to direct and analyze periodic review of enrollee service utilization patterns (including detection of under and over utilization of services);
 - (3) Monitoring and evaluation of non-clinical aspects of service with timely resolution of problems and improvement in processes;
 - (4) Monitoring and evaluation of network quality including, but not limited to:
 - (a) Credentialing and recredentialing processes;
 - (b) Performance improvement projects;
 - (c) Performance measurement;
 - (d) Problem resolution and improvement approach and strategy;
 - (e) Annual program evaluation; and
 - (f) Metrics for monitoring the quality and performance of participating providers related to their continued participation in the network.
- e. The QI plan must also describe:
 - (1) The process for selecting evaluation and study design procedures;

- (2) A standard describing the process the QI program will use to review and suggest new and/or improved QI activities;
- (3) Description of the health management information systems that will be used to support the QI program;
- (4) The process to report findings to appropriate executive authority, staff and departments within the Managed Care Plan as well as relevant stakeholders, such as participating providers. The QI plan also shall include how this communication will be documented for Agency review; and
- (5) The process for annual QI program evaluation.

6. EQRO Coordination Requirements

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

B. Performance Measures (PMs)

1. Required Performance Measures (PMs)

- 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 Abandonment (CAB)
2	Call Answer Timeliness (CAT)

- b. The Managed Care Plan shall collect and report with additional PMs with respect to the applicable SMMC program as follows:
 - (1) MMA Managed Care Plans shall collect and report results of additional PMs to the Agency as specified in the MMA Exhibit.
 - (2) LTC Managed Care Plans shall collect and report results of additional PMs to the Agency as specified in the LTC Exhibit.

- (3) Comprehensive LTC Managed Care Plans shall collect and report results of additional PMs to the Agency as specified in both the MMA Exhibit and the LTC Exhibit.
- c. The Managed Care Plan shall report results of PMs to the Agency as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide and Performance Measures Specifications Manual.
- d. The Agency may add or remove PM requirements with sixty (60) days' advance notice.

2. 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 National Committee for Quality Assurance (NCQA) certified HEDIS auditor that the performance measure data reported for the previous calendar year are fairly and accurately presented. The report shall be certified by the HEDIS auditor, and the auditor must certify the actual file submitted to the Agency. Extensions to the due date may be granted by the Agency for up to thirty (30) days and require a written request signed by the Managed Care Plan CEO or designee. The request must be received by the Agency before the report due date and the delay must be due to unforeseen and unforeseeable factors beyond the Managed Care Plan's control. Extensions will not be granted on oral requests.
- b. A report, certification or other information required for PM reporting is incomplete when it does not contain all data required by the Agency or when it contains inaccurate data. A report that is incomplete or contains inaccurate data shall be considered deficient and each instance shall be subject to administrative penalties pursuant to Section XI, Sanctions. A report or certification is "false" if done or made with the knowledge, of the preparer or a superior of the preparer, that it contains data or information that is not true or not accurate. A report that contains an "NR" due to bias for any or all measures by the HEDIS auditor, or is "false," shall be considered deficient and will be subject to administrative penalties pursuant to Section XI Sanctions. The Agency may refer cases of inaccurate or "false" reports to its Bureau of Medicaid Program Integrity.

3. Publication of Performance Measures

Pursuant to s. 409.967(2)(e)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.

4. Performance Targets and Penalties

- a. The Managed Care Plan shall meet Agency-specified performance targets for all PMs. For HEDIS and Agency-defined measures, the Agency will establish performance targets prior to execution of the Contract. The Agency may change

these targets and/or change the timelines associated with meeting the targets. The Agency shall make these changes with sixty (60) days' advance notice to the Managed Care Plan.

- b. If the Agency determines that the Managed Care Plan performance relative to the performance targets is not acceptable, the Agency may require the Managed Care Plan to submit a performance measure action plan (PMAP) within thirty (30) days after the notice of the determination in the format prescribed by the Agency. If the Managed Care Plan fails to provide a PMAP within the time and format specified by the Agency or fails to adhere to its own PMAP, the Agency may sanction the Managed Care Plan in accordance with the provisions of Section XI, Sanctions, and require the Managed Care Plan to submit reports to the Agency on the progress of all PMAPs.
- c. If the Agency-defined or HEDIS PMs indicate that the Managed Care Plan's performance is not acceptable, the Agency may sanction the Managed Care Plan in accordance with the provisions of Section XI, Sanctions. When considering whether to impose specific sanctions, such as applying civil monetary penalties or limiting enrollment activities or automatic assignments, the Agency may consider the Managed Care Plan's cumulative performance on all quality and performance measures.
- d. If the Managed Care Plan's performance on Agency-defined and HEDIS performance measures is not acceptable and the Managed Care Plan's performance measure report is incomplete or contains inaccurate data, the Agency may sanction the Managed Plan in accordance with the provisions of Section XI, Sanctions. Acceptable performance under this section will be determined using the initial performance measure submission, due July 1, with its corresponding attestation of accuracy and completeness. In the event that the Managed Plan later determines the submission contained errors, the Agency may consider using the updated data for public reporting purposes. In that instance, the earliest submission will apply. Likewise, eligibility for incentives and/or pay-for-performance initiatives will be determined based on the initial submission unless subsequent submissions indicate that the July 1 submission had inflated performance ratings.

C. Performance Improvement Projects (PIPs)

1. General Provisions

- a. Annually, 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.
 - (1) MMA Managed Care Plans shall perform the Agency-approved statewide performance improvement projects as specified in the MMA Exhibit;
 - (2) LTC Managed Care Plans shall perform the Agency-approved statewide performance improvement projects as specified in the LTC Exhibit; and

- (3) Comprehensive LTC Managed Care Plans shall perform the Agency-approved statewide performance improvement projects as specified in both the MMA Exhibit and the LTC Exhibit.
- b. All PIPs shall achieve, through ongoing measurements and intervention, significant improvement to the quality of care and service delivery, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at the ninety-five percent (95%) confidence level and must be sustained for a period of two (2) additional re-measurements. Measurement periods and methodologies shall be submitted to the Agency for approval before initiation of the PIP. PIPs that have successfully achieved sustained improvement, as approved by the Agency, shall be considered complete and shall not meet the requirement for one (1) of the number of PIPs required by the Agency, although the Managed Care Plan may wish to continue to monitor the performance indicator as part of its overall QI program. In this event, the Managed Care Plan shall select a new PIP and submit it to the Agency for approval.
 - c. Each PIP shall include a sample size sufficient to produce a statistically significant result.
 - d. The Managed Care Plan's PIP methodology must comply with the most recent protocol set forth by CMS, Conducting Performance Improvement Projects, available from the websites listed above.
 - e. Populations selected for study under the PIP shall be specific to this Contract and shall not include Medicaid recipients from other states, or enrollees from other lines of business. If the Managed Care Plan contracts with a separate entity for management of particular services, PIPs conducted by the separate entity shall not include enrollees for other Managed Care Plans served by that entity.

2. PIP Proposals

- a. On or before August 1, 2014, the Managed Care Plan shall submit to the Agency in writing, a proposal for each planned PIP.
- b. Each initial PIP proposal shall be submitted using the most recent version of the EQRO PIP validation form. Instructions for using the form to submit PIP proposals and updates may be obtained from the Agency.
- c. Activities 1 through 6 of the EQRO PIP validation form must be addressed in the PIP proposal.
- d. In the event the Managed Care Plan elects to modify a portion of the PIP proposal after initial Agency approval, a written request to do so must be submitted to the Agency.

3. Annual PIP Submission

- a. The Managed Care Plan shall submit ongoing PIPs annually by August 1 to the Agency for review and approval.
- 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 contract with a qualified, Agency-approved, NCQA-certified vendor to conduct annual enrollee satisfaction surveys required under this Contract.
- b. 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.
- c. The Managed Care Plan shall submit to the Agency in writing, by the date specified by the Agency of each Contract year, a proposal for survey administration and reporting that includes identification of 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 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 as follows:
 - (1) MMA Managed Care Plans shall conduct enrollee satisfaction surveys as specified in the MMA Exhibit;
 - (2) LTC Managed Care Plans shall conduct enrollee satisfaction surveys as specified in the LTC Exhibit; and

- (3) Comprehensive LTC Managed Care Plans shall conduct enrollee satisfaction surveys as specified in both the MMA Exhibit and the LTC Exhibit.

2. Provider Satisfaction Survey

- a. The Managed Care Plan shall conduct an annual Provider Satisfaction survey. The Managed Care Plan shall submit a provider satisfaction survey plan (including tool and methodology) to the Agency for written approval within ninety (90) days after initial Contract execution and annually thereafter.
- b. The Managed Care Plan shall conduct the survey by the end of the first year of this Contract.
- c. The survey tool should utilize a four-point Likert scale and shall include the following domains:
 - (1) Provider relations and communication;
 - (2) Clinical management processes;
 - (3) Authorization processes including denials and appeals;
 - (4) Timeliness of claims payment and assistance with claims processing;
 - (5) Complaint resolution process; and
 - (6) Care coordination/ case management support.
- d. The Managed Care Plan shall 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. 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 the 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 (see 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 grievances filed against the provider relating to medical treatment;
 - (2) Evaluation of the appropriateness of care rendered by providers;

- (3) Implementation of corrective action(s) when the Managed Care Plan deems it necessary to do so;
- (4) Development of policy recommendations to maintain or enhance the quality of care provided to enrollees;
- (5) Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider's medical/case records, adherence to standards generally accepted by a provider's peers and the process and outcome of a provider's care;
- (6) Appointment of a peer review committee, as a sub-committee to the QI program committee, to review provider performance when appropriate. The medical director or a designee shall chair the peer review committee. Its membership shall be drawn from the provider network and include peers of the provider being reviewed;
- (7) Receipt and review of all written and oral allegations of inappropriate or aberrant service by a provider; and
- (8) Education of enrollees and Managed Care Plan staff about the peer review process, so that enrollees and the Managed Care Plan staff can notify the peer review authority of situations or problems relating to providers.

3. Medical/Case Record Review

- a. The Managed Care Plan shall establish and implement a mechanism to ensure provider records meet established medical/case record standards. If the Managed Care Plan is not yet fully accredited by a nationally recognized accrediting body, the Managed Care Plan shall establish processes for medical/case record review that meet or exceed nationally recognized accrediting body medical/case record review standards. The Managed Care Plan shall conduct medical/case record reviews to ensure that enrollees are provided high quality health care that is documented according to established standards below and in Section VI.E, Medical/Case Record Requirements.
- b. By June 1 of each Contract year, the Managed Care Plan shall submit a written strategy for conducting medical/case 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;
 - (3) Sampling methodology for case selection;
 - (4) The anticipated number of reviews by practice site (non-facility service providers such as home health agencies with multiple offices locations serving the region);

- (5) Record confidentiality and security;
 - (6) The tool that the Managed Care Plan will use to review each site;
 - (7) Analysis and reporting, and
 - (8) How the Managed Care Plan shall link the information compiled during the review to other Managed Care Plan functions (e.g., QI, recredentialing, peer review).
- c. The Managed Care Plan shall conduct these reviews at all provider and facility provider sites (provider sites refers to service providers such as home health agencies with multiple office locations serving a region and facility provider sites refers to assisted living facilities, adult family care homes and adult foster care facilities sites) that meet the criteria in this subsection.
 - d. The Managed Care Plan shall conduct medical/case record reviews of all provider sites with a pattern of complaints or poor quality outcomes.
 - e. The standards, which must include all medical/case record documentation requirements addressed in this Contract, must be distributed to all providers.
 - f. The Managed Care Plan shall incorporate additional requirements into the conduct these medical/case record reviews as follows:
 - (1) MMA Managed Care Plans shall conduct reviews in accordance with standards specified in the MMA Exhibit;
 - (2) LTC Managed Care Plans shall conduct reviews in accordance with standards specified in the LTC Exhibit; or
 - (3) Comprehensive LTC Managed Care Plans shall conduct reviews in accordance with standards specified in the MMA Exhibit for enrollees with MMA benefits only and in the LTC Exhibit for enrollees with LTC benefits.

F. Other Quality Management Requirements

1. Critical Incidents

- a. The Managed Care Plan shall develop and implement a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety, or welfare of enrollees. Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents.
- b. The Managed Care Plan shall require participating and direct service providers to report adverse incidents to the Managed Care Plan within twenty-four (24) hours of the incident. The Managed Care Plan must ensure that all participating and direct service providers are required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours of the incident. Reporting will include

information including the enrollee's identity, description of the incident and outcomes including current status of the enrollee.

