Section I. General Overview

This Exhibit includes additional provisions to **Attachment B** Scope of Services – AHCA Core Provisions.

A. Background

1. The Department is the designated Title V, Maternal Child Health Agency in the State and is contracted with AHCA to operate the CMS Health Plan.

2. The Department serves as a Medicaid specialty plan for children ages 0 through 20 years of age with chronic conditions through AHCA's Prime Contract under the Statewide Medicaid Managed Care (SMMC) program pursuant to Chapter 409, Part IV, F.S., and as a KidCare plan for children ages 1 through 18 years of age under the CHIP State Plan Agreement, pursuant to Chapter 409, Part II, F.S.

3. The provisions in this Contract apply to all Medicaid (i.e., Title XIX) and CHIP (i.e., Title XXI) recipients unless specifically noted otherwise. Provisions unique to a specific recipient type are described in this Contract and its Exhibits.

4. Unless otherwise stated, each section of this Contract outlines Provider's responsibilities and must be completed as specified.

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B. Authorized Regions

Provider is authorized to provide services pursuant to this Contract for the Children' s Medical Services Health Plan in the region(s) as specified in Table 1 below.

Table 1: Authorized Regions	
Region	**Medicaid (TXIX)**
Region A	X
Region B	X
Region C	X
Region D	X
Region E	X
Region F	X
Region G	X
Region H	X
Region I	X
	CHIP (TXXI)
North Region	X
Central Region	X
South Region	X

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Section II. Eligibility and Enrollment

A. General Provisions

There are no additional general provisions for eligibility and enrollment unique to the Respondent.

B. Eligibility

1. Medicaid recipients as defined in Section 409.972, F.S., shall receive Medicaid covered services through the SMMC program.

2. The specialty population eligible to enroll in the Department will consist of recipients who are:

a. Identified pursuant to a rule(s) promulgated by the Department; and

b. Children ages 0 through 20 years of age (Medicaid) and ages 1 through 18 years of age (CHIP) with a qualifying condition and eligible for Medicaid or CHIP.

3. Eligibility and Enrollment of Medicaid children under Title XIX

a. The State has the sole authority for determining eligibility for Medicaid. DCF acts as the Agency's agent by enrolling recipients in the Medicaid program.

b. The Agency has the sole authority for determining whether Title XIX recipients are required to enroll in, may volunteer to enroll in, may not enroll in a SMMC plan, or are subject to annual open enrollment. The Agency or its enrollment broker is responsible for enrollment, including enrollment into the Department, disenrollment, and enrollment related outreach and education activities. The Agency will use an established algorithm to assign mandatory potential enrollees who do not select an MMA Managed Care Plan during their choice period. The enrollment process may differ for the Department as required by sections 409.977, and 409.987 F.S., and any other State law and federally approved State Plan amendments or waivers.

c. A child must meet clinical and Medicaid eligibility requirements to be enrolled in the Managed Care Plan.

4. Eligibility and Enrollment of CHIP children under Title XXI

a. The Department has the sole authority for determining clinical eligibility for CHIP. Florida Healthy Kids Corporation acts as the AHCA's agent in conducting financial eligibility and enrolling recipients in the CHIP program.

b. A child must meet clinical and CHIP eligibility requirements to be enrolled in the Managed Care Plan.

c. DCF determines clinical eligibility for the BNet program. Children determined eligible for BNet are eligible to enroll in the Managed Care Plan. DCF or its agent will provide the Department a list of BNet enrolled children for enrollment in the Plan.

d. Florida Healthy Kids Corporation or its agent will provide to the Department or the Respondent, via the X12-834 enrollment file, a list of CHIP recipients enrolled in the Managed Care Plan.

The Department will coordinate eligibility determinations with Florida Healthy Kids as necessary for all enrollment and disenrollment functions. The Respondent, or its subcontractors, service providers, or vendors, will not provide or assist in the completion of enrollment or disenrollment requests or restrict the enrollee's right to disenroll voluntarily in any way in accordance with 42 CFR. §§ 438.56(b) (1)-(3), and 457.110.

C. Enrollment

1. Notification of Enrollee Pregnancy

a. The Respondent shall be responsible for newborns of pregnant enrollees from the date of their birth. The Respondent shall comply with all requirements and procedures set forth by the Agency or its agent related to unborn activation and newborn enrollment.

b. Newborns are enrolled in the Managed Care Plan of the mother unless the mother chooses another Plan, or the newborn does not meet the enrollment criteria of the mother's Plan. When a newborn does not meet the criteria of the mother's plan, the newborn will be enrolled in a plan in accordance with **Attachment B**, **Section II.**, Eligibility and Enrollment, **Sub Section B.**, Eligibility, of this Contract.

c. The Respondent shall ensure its service providers check the newborn's eligibility and MMA plan enrollment on the specific date of service. Require service providers to immediately notify the Respondent of an enrollee's pregnancy, including the mechanism of doing so, whether identified through medical history, examination, testing, claims, or otherwise.

d. Newborns of the Managed Care Plan's enrolled CHIP recipients are enrolled pursuant to its own eligibility.

e. The Respondent shall notify DCF in a manner prescribed by the Department in writing.

2. PCP Assignment

a. If the enrollee has not chosen a PCP, the Agency's enrollment confirmation notice will advise the enrollee that a PCP will be assigned by the Respondent.

b. The Respondent shall ensure that PCP selection occurs at the time of enrollment in the Managed Care Plan if the enrollee has not selected a PCP as provided on the enrollment file or if the enrollee's selected PCP is not a participating service provider in the Respondent's network.

c. The Respondent shall assign the enrollee a PCP, using the Department's approved algorithm, if the enrollee has not chosen a PCP or the PCP is not a participating service provider in the Respondent's network.

3. Verification of Eligibility

a. Children's Medical Services Eligibility Verification

(1) The Department shall identify the population eligible for enrollment in the Managed Care Plan based on criteria identified during screening.

(2) The Respondent shall review its X12-834 enrollment files to ensure that all enrollees are eligible to receive services from the Managed Care Plan, including that:

a. Each enrollee of the Managed Care Plan is residing in the same region in which they were enrolled; and

b. Each enrollee of the Managed Care Plan is not ineligible for services under the Managed Care Plan, in accordance with this Section.

(3) The Respondent shall notify the Department and Agency of any discrepancies in enrollment, including enrollees not residing in the same region in which they were enrolled and enrollees not eligible for the Managed Care Plan, within five (5) business days of receipt of the enrollment file.

(4) The Respondent shall have policies and procedures, subject to the Department and Agency approval, to verify the eligibility criteria of each enrolled recipient.

(5) Policies and procedures regarding screening for eligibility must include:

a. Timeframes for verification of eligibility criteria.

b. Mechanisms for reporting the results of eligibility screening to the Department.

c. Mechanisms for submitting disenrollment requests for enrollees that do not meet eligibility criteria.

d. Such other verifications, protocols, or mechanisms as may be required by the Department to ensure enrolled recipients meet defined eligibility criteria.

D. Disenrollment

1. The Respondent shall submit involuntary disenrollment requests for enrollees to the Department or its designee, in a format and timeframe prescribed by the Department, for each enrollee that does not meet the eligibility criteria, pursuant to the screening requirements specified above in **Section C.**, Enrollment.

2. CHIP enrollees may opt out of the Managed Care Plan and choose a different KidCare health plan or can stop paying premiums to be completely disenrolled. There is no involuntary disenrollment process for Title XXI enrollees.

E. Medicaid Redetermination Assistance

1. The Respondent shall develop a process for tracking redeterminations for the Medicaid ICP when an enrollee under the age of eighteen (18) years resides in a nursing facility, and for documenting the assistance provided by the Respondent, to ensure the enrollee continues to meet medical/functional eligibility for the Medicaid ICP.

2. The Respondent shall identify enrollees under the age of eighteen (18) years who do not have a disability determination and receive private duty nursing, Prescribed Pediatric Extended Care (PPEC) services, or medical foster care services. For an enrollee identified as not having a disability determination, the Respondent shall instruct each enrollee's parent(s) or legal guardian to apply for a disability determination for the enrollee from the Social Security Administration (SSA) or DCF prior to the enrollee's nineteenth (19th) birthday.

3. The Respondent shall develop and maintain policies and procedures to provide assistance with CHIP eligibility redetermination to enrollees in order to promote continuous CHIP eligibility as needed. All policies and procedures must be submitted to the Department for approval prior to implementation.

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Section III. Marketing

1. The Respondent shall develop and implement, subject to Department approval, policies and procedures that ensure the confidentiality of recipients in the conduct of any marketing activities pursuant to **Attachment B**.

2. The Respondent shall meet the following requirements, which the corresponding requirements in Attachment B:

    a. For marketing agents, report to the Department any marketing agent who violates any requirements of this Contract, within ten (10) days of knowledge of such violation. Submit reports to the Department as specified in Section XVI., Reporting Requirements, and the Respondent Report Guide, and in the manner and format determined by the Department.

3. The Respondent shall also meet the following requirements in addition to the activities described in Attachment B:

    a. For written marketing materials, include the following statements and disclaimers verbatim in any Managed Care Plan marketing materials that include information on benefits, or language agreed to in writing by the Department and Respondent: 1. "The CMS Health Plan is a Managed Care Plan with Florida Medicaid and CHIP contracts." 2. "The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact Respondent."

    b. For regional distribution of marketing materials, ensure the single name of "Florida Department of Health, Children's Medical Services Health Plan" is used in any marketing performed under this Contract throughout the region. Alternative language shall be agreed to in writing by the Department and Respondent.

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Section IV. Enrollee Services

A. General Provisions

There are no additional general provisions unique to the Respondent.

B. Enrollee Material

1. Provider Directory

In addition to the requirements in **Attachment B**, **Section V**, Service Administration, **Subsection B**, Expanded Benefits, the Respondent is not required to include outpatient -based Specialty providers in ambulatory surgical centers in the online provider database or printed provider directory. However, the Respondent shall include these providers in the provider network file it submits to the Department.

2. Online Enrollee Materials

The Respondent shall provide a link to the AHCA's Medicaid PDL on the Respondent's Managed Care Plan website without requiring enrollee login. The Respondent shall also post the list of covered drugs that are not on the AHCA's Medicaid PDL, and that are subject to prior authorization.

3. Provisions Specific to the Plus Plan

a. Enrollee information for Title XXI enrollees shall be in accordance with 42 CFR 457.1207.

b. Any Title XXI enrollee notices regarding the right to change their Managed Care Plan selection shall include information about change procedures, the KidCare (CHIP) enrollment website (https://www.floridakidcare.org) and toll-free enrollment broker telephone number (1-888-540-5437), as appropriate.

c. Materials for Title XXI enrollees shall include information on how to update the enrollee's name, address (home and mailing), county of residence, and telephone number with the Respondent and through DCF, Florida Healthy Kids Corporation, and/or the Social Security Administration.

d. For enrollees in the Child Welfare system, the Respondent shall develop and implement, subject to Department approval, policies and procedures that ensure the confidentiality of enrollees in the distribution of all enrollee materials pursuant to **Attachment B**.

C. Enrollee Services

1. Reinstatement Notice

a. In addition to requirements in **Attachment B**, **Section IV**, Enrollee Services, **Subsection B**, Enrollee Material, **Item 6**, Reinstatement Notice, the Respondent shall

include in its reinstatement notice:

(1) The enrollee's PCP, unless the enrollee is dual eligible.

2. Enrollee ID Card Requirements

a. The Respondent shall include on its enrollee ID card:

(1) The enrollee's PCP, unless the enrollee is dual eligible;

(2) Pharmacy contact information;

(3) Non-emergency medical transportation contact information; and

(4) After hours care coordination contact information.

3. Toll-Free Enrollee Help Line

The Respondent shall operate, as part of its emergency services, a crisis emergency hotline available to all enrollees twenty-four hours a day, seven days a week (24/7).

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Section V. Services Administration

A. Required MMA Benefits

1. General Provisions

Medicaid service-specific and all other coverage policies shall also apply to Title XXI enrollees for the purpose of this Contract.

2. Specific MMA Services to be Provided

The Respondent shall provide covered services specified in section 409.973, F.S., in accordance with **Attachment B**, **Section V**, Service Administration, the approved federal waiver for the MMA managed care program, the CHIP State plan, and the following Medicaid rules and services listed on the associated fee schedules in **Table 1**, the Florida Medicaid Policies and Rule References for MMA Services Table, below:

TABLE 1
FLORIDA MEDICAID POLICIES AND RULE REFERENCES FOR MMA SERVICES

Rule No.	Policy Name
59G-4.013	Allergy Services Coverage Policy
59G-4.015	Ambulance Transportation Services Coverage Policy
59G-4.020	Ambulatory Surgical Center Services Coverage Policy
59G-4.022	Anesthesia Services Coverage Policy
59G-4.025	Assistive Care Services Coverage Policy
59G-4.125	Behavior Analysis Services Coverage Policy
59G-4.028	Behavioral Health Assessment Services Coverage Policy
59G-4.031	Behavioral Health Community Support Services Coverage Policy
59G-4.370	Behavioral Health Intervention Services Coverage Policy
59G-4.029	Behavioral Health Medicaid Management Services Coverage Policy
59G-4.027	Behavioral Health Overlay Services Coverage and Limitations Handbook
59G-4.052	Behavioral Health Therapy Services Coverage Policy
59G-4.033	Cardiovascular Services Coverage Policy
59G-8.700	Child Health Services Targeted Case Management
59G-4.040	Chiropractic Services Coverage Policy
59G-4.055	County Health Department Services
59G-4.105	Dialysis Services Coverage Policy
59G-4.070	Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook
59G-4.085	Early Intervention Services Coverage Policy
59G-4.015	Emergency Transportation Services Coverage Policy
59G-4.087	Evaluation and Management Services Coverage Policy
59G-4.100	Federally Qualified Health Center Services
59G-4.026	Gastrointestinal Services Coverage Policy

59G-4.108	Genitourinary Services Coverage Policy
59G-4.110	Hearing Services Coverage Policy
59G-4.130	Home Health Services Coverage Policy
59G-4.140	Hospice Services Coverage Policy
59G-4.150	Inpatient Hospital Services Coverage Policy
59G-4.032	Integumentary Services Coverage Policy
59G-4.190	Laboratory Services Coverage Policy
59G-1.045	Medicaid Forms
59G-4.197	Medical Foster Care Services
59G-4.199	Mental Health Targeted Case Management Handbook
59G-4.201	Neurology Services Coverage Policy
59G-4.330	Non-Emergency Transportation Services Coverage Policy
59G-4.200	Nursing Facility Services Coverage Policy
59G-4.318	Occupational Therapy Services Coverage Policy
59G-4.207	Oral and Maxillofacial Surgery Services Coverage Policy
59G-4.211	Orthopedic Services Coverage Policy
59G-4.160	Outpatient Hospital Services Coverage Policy
59G-4.222	Pain Management Services Coverage Policy
59G-4.215	Personal Care Services Coverage Policy
59G-4.320	Physical Therapy Services Coverage Policy
59G-4.220	Podiatry Services Coverage Policy
59G-4.250	Prescribed Drug Services Coverage Policy
59G-4.261	Private Duty Nursing Services Coverage Policy
59G-4.002	Provider Reimbursement Schedules and Billing Codes
59G-4.240	Radiology and Nuclear Medicine Services Coverage Policy
59G-4.264	Regional Perinatal Intensive Care Center Services
59G-4.030	Reproductive Services Coverage Policy
59G-4.235	Respiratory System Services Coverage Policy
59G-4.322	Respiratory Therapy Services Coverage Policy
59G-4.280	Rural Health Clinic Services
59G-4.295	Specialized Therapeutic Services Coverage and Limitations Handbook
59G-4.324	Speech-Language Pathology Services Coverage Policy
59G-4.120	Statewide Inpatient Psychiatric Program Coverage Policy
59G-4.295	Therapeutic Group Care Services Coverage Policy
59G-4.360	Transplant Services Coverage Policy
59G-4.340	Visual Aid Services Coverage Policy
59G-4.210	Visual Care Services Coverage Policy

(1) Ambulatory Surgical Center Services

The Respondent shall not be responsible for dental services provided in an Ambulatory Surgical Center unless otherwise specified in this Contract.

(2) Behavior Analysis Services

The Respondent shall be responsible for the coverage of behavior analysis services to its enrollees.

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(3) Child Health Services Targeted Case Management Services

(a) The Respondent shall provide Child Health Services Targeted Case Management services to all enrollees who are eligible for and enrolled in the Early Steps program.

(b) The Respondent shall only utilize case managers who are trained and certified by the Department of Health (Department) Early Steps program to provide Child Health Services Targeted Case Management services for enrollees who are eligible for and enrolled in the Early Steps program.

(c) The Respondent shall not require prior authorization for Child Health Services Targeted Case Management Services that are provided to assist an enrollee with obtaining the initial screening and/or evaluation to determine eligibility for the Early Steps program and that are provided to assist with the development of the initial Individualized Family Service Plan. Once the initial IFSP has been completed, the Respondent shall not implement prior authorization requirements for ongoing receipt of Child Health Services Targeted Case Management Services, unless, as provided in **Attachment B**, **Exhibit B-2**, **Section IX**, Administration and Management, **Subsection F**, Encounter Data Requirements, the Respondent has identified suspected fraud, waste, or abuse in the utilization of such services.

(4) Clinic Services

(a) The Respondent shall provide Rural Health Clinic (RHC) services. RHCs provide ambulatory primary care to a medically underserved population in a rural geographical area. An RHC provides primary health care and related diagnostic services.

(i) RHC services reimbursed through the clinic encounter rate include:

- Well-child visits.
- Chiropractic services.
- Family planning services.
- HIV counseling services.
- Medical primary care services.
- Mental health services.
- Optometric services.

- Podiatric services.

(ii) RHC services reimbursed outside the clinic encounter rate include:

- Emergency services.
- Immunization services.
- Any health care services rendered away from the RHC, at a hospital, or a nursing facility, including off-site radiology services and off-site clinical laboratory services.
- Radiology and other diagnostic imaging services.
- Home health services.
- Prescribed drug services.
- WIC certifications or recertifications.
- Clinic visits for the sole purpose of obtaining lab specimens or to obtain results from a diagnostic test.
- Clinic visits for the sole purpose of obtaining immunizations.
- Mental health services for chronic conditions without acute exacerbation.

(b) The Respondent shall provide Federally Qualified Health Center (FQHC) services. An FQHC provides primary health care and related diagnostic services.

(i) FQHC services reimbursed through the clinic encounter rate include:

- Well-child visits.
- Chiropractic services.
- Family planning services.
- Medical primary care.
- Mental health services.
- Optometric services.
- Podiatric services.

- Diagnostic and treatment radiology services.

(ii) FQHC services reimbursed outside of the clinic encounter rate include:

- Emergency services.
- Services rendered away from the FQHC clinic or satellite clinic.
- Immunization services.
- Home health services.
- Prescription drug services.
- WIC certifications and recertifications.

(c) The Respondent shall provide County Health Department (CHD) Services. CHDs provide public health services in accordance with Chapter 154, F.S. A CHD provides primary and preventive health care, and related diagnostic services, including but not limited to:

(i) Well-child visits.

(ii) Family planning services.

(iii) Immunization services.

(iv) Medical primary care services.

(v) Registered nurse services.

(5) Community Behavioral Health Services

(a) The Respondent shall provide behavioral health services in compliance with 42 CFR 438.3(n) with respect to quantitative and non-quantitative limits.

(b) Under the authority of 42 U.S.C. 1396d(r)(5), the Respondent shall partner with DCF to offer the following evidence-based programs for children with intense behaviors, when medically necessary:

(i) Homebuilders.

(ii) Motivational interviewing.

(iii) Multisystemic therapy.

(iv) Parent-child interaction therapy.

(v) Functional family therapy.

(vi) Parents as teachers.

(vii) Brief strategic family therapy.

(viii) Healthy families.

(ix) Nurse family partnership.

(c) The Respondent shall ensure the provision of behavioral health services to enrollees on the iBudget Waiver or Waitlist who are dually diagnosed with a developmental disability and a mental health diagnosis.

(6) Early Intervention Services

(a) The Respondent shall promote increased use of prevention and early intervention services (EIS) for at-risk enrollees, birth through thirty-six (36) months of age. The Respondent shall provide covered EIS services specified in accordance with the following Medicaid rules and contractual requirements, utilizing only the procedure codes and modifiers listed in the associated fee schedules in **Table 2**, Early Intervention Services Table, below:

TABLE 2
EARLY INTERVENTION SERVICES TABLE

Service	Coverage Policy	Procedure Code and Modifier
Evaluation and screenings	59G-4.085 Early Intervention Services Coverage Policy	Per Early Intervention Services Fee Schedule
Assistive technology services and devices	59G-4.070 Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook	Per the Durable Medical Equipment and Medical Supply Services Provider Fee Schedule for All Medicaid Recipients. Procedure codes must include the TL modifier.
Audiology services	59G-4.110 Hearing Services	Per the Hearing Services Fee Schedule. Procedure codes must include the TL modifier.
Nursing services	59G-4.130 Home Health Services Coverage Policy	Per the Home Health Visit Services Fee Schedule. Procedure

		codes must include the TL modifier.
Medical services (e.g., physician services)	59G-4.087 Evaluation and Management Services Coverage Policy	Per the Practitioner Fee Schedule. Procedure codes must include the TL modifier.
Nutrition services	59G-4.085 Early Intervention Services Coverage Policy	Must use Sessions as provided in the Early Intervention Services Fee Schedule
Occupational therapy services	59G-4.318 Occupational Therapy Services Coverage Policy	Per the Occupational Therapy Services Fee Schedule. Procedure codes must include the TL modifier.
Physical therapy services	59G-4.320 Physical Therapy Services Coverage Policy	Per the Physical Therapy Services Fee Schedule. Procedure codes must include the TL modifier.
Psychological services	59G-4.050 Community Behavioral Health Services Coverage and Limitations Handbook	Per the Community Behavioral Health Services Fee Schedule. Procedure codes must include the TL modifier.
Sessions	59G-4.085 Early Intervention Services Coverage Policy	Per Early Intervention Services Fee Schedule
Speech-language pathology	59G-4.324 Speech-Language Pathology Services Coverage Policy	Per the Speech-Language Pathology Services Fee Schedule. Procedure codes must include the TL modifier.
Vision services	59G-4.210 Visual Care Services Coverage Policy	Per the Visual Services Fee Schedule. Procedure codes must include the TL modifier.

(b) The Respondent shall cover early intervention screening and evaluation services without authorization. The Respondent shall not impose any administrative or clinical barriers that impede the early intervention

screening and evaluation from being completed within forty-five (45) days of the enrollee's referral to the Early Steps program.

(c) The Respondent shall reimburse each qualified provider, as identified in **Section VII.**, Provider Network and Services, **Sub-Section A.**, Network Adequacy Standards, **Item 5.**, Specialists and Other Providers, **Sub-Item b**., of this Exhibit, conducting the early intervention services evaluation.

(d) The Respondent shall participate in the MDT meetings scheduled to develop and review the Individualized Family Service Plan (IFSP), which documents the need for early intervention services, when:

(i) Invited by the local Early Steps office; or

(ii) The Respondent has identified specific concerns about the enrollee's care needs.

(e) The Respondent shall ensure that all early intervention services as described in **Item (5)**, **Sub-Item (a)**, above and included on the IFSP are provided to enrollees in their natural environment (e.g., home, school, daycare), when appropriate.

(f) The Respondent shall make a good faith effort to enter into and maintain agreements with the Local Early Steps Program Office to establish methods of communication and procedures for the timely approval of services covered by Medicaid in accordance with section 391.308, F.S., and **Section V**, Services Administration.

(7) Emergency Services

(a) The Respondent shall provide pre-hospital and hospital-based trauma services and emergency services and care to enrollees *See* sections 395.1041, 395.4045, and 401.45, F.S.

(b) The Respondent shall authorize a minimum of three (3) days' coverage of emergency behavioral health inpatient services and care when provided according to this provision and resulting from a Baker Act admission.

(c) When an enrollee presents at a hospital seeking emergency services and care, a physician of the hospital or, to the extent permitted by applicable law, other appropriate personnel under the supervision of a hospital physician, shall make a determination that an emergency medical condition exists for the purposes of treatment. *See* sections 409.9128, 409.901, and 641.513, F.S.

(d) The Respondent shall not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, the Respondent shall not deny payment for treatment obtained when a

representative of the Respondent instructs the enrollee to seek emergency services and care in accordance with section 743.064, F.S.

(e) The Respondent shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as the Respondent can safely transport the enrollee to a participating facility. The Respondent may transfer the enrollee, in accordance with State and federal law, to a participating hospital that has the service capability to treat the enrollee's emergency medical condition. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

(f) In accordance with 42 CFR 438.114 and section 1932(b)(2)(A)(ii) of the Social Security Act, the Respondent shall cover post-stabilization care services without authorization, regardless of whether the enrollee obtains a service through a participating or non-participating provider. Those post--stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Respondent can choose not to cover non-emergency services if they are provided by a non-participating provider, except in any circumstances detailed below.

(i) Post-stabilization care services that were pre-approved by the Respondent.

(ii) Post-stabilization care services that were not pre-approved by the Respondent because the Respondent did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request.

(iii) The treating provider could not contact the Respondent for pre-approval.

(g) The Respondent shall provide emergency services and care without any specified dollar limitations.

(h) The Respondent shall authorize payment for non-participating physicians for emergency ancillary services provided in a hospital setting.

(i) The Respondent shall provide emergency behavioral health services pursuant, but not limited, to section 394.463, F.S.; section 641.513, F.S.; and Title 42 CFR Chapter IV. Emergency service providers shall make a reasonable attempt to notify the Respondent within twenty-four (24) hours of the enrollee's presenting for emergency behavioral health services. In cases in which the enrollee has no identification or is unable to identify himself/herself orally when presenting for behavioral health services, the

provider shall notify the Respondent within twenty-four (24) hours of learning the enrollee's identity.

(j) In addition to the requirements outlined in section 641.513, F.S., the Respondent will ensure:

(i) The enrollee has a follow-up appointment scheduled within seven (7) days after discharge.

(ii) All required prescriptions are authorized at the time of discharge.

(8) Family Planning Services and Supplies

(a) The Respondent shall furnish family planning services on a voluntary and confidential basis.

(b) The Respondent shall allow enrollees freedom of choice of family planning methods covered under the Medicaid program, where there are no medical contra-indications.

(c) The Respondent shall allow each enrollee to obtain family planning services and supplies from any provider and shall not require a referral for such services.

(d) The Respondent shall make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning. The Respondent shall direct providers to maintain documentation in the enrollee records to reflect this provision (section 409.967(2), F.S.).

(e) The Respondent shall implement an outreach program and other strategies for identifying every pregnant enrollee. This includes but is not limited to care coordination/case management, claims analysis, and use of health risk assessment. The Respondent shall require its participating providers to notify the plan of any enrollee who is identified as being pregnant.

(9) Hearing Services

Newborn and infant hearing screenings are covered through the Medicaid fee-for-service (FFS) delivery system.

(10) Hospice Services

The Respondent shall cover hospice services for enrollees who have been certified terminally ill in accordance with Rule 59G-4.140, F.A.C. and 42 CFR 418.22, except for 42 CFR 418.22(a)(4)(i) wherein no face-to-face examination by a physician or advanced practice registered nurse is required for hospice services for the third benefit period certification and every benefit period certification thereafter.

(11) Hospital Services

(a) Inpatient services also include inpatient care for any diagnosis including tuberculosis and renal failure, when provided by general acute care hospitals in both emergent and non-emergent conditions.

(b) The Respondent shall adhere to the provisions of the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) regarding postpartum coverage for mothers and their newborns. Therefore, the Respondent shall provide for no less than a forty-eight (48) hour hospital length of stay following a normal vaginal delivery, and at least a ninety-six (96) hour hospital length of stay following a Cesarean section. In connection with coverage for maternity care, the hospital length of stay shall be decided by the attending physician in consultation with the mother.

(c) The Respondent shall prohibit the following practices related to the NMHPA:

(i) Providing monetary payments or rebates to mothers to encourage them to accept less than the minimum protections available under NMHPA.

(ii) Penalizing or otherwise reducing or limiting the reimbursement of an attending physician because the physician provided care in a manner consistent with NMHPA.

(iii) Providing incentives (monetary or otherwise) to an attending physician to induce the physician to provide care in a manner inconsistent with NMHPA.

(d) For all child/adolescent enrollees (under the age of twenty-one (21) years) and pregnant enrollees, the Respondent shall be responsible for providing up to three hundred sixty-five (365) days of health-related inpatient care, including behavioral health, for each State fiscal year.

(e) The Respondent shall count inpatient days based on the lesser of the actual number of covered days in the inpatient hospital stay and the average length of stay for the relevant All Patient Refined Diagnosis Related Group (APR-DRG or DRG). This requirement applies whether or not the Respondent uses DRGs to pay the provider. DRGs can be found at the following website: http://ahca.myflorida.com/medicaid/cost_reim/hospital_rates.shtml.

(f) Unless otherwise specified in this Contract, where an enrollee uses non-emergency services available under the Managed Care Plan from a non-participating provider, the Respondent shall not be liable for the cost

of such services unless the Respondent referred the enrollee to the non-participating provider or authorized the out-of-network service.

(g) The Respondent shall be responsible for the reimbursement of care for enrollees who have been diagnosed with Tuberculosis disease, or show symptoms of having Tuberculosis and have been designated a threat to the public health by the Florida Department of Health Tuberculosis Program and shall observe all of the following:

(i) Treatment plans and discharge determinations shall be made solely by Department and the treating hospital.

(ii) For enrollees determined to be a threat to public health and receiving Tuberculosis treatment at a Department contracted hospital, the Respondent shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and the Department, and shall also pay any wrap-around costs not included in the per-diem rate.

(iii) The Respondent shall not deny reimbursement for failure to prior authorize admission or for services rendered pursuant to section 392.62 F.S.

(i) The Respondent shall require prior authorization for all non-emergency inpatient hospital admissions.

(j) The Respondent shall not:

(i) Limit inpatient days for services that are unrelated to the Provider Preventable Condition (PPC) diagnosis present on admission.

(ii) Reduce authorization to a provider when the PPC existed prior to admission.

(k) The Respondent shall enroll and participate in the Florida Health Information Exchange (HIE) Encounter Notification Service (ENS) as directed by the Agency.

(l) The Respondent shall not be responsible for dental services provided in an outpatient hospital setting unless otherwise specified in this Contract.

(12) Immunizations

(a) The Respondent shall provide immunizations in accordance with the Recommended Childhood and Adolescent Immunization Schedule for the United States, or when medically necessary for the enrollee's health.

(b) The Respondent shall participate, or direct its providers to participate, in the Vaccines for Children (VFC) Program. See section 1905(r)(1)(B)(iii) of the Social Security Act.

(i) The Respondent shall provide coverage and reimbursement to the participating provider for immunizations covered by Medicaid, but not provided through VFC. Title XXI enrollees are excluded from VFC. Coverage and reimbursement for all recommended immunizations shall be provided for Title XXI enrollees who are over one years old.

(ii) The Respondent shall ensure that providers have a sufficient supply of immunizations if the provider is enrolled in the VFC program. The Respondent shall direct those providers that are directly enrolled in the VFC program to maintain adequate immunization supplies.

(e) The Respondent shall enroll as a data partner with Florida SHOTS (State Health Online Tracking System) and submit immunization data using the process and format specified by the Agency.

(13) Medical Foster Care Services

(a) The Respondent shall provide medical foster care services for enrollees under the age of twenty-one (21) years who meet all other eligibility requirements to receive this service.

(b) The Respondent shall work cooperatively with the Department, Medical Foster Care program staff, and the Community-based Care (CBC) Lead Agencies in the provision of medical foster care services.

(c) The Respondent shall participate in initial and ongoing medical foster care CMAT staffing meetings for its enrollees.

(d) The Respondent shall ensure that assigned case managers have the authority to authorize medical foster care services during the CMAT staffing if the team reaches consensus on the level of care recommendation.

(e) If there is lack of consensus among the CMAT members in determining the eligibility and recommended level of care for medical foster care services for the enrollee, the Respondent shall have the authority to make the final determination for its enrollees.

(f) The Respondent shall develop and maintain plan of care for enrollees receiving Medical Foster Care services that describes all interventions that the Medical Foster Care provider must implement in accordance with the physician's order. The Respondent shall update the plan of care for Medical Foster Care services at least one-hundred eighty (180) days, or more frequently to reflect changes in the physician's orders. The Respondent shall ensure that the medical foster plan of care is signed by a physician

who is experienced in providing services to children with complex medical needs. The Respondent shall provide a copy of the plan of care to the Department, Medical Foster Care program staff, the Community- Based Care Lead Agency, and the Medical Foster Care provider.

(g) The Respondent shall submit the signed MFC plan of care to Department, Medical Foster Care program staff, the Community-Based Care Lead Agency, and the Medical Foster Care provider within forty-eight (48) hours of notification that an MFC bed is available for enrollees awaiting placement in a medical foster care home. For members not awaiting placement, the Respondent shall submit the signed MFC plan of care to the Department, Medical Foster Care program staff, the Community-Based Care Lead Agency, and the Medical Foster Care provider within five (5) business days.

(14) Medical Supplies, Durable Medical Equipment, Prostheses, and Orthoses

Notwithstanding the limitations prescribed by the Durable Medical Equipment Services Coverage and Limitations Handbook, the Respondent shall provide specialized medical equipment and supplies (e.g., incontinence supplies) to enrollees with a diagnosis of AIDS, and who have had a history of an AIDS -related opportunistic infection. The Respondent may place appropriate limits on such services on the basis of medical necessity.

(15) Nursing Facility Services

(a) The Respondent shall provide nursing facility services for enrollees under the age of eighteen (18) years.

(b) The Respondent shall provide nursing facility services for enrollees ages eighteen (18) years of age and older in the following circumstances:

(1) For up to one-hundred twenty (120) days from the date of the most recent nursing facility admission, regardless of payer, when:

i. The enrollee needs long-term nursing facility services and is not receiving nursing facility services in lieu of inpatient hospital services nor admitted for rehabilitation services.

ii. The enrollee has completed all preadmission screening and resident review (PASRR) requirements.

iii. The DCF has determined the enrollee is eligible for Institutional Care Program (ICP) Medicaid.

iv. The enrollee is not yet enrolled in the Long-Term Care program.

(2) Reimburse in accordance with Rule 59G-1.052, F.A.C. for nursing facility services provided during the Medicare coinsurance days (day twenty-one (21) up to day one-hundred (100) for Medicare co-payments and co-insurance if the requirements of PASRR are met and the enrollee: has QMB benefits and is also eligible for full Florida Medicaid benefits; is receiving SSI; or has Medicare benefits other than QMB and is also eligible for the Institutional Care Program.

(c) The Respondent shall provide a monthly report of enrollees who are eighteen (18) years of age and older who are receiving nursing facility services for thirty (30) or more consecutive days from the date of admission and have not yet been determined eligible for ICP Medicaid. The Respondent shall submit the monthly report to the Agency in accordance with **Section XV**, Accountability, and the Respondent Report Guide.

(16) Oral and Maxillofacial Surgery Services

The Respondent shall be responsible for the coverage of services to its enrollees for treatment of cleft lip, cleft palate, or other craniofacial deformities.

(17) Physician Services

The Respondent shall be responsible for coverage of preventive dental services when rendered by a non-dental provider.

(18) Laboratory and Imaging Services

The Respondent shall be responsible for newborn screening services in accordance with section 383.14, F.S., which outlines the required laboratory screening process to test for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect. These required laboratory tests shall be processed through the State Public Health Laboratory. The Respondent shall reimburse for these screenings at the established Medicaid rate and must enter into a provider agreement or a contract with the State Public Health Laboratory.

(19) Prescribed Drug Services

(a) AHCA shall be responsible for administration of the Medicaid prescribed drug program. AHCA shall maintain the Medicaid P&T Committee review of drug options to maintain an array of choices for prescribers within each therapeutic class on the Agency's Medicaid Preferred Drug List (PDL). The Respondent shall use AHCA's Medicaid PDL in its coverage of prescription drugs for Medicaid enrollees. Provider may develop a separate PDL for CHIP enrollees with the Department's prior approval but shall, at a minimum, provide coverage to all drugs in the Medicaid formulary.

(b) The Respondent shall not negotiate any drug rebates with pharmaceutical manufacturers for drugs on AHCA's Medicaid PDL for prescribed drug

services under this Contract. AHCA will be the sole negotiator of pharmaceutical rebates for drugs on AHCA's Medicaid PDL, and all rebate payments for drugs on AHCA's Medicaid PDL will be made to AHCA. The Respondent may negotiate rebates related to its development and administration of a CHIP PDL so long as all drugs on the Medicaid formulary are covered.

(c) The Respondent shall provide coverage of outpatient drugs as defined in section 1927(k)(2) of the SSA.

(d) The Respondent shall provide those products and services associated with the dispensing of medicinal drugs pursuant to a valid prescription, as defined in chapter 465, F.S., prescribed drug services shall include all prescription drugs listed in the Agency's Medicaid PDL.

(e) The Respondent shall make available those drugs and dosage forms listed on the AHCA's Medicaid PDL and shall comply with the requirements of Section 409.912(5)(a)(5), F.S., regarding the use of counterfeit-proof prescription pads.

(f) The Respondent may make available generic drugs in a therapeutic category that are not on AHCA's Medicaid PDL and the Respondent's CHIP PDL, unless a brand-name drug containing the same active ingredient is on AHCA's Medicaid PDL or the Respondent's CHIP PDL.

(g) The Respondent shall make available those brand name drugs that are not on AHCA's Medicaid PDL and the Respondent's CHIP PDL, when medically necessary, if the prescriber:

(i) Writes in his/her own handwriting on the valid prescription the words "MEDICALLY NECESSARY" (pursuant to section 465.025, F.S.); and

(ii) Submits a completed "Multisource Drug and Miscellaneous Prior Authorization" form to the Respondent indicating that the enrollee has had an adverse reaction to a generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug.

(h) The Respondent may have a pharmacy lock-in program that complies with the AHCA-established Pharmacy Lock-in Policy and Guidelines. The lock -in period shall not exceed twelve (12) consecutive months. The Respondent shall submit its lock-in program procedures in writing for approval by Department and AHCA in advance of implementation.

