

ATTACHMENT II
EXHIBIT II-B – Effective Date: February 1, 2018
LONG-TERM CARE (LTC) MANAGED CARE PROGRAM

Section I. Definitions and Acronyms

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

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Section II. General Overview

The provisions in this Exhibit apply to all Comprehensive LTC Managed Care Plans.

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

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Section III. Eligibility and Enrollment

A. Eligibility

1. Mandatory Populations

- a. Eligible recipients age eighteen (18) years or older in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:
 - (1) Temporary Assistance to Needy Families (TANF);
 - (2) SSI (Aged, Blind and Disabled);
 - (3) Institutional Care;
 - (4) Hospice;
 - (5) Individuals who age out of Children's Medical Services and meet the following criteria:
 - (a) Received care from Children's Medical Services prior to turning age twenty-one (21) years;
 - (b) Age twenty-one (21) years and older;
 - (c) Cognitively intact;
 - (d) Medically complex; and
 - (e) Technologically dependent.
 - (6) Low Income Families and Children;
 - (7) MEDS (SOBRA) for children born after 9/30/83 (age eighteen (18) through twenty (20) years);
 - (8) MEDS AD (SOBRA) for aged and disabled;
 - (9) Protected Medicaid (aged and disabled);
 - (10) Full Benefit Dual Eligibles (Medicare and Medicaid); and
 - (11) Medicaid Pending for Long-term Care Managed Care HCBS waiver services.
- b. Eligible recipients age eighteen (18) or older with Cystic Fibrosis that meet hospital level of care as determined by CARES.

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Section III. Eligibility and Enrollment

2. Voluntary Populations

Eligible recipients eighteen (18) years or older in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

- a. Program of All-Inclusive Care for the Elderly (PACE) plan members;
- b. Familial Dysautonomia waiver;
- c. Model waiver (age eighteen (18) through twenty (20) years);
- d. Developmental Disabilities waiver (iBudget);
- e. Medicaid for the Aged and Disabled (MEDS AD) — Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled — enrolled in Developmental Disabilities (DD) waiver; and
- f. Recipients with other creditable coverage excluding Medicare.

3. Excluded Populations

- a. Recipients in any eligibility category not listed in items A., Eligibility, sub-items 1., Mandatory Populations and 2., Voluntary Populations, above, are excluded from enrollment in a Comprehensive LTC Managed Care Plan.
- b. In addition, regardless of eligibility category, the following recipients are excluded from enrollment in a Comprehensive LTC Managed Care Plan:
 - (1) Recipients residing in residential commitment facilities operated through DJJ or treatment facilities as defined in s. 394.455(47), F.S.;
 - (2) Recipients residing in DD centers including Sunland and Tacachale;
 - (3) Children receiving services in a prescribed pediatric extended care center (PPEC);
 - (4) Children with chronic conditions enrolled in the Children's Medical Services Network; and
 - (5) Recipients in the Health Insurance Premium Payment (HIPP) program.

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Section III. Eligibility and Enrollment

4. Medicaid Pending for Home and Community-Based Services

- a. The Managed Care Plan shall authorize and provide services to Medicaid Pending enrollees as specified in Section V, Covered Services.
- b. Medicaid Pending recipients may choose to disenroll from the Managed Care Plan at any time, but the Managed Care Plan shall not encourage the enrollee to do so. However, Medicaid Pending recipients may not change managed care plans until full financial Medicaid eligibility is complete.
- c. The Managed Care Plan shall be responsible for reimbursing subcontracted providers for the provision of home and community-based services (HCBS) during the Medicaid Pending period, whether or not the enrollee is determined financially eligible for Medicaid by DCF. The Managed Care Plan shall assist Medicaid Pending enrollees with completing the DCF financial eligibility process.
- d. The Agency will notify the Managed Care Plan in a format to be determined by the Agency of Medicaid Pending recipients that have chosen to enroll in the Managed Care Plan on a schedule consistent with the X-12 834 monthly enrollment files. On the first of the month after the notification, the Managed Care Plan shall provide services as indicated in Section V, Covered Services. The Managed Care Plan shall not deny or delay services covered under this Contract to Medicaid Pending enrollees based on their Medicaid eligibility status.
- e. The Agency will notify the Managed Care Plan if and when Medicaid Pending enrollees are determined financially eligible by DCF via the X-12 834 enrollment files. If full Medicaid eligibility is granted by DCF, the Managed Care Plan shall be reimbursed a capitated rate, by whole months, retroactive to the first of the month in which the recipient was enrolled into the Managed Care Plan as a Medicaid Pending enrollee. At the request of the Agency, the Managed Care Plan shall provide documentation to prove all medically necessary services were provided for the Medicaid Pending recipient during their pending status.
- f. If DCF determines the recipient is not financially eligible for Medicaid, the Managed Care Plan may terminate services and seek reimbursement from the enrollee. In this instance only, the Managed Care Plan may seek reimbursement only from the individual for documented services, claims, copayments and deductibles paid on behalf of the Medicaid Pending enrollee for services covered under this Contract during the period in which the Managed Care Plan should have received a capitation payment for the enrollee in a Medicaid Pending status. The Managed Care Plan shall send the affected enrollee an itemized bill for services. The itemized bill and related documentation shall be included in the enrollee's case notes. The Managed Care Plan shall not allow subcontractors to seek payment from the Medicaid Pending enrollee on behalf of the Managed Care Plan.