- c. The Managed Care Plan shall report suspected abuse, neglect and exploitation of enrollees immediately, in accordance with s.30.201 and Chapter 415, F.S. The Managed Care Plan shall report suspected cases of abuse, neglect and/or exploitation to the appropriate protective services unit/hotline
- d. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee's case file, that is designated as confidential. Such file shall be made available to the Agency upon request.
- e. The Managed Care Plan shall implement and maintain a risk-management program.
- f. 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.
- g. Enrollee quality of care issues must be reported to and a resolution coordinated with the Managed Care Plan's Quality Management Department.
- h. The Managed Care Plan shall report to the Agency, as specified in Section XIV, Reporting Requirements, and in the Managed Care Plan Report Guide, and in the manner and format determined by the Agency, any death and any adverse incident that could impact the health or safety of an enrollee (e.g., physical or sexual abuse) within twenty-four (24) hours of detection or notification.
- i. The Managed Care Plan shall report a summary of critical incidents in a report to the Agency as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.
- j. The Managed Care Plan, shall report to the Agency all serious enrollee injuries occurring through health services within fifteen (15) days after the Managed Care Plan received information about the injury. The Managed Care Plan must use the Agency's Division of Health Quality Assurance's (HQA's) online Code 15 report to document and report the incident. The Managed Care Plan can find the Code 15 report at: http://ahca.myflorida.com/SCHS/RiskMgtPubSaftey/on_line.shtml
- k. 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.

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

- a. The Managed Care Plan shall furnish specific data requested in order for the Agency to conduct the medical/case record audit, including audit of enrollee plan of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under this Contract.

- b. If the medical/case record audit and/or other document audits indicate that quality of care is not acceptable within the terms of this Contract, the Managed Care Plan shall correct the problem immediately and may be required to submit a CAP to address the problem. The CAP shall be time limited based upon the nature of the deficiency. Regardless of a CAP, health and safety issues, and problems not corrected, shall result in the Agency sanctioning the Managed Care Plan, in accordance with the provisions of Section XI, Sanctions, and may immediately terminate all enrollment activities and mandatory assignments, until the Managed Care Plan attains an acceptable level of quality of care as determined by the Agency.

G. Utilization Management (UM)

1. General Provisions

- a. The UM program shall be consistent with 42 CFR Parts 438 and 456 (as applicable), reflected in a written Utilization Management Program Description and include, but not be limited to:
 - (1) Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;
 - (2) Procedures for reporting fraud and abuse information identified through the UM program to the Agency's MPI as described in Section VIII, Administration and Management, and referenced in 42 CFR 455.1(a)(1);
 - (3) 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.; and
 - (4) Protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; objective evidence-based criteria to support authorization decisions; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting provider when appropriate; hospital discharge planning; physician profiling; and 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.
- b. The Managed Care Plan shall ensure that applicable evidence-based criteria are utilized with consideration given to characteristics of the local delivery systems available for specific members as well as member-specific factors, such as member's age, co-morbidities, complications, progress in treatment, psychosocial situation and home environment.
- c. The Managed Care Plan must provide that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

2. Service Authorization System

- a. Managed Care Plans 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 confirmation of all denials, service limitations and reductions of authorization to providers (See 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.
- 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 may request to be notified, but shall not deny claims payment based solely on lack of notification, for the following:
 - (1) Inpatient emergency admissions (within ten (10) days);
 - (2) Obstetrical care (at first visit);
 - (3) Obstetrical admissions exceeding forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for caesarean section; and
 - (4) Transplants.
- g. The Managed Care Plan shall provide post-authorization to CHDs for emergency shelter medical screenings provided for children being taken into the child welfare system.

- h. 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 providers, including posting appropriate contact information on its website and providing timely responses to providers.

3. Practice Guidelines

- a. The Managed Care Plan shall adopt practice guidelines that meet the following requirements (see 42 CFR 438.236(b)):
 - (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field;
 - (2) Consider the needs of the enrollees;
 - (3) Are adopted in consultation with providers; and
 - (4) Are reviewed and updated periodically, as appropriate.
- b. The Managed Care Plan shall disseminate any revised practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
- c. The Managed Care Plan shall ensure consistency with regard to all decisions relating to UM, enrollee education, covered services and other areas to which the practice guidelines apply.

4. Clinical Decision-Making

- a. The Managed Care Plan shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, are made by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease (see 42 CFR 438.210(b)(3)).
- b. Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for behavioral health services. The psychiatrist's review shall be part of the UM process and not part of the clinical review, which may be requested by a provider or the enrollee, after the issuance of a denial.
- c. Licensed Clinical Social Workers, while classified as Health Care Professionals, are not permitted to make decisions to reduce, deny, suspend, or terminate services, unless it is within the scope of their license to do so according to Chapter 491, F.S. Under no circumstances will Licensed Clinical Social Workers diagnose and treat individuals as defined in Chapter 491, F.S.

5. Notices of Action (See 42 CFR 438.210)

- a. The Managed Care Plan shall notify the provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.

- b. For standard authorization decisions, the Managed Care Plan shall provide notice as expeditiously as the enrollee's health condition requires and within no more than seven (7) days following receipt of the request for service.
- c. The timeframe for standard authorization decisions can be extended 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.
- d. Expedited authorization is required when a provider indicates, or the Managed Care Plan determines, that following the standard timeline could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. An expedited decision must be made no later than forty eight (48) hours after receipt of the request for service.
- e. 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.

6. Notices of Action to Enrollees (See 42 CFR 438.404)

- a. The Managed Care Plan shall provide the enrollee with a written notice of action that includes the following:
 - (1) The action the Managed Care Plan or its subcontractor has taken or intends to take;
 - (2) The reasons for the action;
 - (3) The enrollee or provider's right to file an appeal with the Managed Care Plan;
 - (4) The enrollee's right to request a Medicaid Fair Hearing;
 - (5) The procedures for exercising the rights specified in the notice;
 - (6) The circumstances under which expedited resolution is available and how to request it; and
 - (7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances in which the enrollee must have to pay the cost of those benefits.
- b. The Managed Care Plan shall mail the notice of action as follows:
 - (1) For termination, suspension or reduction of previously authorized Medicaid covered services no later than ten (10) days before the action is to take effect. Certain exceptions apply under 42 CFR 431.213 and 214;
 - (2) For denial of payment, at the time of any action affecting the claim;

- (3) For standard service authorization decisions that deny or limit services no more than seven (7) days following the request for service or within forty-eight (48) hours following an expedited service request;
- (4) If the Managed Care Plan extends the timeframe for a service authorization decision, in which case it shall:
 - (a) 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;
 - (b) Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires; and
 - (c) Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.
- (5) For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse action; and
- (6) For expedited service authorization decisions within the timeframes specified.

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 thirty (30) 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.

H. Continuity of Care in Enrollment

- 1. The Managed Care Plan shall be responsible for coordination of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers. The Managed Care Plan shall reimburse non-participating providers at the rate they received 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.
- 2. LTC Managed Care Plans shall provide continuation of LTC services until the enrollee receives an assessment, a plan of care is developed and services are arranged and authorized as required to address the long-term care needs of the enrollee, which shall be no more than sixty (60) days after the effective date of enrollment.

3. MMA Managed Care Plans shall provide continuation of MMA 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, which shall be no more than sixty (60) days after the effective date of enrollment. 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 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 year 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 Hepatitis C treatment drugs.
4. Comprehensive LTC Managed Care Plans shall provide continuation of LTC services for enrollees with LTC benefits and MMA services for enrollees with MMA benefits as indicated above.

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Section VIII. Administration and Management

A. Organizational Governance and Staffing

1. General Provisions

- a. The Managed Care Plan's governing body shall set forth policy and has overall responsibility for the organization of the Managed Care Plan.
- b. 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.
- c. 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.
- d. 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.

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 with one asterisk, within five (5) business days of the changes in staffing, to the Agency.

- a. **Contract Manager***: The Managed Care Plan shall designate a Contract Manager to work directly with the Agency. The Contract Manager shall be a full-time employee of the Managed Care Plan 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 maximize the efficiency and effectiveness of services required under the Contract. The Contract Manager cannot be designated to any other position in this section, including in other lines of business within the Managed Care Plan. The Managed Care Plan shall meet in person, or by telephone, at the request of Agency representatives to discuss the status of the Contract, Managed Care Plan performance, benefits to the state, necessary revisions, reviews, reports and planning. The Contract Manager shall be located in the State of Florida.
- b. **Medical Director***: The Medical Director shall be a full-time employee of the Managed Care Plan and shall be a physician with an active unencumbered Florida

license in accordance with Chapter 458 or 459, F.S., and shall have experience providing services to the population served under this Contract. The medical director shall oversee and be responsible for the proper provision of covered services to enrollees, the quality management program and the grievance system. The medical director cannot be designated to serve in any other position; however, if the Managed Care Plan has both a long-term care Contract and a medical assistance Contract with the Agency, the medical director can serve both Contracts. Under that circumstance, the medical director must then have experience serving both long-term care and medical assistance populations.

- c. Compliance Officer*: The Managed Care Plan shall have a designated full-time employee qualified by training and experience in health care or risk management, to oversee the compliance program. The compliance officer shall also be qualified to oversee a fraud and abuse program designed to ensure program integrity through fraud and abuse prevention and detection pursuant to this Contract and state and federal law. If the Managed Care Plan has both a long-term care Contract and a medical assistance Contract with the Agency, the compliance officer can serve both Contracts.
- d. Medical/Case Records Review Coordinator: The Managed Care Plan shall have a designated employee, qualified by training and experience, to ensure compliance with the medical/case records requirements as described in this Contract. The medical/case records review coordinator shall maintain medical/case record standards and direct medical/case record reviews according to the terms of this Contract.
- e. Data Processing and Data Reporting Coordinator*: The Managed Care Plan shall have a person trained and experienced in data processing, data reporting and claims resolution, as required, to ensure that computer system reports the Managed Care Plan provides to the Agency and its agents are accurate, and that computer systems operate in an accurate and timely manner.
- f. Community Outreach Oversight Coordinator: If the Managed Care Plan engages in community outreach, it shall have a designated employee, qualified by training and experience, to ensure the Managed Care Plan adheres to the community outreach and marketing requirements of this Contract.
- g. QI Professional: The Managed Care Plan shall have a designated employee, qualified by training and experience in QI and who holds the appropriate clinical certification and/or license.
- h. UM Professional*: The Managed Care Plan shall have a designated employee, qualified by training and experience in UM and who holds the appropriate clinical certification and/or license.
- i. Grievance System Coordinator*: The Managed Care Plan shall have a designated employee, qualified by training and experience, to process and resolve complaints, grievances and appeals and be responsible for the grievance system.
- j. Claims/Encounter Manager*: The Managed Care Plan shall have a designated employee qualified by training and experience to oversee claims and encounter

submittal and processing, where applicable, and to ensure the accuracy, timeliness and completeness of processing payment and reporting.

- k. Fraud Investigative Unit (also known as Special Investigative Unit) Manager*: The Managed Care Plan shall have a designated employee qualified by training and experience to oversee the special investigative unit for the investigation of possible fraud, abuse and overpayment and ensures mandatory reporting as required by this Contract, state and federal law.

3. Medical and Professional Support Staff

The Managed Care Plan shall have medical and professional support staff sufficient to conduct daily business in an orderly manner, including having enrollee services staff directly available during business hours for enrollee services consultation, as determined through management and medical reviews. The Managed Care Plan shall maintain sufficient medical 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. See the LTC Exhibit for required case manager qualifications for enrollees with LTC benefits.

5. Staff Training and Education

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

6. Emergency Management Plan

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

B. Subcontracts

1. General Provisions

- a. The Managed Care Plan shall be responsible for all work performed under this Contract, but may, with the prior written approval of the Agency, 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 to determine compliance with Contract requirements for subcontracts. 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 to bring it into compliance. In addition, the Managed Care Plan may be subject to sanctions pursuant to Section XI, Sanctions, and/or liquidated damages pursuant to Section XIII, Liquidated Damages.

- b. All subcontracts must comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106 and any other applicable state or federal law.
- c. No subcontract that the Managed Care Plan enters into with respect to performance under the Contract shall, in any way, relieve the Managed Care Plan of any responsibility for the performance of duties under this Contract. The Managed Care Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract and shall provide the Agency with its monitoring schedule annually by December 1 of each Contract year. The Managed Care Plan shall identify in its subcontracts any aspect of service that may be further subcontracted by the subcontractor.
- d. All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall be in writing, signed, and dated by the Managed Care Plan.

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.