(i) The Respondent shall notify providers who may prescribe or are currently prescribing a drug that is being deleted from the AHCA's Medicaid PDL within thirty (30) days of the Respondent being notified of the change by AHCA or within thirty (30) days of the Respondent deleting a drug from its CHIP PDL. Implementation of PDL changes must be completed within forty-five (45) days of being notified of the change by the Agency.

(j) For CHIP enrollees, the Respondent shall cover Hemophilia factor-related drugs, Exondys and Spinraza.

(k) During operation of the Comprehensive Hemophilia Disease Management Program, the Respondent shall coordinate the care of its enrollees with AHCA-approved organizations.

(l) The Respondent shall implement formulary management tool (FMT) changes from the weekly comprehensive drug list update within fourteen (14) days of a file being provided to the Respondent by AHCA. Pharmacy prior authorization automation system changes must be implemented within ninety (90) days of being notified by AHCA.

(m) The Respondent shall report Medicaid drug utilization data as specified by the Department necessary to bill manufacturers for rebates within forty-five (45) days of the end of the quarterly rebate period.

(n) The Respondent shall establish procedures to exclude utilization data for drugs subject to 340B discounts.

(o) The Respondent shall operate a drug utilization review (DUR) program that complies with section 1927(g) of the Social Security Act and will provide a DUR program annual report.

(p) The Respondent shall conduct drug prior authorization in compliance with section 1927(d) (5) of the Social Security Act.

(q) All participating prescribed drug services providers enrolled in the Medicaid program must be in compliance with the provisions of the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook, July 2001, which is incorporated by reference, and available from the Medicaid fiscal agent.

(r) The Respondent shall comply with all pharmacy requirements in 42 CFR Part 438 including requirements for:

a. Enrollee health records and enrollee assessments;

b. Transition of care policies;

c. Time and distance standards for pharmacy providers; and

d. Standardized terminology and enrollee information.

i. Other pharmacy reimbursement methodologies

1. Florida utilizes the actual purchased drug price plus a PDF in the reimbursement methodology for drugs acquired via the Federal Supply Schedule (FSS).

2. Florida utilizes the actual purchased drug price plus a PDF in the reimbursement methodology for drugs acquired via Nominal price.

3. Florida reimburses for drugs purchased under the 340B program at the actual purchased drug price, which cannot exceed the 340B ceiling price, plus a dispensing fee of $10.24.

4. Florida reimburses for clotting factor to the vendor awarded the State's hemophilia contract at the negotiated price.

5. Florida reimburses for covered prescribed drugs administered by a licensed practitioner in an office setting at WAC.

6. Florida reimburses for covered prescribed drugs administered in an outpatient facility at WAC.

7. Florida reimburses for covered prescribed drugs purchased under the 340B program administered in an outpatient facility at an amount not to exceed the 340B ceiling price.

8. Florida does not reimburse for investigational or experimental drugs.

(20) Therapeutic Group Care Services

(a) The Respondent shall provide qualified residential treatment program (QRTP) services for children who are removed from their families and entered into foster care in accordance with the coverage requirements in Rule 59G-4.295, F.A.C. Therapeutic Group Care Services.

(b) The Respondent shall ensure that a cooperative agreement and community living support plan, as defined in section 429.02, F. S., are developed by the ALF administrator and the Managed Care Plan's Cas Manager for enrollees that are residents of an ALF and qualify as a mental health resident.

(21) Therapy Services

The Respondent shall provide medical massage therapy services to enrollees diagnosed with AIDS, and who have had a history of an AIDS-related opportunistic infection, as confirmed by the Department, for the treatment of peripheral neuropathy or severe neuromuscular pain and lymphedema. The Respondent may place appropriate limits on such services on the basis of medical necessity.

(22) Transplant Services

The Respondent shall provide medically necessary transplants and related services as outlined in **Table 3**, Transplant Summary of Responsibility Table, below. Transplant services specified with one (1) asterisk are covered through Medicaid on a FFS basis and not by the Managed Care Plan.

TABLE 3 **TRANSPLANT SUMMARY OF RESPONSIBILITY**		
Transplant Service		**Pediatric** (Twenty (20) and Under)
Evaluation		Managed Care Plan
Bone Marrow		Managed Care Plan
Cornea		Managed Care Plan
Heart		Managed Care Plan
Intestinal/ Multivisceral		Medicaid*
Kidney		Managed Care Plan
Liver		Managed Care Plan
Lung		Managed Care Plan
Pancreas		Managed Care Plan
Pre- and Post-Transplant Care, **including** Transplants Not Covered by Medicaid		Managed Care Plan
Other Transplants Not Covered by Medicaid		Not Covered

(23) Transportation Services

(a) The Respondent shall provide emergency and non-emergency transportation services to eligible enrollees twenty-four (24) hours per day, seven (7) days per week for its enrollees who have no other means of transportation available to any covered service and transportation to services not covered by the Managed Care Plan specified in **Section V**, Services Administration, **Subsection C**, Excluded Services, including prepaid dental services, prescribed drugs, and expanded benefits.

(b) The Respondent shall develop and implement written procedures for transportation services for the following:

(i) Determining service eligibility for each enrollee and what type of transportation to provide that enrollee.

(ii) Establishing a minimum twenty-four (24) hour advance notification policy to obtain transportation services, and communicating that policy to its enrollees and transportation providers. However, advance notification policies shall comport with the timely access to medical care requirements as specified in **Section VII**, Provider Network and Services, **Sub-Section A**, Network Adequacy Standards, of this Exhibit.

(iii) Complying with Department-prescribed pick-up windows to enrollees and transportation providers.

2. **In Lieu of Services**

The Respondent may provide any of the following in lieu of services to enrollees when determined medically appropriate, in accordance with the requirements specified in **Attachment B, Section V,** Services Administration.

a. The Respondent may provide the following in lieu of services without any Department approval:

(1) Nursing facility services in lieu of inpatient hospital services when the enrollee does not require long-term nursing facility care and meets the requirements of PASRR. Such services shall not be counted as inpatient hospital days.

(2) Crisis stabilization units (CSU) and Class III and Class IV freestanding psychiatric Specialty hospitals in lieu of inpatient psychiatric hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If CSU beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Respondent shall demonstrate adequate capacity for psychiatric inpatient hospital care in anticipation of such transfers. Such services shall be subject to the requirements of 42 CFR 438.6(e).

(3) Detoxification or addictions receiving facilities licensed under chapter 397, F.S., in lieu of inpatient detoxification hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If detoxification or addictions receiving facility beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Respondent shall demonstrate adequate capacity for inpatient detoxification hospital care in anticipation of such transfers. Such services shall be subject to the requirements of 42 CFR 438.6(e).

b. The Respondent may provide the following in lieu of services subject to Department and Agency review and approval:

(1) For partial hospitalization services in a hospital in lieu of inpatient psychiatric hospital care, there is no annual limit for children under the age of twenty-one (21) years old.

(2) Mobile crisis assessment and intervention for enrollees in the community may be provided in lieu of emergency behavioral health care.

(3) Ambulatory detoxification services may be provided in lieu of inpatient detoxification hospital care when determined medically appropriate.

(4) Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services.

(5) Drop-In Center in lieu of Clubhouse services.

(6) Infant Mental Health Pre and Post Testing Services in lieu of Psychological Testing services.

(7) Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services.

(8) Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.

(9) Behavioral Health Services – Child Welfare in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.

(10) Substance Abuse Intensive Outpatient Program (IOP) in lieu of inpatient detoxification hospital care.

(11) Substance Abuse Short-Term Residential Treatment (SRT) in lieu of inpatient detoxification hospital care.

(12) Mental Health Partial Hospitalization Program (PHP) in lieu of inpatient psychiatric hospital care.

(13) Multi Systemic Therapy in lieu of inpatient and residential stay or SIPP.

(14) Telehealth visits in lieu of in-person visits for mental illness and substance use disorder.

(15) Psychotropic injection services provided by licensed nurses to adults in lieu of physician administration.

(16) Prescription digital therapeutic when paired with outpatient visit in lieu of inpatient hospitalization.

(17) Housing Assistance and Targeted Case Management for people with homelessness or at risk for homelessness and diagnosis of SMI and/or SUD in lieu of emergency department visit or inpatient hospitalization for SMI and/or SUD.

(18) Functional family therapy in home or community for children or adolescents with a history of justice involvement or at high risk for justice involvement in lieu of outpatient clinic visits, emergency department visits, or inpatient hospitalization.

c. The Respondent shall develop and implement a tool that allows the Case Manager the ability to determine if a child should receive an in lieu of service benefit. Submit the tool to the Department for approval prior to implementation. The tool, which may be the same as used for Expanded Benefits eligibility determinations, must meet at a minimum the following criteria:

(1) Provide a mechanism for the Case Manager to determine that the in lieu of service to be provided is more cost effective than the covered service and to document the clinical rationale supporting the determination.

(2) Provide for the Case Manager to provide the in lieu of service that may be deemed necessary to enable the enrollee to live in their home and community or to be discharged from and institutional setting.

(3) Clearly outline the required authorization process for the Case Manager or the enrollee to following order to receive the in lieu of service.

(4) Nor represent a process that can be reasonably be interpreted as onerous for the case Manager of the enrollee to follow.

(5) Provide for the identification of any services medically necessary under 1905(a) to which the child is entitled to under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), which shall be authorized regardless of whether the service is cost-effective and not considered expanded benefits of in lieu of services.

3. Customized Benefits

a. As permitted by section 409.973(2), F.S., the Respondent may customize expanded benefit packages for non-pregnant enrollees, vary cost-sharing provisions, and provide coverage for additional services.

b. Submitted proposals for customized benefit packages must comply with instructions available from the Department. The Department shall evaluate the Respondent's CBP for actuarial equivalency and sufficiency of benefits before approving the CBP. Actuarial equivalency is tested by using a proposal that:

(1) Compares the value of the level of benefits in the proposed package to the value of the contracted benefit package for the average member of the covered population;

(2) Ensures that the overall level of benefits is appropriate; and

(3) Compares the proposed CBP to State-established standards. The standards are based on the covered population's historical use of Medicaid services. These standards are used to ensure that the proposed CBP is adequate to cover the needs of the vast majority of the enrollees.

c. If, in its CBP, the Respondent limits a service to a maximum annual dollar value, the Respondent must calculate the dollar value of the service using the Medicaid fee schedule.

d. The CBPs may change on a Contract year basis and only if approved by the Department in writing. The Respondent shall submit to the Department a proposal for its proposed CBP for evaluation of actuarial equivalency and sufficiency standards no later than the date established by the Department each year.

e. The Respondent shall send letters of notification to enrollees regarding exhaustion of benefits for services restricted by unit amount if the amount is more restrictive than Medicaid. The Respondent shall send an exhaustion of benefits letter, including notification of the enrollee's right to a Medicaid Fair Hearing, for any service restricted by a dollar amount. The Respondent shall implement said letters upon the written approval of the Department. The letters of notification include the following:

(1) A letter notifying an enrollee when he/she has reached fifty percent (50%) of any maximum annual dollar limit established by the Respondent for a benefit;

(2) A follow-up letter notifying the enrollee when he/she has reached seventy-five percent (75%) of any maximum annual dollar limit established by the Respondent for a benefit; and

(3) A final letter notifying the enrollee that he/she has reached the maximum dollar limit established by the Respondent for a benefit.

f. The Respondent shall submit the Customized Benefit Notifications Report to the Agency in accordance with **Section XV**, Accountability, and the Managed Care Plan Report Guide.

B. Expanded Benefits

The Respondent shall offer any specific expanded benefits to eligible enrollees with a specialty condition, subject to any Department-approved service limitations set forth in **Attachment I** of the resulting Contract.

C. Excluded Services

1. The following services are excluded services for purposes of Title XXI children:

a. Home and Community-Based Services; and

b. Behavioral health services for BNet enrolled Department members within the coverage policy and up to the coverage and funding limits of BNet as described in Rule 65E-11.003, Florida Administrative Code.

2. The following services are not provided by the Respondent, but are available to eligible Medicaid recipients through the Medicaid FFS delivery system:

a. CHD Certified Match Program services.

b. Developmental Disabilities Individual Budgeting (iBudget) HCBS Waiver services.

c. Familial Dysautonomia HCBS Waiver services.

d. Hemophilia Factor-related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program services.

e. ICF/IID services.

f. School-based services provided through the Medicaid Certified School Match Program.

g. Model HCBS Waiver services.

h. Newborn Hearing services.

i. Prescribed Pediatric Extended Care services.

j. Program for All-Inclusive Care for Children services.

k. Substance Abuse County Match Program services.

l. Florida Assertive Community Treatment (FACT) services.

D. Coverage Provisions

1. Primary Care Provider Initiatives

a. Pursuant to section 409.973(4), F.S., the Respondent shall establish a program to encourage enrollees to establish a relationship with their PCP.

b. The Respondent shall provide information to each enrollee on the importance of selecting a PCP and the procedure for selecting a PCP (section 409.973(4), F.S.) and shall allow each enrollee to choose his or her network provider to the extent possible and appropriate (42 CFR § 438.3(l)).

c. The Respondent shall offer each enrollee a choice of PCPs. After making a choice, each enrollee shall have a single or group PCP.

d. The Respondent shall allow pregnant enrollees to choose Respondent obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP, as specified in **Section VII**, Provider Network and Services.

e. No later than the beginning of the last trimester of gestation, the Respondent shall assign a pediatrician or other appropriate PCP to all pregnant enrollees for the care of their newborn babies if the enrollee has not selected a provider for a newborn.

f. The Respondent shall assign a PCP to those enrollees who did not choose a PCP at the time of Managed Care Plan selection. The Respondent shall take into consideration the enrollee's last PCP (if the PCP is known and available in the Respondent's network), closest PCP to the enrollee's ZIP code location, keeping children/adolescents within the same family together, enrollee's age, and PCP performance measures.

    (1) If the language and/or cultural needs of the enrollee are known to the Respondent, the Respondent shall assign the enrollee to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee.

    (2) If the enrollee is a full-benefit dual eligible: the Respondent:

        (a) Shall not assign or require the enrollee to choose a new PCP through the Managed Care Plan.

        (b) Shall not prevent the enrollee from receiving primary care services from the enrollee's existing Medicare PCP.

        (c) May assist the enrollee in choosing a PCP, if the enrollee does not have a Medicare assigned PCP or requests to change PCP.

g. The Respondent shall permit enrollees to request to change PCPs at any time. If the enrollee request is not received by the Respondent's established monthly cut-off date for system processing, the PCP change will be effective the first day of the next month.

h. The Respondent shall assign all enrollees that are reinstated after a temporary loss of eligibility to the PCP who was treating them prior to loss of eligibility, unless the enrollee specifically requests another PCP, or the PCP no longer participates in the Respondent or is at capacity.

i. Pursuant to section 409.973(4), F.S., the Respondent shall report on the number of enrollees assigned to each participating PCP and the number of enrollees who have not had an appointment with their PCP within their first (1st) year of enrollment as specified in **Section XV**, Accountability, and the Managed Care Plan Report Guide.

j. Pursuant to section 409.973(4), F.S., the Respondent shall report on the number of emergency room visits by enrollees who have not had at least one (1) appointment with their PCP as specified in the Managed Care Plan Report Guide and as referenced in **Section XV**, Accountability.

2. Behavioral Health

a. In addition to Attachment B, Section V.D.3, the Respondent shall identify Title XXI enrollees for the BNet Program. The Respondent's Case Manager is responsible for the following related to the BNet Program:

(i) The Case Manager will identify and make outreach attempts to assess enrollees for BNet program eligibility.

(ii) The Case Manager will educate eligible enrollees on the program benefits.

(iii) The Case Manager will refer all eligible Title XXI enrollees who express interest in the program to the BNet program.

(iv) The Case Manager will continue to coordinate services in collaboration with the BNet program liaison throughout enrollee's enrollment in the BNet Program.

(v) All efforts to reach and educate potentially eligible enrollees on the program and subsequent referrals to the BNet program will be documented in the enrollee record.

b. The Respondent shall coordinate medically necessary behavioral health services above the coverage limits of BNet for TXXI eligible enrollees. This includes medically necessary behavioral analysis services for all eligible Title XXI enrollees.

c. For all enrollees the Respondent shall work in coordination with the Department and DCF's behavioral health managing entity to establish specific organizational supports and protocols that enhance the integration and coordination of primary care and behavioral health services for enrollees, in accordance with section 409.973(6), F.S.

The Respondent shall establish and maintain written procedures for discharge planning through the evaluation of an enrollee's medical care needs, mental health service needs, and substance use service needs and coordination of appropriate care after discharge from one (1) level of care to another as follows:

(1) Monitor all enrollee discharge plans from behavioral health inpatient admissions to ensure that they incorporate the enrollee's needs for continuity in existing behavioral health therapeutic relationships.

(2) Ensure enrollees' family members, guardians, outpatient individual practitioners and other identified supports are given the opportunity to participate in enrollee treatment to the maximum extent practicable and appropriate, including behavioral health treatment team meetings and discharge plan development. For

adult enrollees, ages eighteen (18) years and older, family members and other identified supports may be involved in the development of the discharge plan only if the enrollee consents to their involvement.

(3) Designate case management staff who are responsible for identifying and providing case management to enrollees who remain in the hospital for nonclinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk enrollees, and enrollees with multiple agency involvement).

(4) Develop and implement a plan that monitors and ensures that clinically indicated behavioral health services are offered and available to enrollees within seven (7) days of discharge from an inpatient setting.

(5) Ensure that a behavioral health program clinician provides medication management to enrollees requiring medication monitoring within seven (7) days of discharge from a behavioral health program inpatient setting. Provider will ensure that the behavioral health program clinician is duly qualified and licensed to provide medication management.

(6) Make best efforts to ensure the enrollee's smooth transition to the next service or to the community upon admission of an enrollee. Require that behavioral health care service providers:

(a) Assign a mental health targeted case manager to oversee the care given to the enrollee;

(b) Develop an individualized discharge plan, in collaboration with the enrollee where appropriate, for the next service or program or the enrollee's discharge, anticipating the enrollee's movement along the continuum of services; and

(c) Report the number of enrollees under twenty-one (21) years old receiving out-of-home behavioral health treatment, in accordance with Section V, Accountability, and the Respondent Report Guide each month. Participate in AHCA and DCF conference calls and staffings to provide status updates and information on these enrollees.

(7) The Respondent shall retain responsibility for the provision of medically necessary behavioral health evaluation and treatment services to enrollees, regardless of setting, including in the community, a medical facility, an assisted-living facility, or a nursing facility. Provision of services in LTC settings will require coordination with other entities including LTC providers and providers, Medicare plans and providers, and State -funded programs and services.

(8) The Respondent shall coordinate behavioral health services consistent with the Case Management requirements established in Section V, Services Administration, Sub-Section E of this Contract, in cooperation with the administration and treatment providers as follows:

(1) Psychiatric Evaluations and Treatment for Enrollees Applying for Nursing Facility Admission:

(a) Arrange for and authorize psychiatric evaluations for enrollees who are applying for admission to a nursing facility pursuant to Federal Nursing Home Reform Act (OBRA 87), and who, based on screening conducted by Comprehensive Assessment and Review for Long-Term Care Services (CARES) workers, are thought to need behavioral health treatment, upon request from DCF. This evaluation meets the requirement for determination of "specialized treatment" under OBRA 87.

(b) Complete evaluations within five (5) business days from the date a request is received from DCF. Regulations have been interpreted by the State to permit any of the mental health professionals listed in section 394.455, F.S., to make the observations preparatory to the evaluation, although a psychiatrist must sign such evaluations.

(c) Provider will not be responsible for resident reviews as a result of a PASRR evaluation. If the psychiatric evaluation of an enrollee indicates covered behavioral health services are medically necessary, and the enrollee is subsequently admitted to a nursing facility, Provider will retain responsibility for provision or those behavioral health services to enrollee in the nursing facility.

(d) Assessment and treatment of mental health residents who reside in Assisted Living Facilities (ALFs) that hold a limited mental health license: Develop and implement a plan to ensure compliance with section 394.4574, F.S., related to behavioral health services provided to residents of licensed ALFs that hold a limited mental health license.

3. New Enrollee Procedures

a. The Respondent will ensure the selection and assignment of a case manager, including protocols, for new enrollees. All new enrollees will be assigned a case manager and back-up case manager no later than thirty (30) calendar days from enrollment notification.

b. The Respondent shall conduct an initial face-to-face visit with all new enrollees within thirty- (30) calendar days of enrollment into the Plan.

c. The Respondent shall complete a needs assessment within thirty (30) calendar days of enrollment of each new enrollee, and annually thereafter using a Department approved tool.

(1) The Respondent's case manager shall make at least three (3) attempts to contact each new enrollee, if necessary, within thirty (30) days of the enrollee's enrollment to offer to schedule the enrollee's initial appointment with the PCP

and to complete an initial health risk assessment and HOPE Florida screening. This initial appointment is to obtain an initial health assessment, including a well-child visit, if applicable. For this subsection "contact" is defined as mailing a notice to the most recent address or telephoning an enrollee at the most recent telephone number available. Contact may also include emailing as permitted by **Attachment B, Section IV**, Enrollee Services, **Subsection B**, Enrollee Material, **Item 3**., Requirements for Mailing Materials to Enrollees.

(2) In addition to completing the initial health risk assessment, the Respondent shall complete a supplemental caregiver assessment, as described in Section 6.2.1 of the Statewide Medicaid Managed Care Long-term Care Program Coverage Policy., for enrollees enrolled in or on the waitlist for the Developmental Disabilities Individual Budgeting (iBudget) Waiver.

d. Within thirty (30) calendar days of enrollment, the Respondent shall ask the enrollee to authorize release of the provider's enrollee records to the new PCP or other appropriate provider and shall assist by requesting those records from the enrollee's previous provider(s).

e. Within forty-five (45) calendar days of enrollment, the Respondent shall complete the initial plan of care of each new enrollee and update at the frequency determined in this solicitation and as required by changes in the enrollee's condition.

f. Follow up by telephone with an enrollee residing in their home, or the enrollee's authorized representative, within fourteen (14) calendar days after initial contact and plan of care development to ensure that services were started as authorized in the plan of care.

The Respondent shall comply with the following standards, measured on a quarterly basis, for completion of health risk assessments within sixty (60) days of enrollment for enrollees who are identified by the Department enrollment files as being pregnant, on the waitlist for or enrolled in the iBudget Waiver:

(1) The Respondent shall ensure that health risk assessments are completed on at least eighty percent (80%) of:

(a) Pregnant enrollees.

(b) Enrollees on the waitlist for or enrolled in the iBudget Waiver.

(2) The Respondent shall ensure health risk assessments are completed on at least ninety percent (90%) of:

(a) Enrollees diagnosed with an SMI.

(b) Enrollees diagnosed with HIV/AIDS.

g. The Respondent shall comply with the following standards, measured on a quarterly basis, for completion of health risk assessments within sixty (60) days of receipt of a

claim or encounter indicating that a new enrollee is diagnosed with cancer, depression, diabetes, or asthma.

(1) The Respondent shall ensure that health risk assessments are completed on at least eighty percent (80%) of:

(a) Enrollees diagnosed with cancer.

(b) Enrollees diagnosed with depression.

(c) Enrollees diagnosed with diabetes.

(d) Enrollees diagnosed with asthma.

(2) The Respondent agrees to submit a quarterly report of the completion rates for health risk assessments on the target populations identified in c(1) above, to the Department.

h. Honor any written documentation of prior authorization of ongoing covered services for a maximum of one-hundred eighty (180) days after the effective date of enrollment for initial transition of enrollees to the Respondent under this contract or ninety (90) days for all post-transition new enrollments, or until the enrollee's PCP or behavioral health service provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's plan of care, whichever comes first. The enrollee is permitted to retain their current provider for up to ninety (90) days if that provider is not in Respondent's network.

i. Ensure written documentation of prior authorization of ongoing medical and behavioral health services for all enrollees include the following, provided that the services were prearranged prior to enrollment with the Respondent:

(1) Prior existing orders;

(2) Service provider appointments (e.g., transportation, dental appointments, surgeries, etc.);

(3) Prescriptions (including prescriptions at non-participating pharmacies);

(4) Prior authorizations; and

(5) Plan of care.

j. The Respondent will not delay service authorization if written documentation is not available in a timely manner. However, the Respondent will not be required to approve claims for which it has received no written documentation.

k. If the Respondent fails to comply with the requirements of items c., d., and e. above, the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and

Corrective Action Plans, or liquidated damages pursuant to **Section XIII**, Liquidated Damages, as determined by the Department.

2. Enrollee Screening and Education

a. Within thirty (30) days of enrollment, the Respondent shall notify enrollees of, and ensure the availability of, a screening for all enrollees known to be pregnant or who advise the Respondent that they may be pregnant. The Respondent shall refer enrollees who are, or might be, pregnant to a provider to obtain appropriate care.

b. The Respondent shall use the enrollee's health risk assessment and/or released enrollee record to identify enrollees who have not received child health screenings in accordance with the Agency-approved periodicity schedule.

c. The Respondent shall develop and implement an education and outreach program to increase the number of eligible enrollees receiving well-child visits. This program shall include, at a minimum, the following:

(1) A tracking system to identify enrollees for whom a screening is due or overdue;

(2) Systematic reminder notices sent to enrollees before a screening is due. The notice shall include an offer to assist with scheduling and transportation;

(3) If the Respondent's well-child visit rate is below eighty percent (80%), will contact (which may include automated calls) all new enrollees under the age of twenty -one (21) years to inform them of well-child visit services and offer to assist with scheduling and transportation;

(4) A process for following up with enrollees who do not receive timely screenings. This shall include contacting, at least twice, any enrollee more than two (2) months behind in the Agency-approved periodicity screening schedule to urge those enrollees, or their legal representatives, to make an appointment with the enrollee's PCP for a screening visit and offering to assist with scheduling and transportation. The Respondent shall document all outreach education attempts. For this Sub-Section, "contact" is defined as mailing a notice to or calling an enrollee at the most recent address or telephone number available; and

(5) Provision of enrollee education and outreach in community settings.

d. The Respondent shall develop and implement an education outreach program to encourage wellness visits to prevent illness or exacerbations of chronic illness.

e. The Respondent shall take immediate action to address any identified urgent medical needs.

f. Pursuant to section 409.966(3)(c)(2), F.S., the Respondent shall have a program for recognizing patient-centered medical homes (PCMHs) and providing increased compensation for recognized PCMHs, as defined by the Respondent. The Respondent shall submit its procedures for such program to the Department, which

shall include recognition standards and increased compensation protocols developed by the Respondent for the program.

g. In addition to the provisions in above **Item 2.,** Enrollee Screening and Education, the Respondent shall conduct quarterly education and outreach to promote resources on mental health services for children and adolescents.

3. Protective Custody Coverage Provisions

a. The Respondent shall provide a physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter, or the foster care program by the DCF (Rule 65C-29.008, F.A.C.).

The Respondent shall provide these required examinations without requiring prior authorization, or, if DCF uses a non-participating provider, approve and process the claim.

4. PACC/PIC:TFK

a. The Respondent shall provide pediatric palliative care support to enrollees who have been diagnosed with potentially life-threatening conditions and are referred by their primary care physician or specialty physician as specified in section 409.912(11), F.S., through the PACC/PIC:TFK program from the time of diagnosis throughout the treatment phase of their illness, including end-of-life care, to reduce hospitalizations, as appropriate.

b. The Department shall ensure all PACC/PIC:TFK providers have a formal training program to orient new staff regarding the PACC/PIC:TFK model and include ongoing training opportunities for all staff involved in the program. The Department shall ensure PACC/PIC:TFK providers document staff completion of the specialized pediatric palliative care training within twenty-four (24) months of staff participation in the PACC/PIC:TFK model.

c. All Title XIX and Title XXI enrollees with life-threatening conditions are eligible to receive PACC/PIC:TFK program services.

d. Enrollees participating in the PACC/PIC:TFK program must have their medical eligibility certified annually by the enrollee's primary care provider or specialty physician. Provider shall document assistance provided to the enrollee in obtaining initial certification and annual recertification.

e. The PACC/PIC:TFK program provides the following pediatric palliative care support services that will enhance psychosocial interventions:

(1) Support Counseling: In-person support counseling for the enrollee and their family unit provided by a licensed therapist, with documented pediatric training and experience, in the home, school, or hospice facility.

(2) Expressive Therapies: Music, art, and play therapies related to the care and treatment of the child and provided by registered or board-certified providers with pediatric training and experience. These therapies are intended to facilitate a child's expression and understanding of their feelings and provide support to caregivers by enhancing their understanding of the child's coping style.

(3) Respite Support: Inpatient respite in a licensed hospice facility or in- home respite for patients who require supervision and care provided by a registered nurse, licensed practical nurse, certified nursing assistant, or home health aide with pediatric hospice experience. PACC/PIC:TFK is the payor of last resort for respite care if appropriate respite is available from other sources. This service is limited to one-hundred sixty-eight (168) hours per enrollee per calendar year.

(4) Hospice Nursing Services: Treatment by a pediatric hospice nurse to manage pain and symptoms associated with a terminal illness.

(5) Personal Care: Medically necessary assistance, in-home or in the community, with ADL and age-appropriate instrumental Activities of Daily Living (IADL) to enable enrollees to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability. This service is to be used when a hospice trained home health aide or CNA service provider is justified and requires specialized experience, skill, and knowledge to benefit the child who is experiencing pain or emotional trauma due to their medical condition. A registered nurse must visit the recipient's home at least every two (2) weeks when home health aide services are being provided.

(6) Pain and Symptom Management: Provide for the treatment of pain using nerve blocks or steroid injections. Consultation provided by a physician, advanced registered nurse practitioner (ARNP), or physician assistant (PA) with documented experience and training or certification in pediatric pain and symptom management.

(7) Bereavement Services; and

(8) Volunteer Services.

f. Enrollee participation in the PACC/PIC:TFK program is voluntary. A maximum of nine hundred and forty (940) enrollees may be provided PACC/PIC:TFK services each State fiscal year. To participate in PACC/PIC:TFK program, an enrollee must elect to receive at least two (2) different PACC/PIC:TFK services within a three (3) month period. There is no limit to the amount of time an enrollee can participate in the PACC/PIC:TFK program, providing the annual re- certification is signed by enrollee's PCP, and the enrollee is receiving at least two (2) services during a three (3) month period. Enrollment in the PACC/PIC:TFK program is initiated with the completion of the initial plan of care.

(1) Whenever an enrollee elects to participate in the PACC/PIC:TFK program, the enrollee must choose a hospice provider from those designated by the PACC/PIC:TFK program in the service area.

(2) An enrollee or the enrollee's authorized representative may change to another available hospice provider once during the annual re-certification period with the assistance of the case manager. The case manager must document any hospice provider change in the enrollee's medical record and plan of care and include the signature of the enrollee or the enrollee's authorized representative, the date the change is effective, and the names of the hospice provider where the enrollee was receiving care and will be receiving care.

(3) To disenroll from the PACC/PIC:TFK program and convert to full hospice care, the enrollee or the enrollee's authorized representative must complete AHCA Form 5000-21 (5000-21S), Florida Medicaid Hospice Care Services Election Statement, and submit it to the hospice provider.

g. PACC/PIC:TFK services should be provided in the home whenever possible. Assessments and consultations may be provided in the home or hospice facility. Other services may be provided at home, school, or the hospice facility at the request of the enrollee or the enrollee's guardian or authorized representative. PACC/PIC:TFK services will not be provided in a nursing facility or hospital.

(1) Attempt PACC/PIC:TFK initial assessments within ten (10) business days of the receipt of the referral.

(2) If more than twenty-four (24) hours of respite support services are provided to an enrollee who is in the Medical Foster Care (MFC) program, the MFC parent may not file a claim for MFC services for the same period.

h. Provide PACC/PIC:TFK services as required under section 409.912(11), Florida Statutes, and all other State and federal regulations.

i. Ensure that services are coordinated in accordance with the written plan of care and that there is no duplication of services.

j. A review of the PACC/PIC:TFK plan of care must be conducted at least every ninety (90) days and documented by the case manager. The updated PACC/PIC:TFK plan of care must be signed by the hospice provider and the case manager. The case manager will ensure and document in enrollee's record that a copy of the updated PACC/PIC:TFK plan of care and any subsequent reviews will be provided to the hospice provider, the case manager, the PCP or specialty physician, and the enrollee.

k. Approve and process claims for PACC/PIC:TFK services provided to CHIP enrollees in accordance with the requirements set forth in the Contract.

l. Submit monthly reports of PACC/PIC:TFK referrals and PACC/PIC:TFK census/membership to the Department as specified in Section XV, Accountability.

m. Submit quarterly report of the PACC/PIC:TFK services rendered as specified in Section XV, Accountability.

5. PACC/PIC:TFK Interdisciplinary Team

a. The Respondent shall ensure that an MDT is established to:

(1) Implement and maintain the PACC/PIC:TFK initial plan of care;

(2) Provide and suspend PACC/PIC:TFK services according to the PACC/PIC:TFK plan of care; and

(3) Review and update the PACC/PIC:TFK plan of care.

b. The Respondent shall ensure at a minimum, the MDT consist of representation from the hospice PIC:TFK provider and the enrollee's case manager. The Respondent shall ensure the PIC:TKF provider adheres to the following:

(1) Be responsible for conducting an evaluation of service needs and an assessment of the physical, social, psychological, spiritual, respite, and personal care needs of the enrollee. This assessment will include consideration of the needs and dynamics of the enrollee's family and or caregiver.

(2) Attempt to conduct the initial evaluation for the PACC/PIC:TFK plan of care within ten (10) business days of receiving a referral and authorization of services. The initial PACC/PIC:TFK plan of care must be signed by the hospice provider, the Respondent's representative (e.g., Provider Utilization Management approval), and the enrollee after the initial evaluation is complete. The case manager must ensure and document in enrollees record that a copy of the signed initial PACC/PIC:TFK plan of care is provided to the hospice provider, case manager, PCP or specialty physician, and the enrollee's family.

(3) A review of the plan of care must be conducted at least every ninety (90) days and documented by the case manager. The updated plan of care must be signed by the hospice provider and the case manager and a copy of the updated plan of care and any subsequent reviews will be provided to the hospice provider, the case manager, the PCP or specialty physician, and the enrollee.

c. The case manager shall attend and participate in all PACC/PIC:TFK enrollee MDT meetings.

E. Care Coordination/Case Management

1. General Provisions

a. The Respondent shall implement case management processes for all Managed Care Plan enrollees as identified according to the case management tiers in **Subsection 4**, Contact Requirements.

b. The Respondent's implementation of case management shall be in alignment with evidence-based standards of Care For Children And Youth With Special Health Care Needs (CYSHCN).

c. The Respondent's approach to case management shall contain the features of a high -performing case management program including, but not limited to: person and family centeredness; timely, proactive, and planned communication and action; the promotion of self-care and independence; emphasis on cross-continuum and system collaboration and relationships; comprehensive consideration of physical, behavioral, and non-medical needs and community integration; and alignment with national evidence-based best practices for case management of CYSHCN. The ultimate goal of the approach shall eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for enrollees, their families, and providers to optimize quality of care and enrollee health outcomes.

d. The Respondent shall apply a multi-disciplinary approach to case management that includes at a minimum Case Managers, Case Coordinators, Family Support Specialists, and Education Liaisons. The case management team shall also include two (2) ARNP to provide additional clinical support to the case management team for addressing escalated enrollee clinical issues.

e. The Respondent shall ensure it maintains conflict-free case management through the following requirements:

(1) Case managers use data driven needs assessments for determining needs to be addressed in plans of care.

(2) Case managers and evaluators of the enrollee's need for services are not related by blood or marriage to the enrollee, the enrollee's paid caregiver(s), or to anyone legally or financially responsible for the enrollee.

(3) The Respondent monitors and oversees the quality improvement, utilization management, and case management program.

(4) The Respondent establishes clear, well-known, and accessible pathways for enrollees to submit grievances and appeals to the Respondent.

(5) The Respondent tracks and monitors grievances, complaints, appeals regarding conflicts of interest between case management and utilization management.

(6) Quality management staff review the tracking and documenting of consumer experiences through CAHPS, family experiences surveys, and quality of life surveys.

(7) The Respondent maintains appropriate safeguards and firewalls to mitigate risk of potential conflict between case management and utilization management.

(8) The Respondent ensures that enrollee stakeholder engagement strategies are in place to solicit concerns regarding case management.

(9) The Respondent monitors denials and limitations of service authorizations.

(10) Annually, the Respondent completes and submits to the Department an external audit of assessments, plans of care, and service medical necessity determinations to ensure that there is no conflict of interest between case management and utilization management.

f. The Respondent shall communicate and coordinate at a frequency based on the needs of the enrollee, but no less than quarterly with DCF regional Children's Care Coordinators and the managing entities for enrollees under eighteen (18) years of age who are who are high utilizers of CSU and inpatient psychiatric hospital services to ensure access to Medicaid services and other related community resources. The Respondent shall document coordination and communication efforts in the enrollee records.

g. The Respondent shall assess the enrollee's tier level and service needs at a minimum of annually and whenever there is a significant change in a member's condition or level of need, as determined by the Respondent. Reasons for changes to an enrollee's tier level shall be documented by the Case Manager in the enrollee record.

h. The Respondent's Case Managers shall lead the coordination of care for each enrollee. It is anticipated that each enrollee will have multiple healthcare providers, multiple governmental health and human services providers, and multiple community-based organization services, each with their own care coordinators, case managers, financial representatives, patient navigators, support navigators, special education coordinators, and community health workers. Rather than parents or legal guardians coordinating the coordinators, the Respondent's Case Manager shall lead the orchestration of healthcare services, health-related social support services, and education support services for the enrollee. For each enrollee with a Respondent Case Manager, the Respondent Case Manager shall demonstrate leadership among the various coordinators by performing the following minimum actions:

(1) The Respondent's Case Manager shall curate an up-to-date list of healthcare providers, schools, community-based organizations, and governmental health and human service providers that deliver healthcare services, health-related social support services, and education support services to the enrollee. The list shall include the providers' name and contact information, and their key contact care coordinators, case managers, financial representatives, patient navigators, support navigators, special education coordinators, or community health workers.