B. Enrollment

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

Section III. Eligibility and Enrollment

C. Disenrollment

1. An enrollee may continue enrollment in the Managed Care Plan for sixty (60) days upon losing Medicaid eligibility (the SIXT period). The enrollee will be disenrolled from the Managed Care Plan if they do not regain eligibility upon the expiration of the SIXT period.
2. The Managed Care Plan shall continue to provide covered services and may not reduce, or eliminate, service provision, including but not limited to care coordination/case management during the SIXT period.
3. In the event the enrollee regains Medicaid eligibility within the SIXT period, the enrollee will be reinstated with the Managed Care Plan in accordance with Core Provisions, Section III.B.1. sub-items h. and i. The Managed Care Plan will receive payment for any months during the SIXT period for which eligibility was restored retroactively.
4. In the event the enrollee regains Medicaid eligibility after the SIXT period, but within one hundred twenty (120) days of losing eligibility, the enrollee will be reinstated in accordance with Core Provisions, Section III.B.1. sub-item i. effective the next available monthly enrollment date. The Managed Care Plan will receive payment for any months during the SIXT period for which eligibility was restored retroactively.
5. The Managed Care Plan may recommend an enrollee for involuntary disenrollment if the enrollee wishes to remain in an ALF or AFCH that does not, and will not, comply with HCB Settings Requirements.

D. Marketing

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

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Section IV. Enrollee Services and Grievance and Appeal System

A. Enrollee Materials

1. New Enrollee Procedures and Materials

- a. For each new HCBS enrollee, the Managed Care Plan shall complete and submit to DCF a CF-ES 2515 Form (Certification of Enrollment Status Home and Community Based Services (HCBS)) within five (5) business days after receipt of the applicable enrollment file from the Agency or its agent. The Managed Care Plan shall retain proof of submission of the completed CF-ES 2515 Form (Certification of Enrollment Status Home and Community Based Services (HCBS)) to DCF. The Managed Care Plan shall access the CF_ES 2515 Form Instructions on the Medicaid Nursing Facility Provider Information Web site at http://www.ahca.myflorida.com/Medicaid/nursing_fac/index.shtml.
- b. For enrollees with LTC benefits, as long as the materials are provided within five (5) days, the Managed Care Plan may provide new enrollee materials as part of the initial case management visit.

2. Enrollee Handbook Requirements

The Managed Care Plan shall include additional information in its handbooks applicable to the LTC program, as follows:

- a. A verbatim statement of the goal of the LTC program, as follows:

The purpose of the LTC program is to provide you with an array of services that meet your needs and allow you to live in the setting of your choice. This includes allowing you to live in the community for as long as you choose;
- b. An explanation of the role of the case manager and how to access a case manager;
- c. Instructions on how to request an assessment or re-assessment by the Managed Care Plan for use in developing or updating the plan of care;
- d. Information on the person-centered care planning process, including:
 - (1) The role of the enrollee and the case manager
 - (2) The process for developing and updating the plan of care
 - (3) Establishing personal goals
 - (4) Information related to community integration;
- e. Instructions on how to access services included in an enrollee's plan of care;