3. Subcontract Content Requirements

- a. The Managed Care Plan agrees to make payment to all subcontractors pursuant to all state and federal laws, rules and regulations, including s. 409.967, F.S., s. 409.975(6), F.S., s. 409.982, F.S., s. 641.3155, F.S., 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (5) and (6); All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall meet the following requirements with respect to payment:
 - (1) Identification of 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;

- (4) Require any claims payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Managed Care Plan;
 - (5) Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Managed Care Plan;
 - (6) Specify that the subcontractor may not seek payment from a Medicaid Pending enrollee on behalf of the Managed Care Plan; and
 - (7) Specify that the Managed Care Plan shall assume responsibility for cost avoidance measures for third party collections in accordance Section X, Financial Requirements.
- b. 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 and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;
 - (2) Provide for inspections of any records pertinent to the Contract by the Agency and DHHS;
 - (3) In addition to record retention requirements for practitioner or provider licensure, require that records be maintained for a period not less than ten (10) years from the close of the Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the subcontract is continuous.);
 - (4) Provide for monitoring and oversight by the Managed Care Plan and the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the Managed Care Plan's and the Agency's credentialing requirements as found Section VI, Provider Network, if the Managed Care Plan has delegated the credentialing to a subcontractor; and
 - (5) Provide for monitoring of services rendered to Managed Care Plan enrollees through the subcontractor.
- c. All model and executed subcontracts and amendments used by the Managed Care Plan under this Contract shall meet the following requirements with respect to the specification of functions of the subcontractor:
- (1) Identify the population covered by the subcontract;

- (2) Provide for submission of all reports and clinical information required by the Managed Care Plan, including CHCUP reporting (if applicable); and
 - (3) Provide for the participation in any internal and external quality improvement, utilization review, peer review and grievance procedures established by the Managed Care Plan.
- d. 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 compliance with HIPAA privacy and security provisions.
 - (3) Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that Medicaid recipients or the Agency will not be held liable for any debts of the subcontractor.
 - (4) If there is a Managed Care Plan physician incentive plan, include a statement that the Managed Care Plan shall make no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care;
 - (5) Require full cooperation in any investigation by the Agency, MPI, MFCU, DOEA, or other state or federal entity or any subsequent legal action that may result from such an investigation;
 - (6) Contain a clause indemnifying, defending and holding the Agency, its designees and the Managed Care Plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency may waive this requirement for itself, but not Managed Care Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency;
 - (7) Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the Managed Care Plan. Such insurance shall comply with Florida's Workers' Compensation Law;

- (8) Specify that if the subcontractor delegates or subcontracts any functions of the Managed Care Plan, that the subcontract or delegation includes all the requirements of this Contract;
 - (9) Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract;
 - (10) Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate;
 - (11) Provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee; and
 - (12) Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:
 - (a) The False Claim 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.
- e. In conjunction with the Standard Contract, Section III, B., Termination, all provider contracts and subcontracts shall contain termination procedures.

4. Other Contract Requirements

- a. Subcontractors are subject to background checks. The Managed Care Plan shall consider the nature of the work a subcontractor or agent will perform in determining the level and scope of the background checks.
- b. The Managed Care Plan shall document compliance certification (business-to-business) testing of transaction compliance with HIPAA for any subcontractor receiving enrollee data.

5. Minority Business Enterprises

The Agency encourages use of minority business enterprise subcontractors. See Section VI.C., for provisions and requirements specific to provider contracts and for other minority recruitment and retention plan requirements.

C. Information Management and Systems

1. General Provisions

- a. **Systems Functions.** The Managed Care Plan shall have information management processes and information systems that enable it to meet Agency and federal reporting requirements, other Contract requirements, and all applicable Agency policies, state and federal laws, rules and regulations, including HIPAA.
- b. **Systems Capacity.** The Managed Care Plan's system(s) shall possess capacity sufficient to handle the workload projected for the begin date of operations and will be scalable and flexible so to be adapted as needed, within negotiated timeframes, in response to changes in Contract requirements, increases in enrollment estimates, etc.
- c. **E-Mail System.** The Managed Care Plan shall provide a continuously available electronic mail communication link (e-mail system) with the Agency. This system shall be:
 - (1) Available from the workstations of the designated Managed Care Plan contacts; and
 - (2) Capable of attaching and sending documents created using software products other than the Managed Care Plan's systems, including the Agency's currently installed version of Microsoft Office and any subsequent upgrades as adopted. The electronic mail system should include encryption capabilities compliant with Federal Information Processing Standards Publication (FIPS) 140-2.
- d. **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.
- e. **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.

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 the 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 partner with the Agency in the management of standard transaction code sets specific to the Agency. Furthermore, the

Managed Care Plan shall partner with the Agency in the development and implementation planning of future standard code sets not specific to HIPAA or other federal efforts and shall conform to these standards as stipulated in the plan to implement the standards.

- b. **Data Model and Accessibility.** Managed Care Plan systems shall be structured query language (SQL) and/or open database connectivity (ODBC) compliant. Alternatively, the Managed Care Plan's systems shall employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain them.
- 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 six (6) years 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 that are in use as of the Contract execution date.
 - (2) The Managed Care Plan's systems shall be able to transmit, receive and process data in the Agency-specific formats and/or methods that are in use on the Contract execution date.
 - (3) The Managed Care Plan's systems shall conform to future federal and/or Agency-specific standards for data exchange within one-hundred twenty (120) days of the standard's effective date or, if earlier, the date stipulated by CMS or the Agency. The Managed Care Plan shall partner with the Agency in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the Managed Care Plan shall conform to these standards as stipulated in the Agency agreed-upon plan to implement such standards.

- 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 processes to ensure the validity and completeness of the data, including reports, it submits to the Agency. At its discretion, the Agency will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include, but are not limited to: enrollee ID, date of service, assigned Medicaid provider ID, category and subcategory (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and (if and when applicable) date of claim payment. Control totals shall also be reviewed and verified.
- d. State/Agency Website/Portal Integration. Where deemed that the Managed Care Plan's web presence will be incorporated to any degree to the Agency's or the state's web presence (also known as a portal), the Managed Care Plan shall conform to any applicable Agency or state standard for website structure, coding and presentation.
- e. Functional Redundancy with FMMIS. The Managed Care Plan's systems shall be able to transmit and receive transaction data to and from FMMIS as required for the appropriate processing of claims and any other transaction that could be performed by either system.
- 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 US 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 a day, seven days a week (24/7), except during periods of scheduled system unavailability agreed upon by the Agency and the Managed Care Plan. Unavailability caused by events outside of a Managed Care Plan's span of control 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 will 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 Corrective Action Plan. If at any point there is a problem with a critical systems function, at the request of the Agency, the Managed Care Plan shall provide to the Agency full written documentation that includes a corrective action plan (CAP) that describes how problems with critical systems functions will be prevented from occurring again. The CAP shall be delivered to the Agency within five (5) business days of the problem's occurrence. Failure to submit a CAP and to show progress in implementing the CAP shall make the Managed Care Plan subject to sanctions, in accordance with Section XI, Sanctions.
- h. Business Continuity-Disaster Recovery (BC-DR) Plan
 - (1) Regardless of the architecture of its systems, the Managed Care Plan shall develop, and be continually ready to invoke, a BC-DR plan that is reviewed and prior-approved by the Agency. If the approved plan is unchanged from the previous year, the Managed Care Plan shall submit a certification to the Agency that the prior year's plan is still in place annually by April 30th of each Contract year. Changes in the plan are due to the Agency within ten (10) business days after the change.
 - (2) At a minimum, the Managed Care Plan's BC-DR plan shall address the following scenarios: (1) the central computer installation and resident software are destroyed or damaged; (2) system interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage; (3) system interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of data maintained in a live or archival system; (4) system interruption or failure resulting from network, operating hardware, software or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability; and (5) Malicious acts, including malware or manipulation.
 - (3) 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 per the standards outlined in the Contract.
 - (4) In the event that the Managed Care Plan fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Managed Care Plan shall be required to submit to the Agency a corrective action plan in accordance with Section XI, Sanctions, that describes how the failure will be resolved. The corrective action plan shall be delivered within ten (10) business days of the conclusion of the test.

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.

(b) Within twenty (20) days, the correction shall be made or a requirements analysis and specifications document will 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.

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 will 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 Medical/Case 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 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:

- (1) Logical Observation Identifiers Names and Codes (LOINC);
 - (2) Healthcare Common Procedure Coding System (HCPCS);
 - (3) Home Infusion EDI Coalition (HEIC) Product Codes;
 - (4) National Drug Code (NDC);
 - (5) National Council for Prescription Drug Programs (NCPDP);
 - (6) International Classification of Diseases (ICD);
 - (7) Diagnosis Related Group (DRG);
 - (8) Claim Adjustment Reason Codes (CARC); and
 - (9) Remittance Advice Remarks Codes (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).
 - (2) As described in all Agency Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

10. Transition to ICD-10 Coding

The Managed Care Plan shall be responsible for ensuring its ability to transition from ICD-9 codes to the new ICD-10 codes upon Agency implementation and shall modify its policies, procedures and operations to reflect the coding changes brought about by the transition to ICD-10.

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

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

Transaction types include, but are not limited to:

- (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 837D Dental Claim/Encounter Transaction
- (7) ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
- (8) ASC X12N 276 Claims Status Inquiry
- (9) ASC X12N 277 Claims Status Response
- (10) ASC X12N 278/279 Utilization Review Inquiry/Response
- (11) 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 secure file transfer protocol (SFTP) and electronic data interchange (EDI) in their exchanges of data.
- (2) The Managed Care Plan shall encourage network providers to participate in the Agency's Direct Secure Messaging (DSM) service when it is implemented.

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, if applicable; and
- (3) Payments.

12. Social Networking

- a. If the Managed Care Plan uses social networking or smartphone applications (apps), the Managed Care Plan must develop and maintain policies and procedures.

- b. If the Managed Care Plan uses smartphone applications (apps) to allow enrollees direct access to Agency-approved member materials, the Managed Care Plan shall comply with the following:
 - (1) The smartphone application shall disclaim that the app being used is not private and that no PHI or personally identifying information should be published on this application by the Managed Care Plan or end user; and
 - (2) The Managed Care Plan shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines; for example:
 - (a) OWASP [Open Web Application Security Project] Secure Coding Principles — http://www.owasp.org/index.php/Secure_Coding_Principles;
 - (b) CERT Security Coding - <http://www.cert.org/secure-coding/>; and
 - (c) Top 10 Security Coding Practices — <https://www.securecoding.cert.org/confluence/display/seccode/Top+10+Secure+Coding+Practices>

D. Claims and Provider Payment

1. General Claims Provisions

- a. Pursuant to s. 409.967(2)(i), F.S., the Managed Care Plan shall comply with ss. 641.315, 641.3155, and 641.513., F.S.
- b. The Managed Care Plan shall have performance metrics, including those for quality, accuracy and timeliness, and include a process for measurement and monitoring, and for the development and implementation of interventions for improvement in regards to claims processing and claims payment. The Managed Care Plan shall keep documentation of the above and have these available for Agency review.
- c. The Managed Care Plan shall be able to accept electronically transmitted claims from providers in HIPAA compliant formats.
- d. For purposes of this subsection, electronic transmission of claims, transactions, notices, documents, forms and payments shall be used to the greatest extent possible by the Managed Care Plan and shall be HIPAA compliant.
- e. The Managed Care Plan shall ensure that claims are processed and comply with the federal and state requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.
- f. Pursuant to s. 409.967(2)(l), F.S., any claims payment to a provider by the Managed Care Plan must be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement and the identification of the Managed Care Plan.

- g. Pursuant to s. 409.967(2)(k), F.S., MMA and LTC PSNs must ensure that no entity licensed under Chapter 395, F.S., with a controlling interest in the PSN charges a Medicaid Managed Care Plan more than the amount paid to that provider by the PSN for the same service.
- h. The Managed Care Plan is responsible for Medicare co-insurance and deductibles for covered services. The Managed Care Plan shall reimburse providers or enrollees for Medicare deductibles and co-insurance payments made by the providers or enrollees, according to Medicaid guidelines referenced in the Florida Medicaid Provider General Handbook.
- i. The Managed Care Plan shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three (3) years.
- j. The Managed Care Plan shall have a process for handling and addressing the resolution of provider complaints concerning claims issues. The process shall be in compliance with s. 641.3155 F.S. Pursuant to s. 409.967(2)(m), F.S., disputes between the Managed Care Plan and a provider may be resolved as described in s. 408.7057, F.S.
- k. The Managed Care Plan shall not deny claims submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred sixty-five (365) days.

2. Claims Provisions

- a. The Managed Care Plan shall submit an aging claims summary as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, and in the manner and format determined by the Agency.
- b. The Managed Care Plan shall comply with the following requirements:
 - (1) For Medicaid-only enrollees residing in a nursing facility and receiving hospice services, the Managed Care Plan shall pay the hospice provider the per diem rate set by the Agency for hospice services.
 - (2) For dually eligible enrollees residing in a nursing facility and receiving hospice services, the hospice provider shall bill Medicare for the per diem rate for hospice services.
- c. Pursuant to s. 409.975(6), F.S., a MMA Plan and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. For rates, methods, and terms of payment negotiated after this Contract is executed, the MMA shall pay hospitals, at a minimum, the rate the Agency would have paid on the first day of the contract between the provider and the Managed Care Plan. Such payments to hospitals may not exceed one-hundred and 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.

- d. Pursuant to s. 409.975(1)(a) and (b), F.S., a MMA Plan shall make payments to essential providers as specified in the MMA Exhibit. In accordance with s. 409.976(2), F.S., a MMA Plan shall pay statewide inpatient psychiatric programs (SIPPs) the payment rates established by the Agency.
- e. For claims for services:
 - (1) The date of claim receipt is the date the Managed Care Plan receives the claim at its designated claims receipt location.
 - (2) The date of Managed Care Plan claim payment is the date of the check or other form of payment.
 - (3) For all electronically submitted claims for services, the Managed Care Plan shall:
 - (a) 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.
 - (b) 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.
 - (c) 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 additional information or documents necessary to process the claim.
 - (d) 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. (See s. 641.3155, F.S.)
 - (4) For all non-electronically submitted claims for services, the Managed Care Plan shall:
 - (a) 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.
 - (b) 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.