(2) The Respondent Case Manager shall communicate via phone call or in-person visit on a quarterly and ad hoc basis with the list of various care coordinators, case managers, financial representatives, patient navigators, support navigators, , special education coordinators, and community health workers about the enrollee's overall care plan, discharge plan from facility care, transition plan from facility care to home care, optimizing home and community based services and supports, scheduling new patient visits and follow-up visits, medication prescriptions, refills, and availability, durable medical equipment prescriptions and availability, and supports for the enrollee's grade promotion and school graduation.

(3) The Respondent's Case Manager shall identify gaps in care including accessibility issues, identification of service needs to support enrollees in their homes, and review and evaluation of progress and engagement in services, and provide assistance and coordination of those identified services.

(4) If the enrollee has an individual education program (IEP) plan the Respondent's Case Manager shall communicate via phone call or in-person visit with the special education coordinator or director prior to or during the IEP meetings about the enrollee's present level of educational performance, goals, and special education needs for grade promotion and school graduation. The Respondent's Case Manager shall communicate to the special education coordinator or director about school-based services, covered services, and expanded benefits that assist in meeting the enrollee's special education needs. The Respondent's Case Manager shall use the information from the IEP to inform scheduling of healthcare services, such that education of the enrollee is optimized in concert with health needs.

(5) The Respondent's Case Manager, with support from care coordinators, shall address and resolve scheduling conflicts among the various healthcare providers, health-related social support service providers, and schools.

(6) The Respondent's Case Manager shall facilitate medical record sharing among various providers to expedite complex case management and shared decision -making.

(7) The Respondent's Case Manager shall communicate demographic and pertinent health information among the various providers to reduce redundant surveys of parents and legal guardians and to optimize enrollee experience.

(8) The Respondent's Case Manager shall identify opportunities to improve communication, scheduling, and training of the various coordinators involved in the enrollee's healthcare, health-related social needs, and education, and implement changes in communication, scheduling, and training to achieve those improvements.

(9) The Respondent's Case Manager shall establish and track performance metrics for leading care coordination, such as patient satisfaction, care plan adherence,

private duty nursing hour adherence, and potentially preventable visits (e.g., ED visits, readmissions).

(10) The Respondent shall report annually to the Department about its lead role in case management, including the performance metrics developed and used by the Respondent that demonstrate leadership effectiveness.

i. The Respondent's family support specialists shall serve as an additional support at the request of enrollees and their parents or legal guardians to assist with answering questions, navigating the health system, identifying resources, attending appointments, care planning meetings, or other relevant engagements, and providing support to the enrollee and his/her caregiving team from a lived experience perspective.

j. The Respondent's Education Liaisons shall serve as a liaison between the Respondent and school systems and shall provide support to the case management team in addressing school-related issues such as IEP development, implementation, and reevaluation; 504 plan development, implementation, and reevaluation; providing linkages to school or vocational support programs; assisting with coordination of in -school health services; attending school-related meetings as requested by the enrollee or the parent or legal guardian; and supporting educational needs of transition age youth.

k. If an enrollee or parent or legal guardian of an enrollee who is eligible for case management declines to receive case management services, the Respondent shall nevertheless comply with all requirements specified in this Section of the Contract, and shall offer case management services to the enrollee or the enrollee's authorized representative no less than annually. The Respondent shall document all such activities in the enrollee record, including the reason why the enrollee or the enrollee's parent or legal guardian declines case management.

l. The enrollee's assigned Case Manager shall participate in all CMAT meetings for enrollees under the age of twenty-one (21) years receiving private duty nursing, nursing facility services, PPEC, or medical foster care services. The Respondent shall establish Case Manager and back-up Case Manager responsibilities for participating in scheduled and ad hoc CMAT meeting(s) for assigned enrollees. The Respondent shall ensure responsibilities are clearly defined and known to the enrollee and family as follows:

(1) Have the Case Manager available for contact by the enrollee or the enrollee's parent or legal guardian during business hours.

(2) Provide the enrollee with the opportunity to be referred to a back-up Case Manager for assistance when the enrollee's Case Manager is unavailable. The back-up Case Manager must be available for contact by the enrollee or the enrollee's parent or legal guardian during business hours.

(3) Provide the enrollee access to an emergency back-up Case Manager through an after-hours telephone line.

m. The Respondent shall ensure each enrollee receiving services in the Early Steps program is assigned a Child Health Services Targeted Case Manager, as identified by the Agency on the Panel Roster Report.

n. The Respondent shall maintain a secure email account for receipt of scheduling information (date, time, location) for all CMAT and other interagency or MDT staffing meetings for which the plan is required to participate.

o. Respondent for enrollees under eighteen (18) years of age who are high utilizers of inpatient psychiatric hospitals, Baker Act receiving facilities, and/or CSUs (i.e., three (3) or more admissions within a six (6)-month period), the Respondent's Case Manager shall assume a lead role in identifying services that can meet the enrollee's need even when there are multiple State agencies (e.g., DCF and Agency for Persons with Disabilities (APD)) involved in the child's care. The Respondent shall coordinate and maintain routine contact with other State agencies involved in the enrollee's care, including DCF regional Children's Care Coordinators and the local managing entities, to ensure access to Medicaid services and other related community resources. Such communication shall occur at the frequency warranted for the needs of the enrollee, and no less than quarterly. The Respondent shall document coordination and communication efforts in the enrollee records.

p. For enrollees who have been previously unresponsive to the Respondent's case management outreach efforts, but upon contact wish to re-engage in case management, the Case Manager shall refer the enrollee for completion of a comprehensive needs assessment. A plan of care shall be developed if there has been a significant change or at least one (1) year since the last assessment was completed. The Case Manager shall complete outreach to the family within two (2) days of receipt of referral. All attempts to contact the family shall be documented in the enrollee's record.

2. Case Management Program Description

a. General Provisions

(1) In addition to the provisions of **Attachment B**, **Section V**, **Service Administration**, **Subsection E.**, Care Coordination/Case Management, **Subitem 1**, General Provisions, the Respondent shall maintain written procedures for the case management of enrollees which shall include:

(a) A description of how the Respondent will implement and monitor the case management program and standards outlined in this Contract.

(b) The Respondent's procedures for assigning and monitoring case management caseloads and emergency preparedness plans, including outreach to the enrollee or the enrollee's parent or legal guardian to ensure preparedness or follow-up on any needs.

(c) A description of the Respondent's procedures for documenting an enrollee's or the enrollee's authorized representative's rejection of case management services.

(d) The responsibilities of the case manager in participating in all scheduled and any ad hoc CMAT meeting(s) for assigned enrollees.

(2) The Respondent shall ensure that written procedures are consistently communicated and followed among its case management staff. Case management procedures shall be reviewed and updated at a minimum annually and shall be readily available through electronic means or otherwise.

b. Case Management Program Description Requirements

(1) In addition to the provisions set forth in **Attachment B**, **Section V**, **Service Administration**, **Subsection E.**, Care Coordination/Case Management, **Subitem 2.**, Case Management Program Description, the Respondent shall provide case management to enrollees appropriate to the needs of persons meeting the Respondent eligibility criteria. The Respondent shall develop, implement, and maintain a Department-approved case management program specific to the enrollee population.

(2) The Respondent shall submit a case management program description annually to the Department by May 15. The case management program description shall, at a minimum, address:

(a) The organization of care coordination/case management staff, including the role of qualified and trained nursing, social work, Care Coordinator, Education Liaison, Family Support Specialist, Nurse Practitioner, pharmacy, and specialty health personnel in case management processes;

(b) Protocols for ensuring compliance with maximum caseload for case managers with an adequate number of qualified and trained case managers to meet the needs of enrollees.

(c) Case Manager selection and assignment, including protocols to ensure new enrollees are assigned to a case manager in the timeframes specified in **Subsection 2**, New Enrollee Procedures;

(d) Protocols for initial contact with enrollees, as well as requirements for the frequency and type of ongoing minimum contacts with enrollees;

(e) Surrogate decision-making, including protocols if the enrollee is not capable of making his/her own decisions, but does not have a legal representative or authorized representative available;

(f) Outreach programs that make a reasonable effort to locate and/or re-engage enrollees who have not received follow-up care for ninety (90)

days or more.

(g) Enrollee access to case managers, including provisions for access to back-up case managers as needed;

(h) Assessment and reassessment of the acuity level and service needs of each enrollee;

(i) Care planning for pediatric and psychiatric treatment that is tailored to the individual enrollee and is in agreement with evidenced based guidelines for pediatric and psychiatric treatment;

(j) Care planning for treatment of a Specialty condition that is tailored to the individual enrollee and in agreement with evidenced-based guidelines for treatment of the Specialty population;

(k) Coordination of care through all levels of practitioner care (primary care to specialist);

(l) Monitoring compliance with scheduled appointments, laboratory results, and medication adherence;

(m) Coordination with and referrals to providers of other related services for enrollees of the Respondent;

(n) Interventions to avoid unnecessary use of emergency departments, inpatient care, and other acute care services;

Patient education to assist enrollees in better management of their health issues including the principles of recovery and resiliency.

I. A description of how enrollees are identified for disease management, including details regarding the algorithm and data sources used to identify eligible enrollees;

II. A description of how eligible enrollees are contacted for outreach and attempts are made to engage enrollees in case management services. Maintain documentation that demonstrates that three (3) telephonic calls over a period of five (5) business days and one (1) written attempt were made by the Respondent to contact and engage all enrollees into case management services;

III. A description of how the disease management program interfaces with the enrollee's PCP or specialist service providers and ensures coordination of care; and

IV. A description of how the Respondent identifies available community support services and facilitates enrollee referrals to those entities for enrollees with identified community support needs.

A description of how Case Managers will follow up on calls to the crisis line to ensure enrollee needs have been addressed, referral assistance provided and follow up is completed.

3. Initial Plan of Care/ Reviews

a. The Respondent shall develop and use a plan of care for each enrollee that is tailored to the individual enrollee and his/her parent or legal guardian is as follows:

(1) The plan of care must be on file for each enrollee in the Respondent's electronic case management system and shall include the enrollee's services and interventions, strengths and preferences, the enrollee's measurable, outcomes-based goals, and sufficient information to determine if goals are met.

(2) The plan of care shall promote the enrollee's engagement with services and supports including efforts to encourage self-management in care where appropriate.

b. The plan of care shall be updated at the frequency determined in this contract and as required by changes in an enrollee's condition.

c. The Respondent shall convene an MDT every six (6) months for enrollees under the age of twenty-one (21) years receiving private duty nursing, PPEC services, nursing facility services, and medical foster care to provide a comprehensive review of the services and supports that the enrollee needs, and to authorize any Medicaid reimbursable services that are prescribed for the enrollee. The Respondent shall develop a person-centered individualized service plan documenting all service needs for enrollees under the age of twenty-one (21) years receiving private duty nursing or nursing facility services. The Respondent shall convene an MDT meeting more frequently, if needed, based on any changes in the enrollee's medical condition or a significant life change. The MDT meeting will include at a minimum the enrollee's:

(1) Self or legal guardian;

(2) Case Manager;

(3) Family support specialist at the request of the enrollee or the enrollee's legal guardian; and

(4) Other health care professionals involved in the enrollee's care.

d. The Respondent shall develop and maintain a person-centered plan of care for enrollees receiving medical foster care services that describes all interventions that the medical foster care provider must implement in accordance with the physician's

order. The Respondent shall update the plan of care for medical foster care services at least every one-hundred eighty (180) days, or more frequently to reflect changes in the physician's orders. The Respondent shall ensure that the medical foster care plan of care is signed by a physician who is experienced in providing services to children with complex medical needs.

e. The Respondent shall provide a copy of the plan of care to the Department, Medical Foster Care program staff, the CBC Lead Agency, and the medical foster care provider.

f. The Respondent shall participate in interagency staffings (e.g., DCF, DJJ, and community-based care organizations) or school staffings for all enrollees under the age of twenty-one (21) years that may result in the provision of behavioral health or medical services. The Respondent or designee shall participate in such staffings as required by the Agency or the Department.

g. The Respondent shall report the total number of behavioral health-related and medical neglect staffing meetings that are attended as specified in **Section XV**, Accountability, and the Managed Care Plan Report Guide.

4. Contact Requirements

a. The Respondent shall abide by the following contact frequencies for all enrollees receiving case management.

b. The Respondent shall maintain regular contact with the enrollee or parent or legal guardian of enrollees receiving case management based on the enrollee stratification. Enrollees will be stratified based on the enrollee's tiered level of acuity and need. The frequency and intensity of case management assessments, planning, intervention, coordination, monitoring, and evaluation will be tailored to the stratification levels and enrollee needs and preferences.

c. Stratification tiers are as follows:

(1) Tier 1

(a) At a minimum, the Respondent will ensure enrollees receiving twenty-four (24) hour private duty nursing or nursing facility services are stratified in this tier.

(b) For enrollees stratified as Tier 1, case managers will:

(i) Conduct a minimum of two (2) face-to-face visits and two (2) telephone contacts each month. Case managers must make at least three (3) contact attempts to reach the enrollee or the enrollee's parent(s) or legal guardian. At least three (3) attempts must be via telephone on different days at different times. Text messaging is an additional allowable contact method if the enrollee or the enrollee's parent or legal guardian opts-in to text messaging. If the enrollee or

the enrollee's authorized representative cannot be reached after at least three (3) contact attempts, the case manager shall use all available resources, including outreach to service providers to maintain contact and for an update on the enrollee's status and needs. The Respondent shall document all contacts and interactions in the enrollee's record.

(ii) Hold semi-annual MDT meetings. Document contacts in enrollee's record.

(iii) Review the enrollees' plan of care each month and revise as appropriate.

(iv) Revise the plan of care with the enrollee or the enrollee's parent or legal guardian a minimum of once each quarter. Discussion of goals and planned interventions with the enrollee or enrollee's parent or legal guardian shall be documented in the enrollee record.

(v) Ensure quality of enrollee services.

(vi) For children receiving nursing facility services, the case manager will initiate discussions with the family on moving the child to a less restrictive setting by providing information about the benefits of integrated settings.

(vii) Facilitate visits or other experiences in integrated settings.

(viii) Offer opportunities to meet with other individuals with disabilities who are living, working, and receiving services in integrated settings, with their families, and with community providers.

(ix) Perform an annual reassessment and update the plan of care with the enrollee or the enrollee's parent or legal guardian to address any issues or needs identified.

(x) Administer a quality-of-life survey during initial assessment and annual reassessment.

(xi) Ensure the DCF is notified when an enrollee is admitted to or discharged from a nursing facility.

(xii) Submit to DCF a properly completed DCF form CF-ES 2506A (i.e., Client Referral/Change) within ten (10) business days of an enrollee's admission to the nursing facility.

(xiii) Submit to DCF a properly completed DCF form CF-ES 2506 (i.e., Client Discharge/Change Notice) within ten (10) business days of an enrollee's discharge from the nursing facility.

(xiv) The Respondent may delegate the submission of the DCF form CF-ES 2506A or CFES 2506 to the nursing facility. In these cases, the Respondent shall obtain a copy of the completed form submitted by the facility and maintain it in the enrollee record.

(xv) The Respondent will report the most recent Pre-admission Screening and Resident Review (PASRR) date for enrollees entering or residing in a nursing facility in accordance with Section XVI, Reporting Requirements and the Managed Care Plan Report Guide.

(c) The Respondent shall assign enrollees in Tier 1 to a Case Manager who is a Registered Nurse in accordance with Section IX, Administration and Management, Care Coordination/Case Management Staff, **Table A**.

(d) The Respondent will ensure the case manager caseload ratio does not exceed 1:10 for enrollees in this tier.

(2) Tier 2

(a) The Respondent will ensure enrollees receiving less than twenty-four (24) hour private duty nursing, Prescribed Pediatric Extended Care (PPEC) and/or Medical Foster Care services are stratified in this tier.

(b) For enrollees stratified as Tier 2, case managers will:

(i) Conduct a minimum of one (1) face-to-face visit and one (1) telephone contact each month. Case managers must make at least three (3) contact attempts to reach the enrollee. The three (3) attempts must be via telephone on different days at different times. Text messaging is an additional allowable contact method if the enrollee or the enrollee's parent or legal guardian opts-in to text messaging. If the enrollee or the enrollee's parent or legal guardian cannot be reached after at least three (3) contact attempts, the case manager shall use all available resources, including outreach to service providers to maintain contact and for an update on the enrollee's status and needs. The Respondent shall document all contacts and interactions in the enrollee record.

(ii) Participate in semi-annual MDT meetings. Document contacts in enrollee record.

(iii) Review the enrollee's plan of care each month and revise as appropriate.

(iv) Revise the plan of care with the enrollee or enrollee's parent or legal guardian a minimum of semi-annually. Discussion of goals and planned interventions with the enrollee or the enrollee's parent or legal guardian should be documented in the enrollee record.

(v) Ensure that the child is receiving medically necessary services and that there are no health and safety issues.

(vi) Perform an annual reassessment and update the plan of care with the enrollee or parent/guardian to address any issues or needs identified.

(vii) Administer a quality-of-life survey during initial assessment and annual reassessment.

(viii) The Respondent shall ensure the enrollee or the enrollee's parent or legal guardian, who does not wish to receive private duty nursing services for some or all of the hours authorized signs and dates a completed Agency-approved form to document voluntary suspension of private duty nursing services.

(c) The Respondent shall assign enrollees in Tier 2 to a Case Manager who is a Registered Nurse or a Licensed Practical Nurse in accordance with Section IX, Administration and Management, Care Coordination/Case Management Staff, **Table A**.

(d) The Respondent will ensure the case manager caseload ratio does not exceed 1:30 for enrollees in this tier.

(3) Tier 3

(a) The Respondent will ensure enrollees receiving services in a Statewide Inpatient Psychiatric Program (SIPP), enrollees under eighteen (18) years of age who are high utilizers of inpatient psychiatric hospitals, Baker Act receiving facilities, and/or CSUs (i.e., three (3) or more admissions within a six (6) -month period), and enrollees who are enrolled in the iBudget Waiver or on the waitlist for the Waiver are stratified in this tier.

(b) The Respondent shall use a stratification algorithm approved by the Department for Tier 3 which will include enrollees who are not receiving SNF or PDN services, and meet one of the following:

(i) Enrollee is receiving Partners in Care: Together for Kids (PIC:TFK) services
(ii) Enrollee is receiving Behavioral Health Network (BNet) services
(iii) Enrollee is Pregnant
(iv) Enrollee with > 1 inpatient admission in 6-month timeframe
(v) Enrollee with > 2 emergency department (ED) visits in 6-month timeframe,
(vi) Enrollee with > 3 different prescription drugs in 6-month timeframe, OR
(vii) Enrollee with > visits to 3 different specialists in 6-month timeframe, OR

(viii) Enrollee with > 1 physical, occupational, speech, or respiratory evaluation in 30-day timeframe, OR

(c) Enrollee with specified diagnoses including but not limited to:

(i) Cancer
(ii) Pregnancy
(iii) HIV
(iv) Sickle Cell Anemia
(v) Developmental disabilities including Autism
(vi) Substance Use

(c) For enrollees stratified as Tier 3, case managers will:

(i) Conduct a minimum of one (1) quarterly face-to-face visit and one (1) phone contact per month. Case managers must make at least three (3) contact attempts to reach the enrollee. The three attempts must be via telephone on different days at different times. Text messaging is an additional allowable contact method if the enrollee or the enrollee's parent or legal guardian opts-in to text messaging. If the enrollee or the enrollee's parent or legal guardian cannot be reached after at least three (3) contact attempts, the case manager shall use all available resources, including outreach to service providers to maintain contact and for an update on the enrollee's status and needs. The Respondent shall document all contacts, interactions, and monthly contact preference in the enrollee's record.

(ii) Review the member's plan of care at least monthly and revise as appropriate.

(iii) Revise the plan of care with the enrollee or the enrollee's parent or legal guardian at a minimum of semi-annually. Discussion of goals and planned interventions with the enrollee or enrollee's parent or legal guardian should be documented in the enrollee record.

(iv) Perform an annual reassessment and update the plan of care with the enrollee or parent/guardian to address any issues or needs identified.

(v) Administer a quality-of-life survey during initial assessment and annual reassessment.

(d) The Respondent shall assign enrollees in Tier 3 who are residing in a SIPP, residential, specialized therapeutic group home, who are high CSU utilizers or have a primary behavioral diagnosis to a Case Manager who is a Florida Licensed Mental Health Counselor (LMHC) or a Florida Licensed Clinical Social Worker (LCSW) or a Florida Licensed Marriage and Family

Therapist (LMFT) in accordance with Section IX, Administration and Management, Care Coordination/Case Management Staff, Table A.

(e) Tier 3 enrollees not residing in a SIPP, residential, or specialized therapeutic group home, who are not high CSU utilizers or do not have a primary behavioral diagnosis shall be assigned to a Case Manager who is a Florida licensed Registered Nurse, Florida Licensed Practical Nurse, Florida Licensed Mental Health Counselor or a Florida Licensed Clinical Social Worker (LCSW), a Florida Licensed Marriage and Family Therapist (LMFT)in accordance with Section IX, Administration and Management, Care Coordination/Case Management Staff, Table A.

(f) LMHCs, LCSWs, or LMFTs who case manage enrollees whose primary diagnosis is not behavioral health related, shall consult with the Case Manager Supervisor and clinical team as needed.

(g) Case Managers that provide case management to enrollees that have a secondary behavioral diagnosis shall consult with the behavioral clinical team as needed.

(h) The Respondent will ensure case manager caseload ratio does not exceed 1:90 for enrollees in this tier.

(4) Tier 4

(a) The Respondent shall use a stratification algorithm approved by the Department for Tier 4 which will include enrollees that are not tiered as Tiers 1 through Tier 3 and meet one of the following criteria: Enrollees with ≤ 2 ED visits in 6-month timeframe

(b) Enrollees with ≤ 3 prescription drugs in a 6-month timeframe

(c) Enrollees with ≤ visits to 3 different specialists in 6-month timeframe

(d) For enrollees stratified as Tier 4, Case Managers will:

(i) Conduct one (1) telephone contact each quarter. Case Managers must make at least three (3) contact attempts to reach the enrollee. The three (3) attempts must be via telephone on different days at different times. Text messaging is also an additional contact method if the enrollee or the enrollee's parent or legal guardian opts-in to text messaging. The Case Manager shall outreach to service providers for an update on the member's status and needs if the enrollee or the enrollee's parent/legal guardian cannot be reached after at least three (3) contact attempts. The Respondent shall document all contacts and interactions in the enrollee's record.

(ii) Review the enrollee's plan of care at a minimum of once each quarter and revise as appropriate.

(iii) Revise the plan of care with the enrollee or the enrollee's parent or legal guardian at a minimum of annually. Discussion of goals and planned interventions with the enrollee or the enrollee's parent or legal guardian should be documented in the enrollee record.

(iv) Perform an annual reassessment and update the plan of care with the enrollee or the enrollee's parent or legal guardian to address any issues or needs identified.

(v) Administer a quality-of-life survey during initial assessment and annual reassessment.

(e) The Respondent shall assign enrollees in Tier 4 to a Case Manager who is a Florida Registered Nurse, Florida Licensed Practical Nurse, Florida Licensed Mental Health Counselor, Florida Licensed Clinical Social Worker (LCSW) or a Florida Licensed Marriage and Family Therapist (LMFT)

(f) The Respondent will ensure Case Manager caseload ratio does not exceed 1:150 for enrollees in this tier.

(5) Tier 5 Unable to Reach (UTR)

(a) The Respondent shall assign enrollees who have documented failed contact attempts for six (6) consecutive months to Tier 5.
(b) For enrollees stratified in this tier, Care Coordinators will:

(i) Conduct at a minimum of three (3) outreach calls each quarter, over a period of five (5) business days. Outreach may include calls to the identified emergency contact(s), members of the multidisciplinary team, and/or listed service providers or attempts to find members in the community. Documented efforts shall be made to locate an accurate phone number for the enrollee;

(ii) Mail a "lost contact" letter to all UTR enrollees each quarter.

(iii) For enrollees who are responsive to Care Coordinator contact attempts, the Care Coordinator must refer the enrollee to a Case Manager for completion of a comprehensive needs assessment and plan of care. The Case Manager must complete outreach to the family within two business days of receipt of referral. All attempts to reach the family shall be documented in the enrollee record.

b. The Respondent will ensure Care Coordinator caseload ratio does not exceed 1:200 for enrollees in this tier.

c. The Respondent must use the Department-approved stratification algorithm to determine the enrollees stratified tier designation. This algorithm should be run on a monthly basis to ensure all enrollees are stratified in the correct tier.

d. The Respondent shall ensure an enrollee under the age of twenty-one (21) years receiving private duty nursing services, or the enrollee's authorized representative signs and dates a completed Agency approved form to document voluntary suspension of private duty nursing services, if applicable.

a. Regardless of the enrollee's Specialty condition type or tier, the Respondent shall maintain, at a minimum, monthly telephone contact with enrollees of the Respondent receiving case management, or the enrollee's authorized representative, to verify satisfaction with and receipt of services.

b. The case manager shall discuss in-person, at least every ninety (90) days with the enrollee and/or the enrollee's authorized representative, in order to:

(1) Review the enrollee's plan of care and, if necessary, update the enrollee's plan of care. The Respondent shall review the plan of care in a face-to-face visit more frequently than once every ninety (90) days if the enrollee experiences a significant change.

(2) Discuss the frequency, duration, and amount of authorized services, and the authorized providers for each service. If the enrollee or the authorized representative reports any issues or the case manager discovers any issues during the once every ninety (90) days meeting, the case manager shall document the actions taken to resolve the issues as quickly as possible.

c. The Respondent shall provide a mechanism to ensure enrollee, enrollee's parent or legal guardian, and service providers receive timely communication when messages are left for the case management team.

5. Freedom of Choice

For an enrollee under the age of twenty-one (21) years receiving nursing facility services, the Respondent shall ensure the enrollee or enrollee's parent(s) or guardian reviews, signs, and dates a completed Agency-approved Freedom of Choice Certification Form on the following schedule:

a. Within seven (7) business days of instituting nursing facility services and prior to authorization of such services; and

b. At the bi-annual MDT meeting every six (6) months thereafter, for the duration that the enrollee resides in a nursing facility.

6. Pre-Admission Screening and Resident Review

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

7. Chronic Disease Management (CDM) Program

a. The Respondent must offer CDM program interventions for the four chronic conditions listed below:

(1) Cancer and cancer prevention.

(2) Asthma.

(3) Attention deficit hyperactivity disorder (ADHD).

(4) Anxiety disorders.

b. For enrollees with a specialty condition, the Respondent shall substitute a CDM program targeted in place of (4) of Item a. above.

c. The Respondent shall offer a minimum of two (2) additional CDM interventions to be selected from the list below. The conditions chosen by the Respondent for its CDM interventions shall match the needs of its enrollee population and shall be tied to the target population.

(1) Depression and depression prevention (including suicide prevention).

(2) Diabetes and diabetes prevention.

(3) Human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and HIV prevention.

(4) Bipolar disorder.

(5) Cardiovascular disease.

(6) Chronic kidney disease.

(7) Sickle cell disease.

d. For enrollees with a specialty condition, the Respondent shall offer a minimum of two (2) additional CDM interventions to be selected from the list below. The conditions chosen by the Respondent shall match the needs of its enrollee with a specialty condition and shall be tied to the target population.

(1) Enrollees who are hospitalized more than twice in six (6) months.

(2) Enrollees with disparities in health outcomes due to demographic or socioeconomic status.

(3) Enrollees with co-morbid conditions that complicate care.

(4) Enrollees with medication non-adherence.

(5) Enrollees with worse health outcomes due to disease refractoriness.

(6) Enrollees with worse health outcomes due to issues with accessing or utilizing health care services.

8. Transition of Care

a. Transition of Care Provisions for Hospital/Institutional Discharge

(1) It is the Department's intention that the Respondent take all necessary action to ensure the provision of safe and coordinated discharge planning is provided to each enrollee transitioning from a hospital or institutional setting to another level of care.

(2) In addition to the provisions of **Attachment B**, **Section V**, Service Administration, **Subsection E.**, Care Coordination/Case Management, **Item 2**, Case Management Program Description, the Plan's transition of care procedures shall include the following minimum functions:

(a) Coordination of hospital/institutional discharge planning and post discharge care, to include:

i. Contacting hospital/institutional providers, enrollees, parent(s), and guardians within forty-eight (48) hours of admission to begin coordination and discharge planning. The discharge planning shall identify enrollee needs, barriers to discharge, and solutions to barriers.

ii. Ensuring post-discharge appointments are scheduled prior to discharge and following up with enrollees within forty-eight (48) hours after the appointment time to confirm appointments were kept and assisting in rescheduling if needed; and

iii. Documenting coordination and communication efforts in enrollee records.

(b) Schedule necessary follow-up appointments;

(c) Direct communication with the hospital/institution discharge planner/coordinator to implement the discharge plan in the enrollee's home;

(d) Direct communication with the necessary clinical staff at the enrollee's health home or primary care provider's clinical office.

(e) Direct communication with community service providers; and

(f) Coordination of care after emergency department visits (42 CFR 438.208(b)(2)(i)).

(3) The Plan's transition of care staff will update the enrollee's care plan or transition of care plan where necessary and communicate the change(s) to the enrollee, their parent(s) or guardian(s), and the necessary clinical staff.

b. Transition of Care Provisions for Behavior Analysis Services

The Plan's transition of care procedures shall include coordination and transition of behavior analysis services from the fee-for-service delivery system to the managed care delivery system, provision of continuity of care in accordance with **Attachment B**, **Section VIII**, Quality, **Subsection H**, Continuity of Care in Enrollment, conducting regularly scheduled stakeholder meetings for families and providers of enrollees receiving behavior analysis services, and providing additional enrollee outreach and provider education consistent with **Attachment B**, **Section VII**, Provider Network and Services, **Subsection D**, Provider Services, **Item 4**, Provider Education and Training.

c. Transition of Care Requirements for Enrollees in Child Welfare

(1) The Respondent shall develop and maintain transition of care policies and procedures for enrollees who are transitioning out of the child welfare system which shall include provisions for convening a comprehensive treatment team meeting to discuss the services and supports the enrollee will need post-separation. If the services are not covered by Medicaid, the Plan shall inform the enrollee, or their authorized representative, of any community programs that may be able to meet their needs and make the necessary referrals, as needed.

(2) The Respondent shall begin transition planning one (1) year prior to the expected date upon which an enrollee will age-out of the child welfare system.

(3) The Respondent shall begin transition planning immediately upon notification that an enrollee has achieved permanency status.

d. Transition of Care Requirements for Transition into Adulthood

(1) The Respondent's shall establish a team of Aging-Out Specialists who shall work with enrollees, beginning at twelve (12) years old, and their family on the development and implementation of a transition plan that helps support the enrollee as they transition into adulthood. The transition plan must address, at a minimum, educational and vocational support, housing, income, guardianship

and continued need for ongoing services into adulthood. Case Managers must include, at a minimum, the following in the enrollee's annual plan of care process:

(a) Identification of specific milestones that would trigger the need for or that will be addressed in transition plan; and

(b) Transition planning including the enrollee and his or her family, enrollee's providers, and adult providers. Transition planning will include enrollee and family readiness assessments beginning at fourteen (14) years old. Transition planning shall also include education with the enrollee and his or her family about the differences between child and adult coverage and continuity of care options to update and/or transition the enrollee's diagnoses and services from the pediatric to adult system of care where necessary.

e. The Respondent shall have processes in place to ensure a smooth transition and does not cause a disruption in services when an enrollee's eligibility changes from Medicaid to CHIP or vice versa.

9. Long-Term Care Program Referrals

a. The Respondent shall ensure referrals with the required medical documentation needed to complete the clinical eligibility process for the LTC program are submitted to CARES for the following enrollees:

(1) Six (6) months prior to an enrollee turning the age of eighteen (18) years for enrollees residing in a nursing facility;

(2) Six (6) months prior to an enrollee turning the age of twenty-one (21) years for enrollees receiving private duty nursing services, if the enrollee or their authorized representative has expressed a desire to enroll in the LTC program; and

(3) Upon the request of the enrollee or their representative for an individual who is eighteen (18), nineteen (19), or twenty (20) years of age and who has a chronic debilitating disease or condition of one (1) or more physiological or organ systems which generally make the individual dependent upon twenty-four (24) hour per day medical, nursing, or health supervision or intervention. Section 409.979(3)(f)(1), F.S.

b. The following information must be included with the referral to CARES:

(1) For all referrals, a completed and signed Informed Consent Form and a completed and signed Medical Certification for Medicaid Long-term Care Services and Patient Transfer Form, AHCA Form 5000-3008, and

(2) For referrals made pursuant to section 409.979(3)(f)(1), F.S., in addition to the above, the information in the CARES Long-Term Care Transition Referral Form and Instructions.

All referenced forms may be found at https://ahca.myflorida.com/Medicaid/statewide_MC/app_contract_materials.shtml.

c. The Respondent shall maintain written protocols that address the transition/discharge planning process for enrollees who are receiving services in a skilled nursing facility. The Respondent shall ensure that transition planning begins upon admission to a skilled nursing facility. In those cases where the enrollee has been residing in a skilled nursing facility prior to enrollment in the Respondent, the Respondent shall begin the transition planning process upon enrollment in the Respondent.

10. Additional Care Coordination/Case Management Provisions

a. The Respondent, at a minimum, shall have quarterly contact (telephonic or face-to-face) with each enrollee in case management, or the enrollee's authorized representative, to verify satisfaction with and receipt of services.

b. The Respondent shall establish a supervisor-to-case-manager ratio that is conducive to a sound support structure for case managers. Supervisors must have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers. A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of enrollee assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, must be documented, and made available to the Department upon request.

c. The Respondent shall provide all Care Coordinators, Case Managers, Family Support Specialists, and Education Liaisons with adequate orientation and ongoing training on subjects relevant to enrollees diagnosed with a Specialty condition. The Respondent shall develop a training plan to provide uniform training to all case management staff. This training plan should include formal training classes as well as practicum observation and instruction for newly hired staff.

d. The Respondent shall provide all newly hired care coordination/case management staff orientation and pre-service training covering areas applicable to responsibilities and duties performed.

e. The Respondent shall also provide all care coordination/case management staff with regular ongoing in-service training on topics relevant to the Specialty condition.

f. The Respondent shall maintain documentation of training dates and staff attendance as well as copies of materials used for orientation, pre-service, and in-service training for care coordination/case management staff.

11. Additional Care Coordination/Case Management Requirements

a. The Respondent shall maintain written care coordination and continuity of care procedures that include the following minimum functions:

(1) Appropriate referral and scheduling assistance for enrollees needing Specialty health care or transportation services, including those identified through well--child visits;

(2) Care coordination follow-up services for children/adolescents whom the Respondent identifies through blood screenings as having abnormal levels of lead; and

(3) A mechanism for access to specialists, without the need for a referral, for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs.

b. The Respondent shall ensure that assigned Case Managers receive training through the Department on the level of care requirements for medical foster care services.

c. See **Item 1.**, General Provisions, for provisions on care coordination services to enrollees under the age of eighteen (18) years who are high utilizers of CSU and inpatient psychiatric hospital services. The Respondent shall ensure that care coordinators/case managers for high utilizers complete training provided by DCF on the Marchman Act and Baker Act, as well as "Mental Health First Aid" training from a certified instructor on an annual basis. A completed training attestation signed by the care coordinator/case manager's supervisor must be submitted to the Agency annually on June 1.

d. The Respondent shall attend any dependency court hearings, when requested by the Department of Children and Families (or its designee) to provide status updates related to enrollees in receipt of medical foster care services.

e. Pursuant to section 409.975(4)(b), F.S., the Respondent shall establish specific procedures to improve pregnancy outcomes and infant health, inter-conception care, and reproductive life planning, in coordination with the Healthy Start program.

f. Prenatal Care

The Respondent shall:

(1) Require care coordination through the gestational period according to the needs of the enrollee.

(2) Contact those enrollees who fail to keep their prenatal appointments as soon as possible and arrange for their continued prenatal care.

(3) Assist enrollees in making delivery arrangements, if necessary.

g. The Respondent shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, involvement with the Child Welfare system, or who consistently access services at the highest level of care. This shall include, at a minimum, the following:

(1) Identifying eligible enrollees and stratifying enrollees by severity and risk level including developing an algorithm to identify and stratify eligible enrollees, including:

(a) Identifying enrollees with co-morbid mental health and substance abuse disorders, including a depression screening, and addressing those disorders;

(b) Identifying enrollees with co-morbid medical conditions and addressing the co-morbid medical conditions;

(c) Identifying enrollees in out-of-home behavioral health placements; and

(d) Identifying enrollees with involvement in the Child Welfare system.

(2) Developing different types of interventions and specifying minimum touch frequency for each severity and/or risk level;

(3) Specifying experience and educational requirements for case managers and case management support staff;

(4) Providing training and continuing education for case management staff;

(5) Using evidence-based guidelines to enhance enrollee engagement;

(6) Developing treatment plans that address all of the following:

(a) Incorporate the health risk issues identified during the assessment;

(b) Incorporate the treatment preferences of the enrollee;

(c) Contain goals that are outcomes based and measurable;

(d) Include the interventions and services to be provided to obtain goals;

(e) Include community service linkage, improving support services, and lifestyle management as appropriate based on the enrollee's identified issues;

(f) Assessing enrollees for literacy levels and other hearing, vision, or cognitive functions that may impact an enrollee's ability to participate in his/her care and implementing interventions to address the limitations;

(g) Assessing enrollees for community, environmental, or other supportive services needs and referring enrollees to get needed assistance;

(h) The Respondent shall ensure treatment plans are updated at least every six (6) months when there are significant changes in enrollee's condition;

(i) Interfacing with the enrollee's PCP and/or specialists; and

(j) Ensure a linkage to pre-booking sites for assessment, screening, or diversion related to behavioral health services for enrollees who have justice system involvement.

h. The Respondent shall work in coordination with DCF's behavioral health managing entity to establish specific organizational supports and protocols that enhance the integration and coordination of primary care and behavioral health services for enrollees, in accordance with section 409.973(6), F.S. Additionally, the Respondent shall communicate and coordinate with DCF regional childcare coordinators and the managing entities for enrollees under eighteen (18) years of age who meet the definition of high utilizer to ensure access to Medicaid services and other related community resources. Such communication shall occur at least quarterly. The coordination and communication efforts shall be documented in the enrollee records.

i. See **Item 1,** General Provisions, **Sub-Item b**, for provisions on coordination of care with DCF regional Children's Care Coordinators and the managing entities for enrollees under the age of eighteen (18) years who have high utilization of CSU or inpatient mental health services.

j. See **Item 1,** General Provisions, **Sub-Item h**, for assignment of case managers to enrollees under the age of eighteen (18) years who have high utilization of CSU or inpatient mental health services.

k. See **Item 1**., General Provisions, **Sub-Item. h**., for case management activities on enrollees under the age of eighteen (18) years who have high utilization of CSU or inpatient mental health services, in accordance with Section XV., Accountability, and the Respondent Report Guide.

l. The Respondent shall maintain written procedures for discharge planning through the evaluation of an enrollee's medical care needs, mental health service needs, and substance use service needs and coordination of appropriate care after discharge from one level of care to another. The Respondent shall:

(1) Monitor all enrollee discharge plans from behavioral health inpatient admissions to ensure that they incorporate the enrollee's needs for continuity in existing behavioral health therapeutic relationships;

(2) Ensure development of a comprehensive discharge plan begins at the time of admission to a crisis or inpatient behavioral health program inpatient setting to ensure the enrollee's smooth transition to the next level of service or to the community and shall require that behavioral health care providers:

(a) Assign a mental health targeted case manager to oversee the care given to the enrollee;

(b) Develop an individualized discharge plan, in collaboration with the enrollee where appropriate, for the next level of service or program or the enrollee's discharge, anticipating the enrollee's movement along a continuum of services; and

(c) Document all significant efforts related to these activities, including the enrollee's active participation in discharge planning.