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- f. Information regarding how to develop the enrollee disaster/emergency plan including information on personal and family plans and shelters, dealing with special medical needs, local shelter listings, special needs registry, evacuation information, emergency preparedness publications for people with disabilities, and information for caregivers, all of which is available at the web site www.floridadisaster.org;
- g. Information regarding how to develop a contingency plan to cover gaps in services;
- h. Instructions on how to access appropriate state or local educational and consumer resources providing additional information regarding residential facilities and other Long-term Care providers in the Managed Care Plan's network. At a minimum, the Managed Care Plan shall include the current website addresses for the Agency's Health Finder website (www.FloridaHealthFinder.gov) and the Department of Elder Affairs' Florida Affordable Assisted Living consumer website (<http://elderaffairs.state.fl.us/faal/>).
- i. Information regarding participant direction for the following services:
 - (1) Attendant nursing care services;
 - (2) Homemaker services;
 - (3) Personal care services;
 - (4) Adult companion care services; and
 - (5) Intermittent and skilled nursing.
- j. Patient responsibility obligations for enrollees residing in a residential facility.
- k. An explanation of the enrollee's guaranteed right to receive waiver services in a residential or non-residential setting that complies with HCB Settings Requirements and to participate in his or her community regardless of his or her living arrangement.
- l. Information on how to access a copy of the Florida Medicaid Statewide Medicaid Managed Care Long-term Care Coverage Policy.
- m. Information that the enrollee may be disenrolled from the Long-term Care program if the enrollee will not relocate from an ALF or AFCH that does not, and will not, conform to HCB Settings Requirements.
- n. Information on how to request a copy of the enrollee's case file.
- o. Information regarding the role of the Aging and Disability Resource Center(s) and their contact information (address and numbers) and information on how to utilize the Independent Consumer Support Program operated by the Department of Elder Affairs.

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B. Enrollee Services

1. Medicaid Redetermination Assistance

- a. The Managed Care Plan shall send enrollees Medicaid redetermination notices and assist enrollees with maintaining eligibility.
- b. The Managed Care Plan shall develop a process for tracking eligibility redetermination and documenting the assistance provided by the Managed Care Plan to ensure continuous Medicaid eligibility, including both financial and medical/functional eligibility. If the enrollee loses Medicaid financial eligibility due to inaction or lack of follow-through with the DCF redetermination process, the case manager shall help the enrollee regain Medicaid financial eligibility.
- c. The Managed Care Plan's assistance shall include:
 - (1) Within the requirements provided below, using Medicaid recipient redetermination date information provided by the Agency to remind enrollees that their Medicaid eligibility may end soon and to reapply for Medicaid if needed;
 - (2) Assisting enrollees to understand applicable Medicaid income and asset limits and, as appropriate and needed, supporting enrollees to meet verification requirements;
 - (3) Assisting enrollees to understand any patient responsibility obligation they may need to meet to maintain Medicaid eligibility;
 - (4) Assisting enrollees to understand the implications of their functional level of care as it relates to the eligibility criteria for the program; and
 - (5) If appropriate, assisting enrollees to obtain an authorized representative.
- d. The Agency will provide Medicaid recipient redetermination date information to the Managed Care Plan.
- e. The Managed Care Plan shall train all affected staff, prior to implementation, on its policies and procedures and the Agency's requirements regarding the use of redetermination date information. The Managed Care Plan shall document such training has occurred, including a record of those trained, for the Agency's review within five (5) business days after the Agency's request.
- f. The Managed Care Plan shall use redetermination date information in written notices to be sent to their enrollees reminding them that their Medicaid eligibility may end soon and to reapply for Medicaid if needed. The Managed Care Plan shall adhere to the following requirements:
 - (1) The Managed Care Plan shall mail the redetermination date notice to each enrollee for whom it has received a redetermination date. The Managed Care Plan may send one (1) notice to the enrollee's household when there are

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multiple enrollees within a family who have the same Medicaid redetermination date, provided that these enrollees share the same mailing address.

- (2) The Managed Care Plan shall use the Agency-provided LTC template for its redetermination date notices. The Managed Care Plan may put this template on its letterhead for mailing; however, the Managed Care Plan shall make no other changes, additions or deletions to the letter text.
 - (3) The Managed Care Plan shall mail the redetermination date notice to each enrollee no more than sixty (60) days and no less than thirty (30) days before the redetermination date occurs.
- g. The Managed Care Plan shall keep the following information about each mailing made available for the Agency's review within five (5) business days after the Agency's request. For each month of mailings, a dated hard copy or pdf. of the monthly template used for that specific mailing shall include:
- (1) A list of enrollees to whom a mailing was sent. This list shall include each enrollee's name and Medicaid identification number, the address to which the notice was mailed, and the date of the Agency's enrollment file used to create the mailing list; and
 - (2) A log of returned, undeliverable mail received for these notices, by month, for each enrollee for whom a returned notice was received.
- h. The Managed Care Plan shall keep up-to-date and approved policies and procedures regarding the use, storage and securing of this information as well as address all requirements of this subsection.
- i. Should any complaint or investigation by the Agency result in a finding that the Managed Care Plan has violated this subsection, the Managed Care Plan may be sanctioned in accordance with Section XI, Sanctions. In addition to any other sanctions available in Section XI, Sanctions, the first such violation may result in a thirty- (30) day suspension of use of Medicaid redetermination dates; any subsequent violations will result in thirty (30) day incremental increases in the suspension of use of Medicaid redetermination dates. In the event of any subsequent violations, additional penalties may be imposed in accordance with Section XI, Sanctions. Additional or subsequent violations may result in the Agency's rescinding provision of redetermination date information to the Managed Care Plan.