- (c) 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.
- (5) The Managed Care Plan shall comply with the following standards regarding timely claims processing:
 - (a) The Managed Care Plan shall pay or deny fifty percent (50%) of all clean claims submitted within seven (7) days.
 - (b) The Managed Care Plan shall pay or deny seventy percent (70%) of all clean claims submitted within ten (10) days.
 - (c) The Managed Care Plan shall pay or deny ninety percent (90%) of all clean claims submitted within twenty (20) days.
- f. 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 provider was furnished with the correct name and address of the Managed Care Plan.
 - (2) When the Managed Care Plan is the secondary payer, the provider must submit the claim to the Managed Care Plan within ninety (90) days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook.

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 fee-for-service 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 are closely monitored and enforced.
- b. The Agency will revise and amend these standards with sixty (60) days' advance notice to the Managed Care Plan to ensure continuous quality improvement. The

Managed Care Plan shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with Agency data quality standards as originally defined or subsequently amended. The Managed Care Plan must be capable of sending and receiving any claims information directly to the Agency in standards and timeframes specified by the Agency within sixty (60) days' notice.

- 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 with the certified data and must be based on the knowledge, information and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO) 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. The Managed Care Plan shall provide the certification at the same time it submits the certified data in the format and within the timeframe required by the Agency.
- 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 information technology (IT) and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.
- f. The Managed Care Plan shall participate in Agency-sponsored workgroups directed at continuous improvements in encounter data quality and operations.

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:
 - (1) All Managed Care Plan encounters shall be submitted to the Agency in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P — Professional; I — Institutional; D — Dental), and, for pharmacy services, in the National Council for Prescription Drug Programs (NCPDP) format. 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).
 - (2) The Managed Care Plan shall follow the instructions in the User Guide and Report Guide regarding the reporting of pharmacy encounter data using the National Council for Prescription Drug Program (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.
 - (3) 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.

- (4) 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.
- b. The Managed Care Plan shall implement and maintain review procedures to validate encounter data submitted by providers.
- c. The Managed Care Plan shall submit complete, accurate and timely encounter data to the Agency as defined below.
 - (1) For all services rendered to its enrollees (excluding services paid directly by the Agency on a fee-for-service basis), the Managed Care Plan shall submit encounter data no later than seven (7) days following the date on which the Managed Care Plan adjudicated the claims.
 - (2) Pharmacy Encounters (NCPDP)
 - (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 E.1. of this subsection.
 - (b) Accurate: 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_Pharmacy/tabId/52/Default.aspx.
 - (3) Non-Pharmacy Encounters (X12)
 - (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 D.1. of this subsection.
 - (b) 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.
- 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 and NCPDP 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.
- e. 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 as either actively enrolled Medicaid providers or as Managed Care Plan registered providers. The Managed Care Plan is responsible for ensuring information is sufficient for accurate identification of participating network providers and non-participating providers who render services to Managed Care Plan enrollees.

3. Check Run Summary File Submission

- a. The Managed Care Plan must submit a Check Run Summary File for each provider payment adjudication cycle no later than seven (7) days following each respective adjudication cycle and in a format specified by the Agency.
- b. The Managed Care Plan must submit a Check Run Summary File reporting how total provider payment amounts reconcile with the encounter data submissions for each provider payment adjudication cycle. The Check Run Summary File must be submitted along with the encounter claims data submissions. The Check Run Summary file must be submitted in a format and in timeframes specified by the Agency.

4. 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, the Agency will post encounter data reporting requirements on the following websites:

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

and

http://portal.flmmis.com/FLPublic/Provider_Pharmacy/tabId/52/Default.aspx.

- c. The Managed Care Plan shall adhere to the following requirements for the encounter data submission process:

- (1) Within thirty (30) days after notice by the Agency or its fiscal agent of encounters getting a denied or rejected payment status (failing fiscal agent edits), the Managed Care Plan shall accurately resubmit one-hundred percent (100%) of all encounters for which errors can be remedied.
- (2) The Managed Care Plan shall retain submitted historical encounter data for a period not less than six (6) years as specified in the Standard Contract, Section I., Item D., Retention of Records.
- d. 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 electronic data interface (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
- e. If the Managed Care Plan fails to comply with the encounter data reporting requirements of this Contract, the Agency will impose sanctions pursuant to Section XI, Sanctions.

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 74; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S., and 59A-12.0073, 59G and 69D-2, F.A.C.
- b. The Managed Care Plan shall have adequate Florida-based staffing and resources to enable the compliance officer to investigate indicia of fraud and abuse and develop and implement corrective action plans relating to fraud and abuse and overpayment.
- c. The Managed Care Plan's written fraud and abuse prevention program shall have internal controls and policies and procedures in place that are designed to prevent, reduce, detect, correct and report known or suspected fraud and abuse activities. This shall include reporting instances of fraud and abuse pursuant to ss. 409.91212, F.S., 626.989, F.S., 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 and overpayment issues.

2. Compliance Officer

The Managed Care Plan's compliance officer as described in Section VIII, Administration and Management, shall have unrestricted access to the Managed Care Plan's governing body for compliance reporting, including fraud and abuse 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 or overpayment, or may subcontract such functions.
- b. If a Managed Care Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Managed Care Plan shall file the following with the Bureau of Medicaid Program Integrity (MPI) for approval at least sixty (60) 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 policies and 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. (See ss. 409.91212, F.S. and 409.967(2)(f), F.S.) The Managed Care Plan shall submit these documents via the MPI-MC secure file transfer protocol (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. (See Section XIII, Liquidated Damages.)

- b. At a minimum the compliance plan must include:
- (1) Written policies, procedures and standards of conduct that articulate the Managed Care Plan's commitment to comply with all applicable federal and state standards;
 - (2) The designation of a compliance officer and a compliance committee accountable to senior management;
 - (3) Effective training and education of the compliance officer and the Managed Care Plan's employees;
 - (4) Effective lines of communication between the compliance officer and the Managed Care Plan's employees;
 - (5) Enforcement of standards through well-publicized 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 annually by September 1. The anti-fraud plan shall comply with s. 409.91212, F.S., and, at a minimum, must include:
- (1) A written description or chart outlining the organizational arrangement of the Managed Care Plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse or fraud;
 - (2) A description of the Managed Care Plan's procedures for detecting and investigating possible acts of fraud, abuse and overpayment;
 - (3) A description of the Managed Care Plan's procedures for the mandatory reporting of possible overpayment, abuse or fraud to MPI;
 - (4) A description of the Managed Care Plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse and overpayment;
 - (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, or overpayment which were conducted during the previous fiscal year by the Managed Care Plan's fraud investigative unit.
- d. At a minimum, the Managed Care Plan's compliance plan, anti-fraud plan, and fraud and abuse policies and procedures shall comply with s. 409.91212, F.S., and with the following:
- (1) Ensure that all officers, directors, managers and employees know and understand the provisions;
 - (2) Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. Nothing in this Contract shall require that the Managed Care Plan assure that non-participating providers are compliant with this Contract, but the Managed Care Plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected;
 - (3) Describe the Managed Care Plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols. Such internal investigational methodology and reporting protocols shall ensure the unit's primary purpose is for the investigation (or supervision of the investigation) of suspected insurance/Medicaid fraud and fraudulent claims;
 - (4) Incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including, but not limited to:
 - (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 (see s. 409.967(2)(f), F.S.);
 - (b) A description of the method(s), including detailed policies and procedures, for verifying enrollees' identity and if services billed by providers were actually received. Such methods must be either the use of electronic verification or biometric technology but may also include sending enrollee explanations of Medicaid benefits (EOMB), contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses;
 - (c) 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 clinical record documentation;
 - (iv) Make false statements relating 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 contracts;
 - (vii) Charge enrollees for covered services; and
 - (viii) Bill for services not rendered;
- (d) Prior authorization;
- (e) Utilization management;
- (f) Subcontract and provider contract provisions;
- (g) Provisions from the provider and the enrollee handbooks; and
- (h) Standards for a code of conduct.
- (5) Contain provisions pursuant to this section for the confidential reporting of Managed Care Plan violations to MPI and other agencies as required by law;
- (6) Include provisions for the investigation and follow-up of any reports;
- (7) Ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud and abuse;
- (8) Require all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, Managed Care Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under state and/or federal law be reported to MPI within fifteen (15) days of detection, as specified in s. 409.91212, F.S. and in Section XIV, 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;
- (9) 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 medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended; 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 medical/case records and data, as required by state and/or federal law. Access shall be during Normal Business Hours, except under special circumstances when the Agency, the Florida Attorney General, and DFS shall have After Hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances.
- (10) Ensure that the Managed Care Plan shall cooperate fully in any investigation by federal and state oversight agencies and any subsequent legal action that may result from such an investigation;
 - (11) Ensure that the Managed Care Plan does not retaliate against any individual who reports violations of the Managed Care Plan's fraud and abuse policies and procedures or suspected fraud and abuse;
 - (12) Not knowingly have affiliations with individuals debarred or excluded by federal agencies under ss. 1128 and 1128A of the Social Security Act and 42 CFR 438.610 or subcontractors on the discriminatory vendor list maintained by the Department of Management Services in accordance with s. 287.134, F.S.;
 - (13) On at least a monthly basis check current staff, subcontractors and providers against the federal List of Excluded Individuals and Entities (LEIE) and the federal System for Award Management (SAM) (includes the former Excluded Parties List System (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 engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act;

- (14) Provide details and educate employees, subcontractors and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:
 - (a) The Federal False Claim 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.
- (15) If the Managed Care Plan is approved to provide telemedicine, the Managed Care Plan shall include a review of telemedicine in its fraud and abuse detection activities.

5. Reporting and Disclosure Requirements

- a. The Managed Care Plan shall comply with all reporting requirements as set forth below and in s. 409.91212, F.S.
- b. The Managed Care Plan shall report on a quarterly basis a comprehensive fraud and abuse prevention activity report regarding its investigative, preventive and detective activity efforts, as specified in Section XIV, 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 XIV, 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 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 via email to: floridaexclusions@oig.hhs.gov and copy MPI via email to: mpifo@ahca.myflorida.com. Document information examples include, but are not limited to, court records such as indictments, plea agreements, judgments and conviction/sentencing documents.
- h. In lieu of an e-mail notification, a hard copy notification is acceptable to DHHS OIG at:
- Attention: Florida Exclusions
Office of the Inspector General
Office of Investigations
7175 Security Boulevard, Suite 210
Baltimore, MD 21244
- With a copy to MPI at:
Attention: Florida Exclusions
Office of the Inspector General
Medicaid Program Integrity
2727 Mahan Drive, M.S. #6
Tallahassee, FL 32308-5403
- i. 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.

- j. The Managed Care Plan shall notify MPI and provide a copy of any corrective action plans required by the Department of Financial Services (DFS) and/or federal governmental entities, excluding AHCA, within thirty (30) days after execution of such plans.
- k. 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.

6. Sanctions

- a. Notwithstanding any other provisions related to the imposition of sanctions or fines in this Contract, including any attachments, exhibits, addendums or amendments hereto, the following sanctions will be applied:
- b. If the Managed Care Plan fails to timely submit an acceptable anti-fraud plan or fails to timely submit the reports referenced in Section XIV, Reporting Requirements, and specified in the Managed Care Plan Report Guide, a sanction of \$2,000 per calendar day, from the date the report is due to the Agency, shall be imposed under this Contract until MPI deems the Managed Care Plan to be in compliance.
- c. If the Managed Care Plan fails to implement an anti-fraud plan or investigative unit, a sanction of \$10,000 shall be imposed under this Contract.
- d. If the Managed Care Plan fails to timely report, or report all required information for all suspected or confirmed instances of provider or recipient fraud or abuse within fifteen (15) days after detection to MPI, as specified in s. 409.91212, F.S., a sanction of \$1,000 per calendar day will be imposed under this Contract, until MPI deems the Managed Care Plan to be in compliance.

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Section IX. Method of Payment

A. Fixed Price Unit Contract

This is a fixed price (unit cost) Contract awarded through procurement. The Agency, through its fiscal agent, shall make payment to the Managed Care Plan on a monthly basis for the Managed Care Plan's satisfactory performance of its duties and responsibilities as set forth in this Contract.