(3) Ensure that the discharge plan incorporates the enrollee's needs for continuity in existing behavioral health therapeutic relationships.

(4) Ensure enrollees' family members, guardians, outpatient individual practitioners, and other identified supports are given the opportunity to participate in enrollee treatment to the maximum extent practicable and appropriate, including behavioral health treatment team meetings and discharge plan development. For adult enrollees, family members and other identified supports may be involved in the development of the discharge plan only if the enrollee consents to their involvement.

(5) Designate care coordination/case management staff who are responsible for identifying and providing care coordination/case management to enrollees who remain in the hospital for non-clinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk enrollees, and enrollees with multiple Department involvement).

(6) Ensure that a behavioral health program clinician provides medication management to enrollees requiring medication monitoring within seven (7) days of discharge from a behavioral health program inpatient setting. The Respondent shall ensure that the behavioral health program clinician is duly qualified and licensed to provide medication management.

(7) Develop and implement a plan that monitors and follow-up to ensure that clinically indicated behavioral health services are offered and available to enrollees within seven (7) days of discharge from an inpatient setting.

m. The Respondent shall report monthly on the enrollees under the age of twenty-one (21) years receiving out-of-home behavioral health treatment, in accordance with Sub--Item f in this Section, and the Respondent Report Guide.

n. The Respondent shall maintain written care coordination and continuity of care procedures that include coordination with the enrollee's PDHP for oral health issues that fall within the coverage of this Contract (e.g., oral cancer; services required in a facility, emergency room, or urgent care place of service).

o. The Respondent shall assign a case manager to an enrollee under the age of twenty--one (21) years who has special health care needs and needs out--of--home/residential treatment services (e.g., group home placement) to ensure timely placement and access to care. The Respondent's case manager shall assume a lead role in identifying a service provider that can meet the enrollee's need even when there are multiple State agencies (i.e., DCF and APD) involved in the child's care. The Respondent shall coordinate and maintain routine contact with other State agencies involved in the enrollee's care until placement is made. The Respondent shall document all efforts to find an appropriate placement in the enrollee record.

p. The Respondent shall maintain and operate a centralized case management information system accessible to the case management team. The system shall capture at a minimum:

(1) The results of the health risk assessment and needs assessments;

(2) Plan of care content (including goals, interventions, progress, outcomes, and completion dates);

(3) Case management staff contact with enrollees and outcomes;

(4) The ability to provide information at the enrollee and population level by case management tier and, at a minimum, enrollees receiving CSU, PDN, SIPP or SNF services as well as enrollees on the iBudget waiver;

(5) Enrollee-level alerts for gaps in care tied to the enrollee's care plan, including PDN gaps in care, upcoming well-child appointments, upcoming pharmacy fills, and missed clinical assessments; and

(6) An electronic dashboard of available beds for inpatient facilities which updates daily.

(7) An electronic dashboard of available home health agency PDN nurses.

q. The Respondent shall ensure that its case management staff have timely access to other relevant electronic data about the enrollee (e.g., claims, prior authorization data, admission discharge transfer [ADT] feeds) in order to coordinate and communicate care needs across providers and delivery systems. The Respondent shall use information technology systems and processes to integrate the following data elements: enrollment data, case management data, claims and enrollee services data, prior authorization data, pharmacy data, and information related to an enrollee's participation in the HOPE Florida program. The Respondent's data integration should include alerts to the case management team when information about the enrollee is

updated by other members of the Respondent's staff (e.g., utilization management, pharmacy, or the enrollee help line).

r. The Respondent's systems must have the capability to provide HOPE Florida Navigators with secure viewing access of relevant enrollee information to promote coordination and enrollee referrals.

12. Healthy Behaviors Program

a. General Provisions

(1) Pursuant to section 409.973(3), F.S., the Respondent shall establish and maintain programs to encourage and reward healthy behaviors.

(2) The Respondent shall receive written approval of its healthy behavior programs from the Department before implementing the programs. The Respondent's program shall include a detailed description of the program, including the goals of the program, how targeted enrollees will be identified, the interventions the Respondent intends to use, rewards for or incentives to participate, research to support the effectiveness of the program, and evidence that the program is medically approved or directed, as applicable. Programs administered by the Respondent must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States DHHS OIG. The Respondent is encouraged to seek an advisory opinion from OIG once the specifics of its Healthy Behaviors programs are determined.

(3) The Respondent may, through its healthy behavior programs, deploy a number of interventions as part of the overall therapeutic process. Examples of interventions:

(a) Series of counseling sessions;

(b) Series of health educational classes;

(c) Gym membership;

(d) Tobacco and vaping prevention programs;

(e) Substance use prevention programs;

(f) School-based programming for depression and suicide prevention programs;

(g) School-based programming for bullying prevention and victimization;

(h) Meal planning services (e.g. NutriSystem®);

(i) The provision of medication therapy management support services

provided by a community health worker; and

(j) Healthy weight programs.

(4) The Respondent shall make all programs, including incentives and rewards available to all enrollees and shall not use incentives or rewards to direct individuals to select a particular provider.

(5) The Respondent shall inform new enrollees about the healthy behaviors program and actively engage in outreach and communication about the health benefits of its healthy behavior programs, including incentives and rewards.

(6) The Respondent shall partner with other agencies such as State and local public health entities, provider organizations, local community groups, or other entities to educate enrollees about the program or to help administer it. Examples include, but are not limited to, Tobacco Free Florida, Area Health Education Centers, Florida universities, the Department of Education, and school districts.

(7) The Respondent shall annually inform its entire provider network of the availability of its Healthy Behavior programs and incentives to support enrollee engagement.

(8) The Respondent shall not include the provision of gambling, alcohol, tobacco, or drugs (except for over-the-counter drugs) in any of its incentives or rewards and shall state on the incentive or reward that it may not be used for such purposes.

(9) The Respondent's Healthy Behavior program shall include a detailed description of the rewards and incentives offered to enrollees. Incentives or rewards may have some health- or child development-related function (e.g., clothing, food, books, safety devices, infant care items, subscriptions to publications that include health-related subjects, or membership in clubs advocating educational advancement and healthy lifestyles.). Incentive or reward dollar values shall be in proportion to the importance of the healthy behavior being encouraged or rewarded (e.g., a tee-shirt for attending one (1) health education class, but a gift card for completion of a series of classes).

(10) Both incentives and rewards offered to enrollees shall be reasonable, simple, and provided on a timely basis. Incentives or rewards may include any of the following:

(a) Gift cards;

(b) Flexible spending accounts that may be used for health and wellness items;

(c) Vouchers for health and wellness related items; and

(d) Points or credits which are redeemable for goods or services.

(11) Incentives and rewards shall be limited to a value of twenty dollars (**$20.00**). The exceptions to this monetary limit are as follows:

(a) Programs that require the enrollee to complete a series of activities (e.g.; completion of a series of health education classes). In these instances, the incentive or reward shall be limited to a value of fifty dollars (**$50.00**).

(b) Infant car seats, strollers, and cloth baby carriers/slings that are offered as incentives to engage in a healthy behavior program or rewards for completion of an action or a series of activities may have a special exception to the dollar value, with Agency approval.

(c) Participation in multiple healthy behavior programs. In these instances, the incentive or reward shall be limited to a value of fifty dollars (**$50.00**) for each healthy behavior program.

(12) The Respondent shall not include in the dollar limits on incentives or rewards any money spent on the transportation of enrollees to services or childcare provided during the delivery of services; or the healthy behavior program or associated interventions.

(13) Healthy Behavior incentives/rewards are non-transferable from one Respondent to another.

b. Healthy Behaviors Program Specific Provisions

(1) At a minimum, the Respondent must implement the following Healthy Behaviors programs:
a. An evidence based tobacco prevention and cessation program,
b. An evidence-based healthy weight program, and
c. An evidence-based substance use prevention program.

(2) The Respondent must implement an additional Healthy Behaviors program of its choice that addresses a high priority need of a large proportion of its enrollees. Examples may include depression and suicide prevention, prevention of bullying and victimization, healthy sleep, and safe screentime for families.

(3) The Respondent is encouraged to collaborate with Tobacco Free Florida, Florida Area Health Education Centers, regional planning councils, and other relevant community-based organizations in the implementation of these programs. Specifically, the Respondent must offer financial and in-kind support in the identification, administration, and monitoring of effectiveness of Healthy Behavior programs.

(4) The Respondent is encouraged to communicate with primary care providers the use of SBIRT codes in screening and referring enrollees for Healthy Behavior Program services.

c. Healthy Behaviors Outcomes

(1) The Respondent shall report on its Healthy Behavior programs in accordance with **Section XV**, Accountability, and the Respondent Report Guide. This shall include submitting data related to each Healthy Behavior program, a description of each program, methods of enrollee identification and referral, participation numbers and percentages for each Healthy Behavior program, and the amount and type of rewards/incentives provided for each Healthy Behavior program.

(2) The Respondent shall evaluate each Healthy Behavior program annually to assess enrollee engagement (i.e., the number and percentage of enrollees referred, the number and percentage of enrollees participating), program completion rates, and health outcomes. The Respondent in its evaluation must connect the participation of the Healthy Behavior programs to quality performance measures described in this contract. The Respondent shall submit the results of its annual evaluations to the Department, in a format prescribed by the Department, by October 1 of each Contract year.

(3) The Respondent shall publish the results of its Department-reviewed annual evaluation on the plan's website by October 1 of each Contract year.

d. If the Respondent fails to comply with the requirements of this provision, the Respondent may be subject to sanctions pursuant to Section XII. Sanctions and Corrective Action Plans, or liquidated damages pursuant to Section XIII., Liquidated Damages, as determined by the Agency.

F. Community Partnerships to Improve Outcomes (CPIO)

1. The Respondent shall establish community partnerships to provide services and supports in the following CPIO priority areas:

a. Birth Outcomes. Examples of community organizations include, but are not limited to, the following:

(1) Florida Pregnancy Support Services Program and Florida Pregnancy Care Network.

(2) Family Planning Partnerships.

(3) Teenage Parent Program (TAPP) operated through school districts.

(4) Pregnancy and Prenatal Partnerships.

(5) Postpartum Partnerships.

(6) Lactation Partnerships.

(7) Parenting Partnerships.

(8) Maternal Mental Health Partnerships.

(9) Healthy Start Partnerships operated through the Florida Department of Health and County Health Departments.

(10) Early Steps Partnerships operated through the Florida Department of Health and County Health Departments.

b. Mental Health of Children and Adolescents. Examples of community organizations include, but are not limited to, the following:

(1) School-Based Peer Support Programs.

(2) Youth Mental Health and Awareness Partnerships.

(3) Extended Day Enrichment Programs.

(4) Youth Mentorship or Leadership Development Partnerships.

(5) School Readiness Partnerships.

(6) Youth Tobacco Prevention and Cessation Partnerships such as Tobacco Free Florida and Area Health Education Centers.

(7) Alcohol and Substance Use Prevention Partnerships.

c. Health Related Social Needs. Examples of community organizations include, but are not limited to, the following:

(1) State of Florida Centers for Independent Living.

(2) Vocational Training and Job Placement Partnerships including, but not limited to, Workforce Development Organizations and Job Centers.

(3) Academic Achievement Partnerships.

(4) Intimate Partner Violence Partnerships.

(5) Community Reentry for Justice-Involved People Partnerships.

(6) Supportive Housing Partnerships including, but not limited to, Continuums of Care and Permanent Supportive Housing Organizations.

(7) Literacy Partnerships.

2. The Respondent for enrollees shall establish community partnerships to provide services and supports in the following additional CPIO priority areas:

a. Chronic Diseases. The Respondent shall contract with community organizations to improve the well-being of their population. Examples of community organizations include, but are not limited to, the following:

(1) Disease Awareness Partnerships.

(2) Disease Progression Prevention Partnerships.

(3) Disease Survivorship and Recovery Partnerships.

(4) Foster Care Support Partnerships.

(5) Adoption and Guardianship Support Partnerships.

(6) Healthy Nutrition Partnerships.

(7) Physical Activity and Fitness Partnerships.

b. Mental Health. Examples of community organizations include, but are not limited to, the following:

(1) School-Based Peer Support Programs.

(2) Youth Mental Health and Awareness Partnerships.

(3) Extended Day Enrichment Programs.

(4) Youth Mentorship or Leadership Development Partnerships.

(5) School Readiness Partnerships.

(6) Tobacco Prevention and Cessation Partnerships such as Tobacco Free Florida and Area Health Education Centers.

(7) Alcohol and Substance Use Prevention Partnerships.

c. Health Related Social Needs. Examples of community organizations include, but are not limited to, the following:

(1) State of Florida Centers for Independent Living.

(2) Vocational Training and Job Placement Partnerships including, but not limited to, Workforce Development Organizations and Job Centers.

(3) Academic Achievement Partnerships.

(4) Intimate Partner Violence Partnerships.

(5) Community Reentry for Justice-Involved People Partnerships.

(6) Supportive Housing Partnerships including, but not limited to, Continuums of Care and Permanent Supportive Housing Organizations.

(7) Literacy Partnerships.

G. Authorization of Services

3. General Provisions

a. The Respondent shall not delegate to its subcontractors any aspect of authorization of services for early intervention services. This requirement does not apply to contracts or agreements with the Local Early Steps offices located in the regions in which the Respondent is providing services under this Contract.

b. The Respondent shall have a UM subcommittee as part of its Quality Improvement Committee.

c. With respect to children with medical complexity and EPSDT, the Respondent will assume the following additional requirements:

(1) Cover all services that assist a child with medical complexity in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age. The Respondent will continue to cover services until the enrollee achieves age-appropriate functional capacity.

(2) Ensure that determinations are not based solely upon review standards applicable to (or designed for) adults with medical complexity. Adult standards include, but are not limited to, Medicare rehabilitation standards and the "Medicare 3-hour rule". Determinations for children with medical complexity and EPSDT will take into consideration the specific needs of the enrollee and the circumstances pertaining to their growth and development.

(3) Accommodate unusual stabilization and prolonged discharge plans for children with medical complexity, as appropriate. The Respondent will develop a person centered discharge plan for the enrollee that includes, but is not limited to: sudden reversals of condition or progress, which may make discharge decisions uncertain or more prolonged than for other children or adults; necessary training of parents or other adults to care for a child with medical complexity at home; unusual discharge delays encountered if parents or other responsible adults decline or are slow to assume full responsibility for caring for a child with medical complexity; the need to await an appropriate home or home-like environment rather than discharge to a housing shelter or other

inappropriate setting for a child with medical complexity, the need to await construction adaptations to the home (such as the installation of generators or other equipment); and lack of available suitable specialized care (such as unavailability of pediatric nursing home beds or pediatric ventilator units).

(4) The Respondent will, as part of its provider network management responsibility, identify an available service provider of needed covered services, as determined through a person-centered care plan, to effect safe discharge from a hospital or other facility; payments will not be denied to a discharging hospital or other facility due to lack of an available post-discharge service provider as long as the hospital or other facility has worked with Provider to identify an appropriate service provider. The Respondent will approve the use of out of network (OON) service providers if the Respondent does not have a participating service provider to address the needs of the enrollee.

(5) Ensure that a child with medical complexity receives services from appropriate service providers that have the expertise to effectively treat the enrollee and will contract with service providers with demonstrated expertise in caring for a child with medical complexity. Network providers will make referrals to appropriate in- network community and facility providers to meet the needs of the enrollee or seek authorization from the Respondent for OON service providers when participating service providers cannot meet the enrollee's needs. Authorize services timely as warranted by the enrollee's condition and in accordance with established timeframes.

d. EPSDT services include 1905(a) Medicaid services regularly utilized by children with medical complexity including, but not limited to:

(1) Over-the-counter medical supplies including vitamins, acetaminophen, etc.

(2) Additional dental services including medically necessary sedatives,

(3) Nutritional supplements and supports including low protein foods,

(4) In-home skilled nursing and therapies for chronic conditions,

(5) Additional personal care beyond covered benefits,

(6) Incontinence supplies,

(7) A specially adapted car seat needed by an enrollee because of a medical problem, and

(8) Nutritional counseling necessary for addressing obesity.

e. The Respondent physician peer review (Respondent medical director or staff) in coordination with Department clinical staff review (i.e., Department CMS Health Plan medical director or staff) will include at a minimum, review of:

(1) Medical record content to determine appropriateness of care;

(2) Compliance with program standards; and

(3) Family perception of care.

f. The Respondent shall use the same standards for Title XIX and Title XXI enrollee service authorization determinations.

g. By State law, the DCF is authorized to establish the following for the special behavioral services for children with severe emotional disturbances:

(1) Behavioral health services standards;

(2) Clinical guidelines for referral to behavioral health services;

(3) Practice guidelines for behavioral health services to ensure cost effective treatment and to prevent unnecessary expenditures; and

(4) The scope of behavioral health services, including duration and frequency.

h. The Respondent shall ensure the Utilization Management Program Description, service authorization systems, practice guidelines and clinical decision-making required pursuant to this Contract are consistent with prevailing standards of professional medical practice and with standards regarding the most recent clinical practice guidelines and ensure that enrollees with medical complexity are being referred to the most appropriate specialists. Develop and implement policies and procedures to notify the Department of clinical practice guidelines. All policies and procedures must be submitted to the Department for approval.

4. Utilization Management Program Description

a. The written Utilization Management Program Description required in **Attachment B,** Section **V**, Service Administration, **Subsection G**, Authorization of Services shall be updated annually and submitted to the Department by June of each year.

b. The Respondent shall supplement the Utilization Management Program Description required in **Attachment B, Section V**, Service Administration, **Subsection G**, Authorization of Services, to include distinct procedures related to the authorization of MMA services, including but not limited to:

(1) Procedures for monitoring for and demonstrating compliance with 42 CFR 438, subpart K regarding the Mental Health Parity and Addictions Equity Act (MHPAEA) and 42 CFR 438.910(d), including procedures to monitor for and

assure parity in the application of quantitative and non-quantitative treatment limits for medical and behavioral health services.

(2) Procedures to provide timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. Written follow-up documentation of the approval must be provided to the non-participating service provider within one (1) business day after the approval.

(3) Procedures to require prior authorization for all non-emergency inpatient hospital admissions.

(4) Processes to permit service providers to submit individual and batch prior authorization requests.

(5) Procedures to allow service providers to view Explanation of Benefits (EOB), and remittance advices on-line.

(6) For enrollees with special health care needs identified in accordance with **Section V**, Services Administration, **Subsection E**, Care Coordination/Case Management, **Item 4**, Contact Requirements, **Sub-Item c**, of this Exhibit, , a mechanism to allow enrollees with special health care needs to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

(7) For enrollees enrolled in the iBudget Waiver or on the waitlist for the Waiver, procedures to provide expedited authorization or bypass authorization for dental anesthesia.

(8) For emergency behavioral health inpatient services and care when provided according to this provision and resulting from a Baker Act admission, procedures to provide expedited authorization for continued stays.

(9) If the Respondent requires authorization of early intervention services, use of the IFSP as the sole authorizing document. The Respondent may require additional supplemental documentation, subject to prior approval of the Department.

(10) Streamlined or waived authorization processes for prior authorization of services to promote ease of access to medically necessary services to enrollees involved in the Child Welfare system, as identified by the Department. This provision is applicable to all enrollees involved in the Child Welfare system as indicated on the Department's enrollment file.

(11) A description of a prior authorization program for covered outpatient drugs for Medicaid and CHIP enrollees (i.e., physician-administered and prescribed drug services) that complies with the following:

(a) The requirements of section 1927(d)(5) of the SSA, as if such requirements applied to the Respondent instead of the State.

(b) A description for complying with the requirements of section 409.912(5)(a)(14), F.S., regarding prior authorization for covered outpatient drugs.

(c) The requirements of Section 409.912(5)(a)(1), F.S., regarding responding within a twenty-four (24) hour review period to requests for drug prior authorization, and providing the enrollee with a seventy-two (72)-hour drug supply in an emergency or when the Respondent does not provide a response within twenty-four (24) hours;

(12) The Respondent shall assure that the prior authorization process for prescribed drugs is readily accessible to health care professionals, including posting appropriate contact information on its website and providing timely responses to service providers in accordance with section 409.967(2) (c) (2), Florida Statutes.

(13) The Respondent shall develop prior authorization criteria and protocols for reviewing requests for brand name drugs that are not on AHCA's Medicaid PDL or the Respondent's CHIP PDL. The Respondent's prior authorization criteria and protocols may not be more restrictive than that used by AHCA as indicated in the Florida Statutes, the Florida Administrative Code, the Medicaid State Plan, the CHIP State Plan, and criteria posted on the AHCA website.

(14) For enrollees determined through an assessment by appropriate individuals meeting HCBS coordination requirements consistent with 42 CFR § 438.208(c)(2) to need a course of treatment or regular care monitoring, the Respondent will have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

(15) A procedure for the authorization, in accordance with this Exhibit, **Section VII**, Provider Network and Services, **Sub-item A**, Network Adequacy Standards, **Item 9**, Timely Access Standards, for facility services and associated ancillary medical services secondary to dental care authorized by the PDHP and provided in a facility under the direction of a dentist when considered medically necessary due to the enrollee's special healthcare needs.

(16) Issuing service authorizations to enrollees requesting transportation services.

c. If the Respondent fails to comply with the requirements of this Section, the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII**, Liquidated Damages, as determined by the Department.

5. Service Authorization System

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

4. Practice Guidelines/Evidence-based Criteria

a. The Respondent shall use the American Society of Addiction Medicine (ASAM) practice guidelines for authorization and coverage of substance use disorder services.

b. The Respondent may request notification, but shall not deny services based on a lack of notification, for the following:

(1) Inpatient emergency admissions (within five (5) 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.

c. The Respondent shall provide post-authorization to CHDs for emergency shelter medical screenings provided for children being taken into the welfare system.

d. In accordance with section 409.967(2)(c)(2), F.S., the Respondent 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.

e. The Respondent's prior authorization criteria and protocols for prescribed drugs shall not be more restrictive than those posted on the Agency website and used by the Agency, as authorized by federal and State laws, rules, or regulations, and the federal CMS waivers applicable to this Contract.

f. The Respondent shall ensure its Utilization Management Program Description, service authorization systems, practice guidelines, and clinical decision-making required pursuant to **Attachment B and its Exhibits** are consistent with prevailing standards of professional medical practice and with standards regarding the most recent clinical practice guidelines in treatment for the Respondent's population. The Respondent shall develop and implement, subject to Department approval, policies, and procedures to notify the Department of clinical practice guidelines for treatment of the plan's population.

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5. Clinical Decision-Making

There are no additional clinical decision-making provisions unique to the managed care program.

6. Service Authorization Standards for Decisions

There are no additional service authorization standards for decisions provisions unique to the managed care program.

7. Changes to Utilization Management Components

There are no additional changes to UM components provisions unique to the managed care program.

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Section VI. Enrollee Grievance and Appeal System

A. General Provisions

1. The Respondent shall meet the general enrollee grievance and appeal provisions in Attachment B, in addition to the following requirements:

   (a) CHIP enrollees are not eligible to participate in the Medicaid Fair Hearing process. CHIP enrollees are eligible only for the Respondent's complaint process, grievance process, and plan appeal process. State Fair Hearing references refer only to an appeal to Medicaid enrollees. Provider must facilitate access to an independent review organization for CHIP enrollees.

   (b) The Respondent must not delegate any aspect of the grievance and appeal system to its subcontractors.

B. Use of Independent Review Organization

1. The Respondent shall meet the independent review organization provisions in Attachment B, in addition to the following requirements for Title XXI enrollees:

   (a) The Respondent's external review process must meet the federal consumer protection standards as outlined in 42 U.S. Code § 18001.

   (b) The Respondent may elect to contract with an Independent Review Organization (IRO) or offer enrollees the federal HHS -administered external review process.

   (c) Notify the Department which option it elects to offer CHIP enrollees.

   (d) If the Respondent elects to contract with an IRO, the Respondent must ensure:

      (1) The contracted IRO is accredited and recognized by the National Association of Independent Review Organizations (NAIRO).

      (2) That standard reviews are conducted, and a decision made by the IRO as soon as possible or no later than sixty (60) days after the request is received.

   (e) Offer enrollees an external review at no charge.

   (f) Provide enrollees written instructions on how to request an external review following the completion of the plan appeal process.

   (g) Offer assistance to enrollees to complete the necessary filings to request an external review.

   (h) Accept and notify the enrollee and the service provider in writing of the IRO's decision.

(i) The Respondent may additionally elect to have all of its unresolved grievances and plan appeals subject to external review processes by an IRO in accordance with section 641.185(1)(j), Florida Statutes.

C. Process for Complaints

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

D. Process for Grievances

Title XXI MediKids enrollees are not eligible to participate in the Medicaid Fair Hearing process.

E. Notice of Adverse Benefit Determination

1. In addition to the requirements in **Attachment B**, **Section V.**, Service Administration, **Sub-Section G.**, Authorization of Services, the Respondent shall ensure a notice of action is provided to enrollees under the age of twenty-one (21) years receiving residential psychiatric treatment (including SIPP and TGC services) in each instance during a course of treatment where the Respondent authorizes fewer units or days subsequent to the initial authorization for the service.

2. Hernandez Settlement Agreement Requirements

a. The Respondent shall ensure all participating pharmacy locations provide notice to an enrollee when the payment is denied for a prescription, in compliance with the Settlement Agreement to *Hernandez, et al v. Medows,* Case No. 02-20964-Civ--Gold/Simonton. An HSA situation arises when an enrollee attempts to fill a prescription at a participating pharmacy location and is unable to receive the prescription as a result of:

(1) An unreasonable delay in filling the prescription;

(2) A denial of the prescription;

(3) The reduction of a prescribed good or service; and/or

(4) The expiration of a prescription.

b. The Respondent shall maintain a log of all correspondence and communications from enrollees relating to the HSA ombudsman process. The Respondent shall submit the ombudsman log report quarterly to the Department, as required **in Section XV**, Accountability, and the Respondent Report Guide.

F. Standard Resolution of Plan Appeals

There are no additional standard resolution of plan appeals provisions unique to the managed care program

G. Extension of Plan Appeal

There are no additional extension of plan appeal provisions unique to the managed care program.

H. Expedited Resolution of Plan Appeals

There are no additional expedited resolution of plan appeals provisions unique to the managed care program.

I. Notice of Plan Appeal Resolution

There are no additional notice of plan appeal resolution provisions unique to the managed care program.

J. Process for Medicaid Fair Hearings

There are no additional process for Medicaid Fair Hearings provisions unique to the managed care program.

K. Appellate Responsibilities

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

J. Coordination with the Department Ombudsmen

1. The Department's Ombudsmen are advocates for enrollees and providers. These staff of the Department provide information and work with the Respondent staff to assist enrollees and service providers to navigate the Department's care delivery system.

    a. Cooperate with any inquiries, referrals, and resolution processes from the Department Ombudsmen.

    b. Designate an Ombudsmen Liaison and provide an email address to the Department's ombudsmen to correspond with on emerging issues.

    c. Maintain a log of all correspondence and communications from enrollees relating to the Department Ombudsman process. Submit the Ombudsman log report quarterly to the Department as required in Section XVI., Reporting Requirements, and the Managed Care Report Guide.

    d. Maintain a log of all correspondence and communications from enrollees relating to the HSA Ombudsman process. Submit the Ombudsman log report each quarter to the Department as required in Section XVI., Reporting Requirements, and the Managed Care Report Guide.

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Section VII. Provider Network and Services

A. Network Adequacy Standards

1. General Provisions

a. The Respondent shall not delegate to its subcontractors any aspect of claims payment, utilization management, credentialing, or network management for early intervention services providers. This requirement does not apply to contracts or agreements with the Local Early Steps offices located in the regions in which the Respondent is providing services under this Contract.

b. The Department reserves the right to establish provider network standards for mental health therapists co-located with Primary Care Providers in network, Pediatricians in network, and FQHCs under agreement with the Respondent.

2. Network Capacity and Geographic Access Standards

a. Pursuant to section 409.967(2)(c)(1), F.S., and 42 CFR 438.68(b)(1), the Respondent must maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all plan enrollees. At a minimum, the Respondent shall contract with the providers specified in **Table 4**, Managed Medical Assistance Provider Network Standards Table, below. The Respondent shall ensure regional provider ratios and provider-specific geographic access standards for enrollees in urban or rural counties are met and maintained throughout the life of this Contract, as specified in the table. The regional provider ratios shall be based upon one-hundred percent (100%) of the Respondent's actual monthly enrollment measured at the first of each month, by region, for all regions.

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TABLE 4
MANAGED MEDICAL ASSISTANCE
PROVIDER NETWORK STANDARDS TABLE

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

TABLE 4 **MANAGED MEDICAL ASSISTANCE** **PROVIDER NETWORK STANDARDS TABLE**					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Enrollee*
Otolaryngology	80	60	90	75	1:3,500 enrollees
Pediatrics (including Adolescent Medicine)	50	35	75	60	1:1,500 enrollees
Pharmacy	15	10	15	10	1:2,500 enrollees
24-hour Pharmacy	60	45	60	45	n/a
Podiatry	60	45	75	60	1:5,200
Pulmonology	60	45	75	60	1:7,600 enrollees
Rheumatology	100	75	110	90	1:14,400 enrollees
Therapist (Occupational)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Occupational)	30	20	60	45	1:1,500 enrollees
Therapist (Speech)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Speech)	30	20	60	45	1:1,500 enrollees
Therapist (Physical)	50	35	75	60	1:1,500 enrollees
Therapist, Pediatric (Physical)	30	20	60	45	1:1,500 enrollees
Therapist (Respiratory)	100	75	110	90	1:8,600 enrollees
Therapist, Pediatric (Respiratory)	60	45	75	60	1:1,500 enrollees
Urology	60	45	75	60	1:10,000 enrollees
Facility/ Group/ Organization					
Hospitals (acute care)	30	20	30	20	1 bed: 275 enrollees
Hospital or Facility with Birth/Delivery Services (including Birthing Center)	30	20	30	20	1 bed: 275 enrollees
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	n/a	n/a	n/a	n/a	2: County

TABLE 4 **MANAGED MEDICAL ASSISTANCE** **PROVIDER NETWORK STANDARDS TABLE**					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Enrollee*
Hospice	n/a	n/a	n/a	n/a	2: County
DME/HME	30	20	30	20	2: County
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/ Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees
Statewide Inpatient Psychiatric Program Providers (Inpatient Psychiatric Under 21 State Plan Benefit)	n/a	n/a	n/a	n/a	1 bed: 3,000 enrollees
Medication and Methadone Treatment Programs	30	20	60	45	n/a
Licensed Community Substance Abuse Treatment Centers	30	20	60	45	2: County
Behavioral Health					

TABLE 4 **MANAGED MEDICAL ASSISTANCE** **PROVIDER NETWORK STANDARDS TABLE**					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Enrollee*
Licensed Practitioners of the Healing Arts (LPHA)	30	20	60	45	1:1,500
Board Certified or Board Eligible Child Psychiatrists	30	20	60	45	1:7,100
Board Certified or Board Eligible Adult Psychiatrists	30	20	60	45	1:1,500
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units/Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed: 500 enrollees
Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Units/Freestanding Psychiatric Specialty Hospital	n/a	n/a	n/a	n/a	1 bed: 2,000 enrollees
Inpatient Substance Abuse Detoxification Units	n/a	n/a	n/a	n/a	1 bed: 4,000 enrollees
Pharmacy					

TABLE 4 MANAGED MEDICAL ASSISTANCE PROVIDER NETWORK STANDARDS TABLE					
	Urban County		Rural County		Regional Provider Ratios
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Enrollee*
24-hour Pharmacy	60	45	60	45	2: county

2. Complex Chronic Condition-Specific Network Capacity Enhancements

a. Because complex chronic conditions are serious and long-term, enhanced coordination of care is necessary to achieve high value health care.

b. The Respondent shall establish a process for identifying enrollees with complex chronic conditions. The plan shall report to the Agency on an annual basis their process for enrollee identification and the number and characteristics of their enrollees who have complex chronic conditions. Enrollees with complex chronic conditions are those who meet the following criteria:

(1) One or more chronic conditions that affects three (3) or more body systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink or breath independently) and which also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; OR

(2) One life-limiting illness or rare pediatric disease as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3).

c. Some examples of complex chronic conditions may include, but are not limited to, cerebral palsy, cystic fibrosis, HIV/AIDS, sickle cell disease, muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder, serious emotional disturbance, or serious mental health illness.

d. It is expected that every enrollee with complex chronic conditions will receive primary care in an accredited patient centered medical home (PCMH) where a primary care physician leads enhanced care coordination, disease prevention, health screenings, health promotion, transitional care from inpatient to home settings, family support,

referrals to community and social support services, and use of health information technology to link services. PCMH accrediting bodies include the National Committee for Quality Assurance, The Joint Commission, or The Accreditation Association for Ambulatory Health.

e. The Respondent shall assist multi-disciplinary clinics within their in-network children's hospitals to attain PCMH accreditation and re-accreditation through technical assistance, application preparation, educational seminars, readiness assessments, accreditation sustaining activities, assistance with quality improvement efforts, and assistance with data collection and reporting. The Respondent is encouraged to also provide scholarships or other financial assistance in attaining accreditation and reaccreditation.

f. The Respondent shall recognize and support PCMHs, whether by increasing the percentage of members assigned to a PCMH, increasing the percentage of providers practicing in a PCMH, or offering infrastructure or financial support.

g. The plan shall report to the Agency on an annual basis on the changes in complex chronic conditions enrollee's emergency department visits, inpatient admissions, inpatient length of stays, inpatient re-admissions, drug utilization, durable medical equipment utilization, expanded benefits utilization, total cost of care, quality measures, and patient and caregiver satisfaction resulting from PCMH enhanced coordination. The plan shall also report the number and characteristics of the PCMH health homes where complex chronic condition enrollees received their primary care, and the number and percentage of complex chronic condition enrollees who visited the same PCMH primary care provider two (2) or more times in the reporting year.

3. Primary Care Providers

a. The Respondent shall enter into provider agreements with at least one (1) FTE PCP per five hundred (500) enrollees. The Respondent may increase the physician's ratio by seven hundred fifty (750) enrollees for each FTE ARNP or PA affiliated with the participating physician's office. The Respondent shall ensure a sufficient selection of FTE PCPs in each of the following four (4) Specialty areas within the geographic access standards indicated above:

(1) Family Practice;

(2) General Practice;

(3) Pediatrics; and

(4) Internal Medicine.

b. The Respondent shall ensure the following:

(1) The PCP provides, or arranges for, coverage of services, consultation, or approval for referrals twenty-four hours per day, seven days per week (24/7) by a Medicaid-enrolled PCP(s). After-hours coverage must be accessible using the

medical office's daytime telephone number. After-hours coverage shall consist of an answering service, call forwarding, provider call coverage, or other customary means approved by the Department. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision.

(2) The PCP arranges for coverage of primary care services during PCP absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

4. Specialists and Other Providers

a. The Respondent shall enter into provider agreements with a sufficient number of specialists to ensure adequate accessibility for enrollees of all ages. The Respondent shall ensure the following:

(1) A sufficient selection of the network infectious disease specialists has expertise in HIV/AIDS and its treatment and care, based on the actual number of enrollees with HIV/AIDS;

(2) Female enrollees have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist; and

(3) In accordance with section 641.31(18), F.S., low-risk enrollees have access to midwifery services from providers licensed in accordance with Chapter 467, F.S.

b. For pediatric specialists not listed on **Table 4**, Managed Medical Assistance Provider Network Standards Table, the Respondent may assure access by providing telemedicine consultations with participating pediatric specialists, at an agreed upon location or at a PCP's office within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code. Alternatively, for pediatric specialists not listed in **Table 4**, Managed Medical Assistance Provider Network Standards Table, for which there is no pediatric specialist located within sixty (60) minutes travel time or forty-five (45) miles from the enrollee's residence zip code, the Respondent may assure access to that specialist in another location in Florida through a transportation arrangement with willing participating pediatric provider(s) who have such capability.

c. The Respondent may increase the Psychiatrist's ratio by seven hundred fifty (750) enrollees for each FTE ARNP with a certificate of psychiatric nursing through the American Nurses Credentialing Center or physician's assistant (PA) with a Certificate of Added Qualifications in psychiatry through the National Commission on Certification of Physician Assistants, and affiliated with the participating Psychiatrist's office.

d. The Respondent shall comply with the requirements in section 409.912(5)(a)(4), F.S., regarding limiting pharmacy networks.

e. For each county it serves, the Respondent shall designate an emergency service facility that operates twenty-four hours a day, seven days a week, (24/7) with

Registered Nurse coverage and on-call coverage by a behavioral health specialist (42 CFR 438.3(q)).

f. The Respondent shall enter into provider agreements with a sufficient number of behavioral health providers to ensure adequate accessibility for enrollees to evidence-based practices for children with intense behaviors as provided in **Section V**, Service Administration, **Subsection A**, Required MMA Benefits, **Item 1**, Specific MMA Services to be Provided, **Sub-item a**,

g. The Respondent shall ensure the availability of massage therapists licensed in accordance with Chapter 480, F.S. and physical therapists licensed in accordance with Chapter 486, F.S. for the provision of services under **Section V**, Service Administration, **Subsection A**, Required MMA Benefits, **Item 1**, Specific MMA Services to be Provided, **Sub-item a**, **Part (5)** Community Behavioral Health Services, **Sub-part (b)** of this Exhibit.

h. The Respondent shall enter into agreements with early intervention services providers as identified by the Department.