2. Level of Care Redeterminations

The Managed Care Plan shall:

- a. Conduct level-of-care redeterminations as required by this Contract;
- b. Track level-of-care redeterminations to ensure enrollees are reassessed face-to-face with the Agency-required assessment tool to ensure a new level of care determination is authorized annually. Enrollees residing and remaining in the

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nursing home setting are exempt from the annual level of care redetermination requirement. If the Agency-required assessment tool is not submitted to the state in a timely manner and the level of care expires, the case manager is responsible for ensuring that a new Agency-required certification form is completed, signed and dated by a physician;

- c. Ensure the appropriate staff have received the Agency-specified training for completion of the Agency-defined reassessment form;
- d. For enrollees residing and remaining in the community, conduct the annual reassessment and required medical documentation and submit to CARES no earlier than sixty (60), and no later than thirty (30) days prior to the one (1) year anniversary date of the previous Notification of Level of Care form;
- e. For enrollees transitioned from the nursing facility into the community within twelve (12) months of their initial level of care determination, submit the level of care assessment thirty (30) days prior to the date on the initial Notification of Level of Care form. The Managed Care Plan shall not transition enrollees into home and community based LTC services who have not been released from the LTC wait list or who have not resided in a nursing facility for a minimum of sixty (60) consecutive days prior to transition;
- f. For enrollees that reside in a nursing facility more than twelve (12) months before being transitioned into the community, complete the reassessment thirty (30) days prior to the anniversary date of discharge from the nursing facility; and
- g. Submit quarterly reports to the Agency on those enrollees receiving annual level of care redeterminations, within 365 days of the previous determination, enrollees having current level of care based on the Agency-required assessment tool and required medical documentation, and on enrollees requesting a fair hearing related to their level of care, as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

3. Requirement for Nursing Home Admissions and Discharges

- a. The Managed Care Plan shall ensure the Florida Department of Children and Families (DCF) is notified of an LTC enrollee's admission to a nursing facility.
 - (1) The Managed Care Plan shall submit to DCF a properly completed CF-ES 2506A Form (Client Referral/Change) within ten (10) business days of the LTC enrollee's admission to the nursing facility.
 - (2) The Managed Care Plan may delegate the submission of the CF-ES 2506A Form (Client Referral/Change) to the nursing facility. The Managed Care Plan must obtain a copy of the completed CF-ES 2506A Form (Client Referral/Change) that the facility submitted to DCF.
- b. The Managed Care Plan shall ensure the Florida Department of Children and Families (DCF) is notified of an LTC enrollee's discharge from a nursing facility.

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- (1) The Managed Care Plan shall submit to DCF a properly completed CF-ES 2515 Form (Certification of Enrollment Status, Home and Community Based Services (HCBS)) within ten (10) business days of the LTC enrollee's discharge from the nursing facility.
 - (2) The Managed Care Plan shall not delegate submission of the CF-ES 2515 Form (Certification of Enrollment Status, Home and Community Based Services (HCBS)) to the nursing facility, when the LTC enrollee is discharged from a nursing facility.
- c. The LTC Managed Care Plans and the LTC Comprehensive Plans shall submit reports on these transactions to the Agency as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. The Managed Care Plan shall retain proof of submission of each completed form in the enrollee's case record.

C. Grievance and Appeal System

There are no additional grievance and appeal system provisions unique to the LTC managed care program.

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Section V. Covered Services

A. Required Benefits

1. General Provisions

a. The Managed Care Plan may place appropriate limits on a service on the basis of medical necessity as follows:

(1) In the provision of nursing facility services and mixed services, the Managed Care Plan shall ensure services meet the medical necessity criteria defined in 59G-1.010, F.A.C.