B. Payment Provisions

1. Capitation Rates

- a. The Agency shall pay the applicable capitation rate for each eligible enrollee whose name appears on the HIPAA-compliant X12 820 file for each month, except that the Agency shall not pay for, and shall recoup, any part of the total payment for enrollment that exceeds the maximum authorized enrollment level(s) expressed in Attachment I, as applicable. The total payment amount to the Managed Care Plan shall depend upon the number of enrollees in each eligibility category and each rate group, as provided for by this Contract, or as adjusted pursuant to the Contract when necessary. The Managed Care Plan is obligated to provide services pursuant to the terms of this Contract for all enrollees for whom the Managed Care Plan has received capitation payment or for whom the Agency has assured the Managed Care Plan that capitation payment is forthcoming.
- b. 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 will be adjusted to reflect the level of care profile (risk) for enrollees in each Managed Care Plan.
- c. The rates shall be actuarially sound in accordance with 42 CFR 438.6(c).
- d. Pursuant to s. 409.966(3)(d), F.S., for the first year of the first Contract term, the Agency shall negotiate capitation rates in order to guarantee savings of at least five percent (5%). Determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the Agency paid Managed Care Plans for similar populations in the same areas in the prior year. In a region without any capitated plans in the prior year, savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year. After the first year no further rate negotiations will be conducted.
- e. The base capitation rates prior to risk adjustment are included in Attachment I, titled **"ESTIMATED MANAGED CARE PLAN RATES; NOT FOR USE UNLESS APPROVED BY CMS."**
- f. The Agency may use, or may amend and use these rates, only after certification by its actuary and approval by the Centers for Medicare and Medicaid Services. Inclusion of these rates is not intended to convey or imply any rights, duties or

obligations of either party, nor is it intended to restrict, restrain or control the rights of either party that may have existed independently of this section of the Contract.

- g. By signature on this Contract, the parties explicitly agree that this section shall not independently convey any inherent rights, responsibilities or obligations of either party, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by either party. In the event that the rates certified by the actuary and approved by CMS are different from the rates included in this Contract, the Managed Care Plan agrees to accept a reconciliation performed by the Agency to bring payments to the Managed Care Plan in line with the approved rates. The Agency may amend and use the CMS-approved rates by notice to the Managed Care Plan through an amendment to the Contract.
- h. Unless otherwise specified in this Contract, the Managed Care Plan shall accept the capitation payment received each month as payment in full by the Agency for all services provided to enrollees covered under this Contract and the administrative costs incurred by the Managed Care Plan in providing or arranging for such services. Any and all costs incurred by the Managed Care Plan in excess of the capitation payment shall be borne in total by the Managed Care Plan.
- i. The Agency shall pay a retroactive capitation rate for each newborn enrolled in a MMA or Comprehensive LTC Managed Care Plan retroactive to the month of birth. (see s. 409.977(3), F.S.) The Managed Care Plan is responsible for payment of all covered services provided to newborns.
- j. The Agency shall pay a MMA or Comprehensive LTC Managed Care Plan one kick payment for each covered transplant for enrollees who are not also eligible for Medicare. The Agency shall make kick payments for transplants in the amounts indicated in the MMA Exhibit.
- k. The Agency shall pay an MMA or Comprehensive LTC Managed Care Plan a supplemental payment for eligible primary care services provided between January 1, 2013 and December 31, 2014 as provided in the MMA Exhibit.
- l. The Agency shall prospectively adjust the base capitation rates for LTC and Comprehensive LTC Managed Care Plans in accordance with the LTC Exhibit.

2. Rate Adjustments and Reconciliations

- a. The Managed Care Plan and the Agency acknowledge that the capitation rates paid under this Contract are subject to approval by the federal government.
- b. The Managed Care Plan and the Agency acknowledge that adjustments to funds previously paid, and to funds yet to be paid, may be required. Funds previously paid shall be adjusted when capitation rate calculations are determined to have been in error, or when capitation rate payments have been made for enrollees who are determined not to have been eligible for Managed Care Plan membership during the period for which the capitation rate payments were made. In such events, the Managed Care Plan agrees to refund any overpayment and the Agency agrees to pay any underpayment.

- c. Pursuant to ss. 409.983(6) and 409.983(7), F.S., the Agency shall reconcile a Managed Care Plan's actual payments to nursing facilities, including patient responsibility, and hospices for enrollees with LTC benefits as specified in the LTC exhibit.
- d. Pursuant to s. 409.976(2), F.S., the Agency shall reconcile a Managed Care Plan's actual payments to SIPP's for enrollees with MMA benefits to ensure actual claim payments are, at a minimum, the same as Medicaid FFS claim payments. Any Managed Care Plan provider payments to SIPP's in excess of FFS claim payments 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.
- e. The Agency shall adjust capitation rates to reflect budgetary changes in the Medicaid program. The rate of payment and total dollar amount may be adjusted with a properly executed amendment when Medicaid expenditure changes have been established through the appropriations process and subsequently identified in the Agency's operating budget. Legislatively-mandated changes shall take effect on the dates specified in the legislation. The Agency may not approve any Managed Care Plan request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act. (See s. 409.968(3), F.S.).
- f. In accordance with s. 409.967(3), F.S., the Agency shall verify the Managed Care Plan's achieved savings rebate specified in this Contract.

3. Errors

The Managed Care Plan shall carefully prepare all reports and monthly payment requests for submission to the Agency. If after preparation and electronic submission, the Managed Care Plan discovers an error, including, but not limited to, errors resulting in capitated payments above the Managed Care Plan's authorized levels, either by the Managed Care Plan or the Agency, the Managed Care Plan has thirty (30) days from its discovery of the error, or thirty (30) days after receipt of notice by the Agency, to correct the error and re-submit accurate reports and/or invoices. Failure to respond within the thirty- (30) calendar-day period shall result in a loss of any money due to the Managed Care Plan for such errors and/or sanctions against the Managed Care Plan pursuant to Section XI, Sanctions.

4. Enrollee Payment Liability Protection

- a. 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;
- b. 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 (excluding Medicaid Pending LTC enrollees who are determined ineligible for Medicaid as specified in this Contract), or if the provider, under contract or other arrangement with the Managed Care Plan, fails to receive payment from the Agency or the Managed Care Plan; and/or

- c. 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.

5. Achieved Savings Rebate

- a. In accordance with s. 409.967(3), F.S. and as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide, the Managed Care Plan shall submit:
 - (1) Quarterly unaudited financial statements including the Achieved Savings Rebate exhibits, and an annual financial audit conducted by an independent certified public accountant (CPA) in accordance with generally accepted accounting principles (GAAP);
 - (2) If the Managed Care Plan is regulated by the Office of Insurance Regulation (OIR) annual statements prepared in accordance with statutory accounting principles; and
- b. The Managed Care Plan shall pay to the Agency the expenses of the Agency's achieved savings rebate audit at the rates established by the Agency. 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.
- c. At a Florida location by the date specified by the Agency's contracted CPA, the Managed Care Plan shall make available all books, accounts, documents, files and information that relate to the Managed Care Plan's Medicaid transactions.
 - (1) The Managed Care Plan shall cooperate in good faith with the Agency and the CPA.
 - (2) 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.

- (3) Failure to comply with such record requests shall be deemed a breach of Contract, and the Managed Care Plan shall be subject to sanctions as specified in Section XI, Sanctions.
- d. 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 below, the Managed Care Plan may retain up to an additional one percent (1%) of its revenue.
- (1) For MMA and Comprehensive LTC managed care plans, the following shall apply:
- (a) The Agency shall assign the HEDIS performance measures listed in d.(1)(c) a point value that correlates to the National Committee for Quality Assurance HEDIS National Means and Percentiles. 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
$\geq 90^{\text{th}}$ percentile	6
$75^{\text{th}} - 89^{\text{th}}$ percentile	5
$60^{\text{th}} - 74^{\text{th}}$ percentile	4
$50^{\text{th}} - 59^{\text{th}}$ percentile	3
$25^{\text{th}} - 49^{\text{th}}$ percentile	2
$10^{\text{th}} - 24^{\text{th}}$ percentile	1
$< 10^{\text{th}}$ percentile	0

- (b) In order to be eligible to retain up to an additional one percent (1%) of revenue, the Managed Care Plan shall achieve a group score of four (4) or higher for each of the six performance measure groups in the first year of reporting performance measures. To be eligible to retain up to an additional one percent (1%) of revenue based on the second year and subsequent years of reporting performance measures, the Managed Care Plan shall achieve a group score of five (5) or higher for each of the six (6) performance measure groups.
- (c) Performance measure groups are as follows:
- (i) Mental Health and Substance Abuse
- Antidepressant Medication Management
 - Follow-up Care for Children Prescribed ADHD Medication
 - Follow-up after Hospitalization for Mental Illness (7 day)
 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- (ii) Well-Child
- Adolescent Well Care Visits

- Childhood Immunization Status – Combo 3
 - Immunizations for Adolescents
 - Well-Child Visits in the First 15 Months of Life (6 or more)
 - Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
 - Lead Screening in Children
- (iii) Other Preventive Care
- Adults' Access to Preventive/Ambulatory Health Services
 - Annual Dental Visits
 - BMI Assessment
 - Breast Cancer Screening
 - Cervical Cancer Screening
 - Children and Adolescents' Access to Primary Care
 - Chlamydia Screening for Women
- (iv) Prenatal/Perinatal
- Prenatal and Postpartum Care (includes two (2) measures)
 - Prenatal Care Frequency
- (v) Diabetes – Comprehensive Diabetes Care Measure Components
- HbA1c Testing
 - HbA1c Control (< 8%)
 - Eye Exam
 - LDL-C Screening
 - LDL-C Control
 - Medical Attention for Nephropathy
- (vi) Other Chronic and Acute Care
- Controlling High Blood Pressure
 - Pharyngitis – Appropriate Testing related to Antibiotic Dispensing
 - Use of Appropriate Medications for People with Asthma
 - Annual Monitoring for Patients on Persistent Medications
- (2) In order to eligible to retain up to an additional one percent (1%) of revenue in the first year, a LTC or Comprehensive LTC managed care plan shall exceed the specified threshold for each and all performance measures as listed below:

Measure	Threshold
<u>HEDIS Measures</u>	
Care for Older Adults	90 th percentile
Call Answer Timeliness	90 th percentile
<u>Agency-Defined</u>	

Measure	Threshold
Required Record Documentation	
• 701B Assessment	95%
• Freedom of Choice Form	95%
• Plan of Care/Enrollee Participation	95%
• Plan of Care/PCP Notification	95%
• Plan of Care/PCP Participation	75%
Face-To-Face Encounters	95%
Case Manager Training	95%
Timeliness of Services	98%

- (3) Comprehensive LTC 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.
 - (4) The Agency may amend the performance measure groups and the group scores required for an MMA managed care plan or Comprehensive LTC plan to retain up to an additional one percent (1%) of revenue with sixty (60) days' advance notice.
 - (5) The Agency may amend the performance measures and thresholds required for an LTC or Comprehensive LTC plan to retain up to an additional one percent (1%) of revenue with sixty (60) days' advance notice.
- e. The Agency CPA will validate the achieved savings rebate, and the results will be provided to the Agency. If the CPA validates the achieved savings rebate 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 achieved savings rebate submitted by the Managed Care Plan, the Agency will provide written notice of the CPA's findings to the Managed Care Plan and allow the Managed Care Plan the opportunity to review and respond to the CPA's findings in writing within the timeframe specified by the Agency. The CPA will review the Managed Care Plan's response and issue final results. These results are dispositive.
 - f. The Agency will provide the final results of the audit to the Managed Care Plan, and the Managed Care Plan shall pay the rebate to the Agency within thirty (30) days after the results are provided.
 - g. The achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income ratios:
 - (1) One hundred percent (100%) of income up to and including five (5) percent of revenue shall be retained by the Managed Care Plan.

- (2) Fifty percent (50%) of income above five (5) percent and up to ten percent (10%) shall be retained by the Managed Care Plan, and the other fifty percent (50%) refunded to the state.
 - (3) One hundred percent (100%) of income above ten percent (10%) of revenue shall be refunded to the state.
- h. As further specified in the Managed Care Plan Report Guide, for purposes of the achieved savings rebate:
 - (1) Pretax income is defined as pre-tax revenue minus those expenses permitted in the Managed Care Plan Report Guide.
 - (2) 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.
 - (3) Expenses generally include reasonable and appropriate medical expenses and general and administrative expenses, 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. 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 achieved savings rebate:
 - (a) Payment of achieved savings rebates;
 - (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; and
 - (f) Administrative costs in excess of actuarially sound maximum amounts set by the Agency.
- i. The actuarially sound maximum amount for administrative costs will be calculated by the actuary developing the capitation rates as part of the ratesetting process.

- j. In accordance with s. 409.967(3)(i), F.S., if the Managed Care Plan incurs a loss in the first calendar 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 calendar year of coverage will also carry over to the second year.
- k. 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, the Agency will withhold future payments until the entire amount of the rebate is recouped. If the Agency determines that the Managed Care Plan made an overpayment, the Agency will return the overpayment within thirty (30) days of such determination.
- l. If the Managed Care Plan purchases part or all of the business of another managed care plan, the Managed Care Plan's information and reports regarding its achieved savings rebate shall include information for the purchased business, including for that part of the reporting period that was prior to the purchase.
- m. If the Managed Care Plan's enrollment in the reporting period is greater than or equal to five-thousand (5,000) life-years but fewer than seventy-five thousand (75,000) life-years, the Agency will make a credibility-based adjustment to the amount of pre-tax income that is fully retained by the Managed Care Plan. 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 equals or exceeds five-thousand (5,000) life-years, the achieved saving rebate calculation will be performed subject to the credibility-based adjustment using the combined life-years.
- n. If the Agency determines that payment of an achieved savings rebate 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.