(1) Early intervention services providers must be:

a. Qualified to render early intervention services in accordance with 34 CFR 303.321;

b. Trained and certified by the Department, Early Steps Program;

c. Enrolled in Florida Medicaid;

d. Qualified as specified in the service-specific Medicaid policy. Such providers may include Infant Toddler Developmental Specialists, audiologists, family therapists, nurses, occupational therapists, physical therapists, speech-language pathologists, ophthalmologists/optometrists, pediatricians, psychologists, registered dieticians, targeted case managers, and social workers.

(2) The Respondent shall make a good faith effort to execute agreements with the Local Early Steps offices located in the regions in which the Respondent is providing services under this Contract.

i. When an enrollee has been determined eligible for medical foster care services, and the CBC Lead Agency and the Department, Medical Foster Care Program have identified an appropriate and qualified medical foster care provider (i.e., home) in which to place the enrollee, the Respondent shall enter into an agreement with the provider to furnish medical foster care services within seven (7) days of notification of the placement of the enrollee with the medical foster care parent.

j. For enrollees participating in the Department's Early Steps program, the Respondent shall ensure the availability of EIS authorized on the IFSP to be provided in the enrollee's natural environment (e.g., home, daycare, school).

k. The Respondent shall develop and implement written procedures for determining how the Respondent will provide transportation services outside its region, when medically necessary.

5. Public Health Providers

a. The Respondent shall make a good faith effort to execute memorandums of agreement, as specified in this Subsection, with public health providers, including:

(1) CHDs qualified pursuant to rule 59G-4.055, F.A.C.;

(2) RHCs qualified pursuant to rule 59G-4.280, F.A.C.; and

(3) FQHCs qualified pursuant to rule 59G-4.100, F.A.C. (including those with co--located behavioral health services).

The Respondent shall provide documentation of its good faith effort upon the Department's request.

b. The Respondent shall pay at the contracted rate or the Medicaid FFS rate, without authorization, all authorized claims for the following services provided by a CHD, migrant health centers or community health centers funded under 42 USC § 254b (formerly sections 329 and 330 of the Public Health Services Act). The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD encounter rate as specified by the County Health Department Clinic Rule and the associated Florida Medicaid fee schedule for applicable rates for the following services:

(1) Office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis.

(2) The diagnosis and treatment of sexually transmitted diseases and other reportable infectious diseases, such as tuberculosis and HIV;

(3) The provision of immunizations;

(4) Family planning services and related pharmaceuticals;

(5) School health services provided by CHDs, and for services rendered on an urgent basis by such providers; and

(6) In the event that a -preventable disease emergency is declared, claims from the CHD for the cost of the administration of immunizations.

The Respondent may require prior authorization for all other covered services provided by CHDs.

c. The Respondent shall reimburse the CHD when the CHD notifies the Respondent and provides the Respondent with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.

d. The Respondent shall pay, without prior authorization, at the contracted rate or the Medicaid fee-for-service rate, all valid claims initiated by any CHD for office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis. The Respondent shall reimburse the CHD when the CHD notifies the Respondent and provides the Respondent with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.

e. The Respondent shall not deny claims for services delivered by CHD providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred sixty-five (365) days.

f. The Respondent shall not deny reimbursement for failure to prior authorize services rendered pursuant to section 392.62 F.S.

g. The Respondent shall reimburse CHDs for services at the entity's cost-based reimbursement rate set by the Department.

h. The Respondent shall reimburse FQHCs and RHCs at rates comparable to those rates paid for similar services in the community.

i. When billing for prescribed drug services outside of the cost-based reimbursement rate, the Respondent shall reimburse CHDs for authorized prescription drugs in accordance with Rule 59G-4.251, F.A.C., Prescribed Drugs Reimbursement Methodology.

j. The Respondent shall report quarterly to the Department as part of its quarterly financial reports (as specified in **Section XV**, Accountability, and the Respondent Report Guide), the payment rates, and the payment amounts made to FQHCs and RHCs for contractual services provided by these entities.

k. The Respondent shall make a good faith effort to execute memorandums of agreement with private schools, charter schools, and school districts participating in the certified match program regarding the coordinated provision of school-based services pursuant to sections 409.9071, 409.9072, 409.908(21), and 1011.70, F.S.

    (1) The Department will provide fee-for-service claims data to the Respondent for school-based services provided to Medicaid recipients enrolled in the Respondent.

    (2) The Respondent shall use such data and information to ensure effective program coordination and non-duplication of services, as well as to enhance communication with the enrollees' families to bolster their awareness about the Respondent's EPSDT benefits and the availability of services.

l. The Respondent shall reimburse Indian Health Care Providers (IHCPs) at rates comparable to those rates paid for similar services in the IHCPs' community.

m. The Respondent shall report quarterly to the Department in a format specified by the Department, the payment rates and the payment amounts made to IHCPs for

contractual services provided by these entities. When the amount the IHCP would have received under the fee-for-service reimbursement system, the Department shall comply with 42 CFR 438.14(c)(3).

6. Facilities and Ancillary Providers

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

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

(2) Network facilities are licensed as required by law and rule;

(3) Hospital providers in the Respondent's provider network participate in the ENS; the Respondent shall achieve and maintain Florida HIE ENS participation of at least eighty percent (80%) of total hospital beds in each region of the Respondent's provider network; and

(4) Care for medically high-risk perinatal enrollees is provided in a facility with a NICU sufficient to meet the appropriate level of need for the enrollee.

b. Pursuant to section 409.967(2)(c)(1), F.S., the Respondent may use mail-order pharmacies; however, mail-order pharmacies shall not count towards the Respondent's pharmacy network access standards.

c. The Respondent may have procedures to assign enrollees to Specialty pharmacies for Specialty drugs. The Respondent shall notify an enrollee in writing at the time of a Specialty pharmacy assignment of how to opt-out of a Specialty pharmacy assignment and choose among participating providers. The Respondent shall allow an enrollee to request to opt-out of a Specialty pharmacy assignment at any time. The Respondent shall provide the Department a copy of its procedures for approval in advance of implementation; and

d. In accordance with section 409.975(1)(e), F.S., the Respondent may offer a provider agreement to each licensed home medical equipment and supplies provider and to each Medicaid enrolled DME provider in the region, as specified by the Department, that meets quality and fraud prevention and detection standards established by the Respondent and that agrees to accept the lowest price previously negotiated between the Respondent and another such provider, by service and provider type, as specified by the Department.

e. The Respondent's provider network shall include a sufficient number of qualified providers to cover all services in accordance with the service-specific coverage policy.

7. Essential Providers

a. Pursuant to Section 409.975(1)(b), F.S., certain providers are Statewide resources and essential providers for all Respondents in all regions. The Respondent shall include these essential providers in its network, pursuant to section 409.908(26), F.S., even if the provider is located outside of the region served by the Respondent.

b. Statewide essential providers include:

(1) Faculty plans of Florida medical school faculty physician groups;

(2) Regional perinatal intensive care centers as defined in section 383.16(2), F.S.;

(3) Hospitals licensed as Specialty children's hospitals as defined in section 395.002(28), F.S.;

(4) Florida cancer hospitals that meet the criteria in 42 U.S.C. § 1395ww(d)(1)(B)(v); and

(5) Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

c. The Respondent shall submit all essential provider contracts for Department review to determine compliance with Contract requirements as specified in **Section VII**, Provider Network and Services, **Subsection C**, Provider Credentialing and Contracting, **Item 5**, Provider Agreement Requirements, of this Exhibit.

d. If the Respondent has not contracted with all Statewide essential providers in all regions as of the first date of recipient enrollment, the Respondent must continue to negotiate in good faith.

(1) The Respondent shall make monthly payments to faculty plans of Florida medical school faculty physician groups as specified in **Section VII**, Provider Network and Services, **Subsection E**, Claims and Prover Payment, **Item 22**, Directed Payment Programs, **Sub-item a**, of this Exhibit.

(2) The Respondent shall make payments for services rendered by a regional perinatal intensive care center at the established Medicaid rate as of the first day of this Contract.

(3) Except for payments for emergency services, the Respondent shall make payments to a non-participating Specialty children's hospital, and non-participating Florida cancer hospitals that meet the criteria in 42 U.S.C. § 1395ww(d)(1)(B)(v), equal to the highest rate established by contract between that provider and any other Medicaid Respondent.

e. Pursuant to section 409.975(1)(c), F.S., after twelve (12) months of active participation in the Respondent's network, the Respondent may exclude any essential provider from the network for failure to meet quality or performance criteria.

f. Pursuant to Section 409.975(1)(a), F.S., the Respondent shall include all providers in the region that are determined by the Agency as essential Medicaid providers, unless the Agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Essential providers include SIPP providers.

8. Timely Access Standards

a. The Respondent shall ensure that appointments for medical services and behavioral health services are available on a timely basis.

(1) Appointments for urgent medical or behavioral health care services shall be provided:

(a) Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.

(b) Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization.

(2) Appointments for non-urgent care services shall be provided:

(a) Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.

(b) Within fourteen (14) days for initial outpatient behavioral health treatment.

(c) Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.

(d) Within thirty (30) days of a request for a primary care appointment.

(e) Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.

b. Quarterly, the Respondent shall review a statistically valid sample of PCP, specialist, and behavioral health offices' average appointment wait times to ensure services are in compliance with this **subsection (a)** above, and report the results to the Department as specified in **Section XV**, Accountability, and the Respondent Report Guide. 42 CFR 438.206(c)(1).

c. The Respondent shall ensure that early intervention services are provided no later than thirty (30) days from the date the IFSP was completed for children enrolled in the Early Steps Program.

9. Network Adequacy Measures

a. General Network Adequacy Measures

(1) The Respondent shall collect regional data on the measures as specified in **Table 6**, General Provider Network Adequacy Standards Table, below, in order to evaluate its provider network and to ensure that covered services are reasonably accessible. The Respondent shall collect and report on measures separately by the network of providers serving Title XIX and Title XXI enrollees.

(2) The Respondent shall comply with the regional standards for each measure as specified in **Table 6**, General Provider Network Adequacy Standards Table, below.

(3) The Respondent shall submit the results of the network adequacy standards specified in **Table 6**, General Provider Network Adequacy Standards Table, below, to the Department quarterly as specified in **Section XV**, Accountability, and the Respondent Report Guide.

(4) The Department reserves the right to require the Respondent to collect data and report results on additional network adequacy standards.

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TABLE 6 GENERAL PROVIDER NETWORK ADEQUACY MEASURES TABLE										
Measure		**Region**								
		A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
The Respondent agrees that at least ___ percent of required participating PCPs (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1), by region, are accepting new Medicaid enrollees.	Standard	90	90	85	90	85	90	85	85	85
The Respondent agrees that at least ___ percent of required participating specialist providers, (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1), by region, are accepting new Medicaid enrollees.		90	90	90	90	90	90	90	90	90
The Respondent agrees that at least ___ percent of required participating PCPs (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1), by region, offer after hours appointment availability to Medicaid enrollees.		50	50	45	45	50	40	50	50	50
The Respondent agrees that no more than ___ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in **Section VIII**, Quality, **Subsection H**, Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.		5	8	3	5	5	5	5	10	8
The Respondent agrees that no more than ___ percent of enrollee Specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in **Section VIII**, Quality, **Subsection H**, Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.		10	10	8	8	8	8	10	10	8

b. Network Adequacy Measures Applicable to the Specialty Product

(1) Notwithstanding the Provider Network Standards established in **Attachment B**, **Section VII.**, Provider Network and Services, the Respondent shall comply with the regional standards for each measure as specified below in:

- **Table 7-A**, Provider Network Adequacy Measures CMS Plan Specialty Product Table.

TABLE 7-A
PROVIDER NETWORK ADEQUACY MEASURES
CMS PLAN SPECIALTY PRODUCT TABLE

Measure	Standard	Region								
		A	B	C	D	E	F	G	H	I
The Respondent agrees that no more than ___ percent of enrollee hospital admissions, by region, shall occur in non-participating facilities, excluding continuity of care periods, as defined in **Section VIII**, Quality, **Subsection H**, Continuity of Care in Enrollment. Admissions through the emergency department are not included in this standard.		10	10	6	10	10	-	10	10	10
The Respondent agrees that no more than ___ percent of enrollee Specialty care (physician specialists) utilization, by region, shall occur with non-participating providers, excluding continuity of care periods, as defined in **Section VIII**, Quality, **Subsection H.**, Continuity of Care in Enrollment. Hospital based specialists are not included in this standard.		15	15	15	10	15	-	15	10	15

(2) The Respondent agrees that at least fifty percent (50%) of required participating primary care providers, (as required by **Table 4**, Managed Medical Assistance Provider Network Standards Table), in this region, offer after hour appointment availability.

(3) The Respondent agrees that by the end of Contract Year 1, and in every subsequent Contract Year, at least **forty percent (40%)** of **required Pediatrics** (as required by the Managed Medical Assistance Provider Network Standards Table 4 in Exhibit B-1), in each region, offer **after hours appointment** availability.

(4) The Respondent agrees that by the end of Contract Year 1, and in every subsequent Contract Year, at least **forty percent (40%)** of **required Child Psychiatrists** (as required by the Managed Medical Assistance Provider Network Standards Table 4 in Exhibit B-1), in each region, offer **after hours appointment** availability.

(5) The Respondent agrees that by the end of Contract Year 1, and in every subsequent Contract Year, at least **forty percent (40%)** of **required Pediatrics** (as required by the Managed Medical Assistance Provider Network Standards Table 4 in Exhibit B-1), in each region, offer **telemedicine appointments.**

(6) The Respondent agrees that by the end of Contract Year 1, and in every subsequent Contract Year, at least **fifty percent (50%)** of required **Child Psychiatrists** (as required by the Managed Medical Assistance Provider Network Standards Table 4 in Exhibit B-1), in each region, offer **telemedicine appointments.**

(7) The Respondent agrees that by the end of Contract Year 1, and in every subsequent Contract Year, at least **forty percent (40%)** of required **Adult Psychiatrists** (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1, Table 4), in each region, offer **after hours appointment** availability.

(8) The Respondent agrees that by the end of Contract Year 1, and in every subsequent Contract Year, at least **forty percent (40%)** of required **Licensed Practitioner of the Healing Arts (LPHA)** (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1, Table 4), in each region, offer **after hours appointment** availability.

(9) The Respondent agrees that by the end of Contract Year 1, and in every subsequent Contract Year, at least **fifty percent (50%)** of required **Adult Psychiatrists** (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1, Table 4), in each region, offer **telemedicine appointments** availability.

(10) The Respondent agrees that by the end of Contract Year 1, and in every subsequent Contract Year, at least fifty percent (50%) of required **LPHA** (as required by the Managed Medical Assistance Provider Network Standards Table in Exhibit B-1, Table 4), in each region, offer telemedicine appointments availability.

(11) The Respondent shall maintain network contracts with ninety percent (90%) of the providers available in each region for the following services:

(a) Specialized Therapeutic Foster Care;

(b) Specialized Therapeutic Group Care;

(c) Behavioral Health Overlay Services;

(d) Comprehensive Behavioral Health Assessments; and

(e) Statewide Inpatient Psychiatric Program.

B. Network Management

1. Annual Network Development Plan

a. The Respondent's annual network development plan must include a description or explanation of the current status of the network by each covered service at all levels, including:

(1) The assistance and communication tools provided to PCPs when they refer enrollees to specialists and the methods used to communicate the availability of this assistance to the providers; and

(2) Pharmacy features (the availability of non-sterile compounding, and home delivery pharmacy services).

b. The Respondent shall address in its annual network plan submitted to the Department in accordance with **Attachment B and its Exhibits** the availability and accessibility of Specialty providers relevant to the Respondent's enrollees and its populations with special health care needs.

c. The Respondent shall submit its annual network development plan to the Department by August 1 of each Contract year.

2. Regional Network Changes

In addition to the requirements of **Attachment B**, **Section VII**, Provider Network and Services, **subsection B**, Network Management, the Respondent shall also provide all required notifications to the Department). The Respondent shall also notify the Department within seven (7) business days of a decrease in the total number of PCPs by more than five percent (5%).

3. Provider Workforce Development

a. The Respondent shall work with the Department and other stakeholders to develop and implement workforce development initiatives to promote and maintain a qualified, competent, and sufficient workforce to support provider network adequacy and enrollee access to care, with an emphasis on development of community-based providers and direct service workers.

4. Single Case Agreements

a. The Respondent may enter into single case agreements with providers who are not willing to become a part of the Respondent's provider network.

b. The Respondent shall annually re-evaluate its single case agreements and work with providers under single case agreements towards establishing the provider as an in-network provider.

c. The Respondent shall submit a quarterly report to the Department providing information on its utilization of single case agreements.

C. Provider Credentialing and Contracting

1. General Provisions

There are no additional general provisions applicable to provider credentialing and contracting.

2. Credentialing and Recredentialing

a. The Respondent's credentialing and recredentialing processes must include verification of the following additional requirements for physicians:

(1) Good standing of privileges at the hospital designated as the primary admitting facility by the physician or, if the physician does not have admitting privileges, good standing of privileges at the hospital by another physician with whom the physician has entered into an arrangement for hospital coverage.

(2) Valid Drug Enforcement Administration certificates, where applicable.

(3) Attestation that the total active patient load (all populations, including but not limited to Medicaid FFS, Children's Medical Services, SMMC plans, KidCare, Medicare, and commercial coverage) is no more than three thousand (3,000) patients per primary care physician. An active patient is one that is seen by the provider a minimum of two (2) times per year.

(4) A good standing report on a site visit survey. For each primary care physician, documentation in the Respondent's credentialing files regarding the site survey shall include the following:

(a) Evidence that the Respondent has evaluated the provider's facilities using the Respondent's organizational standards;

(b) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; and

(c) Evidence that the Respondent has evaluated the provider's enrollee record keeping practices at each site to ensure conformity with the Respondent's organizational standards.

(5) Attestation to the correctness/completeness of the provider's application.

(6) Statement regarding any history of loss or limitation of privileges or disciplinary activity as described in section 456.039(a)(8), F.S.

(7) A statement from each provider applicant regarding the following:

(a) Any physical or behavioral health problems that may affect the provider's ability to provide health care; and

(b) Any history of chemical dependency/substance abuse.

(8) Current curriculum vitae or completed credentialing application, which includes at least five (5) years of work history.

(9) Proof of the provider's medical school graduation, completion of residency or other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training, if applicable.

(10) Evidence of Specialty board certification, if applicable.

b. The Respondent shall recredential its providers at least every three (3) years using information from ongoing provider monitoring.

c. Hospital ancillary providers are not required to be independently credentialed if those providers serve Respondent enrollees only through the hospital.

3. Provider Training Verification

a. For enrollees with HIV/AIDS or SMI, the Respondent shall require formal training or verification of completed training for network providers in the use of assessment tools, assessment instruments, and in techniques for identifying individuals with unmet health needs and evidence-based practices.

b. For enrollees in the Child Welfare system, the Respondent shall require formal training or verification of completed training for network providers in the use of behavioral health assessment tools, assessment instruments, and in techniques for identifying individuals with unmet behavioral health needs, and evidence-based practice, the dependency system, and trauma-informed care.

4. Hernandez Settlement Agreement Surveys

The Respondent shall comply with the following requirements of the HSA.

a. The Respondent shall conduct annual HSA onsite surveys of no less than five percent (5%) of all participating pharmacy locations to ensure compliance with the HSA.

b. The Respondent may survey less than five percent (5%), with written approval from the Department, if the Respondent can show that the number of participating pharmacies it surveys is a statistically significant sample that adequately represents the pharmacies that have contracted with the Respondent to provide pharmacy services.

c. The Respondent shall not include in the HSA survey any participating pharmacy location that the Respondent found to be in complete compliance with the HSA requirements within the past twelve (12) months.

d. The Respondent shall require all participating pharmacy locations that fail any aspect of the HSA survey to undergo mandatory training within six (6) months and then be

re-evaluated within one (1) month of the training to ensure that the pharmacy location is in compliance with the HSA.

e. The Respondent shall ensure that it complies with all aspects and surveying requirements set forth in the Managed Care Plan Report Guide.

f. The Respondent shall submit an annual report to the Department by July 1 of each Contract year providing survey results in accordance with **Section XV**, Accountability, and the Managed Care Plan Report Guide.

5. Provider Agreement Requirements

a. The Respondent shall include the following additional provisions in its MMA provider agreements:

(1) For a Respondent physician incentive plan, include a statement that the Respondent shall make no specific payment directly or indirectly under a physician incentive plan to a provider as an inducement to reduce or limit, medically necessary services to an enrollee, and that incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care;

(2) Require that all providers agreeing to participate in the network as PCPs fully accept and agree to responsibilities and duties associated with the PCP designation;

(3) Contain no provision that prohibits the PCP from providing inpatient services in a participating hospital to an enrollee if such services are determined to be medically necessary and covered services under this Contract;

(4) For hospital contracts, include rates that are in accordance with section 409.975(6), F.S.;

(5) For hospital contracts, include a clause that states whether the Respondent or the hospital will complete the DCF Excel spreadsheet for unborn activation;

(6) For hospital contracts, include PPC reporting requirements as specified in **Section IX**, Administration and Management;

(7) For pharmacy contracts, ensure its pharmacy benefits manager provides the following electronic message alerting the pharmacist to provide Medicaid recipients with the HSA notice/pamphlet when coverage is rejected due to the drug not being on the PDL:

Non-preferred drug; Contact provider for change to preferred drug or to obtain prior authorization. Give Medicaid pamphlet if not corrected; and

(8) If the provider has been approved by the Respondent to provide services through telemedicine, specify that the provider be required to have protocols to prevent

fraud and abuse. The provider must implement telemedicine fraud and abuse protocols that address:

(a) Authentication and authorization of users;

(b) Authentication of the origin of the information;

(c) The prevention of unauthorized access to the system or information;

(d) System security, including the integrity of information that is collected, program integrity and system integrity; and

(e) Maintenance of documentation about system and information usage.

(9) For contracts with public health providers, require such providers to contact the Respondent before providing health care services to enrollees and provide the Respondent with the results of the office visit, including test results.

(10) For providers participating as PCPs, require such providers to assess each enrollee's health-related social needs, document identified needs in the enrollee record utilizing the ICD-10-CM Z-codes identified in **Table 8**, Z-Codes for Health -Related Social Needs, below, and provide such codes via claims submissions to the Respondent. The following Z-codes are used to identify socioeconomic and psychosocial circumstances:

TABLE 8
Z-CODES FOR HEALTH-RELATED SOCIAL NEEDS

ICD-10-CM Code	Code Description
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk-factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z61	Problems related to negative life events in childhood
Z62	Other problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances

Z65	Problems related to other psychosocial circumstances

(11) The Respondent shall make good faith effort to contract with residential facilities to address intensive behavioral health needs.

(12) The Respondent shall implement a detailed plan for supporting health homes for children with Medically Complex Conditions (MCC) and execute formal contracts (that comply with the Provider Agreement requirements in Section VII.C.5.) with the Florida children's hospitals that must include the following minimum elements:

(a) Specific name of the health home clinic for children with MCC;

(b) Specific name and Medicaid provider ID of the physician director;

(c) Specific name of the lead care coordinator; and

(d) List of reimbursement codes for special services provided by health homes for children with MCC.

i. Provider Termination and Continuity of Care

a. In addition to the information and notification requirements to the Agency in **Attachment B, Section VII**, Provider Network and Services, **Subsection C**, Provider Credentialing and Contracting, **Subsection 7**, Provider Termination and Continuity of Care, the Respondent shall also provide the required information and notifications to the Department.

b. The Respondent shall notify enrollees in accordance with the provisions of this Contract and State and federal law regarding provider termination. 42 CFR § 438.10(f)(1).

c. Pursuant to section 409.975(1)(c), F.S., if the Respondent excludes any essential provider from its network for failure to meet quality or performance criteria, the Respondent shall provide written notice at least thirty (30) days before the effective date of the exclusion to all enrollees who have chosen that provider for care.

d. The Respondent shall allow pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue receiving medically necessary services from a not-for-cause terminated provider and shall process provider claims for services rendered to such enrollees until the completion of postpartum care.

D. Provider Services

1. Provider Handbook and Bulletin Requirements

The Respondent shall include the following information in provider handbooks:

a. Well-child visit program services and standards;

b. Procedures to obtain authorization of any medically necessary service to enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule;

c. PCP responsibilities;

d. Telemedicine requirements for providers;

e. Specialized provider education requirements;

f. Requirements for care in accordance with the most recent clinical practice guidelines for treatment of the Specialty condition;

g. Treatment adherence services available from the Managed Care Plan;

h. PCP criteria including procedures for required use of approved assessment instruments for treatment of the Specialty condition;

i. Specialty Case Management policies and procedures including role of the provider in the Respondent's medical case management/care coordination services;

j. Referral to services including services outside of the Specialty product's covered services and services provided through interagency agreements;

k. Quality measurement standards for providers and requirements for exchange of data;

l. Enrollee access to clinical trials, including coverage of costs for an enrollee's participation in clinical trials. Such policies and procedures shall be updated at least annually and submitted to the Agency annually by June 1;

m. For enrollees in the Child Welfare system, collaboration with DCF and CBCs to facilitate obtaining medical and case plan information and records; and

n. For enrollees with SMI, coordination protocols for Community Mental Health Centers to ensure appropriate and comprehensive treatment planning that addresses the enrollee's medical and behavioral health needs.

2. Provider Education and Training

a. The Respondent shall offer training to all new and existing participating pharmacy locations about the HSA requirements.

b. The Respondent shall develop and implement, subject to Department approval, a continuing education program that provides ongoing education with continuing education (medical and non-medical) to network providers, at no cost to such providers, on topics including, but not limited to, evidence-based practice.

c. At a minimum the Respondent shall offer training to providers on the following topics:

(1) An overview of CMS Plan including Department priorities, an overview of the Respondent's services (including expanded benefits) and responsibilities, an overview of key provider resources and processes (including claims processing and the provider portal), and an overview of case management and other key areas;

(2) Procedures for arranging referrals with other State agencies and services including the HOPE Florida program; and

(3) Cultural competency, health literacy, the availability, and protocols for use of interpreters for enrollees who speak limited English, and other skills for effective health-related cross-cultural communication.

E. Claims and Provider Payment

1. MMA Physician Incentive Program

a. Pursuant to section 409.967(2)(a), F.S., and as specified by the Agency, the Respondent shall implement an incentive program wherein payment rates for the following eligible physicians, who meet certain qualifying criteria, as established by the Agency, shall equal or exceed Medicare rates for services provided. This incentive program shall be referred to as the MMA Physician Incentive Program (MPIP):

(1) Primary care providers (including pediatricians, family practitioners, and general practitioners) for all services provided to enrollees under the age of twenty-one (21) years.

(2) Specialist Physicians for all services provided to enrollees under the age of twenty-one (21) years.

(3) Obstetricians/Gynecologists for all services rendered to pregnant enrollees of any age.

(4) Hospital-based Specialty physicians for services rendered to enrollees under the age of twenty-one (21) years, regardless of whether the physician is part of the Respondent's network.

Hospital-based Specialty physicians include medical Doctor of Osteopathic Medicine who render the majority of all the Specialty services they provide in an inpatient hospital setting (place of service code 21) or emergency room-hospital (place of service code 23) and who practice in one of the following specialties:

1. Anesthesiology;
2. Critical Care Medicine;
3. Emergency Medicine;
4. Hospitalist;
5. Neonatology;
6. Pathology; or
7. Radiology.

b. The following providers are excluded from the MPIP:

(1) Providers that do not have a contractual arrangement with the Respondent (except as noted above).

(2) Services provided in an FQHC.

(3) Services provided in an RHC.

(4) Services provided in a CHD.

(5) Services provided in a Medical School Faculty Plan.

(6) Services provided by Public Hospital Physicians participating in the Public Hospital Physician State Directed Payment Program.

c. The Respondent shall implement the Agency's MPIP model and qualifying criteria (performance and quality measures) that each physician type must meet in order to earn the enhanced payment. The Agency may update the MPIP model on an annual basis and will notify the Respondent of changes to the MPIP by June 1 of each year.

d. The Respondent shall notify eligible providers of the Agency's MPIP qualifying criteria at least 60 days prior to October 1 of each year. The Respondent shall ensure that the provider contracts for physicians who meet the qualifying criteria are amended and executed with any updated qualification and payment information prior to October 1 of each Contract year.

e. The Respondent shall maintain and continuously update the Provider Network Verification files with the appropriate indicators, as defined by the Agency, to identify those providers that qualify for the MPIP.

f. During the first and second Contract Years, the Respondent that is new to a region shall consider a provider new to its network to be qualified for MPIP if the provider was previously qualified for MPIP under another plan in the same region during the last Contract Year of the 2018–2024 Contract term.

g. If the Respondent fails to comply with the requirements of this Section, including failure to make appropriate payment to an eligible physician that meets the qualifying criteria the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and

Corrective Action Plans, or liquidated damages pursuant to **Section XIII**, Liquidated Damages, as determined by the Department.

h. The Respondent shall submit a report bi-annually to provide MPIP payment data to the Department in accordance with **Section XV**, Accountability, and the Respondent Report Guide.

i. The Respondent agrees to evaluate whether the physician was paid equal to or greater than the Medicare fee schedule amount using the following guiding principles in its rate calculation methodology:

Step 1: The Respondent shall calculate the physician's total compensation for included services provided to eligible enrollees for the time period (e.g., October 1, 2024 – September 30, 2025), including all of the following: fee--for--service payments, capitation payments, case management fees, incentive payments, shared savings payments (upside), and shared risk payments (upside or downside).

Step 2: The Respondent shall calculate the physician's compensation if they were paid at the Medicare fee schedule rate for included services that were provided to eligible enrollee, including:

- For services that the physician was paid under a fee-for-service arrangement, reprice all FFS claims at the Medicare fee schedule amount.

- For services that the physician was paid under a sub-capitated arrangement, reprice all encounter claims at the Medicare fee schedule amount.

Step 3: The Respondent shall compare the results of Step 1 and Step 2. The physician is deemed to be paid equal to or greater than the Medicare rate if the sum of all payments under Step 1 is equal to or greater than the sum of all payments under Step 2.

2. The Respondent shall not deny claims submitted by a non-participating provider rendering services pursuant to **Section V**, Services Administration, **Subsection D**, Coverage Provisions, **Item 1**, Primary Care Provider Initiatives, of this Exhibit, solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

3. The Respondent shall not deny claims for the provision of emergency services and care submitted by a non-participating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

4. Pursuant to section 409.975(6), F.S., a Respondent and hospital(s) shall negotiate mutually acceptable rates, methods, and terms of payment. Such payments to hospitals may not exceed one hundred twenty percent (120%) of the rate the Department would have paid on the first day of the Contract between the provider and the Respondent,

unless specifically approved by the Department. Payment rates may be updated periodically.

5. Regardless of how an inpatient facility is reimbursed (Diagnosis Related Group or per diem), the enrollee's MMA Respondent at the time of admission shall be responsible for payment of the entire inpatient stay for that admission, even if the enrollee changes Respondents during the hospital stay.

6. If the recipient is receiving services through the Medicaid fee-for-service (FFS) delivery system at the time of admission and becomes enrolled in the MMA Respondent during the hospital stay, the Medicaid FFS delivery system shall be responsible for payment of the enrollee's entire stay.

7. The enrollee's MMA Respondent at the time of admission shall be responsible for payment of the entire outpatient observation stay, even if the enrollee changes Respondents during the hospital stay.

8. Pursuant to section 409.975(1)(a) and (b), F.S., except for payment for emergency services, an MMA Respondent shall make payments to essential providers as specified in this Exhibit. In accordance with section 409.976(2), F.S., an MMA Respondent shall pay Statewide inpatient psychiatric program (SIPP) providers, at a minimum, the payment rates established by the Agency.

9. The Respondent shall make payments for institutional hospice services in accordance with section 1902(a)(13) of the Social Security Act.

10. When the Respondent or its authorized physician authorizes medically necessary ancillary medical services in a hospital setting (either inpatient or outpatient), the Respondent shall reimburse the provider of the service at the Medicaid line-item rate, unless the Respondent and the hospital have negotiated another reimbursement rate.

11. Pursuant to section 409.967(2)(b), F.S., the Respondent shall pay for services required by sections 395.1041 and 401.45, F.S., provided to an enrollee for the provision of emergency services and care by a non-participating provider. The Respondent must comply with section 641.3155, F.S., Reimbursement for services under this paragraph is the lesser of:

    a. The non-participating provider's charges.

    b. The usual and customary provider charges for similar hospital-based services in the community where the services were provided.

    c. The charge mutually agreed to by the Respondent and the non-participating provider within sixty (60) days after the non-participating provider submits a claim.

    d. The Medicaid rate which, for the purposes of this paragraph, means the amount the provider would collect from the Agency on an FFS basis, less any amounts for the indirect costs of graduate medical education that are otherwise included in the Agency's FFS payment, as required under 42 U.S.C. § 1396u-2(b)(2)(D). For the

purpose of establishing amounts specified in this paragraph, the applicable FFS fee schedules and their effective dates shall be published on the Agency's website annually, or more frequently as needed, less any amounts for indirect costs of graduate medical education that are otherwise included in the Agency's FFS payments.

The Respondent shall reimburse nonparticipating freestanding psychiatric Specialty hospitals in accordance with a, b, or c above, section 409.975(6), F.S., and 42 CFR 438.3(e)(2)(i).

12. Notwithstanding the requirements set forth for coverage of emergency services and care, the Respondent shall approve all claims for emergency services and care by participating and non-participating providers pursuant to the requirements set forth in section 641.3155, F.S., and 42 CFR 438.114.

13. In accordance with section 409.967(2), F.S., the Respondent shall reimburse any hospital or physician that is outside the Respondent's authorized service area for -Respondent authorized services at a rate negotiated with the hospital or physician or according to the lesser of the following:

    a. The usual and customary charge made to the general public by the hospital provider; or

    b. The Florida Medicaid reimbursement rate established for the hospital or provider.

14. The Respondent may directly reimburse for cochlear implant devices to the manufacturer of the cochlear implant device or the facility performing the implantation of the cochlear implant device.

15. The Respondent shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services.

16. Provider Preventable Conditions

    a. Pursuant to Section 2702 of the Affordable Care Act of 2010 (ACA), the Florida Medicaid State Plan and 42 CFR §§ 434.6(a)(12) and 447.26, the Respondent shall comply with the following requirements:

        (1) Deny reimbursement for PPCs occurring after admission in any inpatient hospital or inpatient psychiatric hospital setting, including CSUs, as listed under Forms at: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/Managed_Care_contracting/MHMO/docs/Forms/ProviderPreventableConditions-PPC-3-1-13.pdf;

        (2) Ensure that non-payment for PPCs does not prevent enrollee access to services;

(3) Ensure that documentation of PPC identification is kept and accessible for reporting to the Department;

(4) Relative to all above requirements, not:

(a) Deny reimbursement to inpatient hospitals and inpatient psychiatric hospitals, including CSUs, for services occurring prior to the PPC event;

(b) Deny reimbursement to surgeons, ancillary and other providers that bill separately through the CMS-1500;

(c) Deny reimbursement for health care settings other than inpatient hospital and inpatient psychiatric hospital, including CSUs; or

(d) Deny reimbursement for clinic services provided in clinics owned by hospitals.

b. By federal law, Deep Vein Thrombosis/Pulmonary Embolism, as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, are not reportable PPCs/HCACs. HCACs also include never events.

17. Unless otherwise stated in this Contract, the Respondent shall pay no more than the Medicaid program immunization administration fee for immunizations.

18. The Respondent shall pay the Medicaid program immunization administration fee when an enrollee receives immunizations from a non-participating provider so long as:

a. The non-participating provider contacts the Respondent at the time of service delivery;

b. The Respondent is unable to provide documentation to the non-participating provider that the enrollee has already received the immunization; and

c. The non-participating provider submits a claim for the administration of immunization services and provides medical records documenting the immunization to the Respondent.

19. The Respondent shall reimburse IHCPs, whether participating in the network or not, for covered managed care services provided to Indian enrollees who are eligible to receive services from the IHCP either at a negotiated rate between the Respondent and the IHCP or, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made to a participating provider which is not an IHCP, in accordance with the American Recovery and Reinvestment Act of 2009 and 42 CFR § 438.14(b).

20. The Respondent may request to be notified, but shall not deny claims payment based solely on lack of notification, for the following:

a. Inpatient emergency admissions (within ten (10) days);

b. Obstetrical care (at first visit);

c. Obstetrical admissions exceeding forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for caesarean section; and

d. Transplants.

21. **Directed Payment Programs**

a. Physician Supplemental Payment (PSP) Program: The Respondent shall make monthly payments as specified in the Plan-specific **Attachment I** of the resulting Contract to faculty plans of Florida medical school faculty physician groups in an amount specified by the Department. The payment amount shall be the per member, per month amount multiplied by the Respondent's monthly enrollment,

b. Florida Cancer Hospital Payment (FCHP) Program: The Respondent shall make monthly payments as specified in the Plan-specific **Attachment I** of the resulting Contract, **Section III**, Method of Payment, to qualified Florida cancer hospitals (FCHP Program). The payment amount shall be the per-member, per-month amount multiplied by the Respondent's monthly enrollment in the applicable region. Florida cancer hospitals that are qualified for monthly payments that meet the criteria under 42 USC § 1395www(d)(1)(B)(v).

c. Directed Payment Program (DPP): The Respondent shall make the MMA hospital increase payments to qualified hospitals as specified in the Plan-specific **Attachment I** of the resulting Contract, **Section III**, Method of Payment. The payment amount shall be the uniform percentage increase amount multiplied by the Respondent's payment amount in the applicable region. Florida hospitals that qualify for these payments are private hospitals, public hospitals, which include State government and non-State government hospitals; and cancer hospitals who meet the criteria in 42 USC § 1395ww(d)(1)(B)(v).

d. Public Hospital Program (PHP): The Respondent shall make the MMA Public Hospital Physician Uniform Payment Increase to qualified physicians as specified in the Plan -specific **Attachment I** of the resulting Contract, **Section III**, Method of Payment. The payment amount shall be the per-member, per-month amount multiplied by the Respondent's monthly enrollment in the applicable region.