(2) In the provision of all other LTC services, the Managed Care Plan shall ensure that services meet all of the following:

(a) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;

(b) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;

(c) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

And, one of the following:

(d) Enable the enrollee to maintain or regain functional capacity; or

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

2. Specific LTC Services to be Provided

a. The Managed Care Plan shall provide the LTC services listed in Attachment I in accordance with Attachment II, Section V., the approved federal waivers for the LTC program, and the Medicaid rules listed below. When providing mixed services exceeding limits outlined in the Medicaid State Plan, Florida Medicaid Coverage and Limitations Handbooks, Florida Medicaid Coverage Policies, and the associated Florida Medicaid Fee Schedules, the Managed Care Plan shall comply with the approved federal waivers for the LTC program and Rule 59G-4.192, F.A.C.

Rule No.	Policy Name	Applicable LTC Services
59G-4.025	Assistive Care Services Coverage and Limitations Handbook	Assistive Care Services

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

b. The Managed Care Plan may provide any of the following in lieu of services to enrollees, in accordance with the requirements for the provision of in lieu of services contained in this contract, after obtaining approval from the Agency.

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

3. Participant Direction Option (PDO)

a. General Provisions

(1) The Managed Care Plan is responsible for implementing and managing the Participant Direction Option (PDO) as defined in Attachment II, Section I,

Section V. Covered Services

Definitions and Acronyms. The Managed Care Plan shall ensure the PDO is available to all Long-term Care enrollees who have any PDO-qualifying service on their authorized care plan and who live in their own home or family home.

- (2) An enrollee's plan of care shall include one or more of the following services in order for the enrollee to be eligible to participate in the PDO: adult companion care, attendant nursing care, homemaker services, intermittent and skilled nursing, or personal care. The enrollee may choose to participate in the PDO for one or more of the eligible PDO services, as outlined in their authorized care plan.
- (3) Enrollees who receive PDO services shall be called "participants" in any PDO specific published materials. The enrollee shall have employer authority. An enrollee may delegate their employer authority to a representative. The representative can neither be paid for services as a representative, nor be a direct service worker. For the purposes of this section, "enrollee" means the enrollee or their representative.
- (4) The Managed Care Plan shall develop PDO-specific policies and procedures that shall be updated at least annually and shall obtain Agency approval prior to distributing PDO materials to enrollees, representatives, direct service workers, and case managers.
- (5) The Managed Care Plan shall operate the PDO service delivery option in a manner consistent with the PDO Manual and the PDO Participant Guidelines provided by the Agency.
- (6) The Agency will provide templates for the following to the Managed Care Plan: PDO Consent Form, PDO Representative Agreement, PDO Participant Guidelines, and PDO Pre-Screening Tool.
- (7) The Managed Care Plan shall maintain books, records, documents, and other evidence of PDO-related expenditures using generally accepted accounting principles (GAAP).
- (8) The Managed Care Plan shall submit a PDO report monthly as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. The Managed Care Plan shall provide ad-hoc PDO related information, records, and statistics, at the request of the Agency within the specified timeframe.
- (9) The Agency will conduct PDO satisfaction surveys on at least an annual basis and shall provide results to the Managed Care Plan for use in quality improvement plans.
- (10) The Managed Care Plan shall cooperate with, and participate in, ongoing evaluations and focus groups conducted by the Agency to evaluate the quality of the PDO.

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b. Training Requirements

- (1) The Managed Care Plan shall ensure all applicable staff receives basic training on the PDO service delivery option
- (2) The Managed Care Plan shall designate staff to participate in PDO training conducted by the Agency.
- (3) The Managed Care Plan shall ensure an adequate number of case managers are trained extensively in the PDO. This extensive PDO training, beyond the general PDO informational training, is provided to case managers who serve enrollees and consists of training specific to PDO employer responsibilities, such as: completing federal and state tax documents, interviewing potential direct service workers, developing Emergency Back-up Plans, training direct service workers, completing the PDO Pre-Screening tool, evaluating direct service worker job performance, and completing and submitting timesheets. The Managed Care Plan shall maintain records of employee training in the employee's file.
- (4) The Managed Care Plan shall provide PDO-trained staff as part of the enrollee and provider call centers to be available during the business hours specified in this Contract.

c. PDO Case Management

- (1) The case manager is responsible for informing enrollees of the option to participate in the PDO when any of the PDO services are listed on the enrollee's authorized care plan.
- (2) The Managed Care Plan shall assign a case manager trained extensively in the PDO within two business days of an enrollee electing to participate in the PDO delivery option.
- (3) In addition to the other case manager requirements in this Contract, all case managers are responsible for:
 - (a) Documenting the PDO was offered to the enrollee, initially and annually, upon reassessment. This documentation shall be signed by the enrollee and included in the case file;
 - (b) Referring Managed Care Plan enrollees, who have expressed an interest in choosing the PDO, to available case managers who have received specialized PDO training.
- (4) In addition to the other case manager requirements in this Contract, case managers who have received extensive PDO training are responsible for:
 - (a) Completing the PDO Pre-Screening Tool with each enrollee and prospective representative;