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The Achieved Savings Rebate shall be calculated in accordance with s. 409.967(3)(f), F.S., as illustrated below.

Note: The following three (3) increments shall be applied to the Managed Care Plan's (Plan's) pre-tax income (AKA: net operating income [NOI])

Achieved Savings Rebates Table – Effective 1/1/2014 – 12/31/2018			
	NOI Range Category	Amount Managed Care Plans will retain	Amount Managed Care Plans will be required to refund to the Agency
I	NOI ranging from Zero (0) up to and including five (5) percent of the Plan's premium revenue:	Managed Care Plans will retain 100% of NOI within this range.	Managed Care Plans will not be required to refund any of their NOI within this range.
II	NOI above five (5) percent and up to and including ten (10) percent of the Plan's premium revenue:	Managed Care Plans will retain 50% of the NOI within this range.	Managed Care Plans will be required to refund 50% of the NOI within this range.
III	NOI above ten (10) percent of the Plan's premium revenue:	Managed Care Plans will not be allowed to retain any of the NOI within this range.	Managed Care Plans will have to refund to the Agency 100% of the NOI within this range.

Example: If the Plan's premium revenues are \$1,000,000 and allowed expenses are \$850,000, the 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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6. Health Insurance Providers Fee

a. General

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

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

b. Health Insurance Providers Fee Methodology

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

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

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

c. Adjustment for federal and state income tax related to the Health Insurance Providers Fee Methodology

- (1) An actuarially sound approach will be developed to calculate the amount of income tax related to the Health Insurance Providers Fee.

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Section X. Financial Requirements

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), and s. 409.912, F.S. The Managed Care Plan shall deposit into that account five percent (5%) of the capitation payments made by the Agency each month until a maximum total of two percent (2%) of the annualized total current Contract amount is reached and maintained. No interest may be withdrawn from this account until the maximum Contract amount is reached and withdrawal of the interest will not cause the balance to fall below the required maximum amount. This provision shall remain in effect as long as the Managed Care Plan continues to contract with the Agency.
- 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 an attestation to this effect annually by 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/MCHQ/Managed Health Care/MHMO/med_prov_0912.shtml](http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml).

All such agreements or other signature cards shall be approved in advance by the Agency.

- c. In the event that a determination is made by the Agency that the Managed Care Plan is insolvent, as defined in Section I, Definitions and Acronyms, the Agency may draw upon the amount solely with the two (2) authorized signatures of representatives of the Agency and funds may be disbursed to meet financial obligations incurred by the Managed Care Plan under this Contract. A statement of account balance shall be provided by the Managed Care Plan within fifteen (15) days of request of the Agency.
- d. If the Contract is terminated, expired, or not continued, the account balance shall be released by the Agency to the Managed Care Plan upon receipt of proof of satisfaction of all outstanding obligations incurred under this Contract.
- e. In the event the Contract is terminated or not renewed and the Managed Care Plan is insolvent, the Agency may draw upon the insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency including, but not limited

to, overpayments made to the Managed Care Plan, and fines imposed under the Contract or, for HMOs, s. 641.52, F.S., for EPOs, s. 627, F.S., and for health insurers, s. 624, F.S., for which a final order has been issued. In addition, if the Contract is terminated or not renewed and the Managed Care Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Managed Care Plan agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

- f. In the event the Contract is terminated or not renewed and the Managed Care Plan is insolvent, the Agency may draw upon the insolvency protection account to pay any outstanding debts the Managed Care Plan owes the Agency including, but not limited to, overpayments made to the Managed Care Plan, and fines imposed under the Contract, for which a final order has been issued. In addition, if the Contract is terminated or not renewed and the Managed Care Plan is unable to pay all of its outstanding debts to health care providers, the Agency and the Managed Care Plan agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to the Agency priority over other claims.

2. Insolvency Protection Account Waiver

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

B. Surplus

1. Surplus Start Up Account

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

2. 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 Department of Financial Services, and restricted funds of deposits controlled by the Agency (including the Managed Care Plan's insolvency protection account) or the Department of Financial Services, a surplus amount equal to the greater of \$1.5 million, ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the Managed Care Plan's prepaid revenues. In the event that the Managed Care Plan's surplus (as defined in Section I, Definitions and Acronyms) falls below the amount specified in this paragraph, the Agency shall

prohibit the Managed Care Plan from engaging in community outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Managed Care Plan's Contract statewide.

- b. In lieu of the surplus requirements under Section X.B., Surplus Requirements, the Agency may consider the following:
 - (1) If the organization is a public entity, the Agency may take under advisement a statement from the public entity that a county supports the Managed Care Plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer or oversee the Managed Care Plan, either partly or wholly, through a county department or agency;
 - (2) The state guarantees the solvency of the organization;
 - (3) The organization is a federally qualified health center (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)(c), F.S.; or
 - (4) The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 CFR 422.380 through 422.390 and the solvency requirements established in approved federal waivers or 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 the when the 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 will be pursued by the

Agency. Covered third party collections exclude all estate, trust and annuity recoveries.

- c. 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-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.
- d. When the Agency has a fee-for-service lien against a third party resource and the Managed Care Plan has also extended services potentially reimbursable from the same third party resource, the Agency's lien shall be entitled to priority.
- e. The 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

LTC Managed Care Plans and Comprehensive LTC Managed Care Plans shall comply with the requirements regarding patient responsibility in the LTC Exhibit.

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 Agency shall approve the assignment or transfer of the appropriate Medicaid Managed Care Plan Contract upon the request of the surviving entity of the merger or acquisition if the Managed Care Plan and the surviving entity have been in good standing with the Agency for the most recent twelve (12) month period, unless the Agency determines that the assignment or transfer would be detrimental to Medicaid recipients or the Medicaid program (see s. 409.912, F.S.). The entity requesting the assignment or transfer shall notify the Agency of the request ninety (90) days before the anticipated effective date.
2. Entities regulated by the Department of Financial Services, Office of Insurance Regulation (OIR), must comply with provisions of s. 628.4615, F.S., and receive OIR approval before a merger or acquisition can occur.
3. For the purposes of this section, a merger or acquisition means a change in controlling interest of a Managed Care Plan, including an asset or stock purchase.
4. To be in good standing, a Managed Care Plan shall not have failed accreditation or committed any material violation of the requirements of s. 641.52, F.S., and shall meet the Medicaid Contract requirements.
5. The Managed Care Plan requesting the assignment or transfer of its enrollees and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, as required by the Agency and to ensure a seamless transition for enrollees, particularly those hospitalized, those requiring care coordination/case management and those with complex medication needs. The Managed Care Plan requesting assignment or transfer of its enrollees shall perform as follows:
 - a. Notice its enrollees, providers and subcontractors of the change in accordance with this Contract; and
 - b. Provide to the Agency the data needed, including encounter data, by the Agency to maintain existing case relationships.

6. The notice to enrollees shall contain the same information as required for a notice of termination according to Section XII.F.

F. Financial Reporting

1. Financial Statements

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

2. Medical Loss Ratio (MLR)

MMA Managed Care Plans shall comply with Medical Loss Ratio requirements as specified in the MMA Exhibit.

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. Pursuant to s. 1903(m)(4)(A) of the Social Security Act and state Medicaid Manual 2087.6(A-B), non-federally qualified Managed Care Plans shall report to the state, upon request, and to the Secretary and the Inspector General of DHHS, a description of certain transactions with parties of interest as defined in s. 1318(b) of the Social Security Act.

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Section XI. 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. In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Managed Care Plan pursuant to any of the following: s. 409.912 (21), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR part 438 subpart I (Sanctions) and s.1932 of the Social Security Act or s.1903(m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to Section XIII.
3. For purposes of this section, violations involving individual, unrelated acts shall not be considered arising out of the same action.
4. In addition to imposing sanctions for a Contract violation or other non-compliance, the Agency may require the Managed Care Plan to submit to the Agency a performance measure action plan (PMAP) within a timeframe specified by the Agency. The Agency may also require the Managed Care Plan to submit a corrective action plan (CAP) for a violation of or any other non-compliance with this Contract.
5. 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. 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 Agency will return the appropriate amount to the Managed Care Plan within sixty (60) days from the date of a final decision rendered.

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

1. If a PMAP or CAP is required as determined by the Agency, the Agency will either approve or disapprove a proposed PMAP or CAP from the Managed Care Plan. If the Agency disapproves the PMAP or CAP, the Managed Care Plan shall submit a new PMAP or CAP within ten (10) business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency. 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 calendar day on the Managed Care Plan for each calendar day that the Managed Care Plan does not implement, to the satisfaction of the Agency, the approved PMAP or CAP.

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, as specified in the MMA Exhibit or the LTC Exhibit, as applicable. The Agency will develop performance measures and may impose monetary sanctions for some or all of performance measures. The Agency will develop performance targets for each performance measure with a methodology for application of sanction specified by the Agency.

2. The Agency shall sanction the Managed Care Plan for failure to achieve minimum scores on performance measures after the first year of poor performance on any measure as specified in the table below. The Agency may impose monetary sanctions and Performance Measure Action Plans (PMAPs) or PMAPs alone as described above.
3. Two (2) HEDIS measures will be compared to the National Committee for Quality Assurance HEDIS National Means and Percentiles. The HEDIS Call Abandonment measure and the HEDIS Call Answer Timeliness measure have threshold rates (percentages) that may trigger a sanction, as indicated in the Performance Measure Sanction Table below.

Performance Measure Sanction Table – Effective 8/01/2014 – 8/31/2019	
HEDIS Measures	Rate and applicable sanction
Call Answer Timeliness	Rate < 25 th percentile - immediate monetary sanction and PMAP may be imposed Rate < 50 th percentile - PMAP may be required
Call Abandonment	Rate > 5% - immediate monetary sanction and PMAP may be imposed

4. The Agency shall sanction MMA Managed Care Plans for failure to achieve minimum scores on additional performance measures after the first year of poor performance on any measure as specified in the MMA Exhibit.
5. The Agency shall sanction LTC Managed Care Plans for failure to achieve minimum scores on additional performance measures after the first year of poor performance on any measure as specified in the LTC Exhibit.
6. The Agency shall sanction Comprehensive LTC Managed Care Plans for failure to achieve minimum scores on additional performance measures after the first year of poor performance on any measure as specified in both the MMA Exhibit and the LTC Exhibit.

D. Other Sanctions

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

3. Pursuant to s. 409.967(2)(a), F.S., after two (2) years of continuous operation under this Contract, the Managed Care Plan's physician payment rates shall equal or exceed Medicare rates for similar services. The Agency may impose fines or other sanctions if the Managed Care Plan fails to meet this performance standard.
4. Pursuant to s. 409.967(2)(h)1., F.S., if the Managed Care Plan reduces its enrollment level or leaves a region before the end of the Contract term, the Managed Care Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities. If more than one (1) MMA or LTC Managed Care Plan leaves a region at the same time, the exiting Managed Care Plans will share the costs in a manner proportionate to their enrollments. In addition to the payment of costs, departing PSNs shall pay a per-enrollee penalty of up to three (3) months' payment and continue to provide services to enrollees for ninety (90) 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 attributable to the provision of coverage to Medicaid enrollees. The Managed Care Plan will 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 the Contract term, the Agency shall terminate all Contracts with the Managed Care Plan in other regions.