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Section VIII. Quality

A. Quality Improvement

1. General Provisions

a. For the purposes of the CMS Plan, the responsibilities of the Agency as specified in **Section VIII,** Quality, **Subsection A.**, Quality Improvement, **Subsection 1**, General Provisions, will be shared between the Agency and the Department, with the exception of contracting with an External Quality Review Organization (EQRO) which is a responsibility of the Agency.

2. Accreditations

a. If the Respondent 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 section 641.512, F.S., and Rule 59A-12.0071, 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 with 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 a minimum of once every three (3) years.

3. Quality Improvement Program Committee

a. The Respondent's QI program committee shall also include:

(1) Department staff including:

(a) The Department's CMS Health Plan Medical Director as co-chair;

(b) Healthcare Quality Assurance Director;

(c) Other CMS Health Plan staff as required; and

(d) Family Representative.

(2) The following positions from the Respondent's staff:

(a) Quality Director;

(b) Grievance Coordinator;

(c) Case Management Director;

(d) Utilization Review Manager;

(e) Credentialing Manager; and

(f) Risk Manager.

4. Quality Improvement Plan

a. The Respondent shall develop and maintain a written QI plan and submit its QI plan to the Department by October 15 of each year.

b. The Respondent and its QI plan shall demonstrate specific interventions in its behavioral health case management to better manage behavioral health services and promote positive enrollee outcomes. The Respondent's written procedures shall address components of effective behavioral health case management including but not limited to: anticipation, identification, monitoring, measurement, evaluation of enrollee's behavioral health needs, and effective action to promote quality of care; participation in the DCF planning process outlined in section 394.75, F.S.; and the provision of enhanced care coordination and management for high-risk populations. Such populations shall include, at a minimum, enrollees that meet any of the following conditions:

(1) Have resided in a State mental health facility for at least six (6) of the past thirty--six (36) months;

(2) Reside in the community and have had two (2) or more admissions to a State mental health facility in the past thirty-six (36) months;

(3) Reside in the community and have had three (3) or more admissions to a crisis stabilization unit, short-term treatment facility, inpatient psychiatric unit, or any combination of these facilities within the past twelve (12) months;

(4) Have been diagnosed with a behavioral health disorder in conjunction with a complex medical condition and have been prescribed numerous prescription medications;

(5) Have been identified as exceeding the Respondent's prescription limits as permitted under **Section V**, Services Administration;

(6) Are under the age of six (6) years and are prescribed a psychotropic medication; or

(7) Have had two (2) or more admissions to residential psychiatric treatment (e.g., SIPP services and comparable treatment settings).

5. Quality Improvement Plan Requirements

In addition to the requirements set forth in **Attachment B and its Exhibits**, the Quality Improvement (QI) Plan shall include measurement of adherence to clinical and preventive health guidelines consistent with prevailing standards of professional medical practice and with standards regarding the most recent clinical and evidence-based practice guidelines for treatment of children and adolescents with special health care needs.

a. For enrollees in the Child Welfare system, such standards shall be consistent with guidelines for pediatric and psychiatric treatment.

b. For enrollees with SMI, such standards shall be consistent with guidelines for SMI treatment.

c. For enrollees with HIV/AIDS, such standards shall be consistent with guidelines for HIV/AIDS treatment.

B. Performance Measures (PMs)

1. Required Performance Measures

a. The Respondent shall collect and report the performance measures in **Table 9**, Required Performance Measures Table, below, certified via a qualified auditor.

TABLE 9 REQUIRED PERFORMANCE MEASURES	
Healthcare Effectiveness Data and Information Set (HEDIS)	
1.	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
2.	Adults' Access to Preventive/Ambulatory Health Services (AAP)
3.	Adult Immunization Status (AIS-E)
4.	Ambulatory Care: Emergency Department Visits (AMB)
5.	Antidepressant Medication Management (AMM)
6.	Asthma Medication Ratio (AMR)
7.	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
8.	Blood Pressure Control for Patients with Diabetes (BPD)
9.	Breast Cancer Screening (BCS)
10.	Cervical Cancer Screening (CCS)
11.	Child and Adolescent Well-Care Visits (WCV)
12.	Childhood Immunization Status (CIS) – Combo 2 and 3
13.	Chlamydia Screening in Women (CHL)
15.	Comprehensive Diabetes Care – (CDC) .
16.	Controlling High Blood Pressure (CBP)
17.	Depression Screening and Follow-up for Adolescents and Adults (DSF-E)
18.	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication (SSD)
19.	Eye Exam for Patients with Diabetes (EED)

20.	Follow-up after Emergency Department Visit for Substance Use (FUA)
21.	Follow-up after Emergency Department Visit for Mental Illness (FUM)
22.	Follow-up after Hospitalization for Mental Illness (FUH)
23.	Follow-up Care for Children Prescribed ADHD Medication (ADD)
24.	Hemoglobin A1c Control for Patients with Diabetes (HBD)
25.	Immunizations for Adolescents (IMA)
26.	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
27.	Kidney Health Evaluation for Patients with Diabetes (KED)
28.	Lead Screening in Children (LSC)
29.	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
30.	Plan All-Cause Readmissions (PCR)
31.	Postpartum Depression Screening and Follow-up (PDS-E)
32.	Prenatal and Postpartum Care (PPC)
33.	Prenatal Depression Screening and Follow-up (PND-E)
34.	Prenatal Immunization Status (PRS-E)
35.	Social Need Screening and Intervention (SNS-E)
36.	Unhealthy Alcohol Use Screening and Follow-up (ASF-E)
37.	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
38.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)
39.	Well-Child Visits in the First 30 Months (W30)
Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)	
40.	Concurrent Use of Opioids and Benzodiazepines (COB-AD)
41.	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)(HPCMI-AD)
42.	HIV Viral Load Suppression (HVL-AD)
43.	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)
44.	Screening for Depression and Follow-up Plan (CDF-AD)
45.	Use of Opioids at High Dosage in Persons without Cancer (OHD-AD)
46.	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)	
47.	All Women Ages 15 to 20 (CCW-CH)
48.	Postpartum Women Ages 15 to 20 (CCP-CH)
49.	Developmental Screening in the First Three Years of Life (DEV-CH)
50.	Screening for Depression and Follow-up Plan (CDF-CH)
Other Measures	
51.	Pregnancies Conceived within 18 Months of a Previous Birth (FP-02)

b. The Respondent shall submit the first Performance Measure Report to the Department no later than July 1, 2025, covering the measurement period of calendar year 2024. Measures should be collected based on the technical specifications for the measure, across the current Contract and the previous Respondent Contract, as applicable. All contractually required performance measures must be reported by region and

Statewide, and must be reported separately for enrollees in Title XIX and Title XXI. The following measures are excluded from regional reporting, but must still be reported at the Statewide level: (1) HIV Viral Load Suppression; (2) Medical Assistance with Smoking and Tobacco Use Cessation; (3) Plan All-Cause Readmissions.

c. Due to calendar year 2024 being a transition year across Contracts, the Department shall collect and may report performance measures publicly and shall label such performance measures as "transition year" measures. The Department shall assess liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting.

d. Beginning with the Performance Measures Report that is due to the Department no later than July 1, 2026, covering the measurement period of calendar year 2025, all performance measure-related liquidated damages and sanctions will be in effect.

e. Beginning with the Performance Measures Report that is due to the Department no later than July 1, 2026, covering the measurement period of calendar year 2025, the Respondent shall report on all contractually required performance measures Statewide, stratified by: age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income. The Respondent shall continue to report all measures by region, with the exception of the measures identified in B.1.a.

f. The Department may require that the Respondent submit performance measures stratified by other factors such as rural/urban and others, with at least sixty (60) days' notice.

g. The Department may calculate certain measures for the Respondent. If the Department will be calculating and reporting certain measures for the Respondent, the Department will provide sixty (60) days' notice and the plan will not be required to calculate and report the measures to the Department.

h. The Respondent shall submit its HEDIS data to the NCQA by the NCQA deadline as well as to the Department by July 1 of each year.

2. Well-Child Visit Performance Measures

a. Pursuant to section 409.975(5), F.S., the Respondent shall achieve a well-child visit rate of at least eighty percent (80%) for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1–September 30). This screening compliance rate shall be based on the well-child visit data reported by the Respondent in its Child Health Check-Up (CMS-416) and Florida eighty (80%) Screening Report and/or supporting encounter data, and due to the Department as specified in **Section XV**, Accountability. The data shall be monitored by the Department for accuracy. Any data reported by the Respondent that is found to be inaccurate shall be disallowed by the Department, and such findings shall be considered in violation of the Contract. Failure to meet the eighty percent (80%) screening rate may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit.

b. The Respondent shall adopt annual participation goals to achieve at least an eighty percent (80%) well-child visit participation rate, as required by the Centers for Medicare & Medicaid Services. This participation compliance rate shall be based on the well-child visit data reported by the Respondent in its Child Health Check-Up (CMS-416) and Florida 80% Screening Report (see **Item a**, above) and/or supporting encounter data. Upon implementation and notice by the Department, the Respondent shall submit additional data, as required by the Department for its submission of the CMS-416, to the Centers for Medicare & Medicaid Services, within the schedule determined by the Department. Any data reported by the Respondent that is found to be inaccurate shall be disallowed by the Department, and such findings shall be considered in violation of the Contract. Failure to meet the eighty percent (80%) participation rate during a federal fiscal year may result in a corrective action plan in addition to the liquidated damages and sanctions provided in this Exhibit per Section 1902(a)(43)(D)(iv) of the Social Security Act.

c. Beginning with the Well-Child Visit Report/Child Health Check-Up (CMS-416) and Florida 80% Screening Report that is due to the Department no later than July 1, 2027, covering the measurement period of FFY 2025–26, all performance measure-related liquidated damages and sanctions will be in effect.

3. Agency-Run Performance Measures

a. The Agency shall calculate the following performance measures for the Respondent in Table 10, Agency-Calculated Performance Measures.

TABLE 10 AGENCY-CALCULATED PERFORMANCE MEASURES	
Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)	
1.	Live Births Weighing Less than 2,500 Grams (LBW-CH)
2.	Low-Risk Cesarean Delivery (LRCD-CH)
3M Potentially Preventable Events (PPEs)	
3.	Potentially Preventable Admissions (PPAs)
4.	Potentially Preventable Readmissions (PPRs)
5.	Potentially Preventable Emergency Department Visits (PPVs)

b. The Respondent shall comply with the minimum performance standards established by the Department for the Agency-Calculated Performance Measures specified above. The Respondent shall achieve at least a two percent (2%) reduction each year of the Contract until the Respondent achieves the performance standards established by the Department.

c. The Agency shall calculate a performance measure for the percentage of pregnant enrollees who received Screening, Brief Intervention, and Referral to Treatment (SBIRT, as measured by codes H0049, H0050, 99408, 99409, G3096, or G0397). The Managed Care Plan shall achieve the following targets:

Contract Year	**Target Rate**
Contract Year 1	10%

Contract Year 2	15%
Contract Year 3	20%
Contract Year 4	25%
Contract Year 5	30%
Contract Year 6	35%

d. If the Respondent fails to comply with the requirements of this Section, the Respondent may be subject to sanctions pursuant to Section XII, Sanctions and Corrective Action Plans, or liquidated damages pursuant to Section XIII, Liquidated Damages, as determined by the Department.

e. Due to calendar year 2024 and contract year 2024–2025 being transition years across contracts, the Agency may calculate and publicly report the measures in Table 10, Agency-Calculated Performance Measures, and shall label such performance measures as "transition year" measures.

f. Beginning with the calendar year 2025 and contract year 2025–2026 Agency -Calculated Performance Measures, all performance measure-related liquidated damages and sanctions will be in effect.

C. Performance Improvement Projects

1. The Respondent shall perform four (4) Department-approved Statewide performance improvement projects (PIPs) as specified below:

   a. One (1) of the PIPs shall focus on improving child and adolescent mental health;

   b. One (1) of the PIPs shall be non-clinical and focus on HOPE Florida; and

   c. One (1) PIP shall focus on closing gaps in health care outcomes between plan sub-populations.

   d. The Respondent shall perform a PIP focused on a clinical area in need of improvement for children and adolescents with special health care needs, as approved by the Department.

   e. The first three PIPs listed above may be collaborative PIPs coordinated by the Department and the EQRO. The Department and EQRO will put together proposed methodologies for the collaborative PIPs, which will be sent to the Respondent for review. Once the proposed methodologies for the collaborative PIPs have been sent to the Respondent, the Respondent has two (2) weeks to submit feedback to the Department and the EQRO on the methodologies. The Respondent shall submit its measurement periods and methodologies to the Department for approval to include the following:

      (1) The initial proposed PIP topics and their indicators;

(2) A brief summary of the baseline data and time period that the Respondent will use for each indicator for each of the proposed PIPs;

(3) An estimate of how many Medicaid and Title XXI members will be in the eligible or affected population for each PIP; and

(4) A brief rationale for why the Respondent has selected each proposed PIP topic.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

a. The Respondent shall conduct an annual CAHPS survey for a time period specified by the Department, using the following surveys, as applicable:

(1) The CAHPS Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items.

b. In addition to the core survey, the Respondent shall include items MH2 through MH4 (related to Behavioral Health) and H.17 through H.20 (related to medical assistance with smoking and tobacco use cessation) from the CAHPS Health Plan Survey – Supplemental Items for the Adult Questionnaires in its Adult and Child CAHPS surveys.

c. The Respondent shall also include the following item in its Adult and Child CAHPS surveys.

(1) How would you rate the number of doctors you had to choose from?

(a) Response options: Excellent, Very Good, Good, Fair, Poor, No Experience.

d. The Respondent shall submit to the Department, in writing within ninety (90) days of initial Contract execution, a proposal for survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a CAHPS survey vendor; sampling methodology; administration protocol; analysis plan; and reporting description.

2. The Respondent shall use the results of the annual CAHPS survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities conducted by the Respondent pertaining to improving member satisfaction resulting from the annual member satisfaction survey must be reported to the Department on a quarterly basis.

3. The Respondent shall conduct an annual quality of care and/or quality of Case Management survey. Provider will submit proposed surveys to the Department for review and approval prior to use.

a. The Respondent shall develop in conjunction with the Department a Quality of Life Survey tool using the SF10 and SF12 for ages 5 to 18 years old, located at http://www.pedsqi.org/about_pedsql.html or a similar NIH recommended tool as a baseline. The tool shall align with realistic goals and outcomes dependent upon the enrollee's acuity. Any issues identified through the survey will be addressed by the case manager in the annual plan of care revision.

E. Enrollee Record Requirements

1. In addition to the requirements of **Attachment B, Section VIII**, Quality, **Sub-Section E,** Enrollee Record Requirements, the Respondent shall ensure the following documentation is included in the enrollee record:

   a. Evidence that the enrollee has been encouraged to establish a relationship with their PCP.

   b. Documentation should include discussion with the case manager and the enrollee or enrollee's parent or legal guardian regarding advance directives.

   c. A copy of the completed screening instrument in the enrollee record and provides a copy to the enrollee.

   d. Documentation of preterm delivery risk assessments in the enrollee record by week twenty-eight (28) of pregnancy.

   e. Documentation of referral services in the enrollee record, including reports resulting from the referral.

   f. Documentation of emergency care encounters in the enrollee record with appropriate medically indicated follow-up.

   g. Documentation of the express written and informed consent of the enrollee's authorized representative prescriptions for psychotropic medication (i.e., antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years. In accordance with section 409.912(13), F.S., the Respondent shall ensure the following requirements are met:

      (1) The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription.

      (2) The prescriber must ensure completion of an appropriate attestation form. Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link:

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

      (e) The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years.

(f) Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.

(g) Every new prescription will require a new informed consent form.

(h) The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents under the age of eighteen (18) years.

(i)

F. Provider-Specific Performance Monitoring

1. In addition to the requirements of Attachment B, Section VIII, Quality, Subsection F, Provider-Specific Performance Monitoring, the Respondent shall have a peer review process that results in:

   a. Appointment of a peer review committee, as a subcommittee to the QI program committee, to review service provider performance when appropriate. The medical director or a designee shall chair the peer review committee. Its membership shall be drawn from the service provider network and include peers of the service provider being reviewed; and

   b. Receipt and review of all written and oral allegations of inappropriate or aberrant service by a service provider.

G. Additional Quality Management Requirements

1. Incident Reporting Requirements

a. Critical Incident Reporting

(1) The Respondent shall develop a reporting and management system for critical and adverse incidents that occur in all service delivery settings applicable to enrollees with MMA benefits only.

(2) The Respondent shall require providers to report adverse incidents to the Respondent within forty-eight (48) hours of the incident.

(3) The Respondent shall not require provider submission of adverse incident reports from the following providers: health maintenance organizations and health care clinics reporting in accordance with section 641.55, F.S.; ambulatory surgical centers and hospitals reporting in accordance with section 395.0197, F.S.; assisted living facilities reporting in accordance with section 429.23, F.S.; nursing facilities reporting in accordance with section 400.147, F.S.; and crisis stabilization units, residential treatment centers for children and adolescents, and residential treatment facilities reporting in accordance with section 394.459, F.S., adverse incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.

b. Serious Adverse Event Reporting for Enrollees

(1) The Respondent shall provide a summary to the Department each year of its RCAs (root cause analysis). (See **Item 4.**, Root Cause Analysis below.) The report must include the following information, at a minimum:

(a) Number and trend of each Serious Adverse Event (SAE) type.

(b) Number of RCAs initiated and completed for each SAE type.

(c) For each SAE type, a compilation of most frequent root causes.

(d) For each SAE type, a compilation of most frequent recommendations for the Respondent.

2. Drug Utilization Review Program

a. The Respondent shall develop and operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the SSA and 42 CFR part 456, subpart K, as if such requirements applied to the Respondent instead of the State.

b. The Respondent shall provide a detailed description of its drug utilization review program activities to the Department on an annual basis which shall include:

(1) Procedures for operating a Drug Utilization Review (DUR) program in compliance with 42 CFR § 438.3(s)(4), including:

(2) A description of the Respondent's design and implementation of a DUR program to encourage coordination between an enrollee's PCP and a prescriber of a psychotropic or similar prescription drug for behavioral health problems.

(3) A process to identify those medications for other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems), where this is a significant risk to the enrollee posed by potential drug interactions between drugs for these conditions and behavioral-related drugs.

(4) A mechanism to notify all related prescribers, in a manner determined by the Respondent, that certain drugs may be contra-indicated due to the potential for drug interactions and shall encourage the prescribers to coordinate their care.

(5) A program to monitor and manage the appropriate use of antipsychotic medications by all children, in compliance with Section 1004 of the SUPPORT Act.

(6) A claims review automated process includes a prospective review of:

(a) The number of days' supply allowed, early refill requirements, duplicate fill requirements, and quantity limitations on opioids. The Respondent shall implement a claims review automated process that indicates fills of opioids in excess of limitations identified by the Department;

(b) The maximum daily morphine equivalent for treatment of pain. The Respondent shall implement a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the Department.

(c) When an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

c. The Respondent shall participate in the Medicaid Pharmaceutical and Therapeutics Committee and Drug Utilization Review Board by asking qualified plan administrators (MDs, DOs, or pharmacists) to volunteer for committee appointment by the Governor's Office.

3. **High Utilizer Medical Record and Case Management File Review**

a. The Respondent shall perform medical record and case management file reviews for enrollees who are high utilizers of CSU and inpatient psychiatric hospital services, Baker Act receiving facilities, and/or CSUs within a six (6)-month period. The Respondent must initiate the review within ninety (90) days of the third readmission and focus on inpatient evaluations, discharge planning, and identifying trends associated with:

(1) Communication between the inpatient facility, health plan, caregiver, and other providers.

(2) Seven (7) day follow-up.

(3) Services scheduled.

(4) Completion of follow-up of services.

b. At a minimum, the review shall encompass three (3) enrollee records of the three (3) inpatient psychiatric hospitals, Baker Act receiving facilities, or CSUs with the highest readmission rates.

c. The results of the medical record and case management file reviews shall be utilized by the Respondent as part of its quality improvement activities and shall be made available to the Agency upon request.

d. If the Respondent fails to perform the medical record and case management file review for enrollees who are high utilizers of CSU and inpatient psychiatric hospital services, the Respondent shall be subject to fines or otherwise sanctioned in accordance with Attachment B, Section XII, Sanctions and Corrective Action Plans.

4. Root Cause Analysis

a. The Respondent shall initiate an RCA within fourteen (14) days following each of the following events involving an enrollee:

(1) Suicide;

(2) Victim of Homicide;

(3) Baker Act of an enrollee aged (21) years or younger;

(4) Death of an enrollee within one (1) year of delivery or pregnancy termination;

(5) Death of an enrollee within one (1) year of life;

(6) Victim of abuse, neglect, or exploitation as defined by section 415.102, F.S.;

(7) Sexual battery or altercation requiring medical intervention; or

(8) Resident elopement for enrollees in assisted care communities, as defined by section 429.41, F.S.

b. The RCA shall include, at a minimum, a description of the event, health record review, case management investigation, and interviews to gather data that may not be present in health record documents, identification of causal factors, determination of root causes of causal factors, and actionable recommendations for the Respondent to prevent the event at the individual level and the population level. The RCA for each event should be completed within thirty (30) days of RCA initiation.

H. Continuity of Care in Enrollment

1. The Respondent shall provide continuation of services until the enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee's treatment plan, in accordance with **Attachment B**, **Section VIII**, Quality, **Subsection H**, Continuity of Care in Enrollment.

2. The Respondent shall honor any written documentation of prior authorization of ongoing covered services for a period of up to sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.

3. For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services shall include the following, provided that the services were prearranged prior to enrollment with the Respondent:

a. Prior existing orders;

b. Provider appointments (e.g., transportation, dental appointments, or surgeries);

c. Prescriptions (including prescriptions at non-participating pharmacies);

d. Prior authorizations; or

e. Treatment plan/plan of care.

4. The Respondent shall not delay service authorization if written documentation is not available in a timely manner. However, the Respondent is not required to approve claims for which it has received no written documentation.

5. The following services may extend beyond the sixty (60) day continuity of care period, and the Respondent shall continue the entire course of treatment with the recipient's current provider as described below:

   a. Prenatal and postpartum care – The Respondent shall continue to pay for services provided by a pregnant woman's current provider for the entire course of her pregnancy, including the completion of her postpartum care (six (6) weeks after birth), regardless of whether the provider is in the Respondent's network.

   b. Transplant services (through the first-year post-transplant) – The Respondent shall continue to pay for services provided by the current provider for one (1) year post-transplant, regardless of whether the provider is in the Respondent's network.

   c. Oncology (Radiation and/or Chemotherapy services for the current round of treatment) – The Respondent 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 Respondent's network.

   d. Full course of therapy for Hepatitis C treatment drugs.

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Section IX. Administration and Management

A. General Provisions

1. Department is responsible for administering the Title XXI CHIP program for clinically eligible CYSHCN. For Respondent's Medicaid and CHIP Contract with the Department, the Department will monitor Respondent's performance for Medicaid and Title XXI CHIP and provide oversight in all aspects of the Department's Title XXI processes in coordination with the Florida Healthy Kids partners in accordance with section 409.814, F.S.

2. Comply with all Title XIX Medicaid and Title XXI CHIP requirements throughout the contract term.

B. Organizational Governance and Staffing

1. General Provisions

a. Ensure staff includes at least the positions outlined in this section.

b. Respondent's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with Contract and Department policy requirements, including the requirement for providing culturally competent services. Additional monitoring and regulatory action may be employed by the Department, including but not limited to requiring the Respondent to hire additional staff if Respondent fails to comply with the Contract or Department requirements.

c. Request approval from the Department a minimum of sixty (60) days prior to implementing any operational changes specified in Respondent's ITN response. Include a description of the current operational procedure and the proposed procedural change.

d. Maintain responsibility for any additional costs associated with on-site audits or other oversight activities which result when required systems are located outside Florida.

e. Member services staff, claims staff, UM staff, and clinical peer reviewers, may work at sites outside of Florida that are located within the United States.

f. Unless otherwise noted, ensure services are available Monday through Friday from 8:00 am to 6:00 pm EST in the Florida service center location.

g. Provide local staff 24 hours a day, seven days a week to work with the Department or other State agencies on urgent issue resolutions as directed by the Department. Ensure staff members have access to information necessary to identify members who may be at risk and their current health or service status. Ensure staff members can initiate new placements or services, perform status checks at affected facilities, and provide ongoing monitoring as necessary. Submit contact information for these staff members to the Department.

2. Minimum Staffing

a. The Respondent shall have a designated employee, qualified by training and experience, to serve as a liaison with the Prepaid Dental Health Plan (PDHP) in order to promote the most optimal outcomes in terms of integrating and coordinating the SMMC (medical, behavioral health, and long-term care) benefits with the pre-paid dental plan delivery system. This employee will serve as a point of contact for the PDHP in helping to resolve operational (i.e., sharing of data/information) and care coordination concerns/issues; and will work directly with the Department on strategic planning efforts to advance the Agency's goals in coordinating dental and SMMC benefits, as well as reporting on any operational or care coordination issues.

b. Regardless of plan type, the Respondent shall have a designated employee(s), qualified by training and experience, in each region of operation to serve as a liaison between the Respondent and the CBC Lead Agency for enrollees with a Child Welfare special condition identified on the Agency's enrollment file.

c. The Respondent shall employ a dedicated Medical Director to oversee case management and utilization management for enrollees.

d. In addition to the requirements set forth in **Attachment B and its Exhibits** for enrollees with SED/SMI, the Respondent shall employ a dedicated Housing Specialist to assist enrollees and their parent(s) or legal guardian contending with homelessness and to coordinate with local and State housing programs to facilitate the enrollee securing and maintaining stable housing.

e. In addition to the requirements set forth in **Attachment B and its Exhibits**, the Respondent shall employ a dedicated Child Welfare Medical Director to oversee case management and utilization management for enrollees in the Child Welfare system.

f. In addition to the requirements set forth in **Attachment B and its Exhibits**, the Respondent shall employ a full-time Nursing Home Transition Champion dedicated to assist enrollees in nursing homes with transition of care.

g. In addition to the requirements set forth in **Attachment B and its Exhibits**, the Respondent shall staff a Home Health Coordinator/Planning Office specifically dedicated to assist enrollees receiving private duty nursing services.

h. In addition to the requirements set forth in **Attachment B and its Exhibits**, the Respondent shall employ a dedicated Education Liaison for each region to ensure enrollees who are at-risk of missing school receive the educational supports needed for grade promotion.

i. If the Respondent fails to comply with the requirements of this Section, the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII**, Liquidated Damages, as determined by the Department.

3. Case Management Staff Qualifications and Experience

a. General Provisions for Case Management Staff Qualifications and Experience

(1) The Respondent shall have sufficient care coordination/case management staff, qualified by training, experience, and certification/licensure applicable to its population, in the local communities where enrollees reside. The Respondent shall ensure staff hired for these positions will have a variety of experiences with children's services and local community supports available.

(2) Staffing level sufficiency will be determined by the Respondent based on enrollment in case management and caseload ratio requirements.

(3) The Respondent shall ensure a multidisciplinary team approach is used to provide services to enrollees and that the Case Manager (clinical) is assisted by Care Coordinators (non-clinical), Family Support Specialists, and Education Liaisons who possess the specified qualifications.

(4) The Respondent's care coordination/case management staff shall be solely dedicated to the Managed Care Plan population and cannot serve other lines of business.

b. Case Management Staff Qualifications

a. The Respondent shall establish, subject to Department approval, qualifications for all case management staff that include clinical training, licensure, and a minimum number of years of relevant experience in accordance with the minimum qualifications listed in this contract. Experience includes managing care for high-risk groups, such as children with serious emotional disturbance, with co-occurring major mental disorders and SUD, who are involved in multiple services systems (education, justice, medical, welfare, and child welfare) and children with medical fragility/complex medical conditions requiring significant medical or technological health supports.

(1) The Respondent shall utilize Case Managers, Care Coordinator, Education Liaisons and Family Support Specialists who possess the following minimum qualifications identified in **TABLE A**.

(2) The Respondent shall establish a supervisor-to-case-management staff ratio that is conducive to a sound support structure for case management staff. Supervisors must have adequate time to train and review the work of newly hired case management staff as well as provide support and guidance to established staff members. A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of enrollee assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis. The results of this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, must be documented, and made available to the Department upon request.

(3) The Respondent shall have a case management administrator/manager responsible for overseeing all case management activities, including but not limited to, disease management activities and coordination between physical and behavioral health services. The case management administrator/manager shall have a minimum of five years of management or supervisory experience in the health care field. The case management administrator/manager shall be a registered nurse, LCSW, or LMHC with at least three (3) years' experience providing case management services to individuals receiving long-term care services and an additional two (2) years' work experience in managed or children's services.

(a) The case management administrator/manager shall have extensive experience in the children with medical -complexity related field, including case management.

(b) The case management administrator/manager will work closely with the Respondent's quality management, medical management, and network departments.

(c) This individual will provide legal and technical assistance for coordination with the legal system for court ordered services. This position will be one of the first positions that a Respondent hires as they begin to plan and implement for this significant program change.

(d) The case management administrator/manager does not report to the utilization management manager to preserve conflict free case management principles.

(4) Case management supervisors must have the qualifications of a case manager and a minimum of three (3) years of management or supervisory experience in the health care field.

(5) The Respondent shall submit the proposed supervisor-to-case management staff ratio to the Department for approval.

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TABLE A
CARE COORDINATION / CASE MANAGEMENT STAFF

Staff	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
State of Florida Registered Nurse (RN)	Registered Nurse with two (2) years of pediatric experience	RN with two (2) years of pediatric experience	RN that must be provided Department approved pediatric training within first year of hiring	RN that must be provided Department approved pediatric training within first year of hiring	N/A
State of Florida Licensed Practical Nurse (LPN)	N/A	LPN with four (4) years of pediatric experience	LPN that must be provided Department approved pediatric training within first year of hiring	LPN that must be provided Department approved pediatric training within first year of hiring	N/A
Master's Social Work (LCSW)	N/A	N/A	LCSW with at least one (1) year of related pediatric experience and must be provided Department approved pediatric training within first year of hiring	LCSW with at least one (1) year of related pediatric experience	N/A
State of Florida Licensed Mental Health Counselor (LMHC)	N/A	N/A	LMHC with a minimum of two (2) years of pediatric experience. LMHCs shall only be assigned to enrollees who have a behavioral health diagnosis. LMHCs may be assigned to an enrollee's sibling who does not have a behavioral diagnosis to ensure a single point of contact for the family.	LMHC with a minimum of two (2) years of pediatric experience preferred	N/A
State of Florida Licensed Marriage an Family Therapist (LMFT)	N/A	N/A	LMFT with a minimum of two years of pediatric experience. LMFTs shall only be assigned to enrollees who have a behavioral health diagnosis. LMFTs may be assigned to an enrollee's sibling who does not have a behavioral diagnosis to ensure a single point of contact for the family.	LMFT with a minimum of two (2) years of pediatric experience preferred.	N/A
Care Coordinator	Support Case Manager	Support Case Manager	Support Case Manager	Support Case Manager	High school diploma or equivalent. Three (3) to five (5) years of pediatric health care, managed care, or physician's office experience. LPN or B.S. in Social Work highly preferred. Within one (1) year of hire, the individual must receive Managed Care Plan-developed training
School Liaison	Support Case Manager B.S. degree in education, educational counseling, social work or related qualifications with at least two (2) years of experience	Support Case Manager B.S. degree in education, educational counseling, social work or related qualifications with at least two (2) years of experience	Support Case Manager B.S.degree in education, educational counseling, social work or related qualifications with at least two (2) years of experience	Support Case Manager B.S. degree in education, educational counseling, social work or related qualifications with at least two (2) years of experience	N/A

3. Staff Training and Education

a. Educate staff that support the Managed Care Plan's line of business on procedures and all applicable provisions of this Contract in accordance with 42 C.F.R. §§ 422.128(b)(1)(ii)(H), 438.3(j)(1)-(2),and 489.102(a)(5).

b. Develop a training plan which incorporates the topics listed in the Attachment B, Section IX.5 and this Exhibit and submit it to the Department for approval prior to implementation. Include knowledge checks, competence testing, and periodic staff reassessments in the training plan. Implement the approved training plan as specified in the training plan.

c. Ensure staff is trained prior to performing work specified in this Contract.

d. Ensure the training schedule and curriculum for all internal staff, subcontractor, provider, and enrollee training sessions is available to the Department. Allow AHCA and the Department staff to attend each training session as requested.

4. Care Coordination/Case Management Staff Training

a. The Respondent shall provide all case management staff with adequate orientation and ongoing training on subjects relevant to the populations served by the Respondent pursuant to this contract.

b. The Respondent shall develop a training plan to provide uniform training to all case management staff. This plan should include formal training classes as well as practicum observation and instruction for newly hired staff. The training plan shall describe how the Respondent will meet the initial and ongoing training requirements, and include initial and ongoing training curricula that at a minimum includes the topics identified in this Exhibit. The training plan shall clearly designate the topics of initial (i.e., pre-service) training and ongoing training.

c. The Respondent shall submit the training plan to the Department for review and approval within ten (10) days from the date of contract execution.

d. The Respondent shall have a designated staff trainer who ensures that all training requirements are met.

e. The Respondent shall provide all newly hired care coordination/case management staff orientation and pre-service training covering areas applicable to responsibilities and duties performed. Prior to independent enrollee contact, case management staff shall receive orientation and training on the following minimum topics:

(1) Overview of case management services, including principles of person-centered planning, clinical assessment and documentation; availability of community resources in the enrollee's respective geographic areas; referrals and case management strategies that are needed as a result of needs assessment and chronic care needs; case management strategies for disease specific processes; interviewing, asking appropriate questions; and medication monitoring;

(2) Programs, services, and prevalent disease states of children and youth served through case management;

(3) Private Duty Nursing;

(4) SNF to community transition;

(5) Mental health first aid;

(6) Trauma informed care;

(7) Cultural competency;

(8) Title XIX and Title XXI services and regulations;

(9) APD;

(10) Hope Florida;

(11)

(12) Partners in Care: Together for Kids (PIC-TFK);

(13) Marchman Act and Baker Act;

(14) Department of Elder Affairs CARES Program;

(15) Freedom of Choice Certification and Survey;

(16) iBudget Waiver;

(17) The BNET program;

(18) School-based services and Individual Education Plans (IEPs) and 504 plans;

(19) Behavioral health services and programs, including the SIPP program, CAT team, wrap around services, TCM, TBOS, managing entities, different residential levels of care, Behavioral Health Hubs and the role of the case manager in BH staffings;

(20) Unmet non-medical needs;

(21) Transitions of care (i.e., between care settings, transition from child to adult systems of care, etc.);

(22) Fraud, waste, and abuse;

(23) Grievance and appeals reporting, processes, and procedures;

(24) HIPAA;

(25) Enrollee rights and responsibilities;

(26) Advance directives and legal designations (e.g., guardian, power of attorney, representative payee, etc.);

f. In addition to review of areas covered in orientation, the Respondent shall also provide all case management staff with regular ongoing in-service training, to occur at least annually, on the following minimum topics:

(1) The role of the case manager in advocating on behalf of the enrollee;

(2) Enrollee rights and responsibilities;

(3) Case management responsibilities as outlined in this Exhibit;

(4) Case management procedures specific to the Respondent;

(5) The Specialty component of SMMC and the continuum of services, including available service settings and service restrictions/limitations;

(6) The Respondent's provider network by location, service type, and capacity;

(7) Information on local resources for housing, education/General Education Diploma, and employment services/program that could help enrollees gain greater self-sufficiency in these areas;

(8) Responsibilities related to monitoring for and reporting of regulatory issues and quality of care concerns, including but not limited to suspected abuse/neglect and/or exploitation and critical incidents (Chapters 39 and 415, F.S.); and

(9) Information on the enrollees' diagnosis, and continuing education and training, including risk factors, signs and symptoms, treatment options, and new developments in the field.

g. The Respondent shall also identify ongoing training topics from its case management monitoring activities, including file reviews, as well as updates in nationally -recognized standards of professional practice for case management, care coordination, or disease management. The Respondent shall conduct an ongoing evaluation of the success of training and assessment for the need for additional training.

h. The Respondent shall provide non-clinical case management staff (i.e., Care Coordinators, Education Liaisons, and Family Support Specialists) with relevant cross -training to support coverage and integration of case management services.

i. The Respondent shall maintain documentation of training dates and staff attendance as well as copies of materials used for orientation, pre-service, and in-service training for care coordination/case management staff.

j. For the assigned Case Managers serving enrollees under the age of eighteen (18) years of age who are high utilizers of CSU and inpatient psychiatric hospital services receive training through the DCF, the Respondent shall submit a completed training attestation, signed by the care coordinator/case manager's supervisor, to the Agency annually on June 1.