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- (b) Ensuring enrollees choosing the PDO understand their roles and responsibilities;
 - (c) Ensuring the Participant Agreement is signed by enrollees and included in the case file;
 - (d) Facilitating the transition of enrollees to, and from, the PDO service delivery system;
 - (e) Ensuring PDO and non-PDO services do not duplicate;
 - (f) Training enrollees, initially, and as needed, on employer responsibilities such as: creating job descriptions, interviewing, hiring, training, supervising, evaluating job performance, and terminating employment of the direct service worker(s);
 - (g) Assisting enrollees as needed with finding and hiring direct service workers;
 - (h) Assisting enrollees with resolving disputes with direct service workers and/or taking employment action against direct service workers;
 - (i) Assisting enrollees with developing emergency back-up plans including identifying Plan network providers and explaining the process for accessing network providers in the event of a foreseeable or unplanned lapse in PDO services;
 - (j) Assisting and training enrollees as requested in PDO related subjects.
- d. Enrollee Employer Authority/Direct Service Workers
- (1) Enrollees may hire any individual who satisfies the minimum qualifications set forth in Section VI, Provider Network, including but not limited to neighbors, family members, or friends. The Managed Care Plan shall not restrict an enrollees' choice of direct service worker(s) or require them to choose providers in the Managed Care Plan's provider network.
 - (2) The Managed Care Plan shall inform enrollees, upon choosing the PDO, of the rate of payment for the PDO services. If the rate of payment changes for any PDO service, the Managed Care Plan shall provide a written notice to the applicable enrollees and direct service workers, at least thirty (30) days prior to the change.
 - (3) The Managed Care Plan shall ensure the enrollees update their Participant/Direct Service Worker Agreement indicating any changes in rate of payment.
 - (4) The Managed Care Plan shall provide instructions to the enrollee regarding the submission of timesheets.

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- (5) The Managed Care Plan shall ensure the Participant/Direct Service Worker Agreement includes, at a minimum, include the following:
 - (a) Service(s) to be provided;
 - (b) Hourly rate;
 - (c) Direct service worker work schedule;
 - (d) Relationship of the direct service worker to the enrollee;
 - (e) Job description and duties;
 - (f) Agreement statement; and
 - (g) Dated signatures of the case manager, enrollee, and direct service worker.
 - (6) The Managed Care Plan shall pay for Level II background screening for at least one representative (if applicable) per enrollee and at least one direct service worker for each service per enrollee, per Contract year. The Managed Care Plan shall receive the results of the background screening and make a determination of clearance, adhering to all requirements in Chapters 435 and 408.809 F.S.
 - (7) The Managed Care Plan shall monitor over and under use of services based on payroll and an enrollee's approved plan of care and provide reports to the Agency, or its designee.
- e. Fiscal/Employer Agent
- (1) The Managed Care Plan shall be the Fiscal/Employer Agent (F/EA) for PDO enrollee's or may sub-contract this function. Should any of the F/EA duties be sub-contracted, the Managed Care Plan shall provide enrollees with at least thirty (30) days' notice informing them that the Managed Care Plan shall utilize a subcontractor to perform certain F/EA duties.
 - (2) The Managed Care Plan shall meet all applicable PDO-related Federal and State requirements and shall be operated in accordance with Section 3504 of the Internal Revenue Code, per Revenue Procedure 70-6 and Section 3504 Agent Employment Tax Liability proposed regulations (REG-137036-08) issued by the IRS on January 13, 2010.
 - (3) The Managed Care Plan remain abreast of all federal and state F/EA requirements and tax forms, and shall ensure all materials distributed to enrollees, representatives, direct service workers, and case managers are current, and in accordance with the appropriate federal and state regulations.
 - (4) The Managed Care Plan shall have a separate Federal Employer Identification Number (FEIN) that is used only for purposes of representing

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enrollees as employers. This FEIN should not be used to file or pay taxes for the Managed Care Plan's staff.