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 will give the Managed Care Plan written notice that explains the basis and nature of the sanction, cites the specific contract section(s) and/or provision of law and the methodology for calculation of any fine.
2. If the Agency decides to terminate the Managed Care Plan's Contract for cause, the Agency will provide advance written notice of intent to terminate including the reason for termination and the effective date of termination. The Agency will also notify Managed Care Plan enrollees of the termination along with information on their options for receiving services following Contract termination.
3. Unless the Agency specifies the duration of a sanction, a sanction will remain in effect until the Agency is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

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.
 - a. The Managed Care Plan must submit, within twenty-one (21) days after the issuance of a sanction, a written dispute of the sanction directly to the Deputy Secretary or designee; this submission 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 the Contract, 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

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

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Section XII. 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: Title 42 CFR Chapter IV, Subchapter C; Title 45 CFR Part 74, General Grants Administration Requirements; Chapters 409 and 641, F.S.; all applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 USC 1857, et seq.); Title VI of the Civil Rights Act of 1964 (42 USC 2000d) in regard to persons served; Title IX of the education amendments of 1972 (regarding education programs and activities); 42 CFR 431, Subpart F; s. 409.907(3)(d), F.S., and Rule 59G-8.100 (24)(b), F.A.C. in regard to the Contractor safeguarding information about enrollees; Title VII of the Civil Rights Act of 1964 (42 USC 2000e) in regard to employees or applicants for employment; Rule 59G-8.100, F.A.C.; Section 504 of the Rehabilitation Act of 1973, as amended, 29 USC 794 (which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance); the Age Discrimination Act of 1975, as amended, 42 USC 6101 et. seq. (which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance); the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance; Medicare - Medicaid Fraud and Abuse Act of 1978; the federal Omnibus Budget Reconciliation Acts; Americans with Disabilities Act (42 USC 12101, et seq.); the Newborns' and Mothers' Health Protection Act of 1996, the Balanced Budget Act of 1997, the Health Insurance Portability and Accountability Act of 1996; 45 CFR 74 relating to uniform administrative requirements; 45 CFR 92 providing for cooperative agreements with state, local and tribal governments; s. 508 of the Federal Water Pollution Control Act as amended (33 U.S.C. 1251, et seq.); Executive Order 11738 as amended; where applicable, Environmental Protection Agency regulations 40.CFR 30; 2 CFR 215 and Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR 60 and 45 CFR 92, if applicable; the Pro-Children Act of 1994 (20 U.S.C. 6081; 2 CFR 180 and Executive Orders 12549 and 12689 "Debarment and Suspension; the Immigration and Nationality Act (8 U.S.C. 1324a); Immigration Reform and Control Act of 1986 (8 U.S.C. 1101); 2 CFR 175 relating to trafficking in persons; 2 CFR 170.110(b) relating to the Transparency Act; and 45 CFR 92.36(i)(10) regarding examination of records.
2. The Managed Care Plan is subject to any changes in federal and state law, rules or regulations and federal Centers for Medicare and Medicaid Services waivers applicable to this Contract and shall implement such changes in accordance with the required effective dates upon notice from the Agency without waiting for an amendment to this Contract. However, an amendment to the Contract will 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 the Contract and the attachments (which includes the ITN), the provisions of the Contract shall govern, unless otherwise noted. The Agency reserves the right to clarify any contractual relationship in writing and such clarification shall govern. Pending final determination of any dispute over any Agency decision, the Managed Care Plan shall proceed diligently with the performance of its duties as specified under the Contract and in accordance with the direction of the Agency's Division of Medicaid.

C. Licensing

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

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

D. 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. The Agency will not contract with Managed Care Plans to operate as Standard MMA Plans that have a business relationship with another Managed Care Plan operating as a Standard MMA Plan in the same region. (See 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 Standard MMA Plan in the same region.
2. Pursuant to s. 409.966(3)(b), F.S., as part of the SMMC procurement, the Managed Care Plan was required to disclose any business relationship, as defined in s. 409.966(3)(b), F.S., that it had with any other eligible plan that responded to the invitation to negotiate. If the Managed Care Plan failed to disclose a business relationship or is considering a business relationship with a Managed Care Plan that has a contract with the Agency under the SMMC program, the Managed Care Plan shall

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

5. 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 VIII, 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, chief executive officer, administrator and chief financial officer.
 - c. Changes in the management of the Managed Care Plan where the Managed Care Plan has decided to contract out the operation of the Managed Care Plan to a management corporation. The Managed Care Plan shall disclose such changes in management control and provide a copy of the contract to the Agency for approval at least sixty (60) days prior to the management contract start date.
6. 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 (see ss. 409.912 and 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 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 s. 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.
- 7. 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.
 - 8. The Agency shall not contract with a Managed Care Plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Managed Care Plan, who has committed any of the above listed offenses (see ss. 409.912 and 435.04, F.S.). In order to avoid termination, pursuant to a timeline as determined by the Agency, the Managed Care Plan shall submit a corrective action plan, acceptable to the Agency, which ensures that such person is divested of all interest and/or control and has no role in the operation and/or management of the Managed Care Plan.
 - 9. The Managed Care Plan shall submit to the Agency reports regarding current administrative subcontractors and affiliates as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

E. Conflict of Interest

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

F. 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 Agency will remove the Managed Care Plan from receipt of new voluntary enrollments, mandatory assignments and reinstatements going forward.
2. The Managed Care Plan shall work with the Agency to develop a transition plan for enrollees, particularly those in the hospital, those under care coordination/case management and those with complex medication needs. The Managed Care Plan withdrawing from a Region shall perform as follows:
 - a. Notice its enrollees, providers and subcontractors of the change at least sixty (60) 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 XII.F.
4. If the Managed Care Plan withdraws from a region before the end of the term of this Contract, the Managed Care Plan shall pay the costs and penalties specified in s. 409.967(2)(h)1, F.S., and Section XI, Sanctions, and the Contract through which the Managed Care Plan operates in any other region will be terminated in accordance with the termination procedures in s. 409.967(2)(h)3, F.S., this section and Section XI, Sanctions.
5. As specified in s. 409.967(2)(h)1. F.S., if the Managed Care Plan intends to withdraw services from a region, the Managed Care Plan shall provide the Agency with one-hundred eighty (180) days' notice and work with the Agency to develop a transition plan for enrollees, particularly those under case management and those with complex medication needs, and provide data needed to maintain existing case relationships.
6. As specified in s. 409.967 (2)(h)1., F.S., Managed Care Plans that reduce enrollment levels or leave a region before the end of the Contract term must continue to provide services to the enrollee for ninety (90) days or until the enrollee is enrolled in another Managed Care Plan, whichever occurs first.

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G. Termination Procedures

1. In conjunction with the Standard Contract, Section III, Item A., Termination, all provider contracts and subcontracts shall contain termination procedures. The Managed Care Plan agrees to extend the thirty (30) calendar-day termination notice found in the Standard Contract, Section III., Item 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 Agency will remove the Managed Care Plan from receipt of new voluntary enrollments, mandatory assignments and reinstatements going forward.
2. The Managed Care Plan will work with the Agency to create a transition plan that shall ensure the orderly and reasonable transfer of enrollee care and progress whether or not the enrollees are hospitalized, under care coordination/case management, and/or have complex medication needs. The Managed Care Plan shall perform as follows:
 - 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 the Contract is terminated, and the date on which such termination shall become effective. In accordance with s. 1932(e)(4), Social Security Act, the Agency shall provide the Managed Care Plan with an opportunity for a hearing prior to termination for cause. This does not preclude the Agency from terminating without cause.
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 the Contract until the termination date unless otherwise required by the Agency;
 - b. Cease enrollment of new enrollees under the Contract;
 - c. Terminate all community outreach activities and subcontracts relating to community outreach;
 - d. Assign to the state those subcontracts as directed by the Agency's contracting officer including all the rights, title and interest of the Managed Care Plan for performance of those subcontracts;
 - e. In the event the Agency has terminated the Managed Care Plan's Medicaid participation in one region, complete the performance of this Contract in all other regions in which the Managed Care Plan's participation was not terminated;

- f. Take such action as may be necessary, or as the Agency's contracting officer may direct, for the protection of property related to the Contract that is in the possession of the Managed Care Plan and in which the Agency has been granted or may acquire an interest;
 - g. Not accept any payment after the Contract ends, unless the payment is for the time period covered under the Contract. Any payments due under the terms of this Contract may be withheld until the Agency receives from the Managed Care Plan all written and properly executed documents as required by the written instructions of the Agency; 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 will no longer participate in the state's Medicaid program and instructions on contacting the Agency's enrollment broker help line to obtain information on enrollment options and to request a change in Managed Care Plans.
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 Agency shall terminate this Contract and all other SMMC contracts with the Managed Care Plan.
 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 Agency shall also terminate all of the Managed Care Plan's participation in other regions by terminating this entire Contract, in accordance with s. 409.967(2)(h)3., F.S.
 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)(h), F.S., for activities in Region 1 or Region 2, the additional awarded regions shall automatically be terminated from this Contract one-hundred eighty (180) days after the imposition of the penalties. The Managed Care Plan shall reimburse the Agency for the cost of enrollment changes and other transition activities.
 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 Agency shall terminate the Managed Care Plan from participation in that region. In addition the following requirements apply to the Managed Care Plan:
 - a. If the Managed Care Plan received an additional award pursuant to s. 409.966(3)(e), F.S., and fails to meet plan readiness criteria in Region 1 or Region 2, the Agency shall terminate the additional awarded region(s) within one-hundred eighty (180) days after the respective Region 1 and/or Region 2 termination from the Contract.
 - b. If the Managed Care Plan has been terminated from participation in all regions of its Contract, the Agency shall terminate this entire Contract with thirty (30) 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 the Contract period, the Agency will assess the performance bond required under this Contract to cover the costs of issuing a solicitation

and selecting a new Managed Care Plan. The Agency's damages in the event of termination shall be considered to be the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

H. Agency Contract Management

1. The Agency shall be responsible for management of the 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 or Contract interpretations. The Managed Care Plan may seek an interpretation from the Agency of any Contract requirement or Medicaid policy. When an interpretation of the contract is sought, the Managed Care Plan shall submit a written request to the Agency's Deputy Secretary for Medicaid.
2. The terms of this Contract do not limit or waive the ability, authority or obligation of the Office of Inspector General, MPI, its contractors, DOEA, or other duly constituted government units (state or federal) to audit or investigate matters related to, or arising out of this Contract.
3. The Contract shall be amended only as follows (unless specified elsewhere in this Contract):
 - a. The parties cannot amend or alter the terms of this Contract without a written amendment and/or change order to the Contract.
 - b. The Agency and the Managed Care Plan understand that any such written amendment to amend or alter the terms of this Contract shall be executed by an officer of each party, who is duly authorized to bind the Agency and the Managed Care Plan.
 - c. The Agency reserves the right to amend this Contract within the scope set forth in the procurement (to include original Contract and all attachments) in order to clarify requirements or if it is determined by the Agency that modifications are necessary to better serve or provide covered services to the eligible population.

I. Disputes

1. To dispute an interpretation of the Contract, the Managed Care Plan must request that the Agency's Deputy Secretary for Medicaid hear and decide the dispute. The Managed Care Plan must submit, within twenty-one (21) days after the interpretation of the Contract, a written dispute of the Contract interpretation directly to the Deputy Secretary; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation and exhibits). The Managed Care Plan waives any dispute not raised within twenty-one (21) days of receiving a notice of the 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 the Contract interpretation in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).

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

J. Indemnification

1. The Managed Care Plan, agrees to indemnify, defend, and hold harmless the Agency, as provided in this Clause.
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) calendar 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, Item M., Requirements of Section 287.058, Florida Statutes, 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 the 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 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;
 - d. 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 the 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.
 - e. If the Managed Care Plan does not comply with a public records request, the Agency shall enforce the Contract provisions in accordance with the 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, §§ 934.01, et seq., Florida Statutes, 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) will ensure that such actions are in full compliance with Communication Privacy Laws (the "Privacy Compliance Plan"); and
 - 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 notarized 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 the contract and/or liquidated damages.

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Section XIII. Liquidated Damages

A. Damages

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

7. To dispute the imposition of liquidated damages, 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, within twenty-one (21) days after receiving notice of the imposition of liquidated damages, a written dispute of the liquidated damages directly to the Deputy Secretary or designee; this submission 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 the Contract, 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
 - 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).
8. The Deputy Secretary or his/her designee will decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Managed Care Plan. This written decision will be final.
9. The exclusive venue of any legal or equitable action that arises out of or relating to the Contract, including an appeal of the final decision of the Deputy Secretary or his/her designee, will be Circuit Court in Leon County, Florida; in any such action, the Managed Care Plan agrees that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Agency will notice the Managed Care Plan of the appropriate administrative remedy.

B. Issues and Amounts

The Managed Care Plan shall pay the Agency the amount for each issue as specified below.

MMA Managed Care Plans shall also pay the Agency the amount for each issue as specified in the MMA Exhibit.

LTC Managed Care Plans shall also pay the Agency the amount for each issue as specified in the LTC Exhibit.

Comprehensive LTC Managed Care Plans shall also pay the Agency the amount for each issue as specified in both the MMA Exhibit and LTC Exhibit as applicable.