5. Caseload Requirements

The Respondent shall ensure the maximum caseloads for case management referenced in **Section V,** Service Administration, **Subsection E,** Care Coordination/Case Management are not exceeded.

a. The Respondent may submit a request to the Department to implement a mixed caseload of enrollees in the community and in nursing facilities. The Respondent may propose a weighted caseload methodology for Tier 3 and Trier 4 enrollees. For enrollees in Tier 1 and Tier 2, mixed caseloads cannot exceed the highest acuity tiered enrollee.

b. The Respondent shall receive authorization from the Department prior to implementing caseloads whose values exceed those outlined in Section V., Service Administration, Sub-section E., Care Coordination/Case Management. Lower caseload sizes may be established by the Respondent and do not require authorization. Any caseload ratios offered by the respondent that fall below the required case manager caseload ratios referenced in **Section V,** Service Administration, **Subsection E,** Care Coordination/Case Management must be offered at no additional cost to the Department. The Respondent shall submit any caseload exception requests to the Department. The Department may revoke the Respondent's authorization to exceed caseload ratios at any time.

c. The Respondent shall have an adequate number of qualified and trained case managers to meet the needs of enrollees. The Respondent shall assign one Case Manager to each enrollee in accordance with **Section V,** Service Administration, **Subsection E,** Care Coordination/Case Management.

d. The Respondent shall have written protocols to ensure assignment of a case manager immediately upon enrollment of newly enrolled enrollees. The case manager assigned to special subpopulations (e.g., individuals with HIV/AIDS, behavioral health issues/serious mental illness, or children with special health care needs) shall have experience or training in case management techniques for such populations.

e. The Respondent shall consider the enrollee's PCP when assigning case managers with the goal of having the minimum number of case managers to meet the ratio requirements assigned to an individual practice.

f. The Respondent will be assessed a liquidated damage of one-thousand dollars ($1,000.00) each occurrence for failure to attend scheduled or ad hoc CMAT staffing(s) for their assigned enrollees receiving private duty nursing services or receiving services in a skilled nursing facility.

6. The Respondent shall report to the Department monthly on its case manager caseloads as specified in **Section XV**, Accountability, and the Managed Care Plan Report Guide.

7. The Respondent shall report monthly on case management activities on enrollees under eighteen (18) years of age who have high utilization of CSU inpatient mental health services, in accordance with **Section XV**, Accountability, and the Respondent Report Guide.

C. Subcontracts

1. Pharmacy Benefit Manager Subcontracts

   a. The Respondent may delegate any or all functions of administering the Medicaid prescription drug benefit to one (1) or more PBMs with prior written approval of the Department. Before entering into a subcontract, the Respondent shall obtain the Department's prior written approval of the delegation in accordance with **Section IX**, Administration and Management, **Subsection C**, Subcontracts.

   b. Provisions Pursuant to State of Florida Office of the Governor Executive Order Number 22-164

      (1) As used in this Subsection, the following terms are defined as:

         a. **Adjudication transaction fees:** Fee charged by the PBM to the pharmacy for electronic claim submission. Fee may be charged for each claim submission that is accepted by the PBM regardless of transmission status.

         b. **Brand or generic effective rate:** Contractual rate set forth by a PBM for the reimbursement of covered brand or generic drugs calculated using the total payments in the aggregate, by drug type, during the performance period. The effective rates are typically calculated as a discount off of industry benchmarks such as average wholesale price (AWP) or wholesale acquisition cost (WAC).

         c. **Direct and indirect remuneration fees (DIR)**: Price concessions that are paid to the Respondent or PBM by the pharmacy retrospectively, which cannot be calculated at the point of sale. DIR can include discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, upfront payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits from manufacturers, pharmacies, or similar entities.

         d. **Dispensing fee:** Fee intended to cover reasonable costs associated with providing the drug to a Medicaid beneficiary. This cost includes the pharmacist's services and the overhead associated with maintaining the facility and equipment necessary to operate the pharmacy.

         e. **Erroneous claims:** Pharmacy claims submitted in error including but not limited to unintended, incorrect, fraudulent or test claims.

f. **Incentive payment:** A retrospective monetary payment made as a reward or recognition by the Respondent or PBM to a pharmacy for meeting and/or exceeding predefined pharmacy performance metrics as related to quality measures such as HEDIS.

g. **Maximum allowable cost (MAC) appeal pricing adjustment:** A retrospective positive payment adjustment made to a pharmacy by the Respondent or PBM pursuant to an approved MAC appeal request submitted by the same pharmacy to dispute the amount reimbursed for a drug based on the PBM's listed MAC price.

h. **Monetary recoupments:** Rescinded or recuperated payments from a pharmacy or provider by the Respondent or PBM.

i. **Network reconciliation offsets:** Process during annual payment reconciliation between a PBM or a Respondent and a provider which allows the PBM to offset over- or under-performance of contractual guarantees across guaranteed line item, channel, network, and/or payer, as applicable.

(2) All Respondent subcontracts with a PBM must contain provisions to prohibit the use of spread pricing.

(a) Contracts between the Respondent and the PBM responsible for coverage of covered outpatient drugs dispensed to the Respondent's enrollees shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the Respondent, be based on a Pass-Through Pricing model.

(b) A Pass-Through Pricing model is the Respondent's payment to the PBM for a covered outpatient drug that is equivalent to the PBM payment to the dispensing pharmacy or provider. Such payments may include a contracted professional dispensing fee between the PBM and its network of pharmacies that would be paid if the Respondent was making the payment directly. The pass-through payment is passed through in its entirety by the Respondent or PBM to the pharmacy or provider that dispenses the drug. Pass-through payments must be paid in a manner that is not offset by any reconciliation process. Pass-through payments must remain consistent with Section 1 of Executive Order Number 22-164.

(c) If the Respondent fails to comply with the provisions prohibiting the use of spread pricing, the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII**, Liquidated Damages, as determined by the Department.

(3) All Respondent PBM subcontracts must prohibit the practice of financial clawbacks by PBMs.

(a) Under the prohibition of "Financial Clawbacks" or Reconciliation Offsets, the Respondent or PBM shall not recuperate direct or indirect remuneration

fees, dispensing fees, brand or generic effective rate adjustments via reconciliation, or any other monetary recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance where a fee may be recuperated from a pharmacy and/or provider.

(b) The following shall be excluded from being defined as Reconciliation Offsets or "Clawbacks":

I. Any incentive payments provided by the Respondent or PBM to a network pharmacy for meeting and/or exceeding predefined quality measures such as Healthcare Effectiveness Data and Information Set measures (HEDIS);

II. Recoupment due to erroneous claims;

III. Fraud, waste, and abuse;

IV. Claims adjudicated in error;

V. Maximum Allowable Cost (MAC) appeal pricing adjustments; or

VI. Any other any recoupment that is returned to the State of Florida.

(c) If the Respondent fails to comply with the provisions prohibiting the practice of financial clawbacks, the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII**, Liquidated Damages, as determined by the Department.

(4) All Respondent PBM subcontracts must require PBMs to ensure all contracts and/or agreements with participating network pharmacies to reflect that spread pricing and the use of financial clawbacks are disallowed under the Statewide Medicaid Managed Care Program.

(a) The Respondent's PBM subcontracts must contain the following verbatim statement:

"Pursuant to State of Florida Executive Order 22-164 issued by Governor Ron DeSantis, any PBM operating on behalf of a Statewide Medicaid Respondent must utilize pass-through pricing and is prohibited from instituting a spread pricing model and implementing financial clawbacks against network pharmacies. Respondents found in violation of this provision are subject to liquidated damages, sanctions, or other Contract actions, up to and including termination, as determined by the Florida Department for Health Care Administration."

(b) If the Respondent fails to comply with the provisions regarding PBM contracts and/or agreements with participating network pharmacies reflecting the prohibition of spread pricing and the use of financial

clawbacks, the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII**, Liquidated Damages, as determined by the Department.

(5) The Respondent and its subcontracted PBM shall provide Annual and Quarterly Reconciliation Reports.

(a) The Quarterly Reconciliation Report shall be provided by the 25th of the first month following the last day of the prior quarter to the Department. Both reports shall include a comparison of all adjudication and reconciliation costs and payments (if applicable) related to covered outpatient drugs and accompanying administrative services incurred, received, or made by the Respondent or the PBM, including ingredient costs, professional dispensing fees, administrative fees, post-sale and post-invoice fees, discounts, paid taxes or any related post-adjudication adjustments such as any incentive payments provided by the Respondent or its subcontracted PBM to network pharmacies for meeting and/or exceeding predefined quality measures such as HEDIS, recoupment due to erroneous claims, Fraud Waste and Abuse claims, claims adjudicated in error, MAC pricing adjustments, and any and all other remuneration.

(b) Quarterly Reconciliation Report and Annual Reconciliation Report templates will be provided by the Department to the Respondent.

(c) If the Respondent fails to provide the necessary data to the Department via the Quarterly and Annual Reconciliation Reports, the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and Corrective Action Plans, liquidated damages pursuant to **Section XIII**, Liquidated Damages, or reduction of capitation payments in the amount of estimated combined federal and supplemental rebates.

(6) The Respondent shall work with the Department's fiscal agent to ensure the transfer of timely, accurate, and complete prescription encounter data, including actual amounts paid to the provider.

(a) The Respondent acknowledges that the transfer of prescription data is required by the ACA.

(b) The Department will invoice pharmaceutical manufacturers for federal rebates mandated under federal law, and for supplemental rebates negotiated by the Department according to section 409.912(5)(a)(7), F.S.

(c) If the Respondent fails to provide claim and provider information that assists the Department in dispute resolution between the Department and a drug manufacturer regarding federal drug rebates that prevents the Department from collecting drug rebates, the Respondent shall be subject to recoupment by the Department of any determined uncollected rebates.

2. If there is a Respondent physician incentive plan, all model and executed subcontracts and amendments used by the Respondent under this Contract shall include a statement that the Respondent shall make no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care (42 CFR § 422.208(c)(1); 42 CFR § 438.3(i)). If the physician incentive plan places a physician or physician group at substantial financial risk (pursuant to 42 CFR § 422.208(d)) for services that the physician or physician group does not furnish itself, the Respondent shall assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR § 422.208(c)(2). The Respondent shall provide assurances to the Secretary of CMS that the requirements of 42 CFR § 422.208 are met in accordance with 42 CFR § 422.210(a).

3. The Respondent may delegate any or all functions relating to behavioral health services. Before entering into a subcontract, the Respondent shall develop and submit an analysis of the subcontractor's compliance with 42 CFR § 438.3(n) with respect to quantitative and non-quantitative limits and obtain the Department's prior written approval of the delegation in accordance with **Section IX**, Administration and Management, **Subsection C**, Subcontracts.

D. Information Management and Systems

1. Maintain information management processes and information systems of sufficient capacity that enable it to meet the Department, AHCA and federal reporting requirements, other Contract requirements, and all applicable AHCA policies, state and federal laws, rules, and regulations, including HIPAA. Establish connectivity to the AHCA, Department, and State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable Department and state policies, standards and guidelines, as well as coordinating activities and developing cohesive systems strategies across vendors and agencies.

2. Implement the information technology requirements within one-hundred twenty (120) days of contract execution. Include information system and end user acceptance testing to assure all systems are functional by February 1, 2025.

3. AHCA and the Department will share historical utilization data with Provider in accordance with 42 C.F.R. § 438.62(b)(1)(iii). Provider will work with AHCA and the Department on technical specifications for the data exchange.

4. Employ traffic and network monitoring software and tools on a continuous basis to:

    a. Ensure the information system is organized in a user-centric manner, with readily accessed data that is easily converted into relevant and meaningful reports and presented to provide a comprehensive view of an enrollee's services, including authorizations, utilization, outcomes, and interactions with the service delivery system.

b. Ensure the information system includes an architecturally distinct, reusable reporting service that facilitates various types of reports, including but not limited to:

(1) Static reports for daily, monthly, quarterly, and annual reporting.

(2) Dynamic or parameter-driven reports.

(3) Ad-Hoc reports with the ability to drill-up and drill-down based on user needs.

(4) Performance, management, and executive dashboards for data visualization, tracking and trending, with the capacity for data drill-up and drill-down based on user needs.

f. Provide real-time data dashboards and reporting, including hospital admission and discharge data, out-of-state admissions and emergency room utilization including:

(1) An interactive internet-based performance dashboard for the Department staff that provides visual displays of system performance measures relative to goals and benchmarks.

(2) Compatibility with modern mobile technology (e.g., computers, smart phones, tablets, iPads) that are accessible twenty-four (24) hours a day, seven (7) days a week via mobile technology for identified Department staff.

(3) A secure internet-based portal or application available to identified and trained Department staff for generating standard and ad hoc reports.

(4) Standard reports required under the ITN would be contained the identified portal.

g. Ensure the information system has the capability to accept enrollment files from both AHCA/the Department and the enrollment broker for the Title XXI program.

h. Ensure the information system has the capability to accept enrollee assessment data via a variety of mechanisms from AHCA and the Department.

i. Maintain both a public and a secure website with multi-level access for users (e.g., enrollees, providers, family members, Department staff, etc.).

j. Ensure the information system has the capability to do on-line credentialing for providers.

k. Respondent and its subcontractors shall cooperate with the Department to provide or grant access to any records, data, or other information the Department deems necessary to carry out its official duties. This may include but is not limited to real time read only system access to case management records, individual member records, quality data, claims, complaints, and grievances.

E. Encounter Data Requirements

1. The Respondent shall ensure all encounter data submissions include PPC information in order to meet the PPC identification requirements.

2. The Respondent shall comply with the Department's encounter claims requirements for outpatient drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, in accordance with 42 CFR § 438.3(s)(3).

3. The Respondent shall report drug utilization data that is necessary for the Department to bill manufacturers for rebates in accordance with 42 CFR § 438.3(s)(2).

4. In compliance with section 409.967(2)(c)(4), Florida Statutes, the Respondent serving children in the care and custody of the DCF must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to DCF, the applicable contracted community-based care lead agency, and the Community Based Care Integrated Health as directed by the Department.

F. Electronic Visit Verification

1.

1. Provider must provide a description including details on EVV system reports and costs.

2. Provider's system will have the ability to electronically verify:

    a. Type of service performed;

    b. Individual receiving the service;

    c. Date of the service;

    d. Location of service delivery;

    e. Individual providing the service; and

    f. Time the service begins and ends.

G. Systems Functions and Capacity

1. Provider will establish and maintain an IS that collects, stores, and produces meaningful reports for the purposes of financial, clinical, and operational management; and serves as an efficient communication vehicle for the Department delivery system.

2. Provider's Information Management System will be capable of:

a. Directly interfacing with the AHCA Medicaid information management and system platform for 837/835 Encounter exchange; the ECGA Report, and mandatory fraud and abuse reporting;

b. Receiving CHIP rosters from the Florida Healthy Kids Corporation and creating Title XXI invoices for the AHCA Budget Office;

c. Accepting Intake and Evaluation screening information via file transfer from Department staff;

d. Provider will propose a process for receiving intake and evaluation screening information from Department staff

e. Matching Death data with the current Title XIX and Title XXI eligibility information;

f. Permitting eligibility segments for a single enrollee across multiple eligibility categories including but not limited to: Title XIX, Title XXI, SSI, TANF, etc.;

g. Tracking unique provider specialties and capabilities including but not limited to Patient Centered Medical Home designation; and

h. Facilitating interface between texting and system/capabilities.

3. At a minimum, the IS will support the following functions:

   a. Electronic verification of Individual and Recipient enrollment in the CMS Health Plan;

   b. Cross reference enrollee eligibility with State-funded Title V programs to avoid duplication of payments;

   c. Verification of Provider enrollment in the CMS Health Plan;

   d. Department Intake and Evaluation including Assessment tools and results, Plan of Care (POC) development, modification, and tracking; and

   e. UM/UR functions including, but not limited to processing authorization requests, submissions, and status checks.

4. The Provider will design a web-based system that at a minimum will:

   a. Authorize Core services.

   b. Offer a batch submission Authorization process.

   c. Provide a real-time electronic registration/authorization response that includes the Service Provider's number, service location, authorization number, units/package authorized, begin and end dates, service class, and billable codes.

d. Permit service providers to obtain information regarding the status of services for which they have been authorized, including units/packages authorized, begin and end dates, and units remaining, through a look-up function or through a response file to Provider's batch submission request.

e. Permit individuals to access their explanation of benefits.

f. Provide secure viewing access to the appropriate web-based applications and reports for designated case manager, Department staff, and service providers.

g. Permit service providers and case manager to download approved authorizations for their files.

h. Track authorized funds by service provider (including Individual direction), Individual, Recipient, and Region.

i. Issues an immediate on-screen notice (or documentation in a batch response file) that informs a service provider that a clinical review is required prior to an authorization because:

(a) The Service Provider is registering a Recipient for a level of care for which an authorization already exists.

(b) The Service Provider is registering a Recipient for a level of care that cannot be simultaneously authorized with an existing service without a clinical review.

(c) The Service Provider is registering a Recipient for a service that otherwise requires clinical review.

(d) Information in the web-portal relating to whether or not services require prior authorizations.

(e) The Recipient has been selected for a random review or targeted review (based on Service Provider's status as an outlier related to utilization patterns).

(f) The Service Provider has been identified as needing additional guidance or assistance in making appropriate UM/UR decisions.

(g) Have the capacity to automate edit pend rules to pend for manual review of specific providers, services, Individual, or Consumers.

(h) Have the capacity to accept and analyze electronic claims data for Medicaid beneficiaries served by Service Providers.

(i) Provide a mechanism for rate exception requests.

(j) Alert Service Providers about the expiration dates of the authorization.

5. Service Provider, Individual, and Recipient outlier management:

a. Promoting high quality care through application of Practice Guidelines in the review Intensive Services.

b. Removing barriers to discharge and transition planning.

c. Facilitating communication between Service Providers and other agencies to promote effective case management and collaboration.

d. Documentation of denials and Notices of Adverse Action.

e. Development of Service Provider Profiles.

6. Quality Management functions including, but not limited to:

a. Implementation of Service Provider's internal QM Program and supporting CMS's QM Program.

b. Performance monitoring relative to Quality Indicators.

c. Performance Measures, Performance Guarantees.

d. Auditing processes, results, and reporting.

e. Incident monitoring and reporting.

f. Service Provider and staff training activities, attendance documentation, and competency testing.

g. Stakeholder collaboration.

h. Service Provider Report Cards.

7. Network Management functions including, but not limited to:

a. An online Service Provider Resource Directory.

b. Prequalification, verification, and network enrollment of Service Providers.

c. Network adequacy assessment (drive time and distance).

d. Network accessibility monitoring (appointment availability).

e. Grievance response and documentation.

f. Financial Management.

g. Claims Payment and Encounter Processing functions, which include but are not limited to:

(1) Claims payment, encounter processing, and reimbursement of State – funded services.

(2) Claims customer service.

(3) Fraud and abuse detection.

h. Data Management and Reporting:

(1) Compliance Monitoring.

(2) Contract Management.

H. Provider-Maintained Website(s)

1. Provider will maintain a website for members, providers, and stakeholders:

a. Provider will have multi-level user rights (e.g., service providers, Department staff/managers/executives, and individuals, enrollees, family members/caretakers) for the website.

b. Provider's website will be compatible with multiple web browsers.

c. Provider's website will meet the Department's IT standards with appropriate upgrades as needed.

d. Provider will make the following accessible without login:

(1) The enrollee handbook(s);

(2) The printed provider directory;

(3) A searchable service provider database;

(4) Crisis information and phone number;

(5) Approved educational materials, including Practice Guidelines, etc.;

(6) Frequently asked questions (FAQs);

(7) Community forums schedule;

(8) Hyperlinks to Department's or AHCA's other websites;

(9) Communications may be in text or document format; and

(10) A searchable communications or notices section where communications from the Department or Provider can be posted for service provider or public viewing.

e. Service providers will have secure access to web content:

(1) Member Portal;

(2) Service provider Portal;

(3) Service provider authorization, claims, remittance advice, and progress for incentivized payments;

(4) Manuals;

(5) Data interface companion guides;

(6) Web-based service provider training; and

(7) Standard reports and ad hoc reporting tools.

f. Users may sign up to receive notification that a communication has been posted.

g. Data access as needed for the effective management and evaluation of the performance of service providers and the service delivery system.

I. Fraud and Abuse Prevention

In compliance with Section 1004 of the SUPPORT Act, the Respondent's written fraud and abuse prevention program shall have internal controls and procedures in place that are designed to identify potential fraud or abuse of controlled substances by enrollees, providers, and pharmacies.

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Section X. Method of Plan Payment

A. General Provisions

1. The Respondent shall complete the Achieved Savings Rebate (ASR) reports on behalf of the Department. The Respondent will include the total revenue the Department receives from the Agency and the CMS Health Plan administrative expenses in all ASRs.

2. The Respondent's financial responsibility ends for post-stabilization care services it has not prior authorized when:

    a. A physician in the Respondent's network who has privileges at the treating hospital assumes responsibility for the enrollee's care;

    b. A physician in the Respondent's network assumes responsibility for the enrollee's care through transfer;

    c. A Respondent representative and the treating physician reach an agreement concerning the enrollee's care; or

    d. The enrollee is discharged.

B. Fixed Price Unit Contract

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

C. Payment Provisions

1. Capitation Rates

a. The Respondent shall be paid the applicable capitation rate for each Title XXI eligible enrollee in the same manner as Medicaid-eligible enrollees. Capitation rates for Title XXI are developed consistent with 42 CFR § 457.1203(a).

b. The Department shall pay the Respondent a retroactive capitation rate for each newborn enrolled in a Respondent retroactive to the month of birth (Section 409.977(3), F.S.).

c. The Respondent shall be responsible for payment of all covered services provided to newborns.

d. The Agency shall be responsible for administration of the Medicaid prescribed drug program, including negotiating rebates on all drugs. During the time that the Respondent is required to utilize the Agency's PDL, the Respondent shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs reimbursed under this Contract. The Agency will be the sole negotiator of pharmaceutical rebates for all prescribed drugs, and all rebate payments for prescribed drugs will be made to the Agency.

e. The Respondent may have their own Title XXI PDL, but will provide all drugs on the Medicaid formulary. The Respondent will be responsible for negotiating supplemental rebates and favorable net pricing.

f. The allocation for Department administrative expenditures, which includes administrative operating costs, salaries and benefits, and ongoing contract costs, will be built into the capitated rate and paid directly to the Department by the Agency.

(1) If the Department incurs additional expenditures above what was funded in the capitation rate to administer the Managed Care Plan, the Department will prospectively reduce the Respondent's payment by the amount of PMPM increase necessary for the Department to provide necessary oversight.

(2) If the Department requires less administrative expenditures than what was funded in the capitation rate, the Department will increase the amount of the PMPM paid to the Respondent accordingly.

2. Rate Adjustments and Reconciliations

a. The Agency shall be responsible for adjusting applicable capitation rates to reflect budgetary changes in the Medicaid program.

b. Pursuant to section 409.976(2), F.S., the Respondent's actual payments to SIPP providers shall be reconciled for enrollees with MMA benefits to ensure actual claim payments are, at a minimum, the same as Medicaid FFS claim payments. The Respondent accepts and assumes all risks of excess payments as a cost of doing business.

3. Enrollee Payment Liability Protection

a. The Respondent shall not hold an enrollee liable for payment of subsequent screening and treatment needed to diagnose or stabilize an emergency medical condition, as long as the enrollee utilizes a provider in the Respondent's network (42 CFR § 438.114(d)(2)).

4. Value-Based Purchasing (VBP) Programs

a. The Respondent shall develop and implement a value-based purchasing (VBP) program to maximize high value care, reduce inappropriate care, and reward best -performing providers. The VBP program must comply with the Department's value-based insurance design parameters described below in General VBP Agreement Requirements. The Respondent shall include VBP agreements between subcontracted provider networks and providers. The Respondent shall submit all encounter claims relevant to its VBP agreements in accordance with **Attachment B, Section IX**, Administration and Management, of the Contract. The Department reserves the right during the Contract term to modify the mandatory program parameters, including outcome-based and quality performance metrics, data sharing, and reporting requirements.

b. Value-Based Purchasing (VBP) Program Parameters

(1) The goals of the VBP program are to maximize high value care, reduce inappropriate care, and reward best-performing providers.

(2) The Respondent's VBP Program shall include contractual agreements with providers focused on defined populations and value-based payment for quality outcomes.

(3) Whenever applicable, The Respondent's VBP Program shall consider the larger system's initiatives in other lines of business or for example in Title XIX to determine potential overlapping relevance and/or coordination.

c. The Respondent shall use the following definitions of patient populations covered in VBP agreements between plans and providers.

(1) **Population-Based**: Payments applied to a broad population for most of their care. Examples may include, but are not limited to, Accountable Care Organization (ACO) Models, Global Capitation, or Total Cost of Care Shared Savings/Risk.

(2) **Targeted Population-Based:** Payments applied to a specific population based on chronic condition or diagnosis. Examples may include, but are not limited to: Asthma, Diabetes, Serious Emotional Disturbance, Serious Mental Illness (SED/SMI) and Substance Use Disorder, children using in-home supports, or people with intellectual disabilities and developmental disabilities. Transition Age Youth, specifically to work with an adult identified provider for transition at age eighteen (18) years old to ensure a smooth transition of treatment.

(3) **Enhanced Primary Care:** Primary care providers (Pediatrics, Including Adolescent Medicine) receive enhanced payment (e.g., Per Member Per Month (PMPM) case management fee or capitation payment) for providing enhanced set of primary care services to attributed patients. Examples may include, but are not limited to, pediatric Primary Care Medical Home (PCMH) Models, Comprehensive Primary Care Plus (CPC+), Primary Care First, Acute Unscheduled Care Model (AUCM), or intensive home-based models for youth with SED/SMI. Examples of measures include increased immunizations or a reduction of higher level of care services, such as hospitalizations.

(4) **Targeted Enhanced Primary Care:** Primary care providers receive enhanced payment (e.g., PMPM case management fee or capitation payment) for providing enhanced set of primary care services to a specific population of attributed patients with a chronic condition or diagnosis. Examples may include, but are not limited to, Integrated Care for Kids (InCK) Model, Patient-Centered Asthma Care Payment (PCACP), or Patient-Centered Payment for Care of Chronic Conditions.

(5) **Episode-Based:** Payment applied to target population for episode care defined by a time period and/or specific diagnoses or procedures. Examples may include, but are not limited to, Asthma, Attention deficit and hyperactivity disorder (ADHD), SED/SMI, autism, or Pediatric acute lower respiratory infection.

(6) **Quality:** Each year, the Department shall withhold a percentage of the managed care plan's capitation payment. The managed care plan may earn back the withhold depending on the plan's performance aligning with the Department's performance measures described in **Section VIII**, Quality, of this Exhibit.

(7) **Foundational Payments for Infrastructure & Operations:** Payments to providers to support advancement toward value-based payment agreements. Examples may include, but are not limited to, Care Coordination Fees (PMPM or Lump Sum), Health Information Technology Investment, support for providers to have weekend hours or utilize telehealth to extend access, or Investment in Payment Reform or Supplemental Payments to Address Health-Related Social Needs.

d. The Respondent shall use the Learning Action Network (LAN)'s alternative payment framework to categorize its VBP agreements with providers. Agreements in categories LAN 3N or 4N are not considered value-based purchasing agreements and are not measured by the Agency. The Agency reserves the right during this Contract term to change the definitions of risk categories.

e. Provider Participation in VBP Agreements with the Respondent

(1) All providers in a Respondent's provider network, including subcontracted provider networks, shall be eligible for VBP agreements.

(2) Physicians who qualify for the MMA Physician Incentive Program (MPIP) shall be given the choice to participate in VBP agreements.

(3) If a physician qualifies for MPIP and chooses to participate in a VBP agreement, then the physician's choice must be documented.

(4) If the physician qualifies for the MPIP program and consents to participate in both the MPIP program and a VBP agreement, then payments in the VBP agreement shall be equal to or exceed MPIP payments for the patient populations included in the MPIP.

(5) MPIP agreements between the Respondent and Providers shall not be considered a VBP agreement, but may be used to augment a VBP agreement.

f. General VBP Agreement Requirements

(1) The Respondent must include the following minimum value-based insurance design parameters in all VBP agreements between the Respondent and its providers:

(a) A detailed methodology used to attribute enrollees to providers. For primary care providers (PCP), it is recommended that the Respondent use the

enrollees' PCP assignments described in **Section V.**, Service Administration, **Sub-Section D.**, Coverage Provisions of this Exhibit.

(b) A detailed methodology used to calculate the VBP target budget. The Respondent is encouraged to use a percent of risk adjusted revenue for the target budget,but should also consider the providers' own historical costs to assess adequacy of the target budget. When calculating target budgets, the Respondent is also encouraged to use the enrollees' area deprivation index or other social vulnerability index rankings to adjust provider risk. VBP payment models are proposed to be self-funded (i.e., paid for through expected reductions in medical spend); if increased funding due to reductions is expected to take more than one (1) year to accrue, the Respondent should explain the expected amounts and associated timeframes for anticipated reductions, as well as any supporting analysis or research informing their estimate. In addition, the proposed VBP payment models should clearly demonstrate how the providers will be paid for their participation.

(c) A detailed methodology of regularly sharing data, at a minimum quarterly, with providers that enables proactive case management to achieve performance targets. Shared data shall be in the forms of clinical (e.g., health care utilization, health outcomes, quality performance), financial (e.g., actual expenditures, bonus payments, withholds, shared savings, shared losses), provider's progress relative to achieving agreement targets (e.g., performance and budget), and others pertinent to the VBP agreement. The Respondent shall offer technical assistance to VBP-participating providers for visualizing and interpreting data.

(d) A list of outcomes-based quality measures used for calculating shared savings or losses, including at least one (1) Tier 1 quality performance measure listed in **Section VIII**. The VBP agreement shall be clear on the performance period start and end dates. For providers who have no history of VBP contracting, the VBP agreement may include a ramp-up period prior to the first performance period to allow providers to put in place administrative systems and protocols needed under the VBP agreement.

(2) The VBP agreement shall be clear on the payment and reconciliation terms with providers, including remittance timeframes (for example, monthly, quarterly, or annually) and the process for appealing the payments.

(3) The VBP agreement shall require providers to participate in the Florida Health Information Exchange (HIE) Encounter Notification Service (ENS). The Respondent shall achieve and maintain ENS participation in one hundred percent (100%) of VBP arrangements.

(4) The Department has the right to review any VBP agreement for compliance with minimum requirements.

(5) The Respondent shall expend a minimum percentage of payments to providers through VBP agreements in accordance with **Table 4**, Incremental Increase in

Expenditures in Value-Based Purchasing Agreements with Providers. The percentage of payments in various LAN risk levels are calculated by dividing the measured claim-based expenditures in VBP agreements by the total claim-based expenditures for all enrollees as reported in the SRAchieved Savings Rebate (Achieved Savings Rebate). If capitation is paid to providers in lieu of fee-for-service claim reimbursement, then the capitation payment amounts shall be included in the numerator and the denominator. If the Respondent falls below these minimum percentages, the Agency shall assess liquidated damages pursuant to Section XIII., Liquidated Damages, as determined by the Agency.

TABLE 4
INCREMENTAL INCREASE IN EXPENDITURES IN VALUE-BASED PURCHASING AGREEMENTS WITH PROVIDERS*

Contract Period	VBP LAN 3A+	VBP LAN 3B+	VBP LAN 4A+
Year 1	10%	5%	0%
Year 2	20%	10%	1%
Year 3	25%	15%	2.5%
Year 4	30%	20%	5%
Year 5	35%	25%	7.5%
Year 6	40%	30%	10%

***The percentages are minimum targets. The plus sign indicates the inclusion of greater risk levels. For example, "3A+" includes LAN risk levels 3A, 3B, 4A, 4B, 4C.**

(6) VBP Reporting Requirements. The Respondent shall submit quarterly reports to the Department on its VBP program in accordance with **Section XV**, Accountability, and the Respondent Report Guide.

5. Quality Withhold Incentive

The withhold from capitated payments intends to incentivize the managed care plan and its provider network to prioritize and consistently deliver high-quality healthcare to enrollees who require continuous and skilled medical care. The goal is to enable enrollees to receive as much necessary medical attention as safely possible in the comfort and familiarity of their home environment.

a. Each year, the Department shall withhold a percentage of the managed care plan's capitation payment. The managed care plan may earn the withhold depending on the plan's statewide PDN utilization ratio over a full rate year. To design an appropriate structure for this withhold, Respondents are required to populate the PDN Utilization Withhold Proposal Template. The intent of this withhold proposal is to ensure that PDN members are appropriately receiving authorized PDN services and align financial compensation for the plan with the level of services provided. This approach will be measured via the PDN utilization ratio which is calculated as the total PDN hours provided divided by total authorized PDN hours for the applicable population. This template allows Respondents to provide a proposed approach that can be used as part of the

CMS Plan negotiation process. There is no Quality Withhold on capitation rates for Title XXI enrollees.

b. The following quality performance measures shall be used to determine withhold earnings. The population from which these quality measures are calculated must be (1) Title XIX children who are authorized for five hours or more of PDN services per week for at least six of twelve months within a rate year. The calculation will only include these identified months. (2) Be enrolled in the same managed care plan for both the PDN service month and capitation payment month.

i. Private Duty Nursing (PDN) Utilization Ratio. The PDN utilization ratio is calculated as the total PDN hours provided divided by total authorized PDN hours for the applicable population.

ii. Potentially Preventable Visits (PPV) to the Emergency Department. The PPV observed rate is calculated as the number of PDN enrollees with PPV in an emergency department divided by the entire population of PDN enrollees for the applicable population.

iii. Potentially Preventable Admissions (PPA) to the Hospital. The PPA observed rate is calculated as the number of PDN enrollees with PPA in a hospital divided by the entire population of PDN enrollees for the applicable population.

c. The managed care plan shall earn the withholds accordingly:

i. Private Duty Nursing (PDN) Utilization Ratio.

(1) As part of the ITN, the PDN Utilization Withhold Proposal Template will allow Respondents to provide a proposed approach that can be used as part of the CMS Plan negotiation process.

ii. Potentially Preventable Visits (PPV) to the Emergency Department.

(1) The structure of this portion of the withhold will be determined as part of the CMS Plan negotiation process.

iii. Potentially Preventable Admissions (PPA) to the Hospital.

(1) The structure of this portion of the withhold will be determined as part of the CMS Plan negotiation process.

d. If the Respondent is contracted by the Florida Department of Health or the Agency for Health Care Administration for healthcare services, then upon determining actuarial soundness, this quality withhold incentive shall be additive to any quality withholds in the other contracts.

e. The Department reserves the right during the contract term to change the quality withhold, as well as implementing the provisions of this section for children in the Title XXI program.

f. The Respondent may use designations and rankings related to high performance on performance measures given by and as approved by the Department.

6. Achieved Savings Rebate One Percent Quality Incentive

The Respondent operating at top tier performance levels may retain an additional one percent (1%) of revenue through the Achieved Savings Rebate.

a. The Department reserves the right during the Contract term to change the Achieved Savings Rebate One Percent Quality Incentive methodology.

7. Prescribed Drugs High Risk Pool (PDHRP)

The Respondent shall participate in and comply with the Prescribed Drugs High Risk Pool (PDHRP) for Title XIX enrollees, which recognizes the disproportionate enrollment of enrollees with high drug costs, exceeding a specific threshold defined by the Department, on a Contract year basis. The PDHRP operates as a revenue neutral redistribution of plan reimbursement associated with enrollees with high drug costs. The risk pool is funded through a small withhold amount applied to the capitation rates. Encounter data submissions are required in accordance with **Attachment B**, **Section IX**, Administration and Management, of the Contract. The PDHRP does not apply to Title XXI.

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Section XI. Financial Requirements

A. General Provisions

The Respondent shall not avoid costs for services covered in this Contract by referring MediKids enrollees to publicly supported health care programs for services that are covered under this Contract (42 CFR **§** 457.1201(p)).

B. Insolvency Protection

All insolvency protections apply to both Title XIX and Title XXI enrollees.

C. Surplus

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

D. Interest

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

E. Third Party Resources

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

F. Assignment

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

G. Financial Reporting

1. Financial reporting shall be separately developed and reported for Title XIX and Title XXI enrollees to the extent required through 42 CFR § 457 including audited financial reports under § 457.1201(k), medical loss ratio reporting under § 457.1203(e), and any other report necessary for the Department to demonstrate compliance with Title XXI requirements.

2. Medical Loss Ratio

a. The Respondent shall maintain an annual (January 1–December 31) medical loss ratio (MLR) of a minimum of eighty-five percent (85%) for the first full year of MMA program operation and subsequent years, beginning January 1, 2025.

b. The Agency will calculate the MLR in a manner consistent with 42 CFR §§ 438.8, 457.1203(e), 45 CFR Part 158, and section 409.9122(9), F.S., To demonstrate ongoing compliance, the Respondent shall complete and submit appropriate financial reports with separate reports for Title XIX and Title XXI enrollees, as specified in **Section XV**, Accountability, and the Respondent Report Guide.

c. The Respondent shall submit an attestation with its MLR reporting, in compliance with 42 CFR §§ 438.8(k) and (n), 457.1201(o).

d. The federal Centers for Medicare & Medicaid Services will determine the corrective action for non-compliance with this requirement.

H. Inspection and Audit of Financial Records

Upon request of the Department, the Respondent shall disclose to the Department all financial terms and arrangements for payment of any kind that apply between the Respondent or the Respondent's Pharmacy Benefits Manager and any provider of outpatient drugs, any prescription drug manufacturer, or labeler. Such financial terms and arrangements include formulary/PDL management; drug-switch programs; educational support; claims processing; discounts, including but not limited to end of period discounts, pharmacy network fees, data sales fees, and any other fees.

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Section XII. Sanctions and Corrective Action Plans

A. Contract Violations and Non-Compliance

There are no additional Contract violations and non-compliance provisions unique to the MMA managed care program.

B. Corrective Action Plans

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

C. Performance Measure Sanctions

1. See **Attachment B**, **Section XII**, Sanctions and Corrective Action Plans, **Subsection A**, Contract Violations and Non-Compliance, **Item 3,** for enhanced provisions on Performance Measure Sanctions.

2. Performance measures shall be assigned a point value by the Department that correlates to the National Committee for Quality Assurance HEDIS National Means and Percentiles for Medicaid plans. The scores will be assigned according to **Table 11**, HEDIS National Means and Percentiles for Medicaid Plans Table, below. Individual performance measures will be grouped, and the scores averaged within each group, rounding down.

TABLE 11
HEDIS NATIONAL MEANS AND PERCENTILES FOR MEDICAID PLANS

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

3. The Department may require the Respondent to complete a Performance Measure Action Plan (PMAP) after the first year of poor performance.