- (5) The Managed Care Plan shall complete the following payroll and F/EA tasks:
- (a) Develop a pay schedule and distribute it to all enrollees at least annually;
 - (b) Collect and process timesheets submitted by the enrollee. Resolve any timesheet issues with the enrollee and/or direct service worker;
 - (c) Disburse payroll (no less than twice per month) by direct deposit or pre-paid card to each direct service worker who has a complete and current Hiring Packet on file and has provided services to an enrollee as authorized in the enrollee's plan of care and the Participant/ Direct Service Worker Agreement by the published pay date;
 - (d) Maintain payroll documentation for all direct service workers;
 - (e) Compute, maintain, and appropriately withhold all employer and direct service worker taxes pursuant to federal and state law. All payments that are not in compliance with federal and state tax withholding, reporting, and payment requirements shall be corrected within two (2) business days of identifying an error;
 - (f) Process applicable direct service worker garnishments, liens, and levies in accordance with state and federal garnishment rules. Submit payments and reports to applicable agencies per garnishment instructions;
 - (g) Deposit direct service worker aggregate payroll deductions per federal and state tax deposit requirements. Federal Income Tax, Social Security and Medicare and enrollee Federal Social Security and Medicare (FICA) taxes in the aggregate per deposit frequency required by _____ an _____ F/EA. (See IRS publication 15-A, located at www.irs.gov/);
 - (h) Deposit employer aggregate tax deductions per federal and state tax deposit requirements. Federal Unemployment Tax (FUTA) shall be deposited in the aggregate per F/EA deposit frequency. (See IRS publication 15-A, located at www.irs.gov/);
 - (i) Refund over-collected FICA for direct service workers who earn less than the Federal FICA threshold for the year (See IRS Publication 15, Circular E for threshold information);
 - (j) File a single IRS Form 941, Employer's Quarterly Tax Return in the aggregate on behalf of all enrollees represented by the Managed Care Plan. Form 941 is completed using the Managed Care Plan's separate F/EA, FEIN. Wages and taxes reported represent total, aggregate wages and taxes for all enrollees represented by the Managed Care

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Plan. Schedule B should be completed per rules. The Managed Care Plan shall also complete and submit Schedule R with the Form 941. Schedule R disaggregates each enrollee's employer wages and federal tax liability;

- (k) Adjust Forms 941 as applicable by completing and filing IRS Form 941-X.
- (l) File a single IRS Form 940, Employer's Annual Federal Unemployment Tax Return in the aggregate on behalf of all enrollees represented by the Managed Care Plan. Form 940 is completed using the Managed Care Plan's separate FEIN. Wages and FUTA tax reported represent total, aggregate wages and taxes for all enrollees represented by the Managed Care Plan. Note: Even Managed Care Plans incorporated with a nonprofit 501c3 status SHALL file and pay FUTA on behalf of enrollees;
- (m) Process and distribute IRS Forms W-2 to the direct service workers and submit them electronically according to IRS Form W-2 instructions, per IRS rules and regulations;
- (n) Track payroll disbursed to all direct service workers and provide reports as may be required by the Agency or its designee in accordance with this Contract;
- (o) Provide written notification to the case manager and enrollee if utilization is less than 10% of the monthly hours as approved on the authorized plan of care for more than one (1) month;
- (p) Obtain workers' compensation coverage for the enrollee's direct service workers, if required by Florida statute or rule (see, e.g., Chapter 440, F.S., and Rule 69L, F.A.C.), which shall be funded by the Managed Care Plan;
- (q) Comply with, and support enrollee compliance with, state workers' compensation audits as applicable;
- (r) Prepare for and support enrollee preparation for unemployment claim proceedings, as applicable;
- (s) Maintain records in compliance with Fair Labor Standards Act requirements for employers;
- (t) Ensure a payroll system with maximum data integrity in which direct service workers are not paid above authorized hours as prescribed in the enrollee's plan of care and the Participant/Direct Service Worker Agreement;
- (u) Respond to requests for direct service worker employment verification;

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- (v) Perform all duties regarding disenrollment of an enrollee from the PDO, including final federal and state tax filings and payments and revocation of accounts, numbers, and authorizations previously obtained by the Managed Care Plan. This includes retiring the FEIN and State Unemployment Tax Account (SUTA) Number;
- (w) Provide a transitioning enrollee's new plan with the enrollee's FEIN and SUTA numbers.

f. PDO Monitoring

The Managed Care Plan shall monitor for compliance with PDO requirements, and shall report to the Agency or its designee upon request for an annual F/EA Quality Assessment and Performance Review, including:

- (1) Whether timesheets are signed by the enrollee (or enrollee's authorized representative, if applicable) and the direct service worker;
- (2) Utilization of services based on payroll and an enrollee's approved plan of care;
- (3) Whether services, duties, and hours listed on the Participant/Direct Service Worker Agreement are in compliance with the authorized plan of care;
- (4) Whether direct service workers are qualified pursuant to the PDO Participant Guidelines and the PDO Manual, prior to providing services to an enrollee;
- (5) Duplication of PDO and non-PDO services.