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Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
1.	Failure to comply in any way with Managed Care Plan staffing requirements as specified in the Contract.	\$250 per calendar day for each day that staffing requirements are not met.
2.	Failure to submit a Provider Network File that meets the Agency's specifications as described in the Contract.	\$250 per day after the due date that the Provider Enrollment File fails to meet the Agency's specifications.
3.	Failure to submit audited HEDIS, CAHPS, and Agency-defined measures results annually by July 1 as described in the Contract.	\$250 per day for every calendar day reports are late.
4.	Failure to timely report termination or suspension of providers for "for cause" as described in the Contract.	\$250 per occurrence.
5.	Submission of inappropriate report certifications and/or failure to submit report attestations as described in the Contract.	\$250 per occurrence.
6.	Failure to timely report staff or marketing or community outreach representative violations as described in the Contract.	\$250 per occurrence.
7.	Failure to maintain and/or provide proof of required insurance as described in the Contract.	\$500 per calendar day.
8.	Failure to terminate providers who become ineligible for Medicaid participation.	\$500 per occurrence, in addition to \$250 per day until the provider is terminated.
9.	Failure to timely submit any complete plan as described in this Contract, including, but not limited to a cultural competency plan. 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 calendar day plans are late.
10.	Failure to achieve and/or maintain insolvency requirements in accordance with the Contract.	\$500 per calendar day for each day that insolvency requirements are not met.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
11.	Failure to timely submit audited annual and quarterly unaudited financial statements as described in the Contract.	\$500 per calendar day for each day that reporting requirements are not met.
12.	Failure to comply with fraud and abuse provisions as described in the Contract.	\$500 per calendar day per occurrence/issue.
13.	Failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency and described in the Contract.	\$500 per calendar day, per occurrence.
14.	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 the Contract.	<p>\$500 per day beginning on the next calendar day after default by the Managed Care Plan in addition to the cost of the services not provided.</p> <p>These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the case management requirements as described in this Contract.</p>
15.	Failure to timely file required reports as described in the Contract.	\$500 per day beyond the due date until submitted.
16.	Failure to respond to an Agency request or ad-hoc report for documentation (such as medical records, complaint logs, or Contract checklists) within the time prescribed by the Agency as described in the Contract.	<p>\$500 per day for each calendar day beyond the due date until provided to the Agency.</p> <p>However, after three (3) instances during the Contract period, the liquidated damages amount is increased by \$1,000 per day.</p>
17.	Failure to obtain approval of enrollee and provider materials, as required by the Contract.	\$500 per day for each calendar day that the Agency determines the Managed Care Plan has provided enrollee or provider material that had not been approved by the Agency.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
18.	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 the Contract.	<p>\$500 per day for each service not initiated timely beginning on the next calendar day after default by the Managed Care Plan in addition to the cost of the services not provided.</p> <p>These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the case management requirements as described in this Contract.</p>
19.	Failure to obtain and/or maintain national accreditation as described in the Contract.	\$500 per day for every calendar day beyond the day accreditation status must be in place as described in this Contract.
20.	Failure to provide covered services within the timely access standards in the Contract.	\$500 per day, per occurrence.
21.	Failure to provide covered services within the geographic access standards in the Contract.	\$500 per day, per occurrence.
22.	Failure to report notice of provider termination of participation in the Managed Care Plan as described in of the Contract.	\$500 per day, per occurrence.
23.	Failure by the Managed Care Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach (see also ancillary business associate agreement between the parties) as described in the Contract.	\$500 per enrollee per occurrence, not to exceed \$10,000,000.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
24.	Failure by the Managed Care Plan to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party (see ancillary business associate agreement between the parties) pursuant to the Contract.	\$500 per enrollee per occurrence.
25.	Failure to cooperate fully with the Agency and/or state during an investigation of fraud or abuse, complaint, or grievances as described in the Contract.	\$500 per incident for failure to fully cooperate during an investigation.
26.	Failure to comply with the notice requirements described in the Contract, the Agency rules and regulations, and all court orders governing appeal procedures, as they become effective.	<p>\$500 per occurrence in addition to \$500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Contract or required by the Agency.</p> <p>\$1,000 per occurrence if the Agency notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective.</p>

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
27.	Failure to timely report changes in Managed Care Plan staffing as described in the Contract.	\$500 per occurrence.
28.	Failure to timely report information about offenses listed in s. 435.04, F.S., as described in the Contract.	\$500 per occurrence.
29.	Failure to comply with community outreach or marketing requirements as described in the Contract.	\$500 per recipient, per verified incident of promotion or marketing of Managed Care Plan.
30.	Failure to timely submit appropriate performance improvement projects (PIPs) as described in this Contract.	\$1,000 per day for every calendar day PIPs are late.
31.	Failure to achieve and/or maintain financial surplus requirements as described in the Contract.	\$1,000 per calendar day for each day Contract requirements are not met.
32.	Failure by the Managed Care Plan to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with 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 (see also ancillary business associate agreement requirements between the parties) as specified in the Contract.	<p>\$1,000 per enrollee per occurrence.</p> <p>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.</p>
33.	Failure to comply with enrollee notice requirements as described in the Contract.	\$1,000 per occurrence if the enrollee notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
34.	Failure to notify enrollees of denials, reductions, or terminations of services within the timeframes specified in the Contract as described in the Contract.	\$1,000 per occurrence plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late.
35.	Failure to acknowledge or act timely upon a request for prior authorization in accordance the Contract.	\$1,000 per occurrence, in addition to \$1,000 for each day that it is determined the Managed Care Plan failed to acknowledge or act timely upon a request for prior authorization.
36.	Failure to update online and printed provider directory in accordance with Contract requirements as described in the Contract.	\$1,000 per occurrence.
37.	Failure to file accurate reports as described in this Contract.	\$1,000 per occurrence.
38.	Failure to facilitate transfers between health care settings as described in the Contract.	\$1,000 per occurrence. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the case management requirements as described in the Contract.
39.	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.
40.	Failure to cooperate with the Agency's contracted external quality review organization (EQRO) as described in this Contract.	\$5,000 per occurrence.
41.	Failure to honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, as specified in this Contract.	\$5,000 per occurrence, in addition to \$5,000 per day services are not authorized.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
42.	Failure to comply with time frames for providing Enrollee Handbooks, I.D. cards and Provider Directories, as required in the Contract.	\$5,000 for each occurrence.
43.	Failure to comply with licensure or background screening requirements for Managed Care Plan principals in the Contract.	\$5,000 per calendar day 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.
44.	Failure to comply with licensure or background screening requirements for subcontractors in the Contract.	\$5,000 per calendar day 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.
45.	Failure to timely report notice of terminated providers due to imminent danger/impairment as described in the Contract.	\$5,000 per occurrence.
46.	Failure to meet provider credentialing requirements, including background screening requirements, specified in the Contract.	\$5,000 per occurrence.
47.	Failure to timely report, or provide notice for, significant network changes as described in the Contract.	\$5,000 per occurrence.
48.	Failure to timely report changes in ownership and control as described in the Contract.	\$5,000 per occurrence.
49.	Failure to comply with claims processing as described in the Contract.	\$10,000 per month, for each month that the Agency determines that the Managed Care Plan is not in compliance.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
50.	<p>Failure to establish an investigative unit as required in this Contract, by the time the Managed Care Plan has enrolled its first recipient.</p> <p>Failure to implement an anti-fraud plan as required by this Contract, within ninety (90) days of its approval by the Agency.</p> <p>Failure to timely submit an acceptable anti-fraud plan, quarterly fraud and abuse report or the annual report required by this Contract.</p> <p>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.</p>	<p>\$10,000 for each occurrence.</p> <p>\$10,000 for each occurrence.</p> <p>\$2,000 per calendar day, until MPI deems the Managed Care Plan to be in compliance.</p> <p>\$1,000 per calendar day, until MPI deems the Managed Care Plan to be in compliance.</p>
51.	Failure to develop and/or implement a transition plan for recipients including the provision of data to the Agency, as specified in the Contract.	\$10,000 per occurrence.
52.	Failure to comply with conflict of interest or lobbying requirements as described in the Contract.	\$10,000 per occurrence.
53.	Failure to disclose lobbying activities and/or conflict of interest as required by the Contract.	\$1,000 per day that disclosure is late.
54.	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.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
55.	Failure to comply with encounter data submission requirements as described in the Contract (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by the Agency).	\$25,000 per occurrence.
56.	Imposition of arbitrary utilization guidelines or other quantitative coverage limits as prohibited in the Contract.	\$25,000 per occurrence.
57.	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 the 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 calendar day the Managed Care Plan fails to provide continuation or restoration as required by the Agency.
58.	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 the 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 calendar day the Managed Care Plan fails to provide continuation or restoration as required by the Agency.
59.	Failure to comply with provider network requirements specified in this Contract.	\$500 per day, per occurrence.
60.	Failure to comply with the quality requirements specified in this Contract under Section VII of Attachment II and its Exhibits.	\$1,000 per occurrence.
61.	Failure to provide notice of noncompliance to the Agency within five (5) days or other Contract-specified period of time in accordance with the Contract.	\$500 per day beginning on the next calendar day after default by the Managed Care Plan.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
62.	Failure to staff the Compliance Officer position with a qualified individual in accordance with the Contract.	\$500 per calendar day starting ninety (90) days from the date of the position vacancy.
63.	Failure to maintain and/or provide proof of the Managed Care Plan's fidelity bond as required in the Contract.	\$500 per calendar day.
64.	Failure to comply with public records laws, in accordance with s. 119.0701, F.S.	\$5,000 for each occurrence.
65.	Failure to develop and document a treatment or service plan for an enrollee, that shall be documented in writing as described in the Contract.	\$500 per deficient/missing treatment or service plan.
66.	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 calendar day after default by the Managed Care Plan.
67.	Failure to require and ensure compliance with ownership and disclosure requirements as required in the 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 455, Subpart B.
68.	Failure to respond to an Agency communication within the time prescribed by the Agency as described in the Contract.	\$500 for each calendar day beyond the due date until provided to the Agency. However, after three (3) instances during the Contract period, the liquidated damages amount is increased by \$1,000 per day.

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
69.	Failure to submit a timely notice of involuntary disenrollment to the enrollee as described in the Contract.	\$1,000 per occurrence if the enrollee notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective.
70.	Failure to timely initiate a background screening via the Clearinghouse for newly hired principals as described in the Contract.	\$500 per occurrence.
71.	Failure to complete or comply with corrective action plans as described in the Contract.	\$500 per calendar day for each day the corrective action is not completed or complied with as required.
72.	Failure to have a rate at or above the 25 th percentile for the HEDIS measures as described in the Contract.	\$500 per each case in the denominator not present in the numerator for the measure.
73.	Failure to comply in any way with the toll-free enrollee help line requirements as described in the 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.
74.	Failure to respond to individual messages on the automated system of the toll-free enrollee help line in a timely manner as described the Contract.	\$500 per calendar day, per occurrence
75.	Failure to comply with any of the standards for timely service authorization decisions as specified in the Contract.	\$5,000 per month, for each month that the Agency determines that the Managed Care Plan is not in compliance, per standard
76.	Failure of a provider contract to comply with a requirement of this Contract.	\$1,000 per failure per provider contract

Liquidated Damages Issues and Amounts		
#	CORE PROGRAM ISSUES	DAMAGES
77.	Failure to receive prior written Agency approval of delegation to a subcontractor.	\$25,000 per occurrence
78.	Failure of a subcontract to comply with a requirement of this Contract.	\$5,000 per failure per subcontract
79.	Failure to meet plan readiness review deadlines set by the Agency	\$2,000 per calendar day per occurrence
80.	Failure to meet plan readiness goals set by the Agency	\$2,000 per occurrence

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Section XIV. 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 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 will be posted on the Agency's website. The Agency shall furnish the Managed Care Plan with appropriate technical assistance in using the Managed Care Plan Report Guide.
- c. Unless otherwise specified, all reports shall be submitted electronically, as prescribed in the reporting guidelines. PHI information 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 Termination	All Plans	Monthly
Marketing/Educational Events Report	All Plans	Monthly
Enrollee Help Line Statistics	All Plans	Monthly
Enrollee Complaints, Grievance and Appeals Report	All Plans	Monthly
Nursing Facility Transfer Report	LTC Plans	Monthly
Provider Network File	All Plans	Weekly
Provider Termination and New Provider Notification Report	All Plans	Weekly

Summary of Reporting Requirements		
Report Name	Plan Type	Frequency
Provider Complaint Report	All Plans	Monthly
Performance Measure Report	All Plans	Annually
Critical Incident Summary Report	All Plans	Monthly
Critical Incident Report	All Plans	Immediately upon occurrence and no less than within twenty-four (24) hours of detection or notification
Claims Aging Report and Supplemental Filing Report	All Plans	Quarterly Optional supplemental filing — due within one-hundred five (105) days after the end of the reporting quarter
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
Achieved Savings Rebate Financial Reports	All Plans	Annually Quarterly
Annual Financial Statements Filed with OIR	All Plans	Annually Quarterly,
Audited Annual and Unaudited Quarterly Financial Reports	All Plans	Annually Quarterly
Administrative Subcontractors and Affiliates Report	All Plans	Quarterly

- b. MMA Managed Care Plans shall comply with the additional reporting requirements specified in the MMA Exhibit.
- c. LTC Managed Care Plans shall comply with the additional reporting requirements as specified in the LTC Exhibit.
- d. Comprehensive LTC Managed Care Plans shall comply with the additional reporting requirements as specified in both the MMA Exhibit and the LTC Exhibit.

4. Modifications to Reporting Requirements

- a. The Agency reserves the right to modify the reporting requirements, with a ninety (90) calendar day notice to allow the Managed Care Plan to complete implementation, unless otherwise required by law.
- b. The Agency shall provide the Managed Care Plan 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.
- b. The Managed Care Plan's chief executive officer (CEO), chief financial officer (CFO) or an individual who reports to the CEO or CFO and who has delegated authority to certify the Managed Care Plan's reports, shall attest, based on his/her best knowledge, information and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful and complete (see 42 CFR 438.606(a) and (b)).
- c. The Managed Care Plan shall submit its certification at the same time it submits the certified data reports (see 42 CFR 438.606(c)). The certification page shall be scanned and submitted electronically.
- d. If the Managed Care Plan fails to submit the required reports accurately or within the timeframes specified, the Agency shall fine or otherwise sanction the Managed Care Plan in accordance with Section XI, Sanctions, and 59A-12.0073, F.A.C.

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