4. The Respondent may receive a monetary sanction of up to ten thousand dollars **($10,000.00)** for each performance measure group where the group score is below three (3). Performance measure groups are as follows:

   a. Mental Health and Substance Abuse:

      (1) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA);

(2) Antidepressant Medication Management (AMM) – Effective Acute Phase Treatment;

(3) Follow-up after Emergency Department (ED) Visit for Substance Use (FUA) – Seven (7) Day;

(4) Follow-up after ED Visit for Mental Illness (FUM) – Seven (7) Day;

(5) Follow-up after Hospitalization for Mental Illness (FUH) – Seven (7) Day;

(6) Follow-up Care for Children Prescribed ADHD Medication (ADD) – Initiation Phase;

(7) Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) – Total – Blood Glucose and Cholesterol Testing; and

(8) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) – Total.

b. Well-Child:

(1) Child and Adolescent Well-Care Visits (WCV) – Total;

(2) Childhood Immunization Status – Combo Three (3);

(3) Immunizations for Adolescents – Combo Two (2);

(4) Lead Screening in Children;

(5) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation;

(6) Well-Child Visits in the First Thirty (30) Months – First Fifteen (15) Months; and

(7) Well-Child Visits in the First Thirty (30) Months – Age Fifteen (15) Months to Thirty (30) Months.

c. Other Preventive Care:

(1) Adults' Access to Preventive/Ambulatory Health Services – Total;

(2) Adult Immunization Status – Influenza;

(3) Breast Cancer Screening;

(4) Cervical Cancer Screening;

(5) Chlamydia Screening in Women – Total; and

(6) Colorectal Cancer Screening.

d. Prenatal/Perinatal:

(1) Prenatal and Postpartum Care – Timeliness of Prenatal Care;

(2) Prenatal and Postpartum Care – Postpartum Care;

(3) Prenatal Depression Screening and Follow-up – Screening;

(4) Postpartum Depression Screening and Follow-up – Screening; and

(5) Prenatal Immunization Status – Combination.

e. Diabetes:

(1) Blood Pressure Control for Patients with Diabetes;

(2) Eye Exam for Patients with Diabetes;

(3) Hemoglobin A1c Control for Patients with Diabetes – Control (<8.0%);

(4) Kidney Health Evaluation for Patients with Diabetes; and

(5) Statin Therapy for Patients with Diabetes – Therapy.

f. Other Chronic and Acute Care:

(1) Asthma Medication Ratio – Total;

(2) Controlling High Blood Pressure; and

(3) Statin Therapy for Patients with Cardiovascular Disease – Therapy.

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

5. In addition to the above provisions, the Department will review data related to the performance measures specified heretofore to determine acceptable performance levels and may establish sanctions for these measures based on those levels after the first year of the Contract. In addition to the provisions set forth in the MMA Exhibits, the Department reserves the right to determine performance measure groups which shall be subject to the sanction provisions for the Specialty product performance measures.

D. Other Sanctions

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

E. Notice of Sanctions

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

F. Dispute of a Corrective Action Plan or Sanctions

1. To dispute a CAP or a sanction, the Respondent must request that the Department, Hearing Officer or designee, hear and decide the dispute.

   a. The Respondent must submit a written dispute of the CAP or sanction directly to the Department via an electronic submission process as well as by U.S. mail and/or commercial courier service.

      (1) The Respondent shall submit each written request for dispute to an SFTP site in a file and format specified by the Department.

      (2) Each dispute request shall include only one (1) electronic file per submission that includes all of the following information:

         (a) A Respondent appeal letter that is addressed directly to the Department and which includes the case and file number from the original compliance action related to the issue being disputed.

         (b) Exhibit A – the original action letter received from the Department.

         (c) Exhibit B – the Respondent's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

      (3) Any time the Respondent uploads the dispute request on the SFTP site, the Respondent shall notify the Department via email that the dispute has been uploaded.

      (4) The Respondent shall also submit written requests via mail to the following address:

         Attn: Agency Clerk, Florida Department of Health
         4052 Bald Cypress Way, BIN #A02
         Tallahassee, FL 32399-1703

      (5) Regardless of whether delivered by U.S. mail or commercial courier service, appeals or disputes not delivered to the address above will be denied.

      (6) Mediation is not available.

   b. The Respondent shall submit its dispute request to the Department by 5:00 P.M., EST on the eighteenth (18^{th}) day after the date of the issuance of any CAP or sanction. The

Department will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Department.

c. The Respondent waives any dispute not raised within eighteen (18) days of receiving the Sanction or CAP. It also waives any arguments it fails to raise in writing within eighteen (18) days of receiving the CAP or sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying the Respondent's submission submitted within eighteen (18) days following its receipt of the CAP or sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court, and any possible administrative venue).

d. The Hearing Officer or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Respondent. This written decision shall be final.

e. The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Hearing Officer shall be Circuit Court in Leon County, Florida; in any such action, the Respondent agrees to waive its right to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Respondent shall receive notice of the appropriate administrative remedy.

f. A party whose substantial interest is affected by this agency action may petition for an administrative hearing pursuant to sections 120.569 and 120.57, F.S. A petition must be filed in writing and must be in conformance with Rules 28-106.201, 28--106.2015, or 28-106.301, F.A.C., as applicable. The petition must be in writing and received by the Agency Clerk for the Department within eighteen (18) days from receipt of this notice.

(1) The petition must be submitted by mail to:

Agency Clerk, Florida Department of Health
4052 Bald Cypress Way, BIN #A-02
Tallahassee, FL 32399-1703

g. Failure to file a petition within eighteen (18) days shall constitute a waiver of the right to a hearing on this agency action. If this notice becomes a Final Order, an adversely affected party is entitled to judicial review pursuant to section 120.68, F.S. The Florida Rules of Appellate procedure govern review proceedings. Review is initiated by filing, within thirty (30) days of the date of the Final Order, a Notice of Appeal with the appropriate Court of Appeal in the appropriate District Court, accompanied by the filing fees required by law, and filing a copy of the Notice of Appeal with the Agency Clerk, Department of Health.

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Section XIII. Liquidated Damages

A. Damages

1. The Respondent shall establish a reporting mechanism with the Department to serve as receipt of notice of payments for damages are made to the Agency.

2. Dispute of Department-Assessed Liquidated Damages

    a. To dispute the imposition of liquidated damages assessed by the Department, the Respondent shall request that the Department's Hearing Officer hear and decide the dispute.

    b. The Respondent shall submit a written dispute of the liquidated damages directly to the Department Agency Clerk or designee by U.S. mail and/or commercial courier service. Hand delivery shall not be accepted.

        (1) The Respondent shall submit written requests to the following address:

            Attn: Agency Clerk
            Florida Department of Health
            4052 Bald Cypress Way, BIN #A02 Tallahassee, FL 32399-1703

            The Department designee shall decide the dispute under the reasonableness standard, reduce the decision to writing, and serve a copy to the Respondent. This written decision shall be final.

    b. An electronic copy of the written dispute shall also be submitted to a specified Department SFTP site. The Contract Manager shall receive electronic mail notification of any Department SFTP dispute submissions.

    c. Dispute requests submitted to the Department SFTP site shall include only one (1) electronic file per submission and include all of the following information:

        (1) A Respondent appeal letter that is addressed to the Department's CMS Plan Deputy Secretary or designee which includes the case and file number from the original compliance action related to the issue being disputed.

        (2) Exhibit A – the original action letter received from CMS Health Plan and from the Agency when applicable.

        (3) Exhibit B – the Respondent's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

    d. Regardless of whether delivered by U.S. mail or commercial courier service, appeals or disputes not delivered to both the Department Agency Clerk and designated Department SFTP site will be denied.

e. The Respondent shall submit its dispute request to the Department by 5:00 P.M., EST on the twenty-first (21st) day after the date of issuance of any Department assessed liquidated damage. The Department will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Department.

f. The Respondent 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 Respondent'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).

3. Agency-Assessed Liquidated Damages

a. To the extent that liquidated damages are assessed against the Department by the Agency for actions or inactions of the Respondent, the Department will notify the Respondent of the same, and the Respondent shall make payment directly to the Agency after notice from the Department. The Department's sole role regarding the Respondent's payment and dispute of liquidated damages assessed by the Agency is to receive and deliver the notices applicable to the liquidated damage assessment as provided below. The Department will not take a position as to the assessment of the liquidated damages by the Agency relating to the action or inaction of the Respondent.

b. The method of payment for Agency-issued liquidated damages shall be direct payment to the Agency. The Respondent must render payment to the Agency as prescribed in any notice of imposition of compliance actions assessed to the CMS Health Plan, and the Respondent will establish a reporting mechanism with the Department to serve as documentation of payments made to the Agency.

c. To dispute the imposition of liquidated damages assessed by the Agency, the Respondent must request that the dispute be presented by the Department to the Agency for the Agency's Deputy Secretary or designee to hear and decide the dispute.

(1) The Respondent must submit a written dispute of the Agency assessed liquidated damages directly to the Department's Deputy Secretary for CMS Plan or designee.

(2) The request and dispute shall be submitted electronically to a specified Department SFTP site.

(3) Dispute requests submitted to the Department SFTP site shall include only one (1) electronic file per submission and contain the following information:

(a) A Respondent appeal letter that is addressed to the Department's CMS Plan Deputy Secretary or designee which includes the case and file

number from the original compliance action related to the issue being disputed.

(b) Exhibit A – the original action letter received from CMS Health Plan and from the Agency when applicable.

(c) Exhibit B – the Respondent's supporting documentation related to the dispute, including all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).

(4) The Contract Manager shall receive electronic mail notification of any Department SFTP dispute submission. Regardless of whether delivered by U.S. mail or commercial courier service, appeals, or disputes not delivered to the Department's Deputy Secretary for CMS Plan or designee via the SFTP site will be denied.

(5) Failure to both submit appeals or disputes to the Department SFTP site and electronically notify the Contract Manager of the dispute or appeal submission will result in denial.

(6) The Respondent shall submit its dispute request to the Department by 5:00 P.M., EST on the eighteenth (18^{th}) day after the date of issuance of any Agency assessed liquidated damage. The Department will deny any appeals or disputes that are not delivered in the format and timeframes specified by the Department.

(7) The Respondent waives any dispute not raised within eighteen (18) days of receiving notice of the imposition of liquidated damages. It also waives any arguments it fails to raise in writing within eighteen (18) days of receiving said notice, and waives the right to use any materials, data, and/or information not contained in or accompanying the Respondent's submission within the eighteen (18) 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).

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

B. Issues and Amounts

1. Liquidated Damages Applicable to All Medical Assistance Plan Types

   a. If the Respondent fails to perform any of the services set forth in the Contract, the Department may assess liquidated damages for each occurrence listed in **Table 12**, MMA Issues and Amounts Table, below.

TABLE 12 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
1.	Failure to comply with the enrollee records documentation requirements pursuant to the Contract.	One thousand dollars **($1,000.00)** per enrollee record that does not include all of the required elements.
2.	Failure to comply with the federal and/or State well-child visit eighty percent (80%) screening rate and/or federal eighty percent (80%) well-child visit participation rate requirements described in the Contract.	Fifty thousand dollars **($50,000.00)** per occurrence in addition to ten thousand dollars **($10,000.00)** for each percentage point less than the target.
3.	Failure to attend scheduled or ad hoc CMAT staffing(s) for their assigned enrollees receiving private duty nursing, receiving medical foster care services, or receiving services in a skilled nursing facility.	One thousand dollars **($1,000.00)** per occurrence.
4.	Failure to convene an MDT meeting focused on transition planning, as required in the Contract, for enrollees receiving services in a skilled nursing facility.	Five hundred dollars **($500.00)** per occurrence.
5.	Failure to develop and maintain a person-centered individualized service plan, as required in the Contract, for enrollees receiving private duty nursing services or receiving services in a skilled nursing facility.	Five hundred dollars **($500.00)** per occurrence.
6.	Failure to develop and maintain a person-centered plan of care, as required in the Contract, for enrollees receiving medical foster care services.	One thousand dollars **($1,000.00)** per occurrence.
7.	Failure to provide early intervention services within thirty (30) days from the date the IFSP was completed for children enrolled in the Early Steps Program.	One thousand dollars **($1,000.00)** per occurrence.

TABLE 12 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
8.	Failure to provide coordination of aftercare services at least thirty (30) days prior to discharge from a residential treatment setting for enrollees receiving residential psychiatric treatment.	One thousand dollars **($1,000.00)** per occurrence.
9.	Failure to pay physician payment rates equal to, or in excess of, Medicare rates for services provided as part of a physician incentive plan approved by the Department in accordance with Section 409.967(2)(a), F.S.	One thousand dollars **($1,000.00)** per occurrence, plus one hundred dollars **($100.00)** per day for each day the physician has not received payment.
10.	Failure to develop and document a treatment or service plan for an enrollee with complex medical issues, high service utilization, intensive health care needs, or who consistently accesses services at the highest level of care, that shall be documented in writing as described in the Contract.	Five hundred dollars **($500.00)** per deficient/missing treatment or service plan.
11.	Failure to provide coordination of hospital/institutional discharge planning and post discharge care of children that are involuntarily or voluntarily admitted to an inpatient psychiatric facility, including a crisis stabilization unit.	One thousand dollars **($1,000.00)** per occurrence.
12.	Failure to make referrals per the requirements and timeframes indicated in the Contract to complete the clinical eligibility process for members turning eighteen years (18) if residing in a nursing facility, or twenty-one (21) years if receiving private duty nursing services, when the enrollee or their authorized representative has expressed a desire to enroll in the LTC program.	One thousand dollars **($1,000.00)** per occurrence, plus one hundred dollars **($100.00)** per day for each day after the six (6) month requirement.
13.	Failure to comply with standards for the completion of health risk assessments.	Two thousand five hundred dollars **($2,500.00)** per occurrence.

TABLE 12 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
14.	Failure to execute each dental plan agreement that is neither reviewed, approved, nor executed by one hundred twenty (120) days after contract initiation with the Department.	Five hundred dollars (**$500.00**) per day for each day following the one hundred twentieth (120th) day after contract execution that the dental plan agreement is not executed as required.
15.	Failure to notify eligible physicians of the Department's MPIP qualifying criteria at least sixty (60) days prior to October 1 of each year.	Five thousand dollars (**$5,000.00**) per occurrence.
16.	Failure to meet minimum requirements of the VBP arrangement as described in the Contract.	Five thousand dollars (**$5,000.00**) per occurrence.
17.	Failure to meet VBP reporting requirements as described in the Contract.	Two thousand five hundred dollars **($2,500.00)** per occurrence.
18.	Failure to meet VBP benchmarks as described in the Contract.	Fifty thousand dollars **($50,000.00)** per occurrence.
19.	Failure to achieve at least a two (2) percent reduction for a Department-Calculated Performance Measure.	Five thousand dollars **($5,000.00)** per occurrence.
20.	Failure to develop and maintain a person-centered plan of care, as required in the Contract, for enrollees.	One thousand dollars **($1,000.00)** per occurrence.
21.	Failure to meet minimum requirements of the VBP arrangement as described in the Contract.	Five thousand dollars ($5,000.00) per occurrence.
22.	Failure to meet VBP benchmarks as described in the Contract.	Fifty thousand dollars ($50,000.00) per occurrence.
23.	Failure to execute and implement health home contracts with Florida Children's hospitals as described in this Contract.	Ten thousand dollars ($10,000.00) per occurrence.

TABLE 12 LIQUIDATED DAMAGES ISSUES AND AMOUNTS		
#	**MMA Program Issues**	**Damages**
24.	Failure to meet Birth Outcome targets as described in this Contract.	Five thousand dollars ($5,000.00) per occurrence.
ADDITIONAL LIQUIDATED DAMAGES ISSUES AND AMOUNTS FOR THE RESPONDENT OFFERING A SPECIALTY PRODUCT		
25.	Failure to verify Specialty population eligibility criteria of an enrolled recipient within the timeframes in the Specialty product's policies and procedures.	One hundred fifty dollars **($150.00)** per day for every day beyond the enrollment date.
26.	Failure to comply with required Specialty product policies and procedures subject to Department approval pursuant to the Contract.	One thousand dollars **($1,000.00)** per occurrence.

2. In addition to the provisions set forth in **Attachment B** and its Exhibits, the Department will review the Respondent's performance related to the performance measures specified heretofore to determine acceptable performance levels and may set liquidated damages for these measures based on those levels after the first year of the Contract.

C. Performance Measure Liquidated Damages

1. The Department may impose liquidated damages for performance measures as described below in the event that the Respondent fails to perform at the level of the Department's expected minimum standards, as specified in **Item 2**, of this **Subsection**.

2. The Respondent's performance measure rates shall be compared to the NCQA HEDIS National Means and Percentiles for Medicaid plans. For each measure where the Respondent's rate falls below the fiftieth (50^{th}) percentile, the Respondent may receive liquidated damages. Liquidated damages will be calculated based on the number of members eligible for the measure who did not receive the service being measured up to the fiftieth (50^{th}) percentile rate. For measures calculated using a sample, liquidated damages will be calculated based on the extrapolated number of eligible members who did not receive the service being measured, not just those in the sample, up to the fiftieth (50^{th}) percentile rate.

3. For performance measures in Tier 1 where the Respondent's rate is below the fiftieth (50^{th}) percentile, liquidated damages may be assessed at one hundred seventy-five dollars **($175.00)** per eligible member not receiving the service being measured up to the fiftieth (50^{th}) percentile rate for the measure.

4. For performance measures in Tier 2 where the Respondent's rate is below the fiftieth (50th) percentile, liquidated damages may be assessed at one hundred twenty-five dollars

($125.00) per eligible member not receiving the service being measured up to the fiftieth (50th) percentile rate for the measure.

5. For performance measures in Tier 3 where the Respondent's rate is below the fiftieth (50^{th}) percentile, liquidated damages may be assessed at one hundred dollars (**$100.00**) per eligible member not receiving the service being measured up to the fiftieth (50^{th}) percentile rate for the measure.

6. The Department may reduce the liquidated damage amount for Tier 1 by fifty dollars (**$50.00**), Tier 2 by thirty-five dollars (**$35.00**), and Tier 3 by twenty dollars (**$20.00**) per eligible enrollee when:

   a. The rate for a performance measure has improved three (3) percentage points or more compared to the previous reporting period; and

   b. The rate for the performance measure is between the fortieth (40^{th}) and fiftieth (50^{th}) percentiles.

7. The Department may assess liquidated damages for each of the following measures:

   a. <u>Tier 1</u>:

      (1) Timeliness of Prenatal Care.

      (2) Postpartum Care.

      (3) Well-Child Visits in the First Thirty (30) Months – First Fifteen (15) Months.

      (4) Well-Child Visits in the First Thirty (30) Months – Age Fifteen (15) Months to Thirty (30) Months.

      (5) Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

      (6) Antidepressant Medication Management – Effective Acute Phase Treatment.

      (7) Follow-up after ED Visit for Mental Illness – Seven (7) Day.

      (8) Follow-up after ED Visit for Substance Use – Seven (7) Day.

      (9) Follow-up after Hospitalization for Mental Illness – Seven (7) Day.

      (10) Child and Adolescent Well-Care Visits – Total.

      (11) Childhood Immunization Status – Combo Three (3).

      (12) Hemoglobin A1c Control for Patients with Diabetes – Control (<8.0%).

      (13) Controlling High Blood Pressure.

(14) Immunizations for Adolescents – Combo Two (2).

b. Tier 2:

(1) Prenatal Immunization Status – Combination.

(2) Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication.

(3) Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase.

(4) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of AOD – Total.

(5) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total.

(6) Adults' Access to Preventive/Ambulatory Health Services – Total.

(7) Asthma Medication Ratio – Total.

(8) Eye Exam for Patients with Diabetes.

(9) Blood Pressure Control for Patients with Diabetes.

(10) Kidney Health Evaluation for Patients with Diabetes.

(11) Statin Therapy for Patients with Diabetes – Therapy.

(12) Statin Therapy for Patients with Cardiovascular Disease – Therapy.

c. Tier 3:

(1) Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total – Blood Glucose and Cholesterol Testing.

(2) Breast Cancer Screening.

(3) Cervical Cancer Screening.

(4) Chlamydia Screening in Women – Total.

(5) Colorectal Cancer Screening.

(6) Lead Screening in Children.

(7) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation.

8. Additional Performance Measure Liquidated Damages

a. Children with Special Health Care Needs

In addition to the Performance Measure Liquidated Damages in the MMA Exhibit, the Department may assess liquidated damages for the following measures when plan performance measure rates are below the sixtieth (60^{th}) percentile:

(3) Tier 1:

(a) Well-Child Visits in the First Thirty (30) Months – Age Fifteen (15) Months to Thirty (30) Months.

(b) Child and Adolescent Well-Care Visits – Total.

(c) Childhood Immunization Status – Combo Three (3).

(d) Immunizations for Adolescents – Combo Two (2).

(4) Tier 2:

(a) Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase.

(b) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total.

(5) Tier 3:

(a) Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total – Blood Glucose and Cholesterol Testing.

(b) Lead Screening in Children.

(c) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation.

9. The Department may amend the performance measure listing and methodology for liquidated damages with sixty (60) days' advance notice.

Section XIV. Special Terms and Conditions

The special terms and conditions in **Attachment B**, **Section XIV**, Special Terms and Conditions, apply to the Respondent covering MMA services.

A. Applicable Laws and Regulations

1. The Mental Health Parity and Addictions Equity Act:

    a. The Respondent shall comply with all applicable federal and State laws, rules and regulations including 42 CFR part 438, Subpart K, and the Mental Health Parity and Addiction Equity Act (MHPAEA).

    b. The Respondent shall conduct an annual review of its administrative, clinical, and utilization management practices to assess its compliance with the MHPAEA under this Contract.

    c. The Respondent shall submit to the Department an attestation of the Respondent's compliance with the MHPAEA no later than November 1 of each year, in a manner and format to be specified by the Department.

2. Regulations implementing Title XXI managed care at 42 CFR § 457.1200–1285.

B. Coordination of Medical and Dental Services

1. The Respondent agrees to participate in meetings with the Department and the PDHP to foster enhanced communication, strategic planning, and collaboration in coordinating benefits provided through the SMMC and PDHP delivery system and to address any major organizational challenges and/or barriers during the implementation process.

2. Within one hundred twenty (120) days of contract execution, the Respondent shall enter into a coordination of benefits agreement with each SMMC Dental Plan. The written agreements must include, at a minimum, sections addressing the following:

    a. Quarterly, bidirectional data sharing between the Respondent and the Dental Plan that specifies the enrollee data to be shared, HIPAA protection of the data, and how the data will be used to improve dental quality performance measures;

    b. Goals, measurable objectives, and actionable strategies to integrate dental and physical health care for enrollees;

    c. Goals, measurable objectives, and actionable strategies to provide prevention, education, screening, and treatment services in schools and other community settings;

    d. Goals, measurable objectives, and actionable strategies for reducing potentially preventable events (PPE), including but not limited to potentially preventable emergency department visits (PPV), potentially preventable hospital admissions (PPA), and potentially preventable hospital readmissions (PPR);

e. Coordination protocols for the timely care of people with cleft lip, cleft palate, or other craniofacial deformities, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;

f. Coordination protocols for the timely dental care of people with intellectual or developmental disabilities (IDD), such as people covered by the iBudget waiver, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;

g. Coordination protocols for the timely dental care of pregnant women, including but not limited to timely data sharing, enhanced care coordination, case managers, regular care coordination meetings between the plans;

h. Coordination protocols for timely anesthesia services for dental procedures, including but not limited to:

(1) How to authorize urgent or same-day anesthesia for enrollees undergoing dental procedures;

(2) Waiver of prior authorization for people with intellectual or developmental disability, such as people covered by the iBudget waiver, who need anesthesia for dental procedures;

i. Coordination protocols for timely access and utilization of ambulatory surgical centers (ASC) for dental procedures, including but not limited to how to authorize urgent ASC care for enrollees undergoing dental procedures;

j. Training the Respondent's medical providers about dental benefits offered by the Dental Plan and how to refer enrollees for dental care; and

k. Plan to evaluate the effectiveness of the agreement on an annual basis.

3. Before dental plan agreement execution, the Respondent must provide the Department thirty (30) days to review and approve the agreements.

4. The Respondent shall be subject to liquidated damages for each dental plan agreement that is neither reviewed, approved, nor executed by 120 days after contract initiation with the Department.

5. The Respondent shall provide an annual report to the Department about its effectiveness in coordinating dental care with the Dental Health Plans. For each Dental Health Plan agreement, the annual report shall include, at a minimum, the following:

a. Summary of data shared between the Respondent and the Dental Plan;

b. Trend data on the dental-related potentially preventable events, including PPV, PPA, PPR, and the impact of the agreement on those trends;

c. Trend data about enrollees with cleft lip and cleft palate (including age, sex, case characteristics, county of residence, and region of residence), proportion in various

stages of repair, the timeliness of various stages of repair, the provider types paid to care for enrollees with cleft lip and cleft palate, and the facilities providing repair for enrollees with cleft lip and cleft palate;

d. Trend data about anesthesia services provided to enrollees during dental procedures, including but not limited to people in the iBudget waiver;

e. Trend data about the use of ambulatory surgical centers for dental procedures, including the number of centers, the geographic distribution of the centers, procedures performed in the centers, and provider types, such as anesthetist, dentist, or surgeon;

f. Trend data on dental quality performance measures and the impact of the agreements on the trend;

g. Descriptions of revisions to coordinated efforts to improve dental quality performance measures that are below fiftieth (50^{th}) percentile; and

h. Summary data on Respondent provider trainings about dental benefits.

6. If the Respondent fails to comply with the requirements of this Sub-Section, the Respondent may be subject to sanctions pursuant to **Section XII**, Sanctions and Corrective Action Plans, or liquidated damages pursuant to **Section XIII**, Liquidated Damages, as determined by the Department.

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Section XV. Accountability

A. General Provisions

1. Notwithstanding the submission timeframes and procedures specified in this Contract or the Managed Care Plan Report Guide, the Respondent shall submit reports to the Department Contract Manager at the Department location and timeframes specified by the Department in writing, if not otherwise agreed between the parties.

2. The Respondent shall report on Title XIX and Title XXI enrollees, activities, and financial experience separately with data stratified for each payer. The Respondent shall use the same reporting templates, instructions, and timeframes for all reporting for Title XXI enrollees, activities, and experience as is used for Title XIX, but information contained in those reports shall be specific to Title XXI.

3. The Respondent shall provide data elements and reports, including data and reports from subcontractors, in a format and frequency determined by the Department and shall perform ad hoc analysis and reporting as requested and within prescribed timeframes established by the Department.

4. The Respondent shall create and maintain performance dashboards (aggregate and regional) for viewing and use in a variety of technologies including smart phones and tablets.

5. The Respondent shall identify a single point of contact that is responsible for the coordination and transmission of all reports.

6. For each report provided to the Department, the Respondent may be required to aggregate results to represent Statewide, Regional, Provider-specific, Funding Source (e.g., Title XIX versus Title XXI), or other data breakouts, as applicable and as requested by the Department.

B. Required Reports

The Respondent shall comply with all reporting requirements set forth in this Contract, including reports specific to the MMA managed care program as well as reports specific to the Department as specified in **Table 13**, Summary of Accountability Table, below, described in this Contract, and the Respondent Report Guide.

TABLE 13
SUMMARY OF REPORTING REQUIREMENTS

Report Name	Program Type	Frequency
Actual Value of Enhanced Payment (AVEP) MMA Physician Incentive Payment (MPIP) Report	MMA Program	Semi-Annual
Appointment Wait Times Report	MMA Program	Quarterly

TABLE 13 **SUMMARY OF REPORTING REQUIREMENTS**		
Report Name	**Program Type**	**Frequency**
Child Staffing Attendance Report	MMA Program	Monthly
ER Visits for Enrollees without PCP Appointment Report	MMA Program	Annually
Estimated Value of Enhanced Reimbursement (EVREVER)/Qualified Provider MMA Physician Incentive Program (MPIP) Report	MMA Program	Annually
Health Risk Assessment Report	MMA Program	Quarterly
Healthy Behaviors	MMA Program	Quarterly
HSA Ombudsman Log	MMA Program	Quarterly
HSA Survey	MMA Program	Annually
Medical Foster Care Services Report	MMA Program	Monthly
Nursing Facility Services Report	MMA Program	Monthly
PCP/PDP Appointment Report	MMA Program	Annually
Hope Florida Reporting	MMA Program	Annually
Pharmacy Benefit Manager	MMA Program	Quarterly
Pharmacy Benefit Manager	MMA Program	Annually
PDN Utilization Report	MMA Program	Quarterly
Residential Psychiatric Treatment Report	MMA Program	Monthly
Service Authorization Timeliness Performance Outcome Report	MMA Program	Monthly
Value-Based Purchasing Report	MMA Program	Quarterly
Well Child Health Check-Up Visit (CMS-416) and FL 80% Screening	MMA Program	Annually
Program for All Inclusive Care for Children (PACC) Utilization Report	MMA Program	Quarterly

TABLE 13 **SUMMARY OF REPORTING REQUIREMENTS**		
Report Name	**Program Type**	**Frequency**
Parental RT Reporting of Failure to Provide Private Duty Nursing	MMA Program	Monthly
Patient Centered Medical Homes	Department Specific	Annually
HEDIS Dashboard	Department Specific	Annually
PACC Referral Report	Department Specific	Monthly
PACC Census Report	Department Specific	Monthly
BNet Potential Referral Status Report	Department Specific	Monthly
BNet Referral Report	Department Specific	Monthly
BNet Membership Report	Department Specific	Monthly
Out of State Placement Report	Department Specific	Monthly
Partners in Care: Together for Kids (PIC: TFK) Provider Report	Department Specific	Monthly
Well Care Visit/Immunization Care Gap Report	Department Specific	Monthly
Case Management Report	Department Specific	Monthly
APD Status Report	Department Specific	Monthly
Extended Inpatient Report	Department Specific	Monthly
Supplement to the Appointment Wait Times Report	Department Specific	Quarterly
Enrollment Discrepancy Report	Department Specific	Monthly

TABLE 13 SUMMARY OF REPORTING REQUIREMENTS		
Report Name	**Program Type**	**Frequency**
Single Case Agreements Report	Department Specific	Quarterly
Notice of Adverse Provider Actions Report	Department Specific	Monthly

C. Required Submissions

The Respondent shall comply with all submission requirements set forth in this Contract, including submissions specific to the MMA managed care program as specified in **Table 14**, Summary of MMA Submission Requirements Table, below, and the Respondent Submissions Summary.

TABLE 14 SUMMARY OF MMA SUBMISSION REQUIREMENTS		
Submission Name	**Program Type**	**Due**
Enrollee Handbook Requirements	Specialty Product	June 1
Mental Health Parity and Addictions Equity Act (MHPAEA) Compliance	MMA Program	November 1
Root Cause Analysis	Specialty Product	November 1

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Section XVI. Definitions and Acronyms

A. Definitions

In addition to the definitions and acronyms in **Attachment B, Section XVI**, Definitions and Acronyms, the following definitions also apply to the Respondent covering MMA services.

Abandoned Call: A call or other type of contact initiated to a call center that is ended before any conversation occurs.

Agency for Health Care Administration (AHCA): The State agency responsible for administration of the Medicaid program and licensure of health care facilities. This term includes AHCA's employees, or its designee, acting in their official capacity.

Aging-Out Specialist - Case management support personnel responsible for facilitating the transition of enrollees from pediatric to adult providers. **Behavioral Health Network (BNet):** The statewide network of service providers of Behavioral Health Services who serve non-Medicaid eligible children with mental or substance-related disorders who are determined eligible for the Title XXI part of the KidCare Program. This network includes providers who are managed behavioral health organizations, private and State funded mental health and substance-related disorders providers, and lead agencies. It is administered by the Department of Children and Family Services to provide a comprehensive behavioral health benefits package for children with serious mental or substance-related disorders.

Capitation Rate: The per-member, per-month amount, including any adjustments, that is paid by the AHCA or the Department to the Respondent for each Medicaid or CHIP recipient enrolled under a Contract for the provision of Medicaid and CHIP services during the payment period.

Care Coordinator: Care Coordinator - A non-licensed or licensed health case management professional who helps to manage member care needs.

Case Manager: An individual employed by the Respondent who furnishes case management services directly to or on behalf of an enrollee, on an individual basis.

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

Centers for Medicare & Medicaid Services (federal 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, whether payments are appropriate, or will be made in certain situations.

Child with Medical Complexity: A child who meets the statutory definition of "children with special health care needs" within Chapter 391, Florida Statutes. "Children with special health care needs" means those children younger than twenty-one (21) years of age who have chronic and serious physical, developmental, behavioral, or emotional condition and who require health care and related services of a type or amount beyond that which is generally required by children."

Children's Health Insurance Program (CHIP): The medical assistance program authorized by Title XXI of the Social Security Act.

Conflict Free Case Management: Pursuant to 42 C.F.R. §§ 441.301(c) (1) (vi), 441.730(b), case management provided by an individual who is not related to the enrollee, their paid caregivers, or anyone financially responsible for the enrollee and who is not employed by, does not have a financial interest in, nor is affiliated to any degree with a provider of services.

Disease Management: A system of coordinated health care interventions and communications 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.

Early Intervention Services (EIS): A program designed for children receiving services through the Department'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 EIS providers throughout the State.

Education Liaison: Case management support personnel responsible for collaboration with families and school districts to promote educational success and access to health-related services in the school setting.

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 as defined in section 395.002, F.S.

Enrollee: A Medicaid or CHIP enrollee participating in a Respondent. Member and enrollee are equivalent.

Exploitation: As defined in Chapter 39 and section 415.102(8), F.S.

Family Support Specialist: Case management support staff with lived experience in caring for a child or youth with special health care needs. Provide family-centered support to families caring for medically complex children.

Florida Healthy Kids Corporation: Designated eligibility processor for the non--Medicaid parts of CHIP. The Corporation is also responsible for conducting the dispute review process and preparing all written dispute review responses related to its eligibility processing. The Corporation also administers the Florida Healthy Kids program, a component of CHIP for children ages five (5) to eighteen (18). The Corporation collects monthly premiums monthly premiums for CHIP and manages the KidCare customer service call center.

Health Reassessment: A complete health reevaluation combining health history, physical assessment, and the monitoring of physical and psychological growth and development within a prescribed time period.

Managed Medical Assistance Program (MMA): The component of SMMC through which Medicaid recipients receive medical services through a Managed Care Organization.

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 AHCA under section 409.901, F.S.

Medicaid or CHIP Recipient: Any individual whom DCF, or the Social Security Administration on behalf of DCF, or the Florida Healthy Kids Corporation (FHKC) determines is eligible, pursuant to federal and State law, to receive medical or allied care, goods or services for which the AHCA or the Department may make payments under the Medicaid or CHIP program, and who is enrolled in the Medicaid or CHIP program.

Medical 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, 456.211.

Mixed Services: Services that include a combination of the following: assistive care services, home health (intermittent nursing, aide and skilled therapies and private duty nursing (continuous skilled nursing), hospice services, medical equipment and supplies (including durable medical equipment), therapy services (physical, occupational, respiratory, and speech), and non-emergency transportation services.

Neglect: As defined in Chapter 39 and section 415.102, F.S.

PACC/PIC:TFK Annual Recertification Period: Children participating in the PACC/PIC:TFK program must be recertified as medically eligible for the PACC/PIC:TFK program on an annual basis. During this period, the child's primary care provider or specialty physician must recertify that the child remains diagnosed with a potentially life-threatening condition and is at risk for a death event prior to reaching twenty-one (21) years of age.

Pediatric Board-Certified Provider: A pediatric specialist who has completed the necessary education, fellowship, and board certification exam as defined by the certifying pediatric specialty board and has a current board certificate in the pediatric specialty area. This condition also extends to newly credentialed providers who are board-eligible as well as, those who have been grandfathered by the MCO.

Periodicity Schedule: A schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.

Plan of Care: A plan based on the assessed physical and psychological care needs of an enrollee.

Prime Contract: Contract between AHCA and the Department, as amended, referenced as AHCA Contract No. FP078, located at https://ahca.myflorida.com/medicaid/statewide_mc/model_health_FY18-23.shtml. For purposes of this Contract, references to specific sections of the Prime Contract are made for informational and explanatory value.

Program of All-Inclusive Care for Children (PACC)/Partners in Care –Together for Families (PIC:TFK): A palliative care program for children enrolled in the Department with a potentially life-threatening condition. Program of All-Inclusive Care for Children is the name of the national program model and the one used by Florida Medicaid. Partners in Care- Together for Kids is the specific name of the program in Florida.

Public Event: An event planned or sponsored by at least two (2) unaffiliated community organizations to benefit, educate, and/or assist the community with information concerning health-related matters or public awareness. Respondents cannot market at Public Events.

Qualifying Condition: A serious and chronic condition, as outlined in Rule 64C-2.002 F.A.C., required for enrollment in the CMS Health Plan.

Quality Enhancements: Certain health-related, community-based services that the Respondent must offer and coordinate access to its enrollees. Respondents are not reimbursed by the Department or Medicaid for these types of services.

Respondent: The entity that submits a Proposal in response to this ITN. This term also may refer to the entity awarded a contract by the Department in accordance with terms of this ITN.

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

Securities: United States Treasury Securities which are backed by the full faith and credit of the United States government. For the purpose of this Contract, the term shall be limited to those securities approved by AHCA or the Department as specified in this Contract.

Service Level: The percentage of incoming calls that are answered within a specified threshold (e.g., "X percent of calls answered in Y seconds").

Service Organization Control (SOC) 2 Type II Audit (SOC 2 Type II Audit): An audit of the internal controls of a service organization according to specifications defined by the American Institute of Certified Public Accountants.

Service Provider: A person or entity eligible for a Medicaid provider agreement or a participating provider with the Respondent.

Specialty Plan: A Respondent providing MMA services that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

Spoken Script: Standardized text used by Respondent staff in verbal interactions with enrollees or potential enrollees designed to provide information and/or to respond to questions and requests. Spoken scripts also include IVR and on-hold messages.

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

Statewide Medicaid Managed Care Program (SMMC): Pursuant to Part IV of Chapter 409, F.S., Florida Medicaid's statewide managed care program.

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.

Unable to Reach (UTR): A case management status for an enrollee who has documented failed attempts to successfully contact via phone or in-person for six (6) consecutive months.

Vaccines for Children (VFC): A federally funded program that provides immunizations at no cost to children who might not otherwise be immunized because of inability to pay. The Centers for Disease Control buys immunizations at a discount and distributes them to grantees (i.e., State health departments and certain local and territorial public health agencies) which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC providers.

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