B. Expanded Benefits

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

C. Excluded Services

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

D. Coverage Provisions

1. Case Closure Standard

- a. Case managers are required to provide community referral information on available services and resources to meet the needs of enrollees who are no longer eligible for the Long-term Care component of the SMMC program.
- b. If a service is closed because the Managed Care Plan has determined that it is no longer medically necessary, the enrollee shall be given a written Notice of Action

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regarding the intent to discontinue the service that contains information about his/her rights with regards to that decision.

- c. When the enrollee's enrollment will be changed to another Managed Care Plan, the case manager shall coordinate a transfer between the managed care plans. This includes transferring case management records from the prior twelve (12) months to the new managed care plan.
- d. The case manager is responsible for notification of and coordination with service providers to assure a thorough discharge planning process and transition case management.
- e. Case notes shall be updated to reflect closure activity, including but not limited to:
 - (1) Reason for the closure;
 - (2) Enrollee's status at the time of the closure; and
 - (3) Referrals to community resources if the enrollee is no longer Medicaid eligible.

2. Monitoring of Care Coordination and Services

- a. Service Gap Identification and Contingency Plan
 - (1) The Managed Care Plan shall ensure the case manager review, with the enrollee and/or enrollee's authorized representative, the Managed Care Plan's process for immediately reporting any unplanned gaps in service delivery at the time of each plan of care review for each HCBS enrollee receiving in-home HCBS.
 - (2) The Managed Care Plan shall develop a standardized system for verifying and documenting the delivery of services with the enrollee or enrollee's authorized representative after authorization. The case manager shall verify the Managed Care Plan's documentation of assisted living services components on the individualized plan of care and their delivery as detailed in the plan of care during each face-to-face review.
 - (3) The Managed Care Plan shall develop a form for use as a Service Gap Contingency and Back-Up Plan for enrollees receiving HCBS in the home. A gap in in-home HCBS is defined as the difference between the number of hours of home care worker critical service scheduled in each enrollee's HCBS plan of care and the hours of the scheduled type of in-home HCBS that are actually delivered to the enrollee. This form shall be reviewed and approved by the Agency prior to implementation. The Service Gap Contingency and Back-Up Plan shall also be completed for those enrollees who will receive any of the following HCBS services that allow the enrollee to remain in their own home:
 - (a) Personal Care/Attendant Nursing Care Services, including participant directed services;

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- (b) Homemaker;
 - (c) In-Home Respite; and/or
 - (d) Skilled and intermittent Nursing.
- (4) The following situations are not considered gaps:
- (a) The enrollee is not available to receive the service when the service provider arrives at the enrollee's home at the scheduled time;
 - (b) The enrollee refuses the caregiver when s/he arrives at the enrollee's home, unless the service provider's ability to accomplish the assigned duties is significantly impaired by the caregiver's condition or state (e.g., drug and/or alcohol intoxication);
 - (c) The enrollee refuses services;
 - (d) The provider agency or case manager is able to find an alternative service provider for the scheduled service when the regular service provider becomes unavailable;
 - (e) The enrollee and regular service provider agree in advance to reschedule all or part of a scheduled service; and/or
 - (f) The service provider refuses to go or return to an unsafe or threatening environment at the enrollee's residence.
- (5) The contingency plan shall include information about actions that the enrollee and/or enrollee's authorized representative should take to report any gaps and what resources are available to the enrollee, including on-call back-up service providers and the enrollee's informal support system, to resolve unforeseeable gaps (e.g., regular service provider illness, resignation without notice, transportation failure, etc.) within three (3) hours unless otherwise indicated by the enrollee. The informal support system shall not be considered the primary source of assistance in the event of a gap, unless this is the enrollee's/family's choice.
- (6) The Managed Care Plan's contingency plan shall include the telephone numbers for provider and/or Managed Care Plan that will be responded to promptly twenty-four hours per day, seven days per week (24/7).
- (7) In those instances where an unforeseeable gap in in-home HCBS occurs, it is the responsibility of the Managed Care Plan to ensure that in-home LTC services are provided within three hours of the report of the gap. If the provider agency or case manager is able to contact the enrollee or enrollee's authorized representative before the scheduled service to advise him/her that the regular service provider will be unavailable, the enrollee or enrollee's authorized representative may choose to receive the service from a back-up substitute service provider, at an alternative time from the regular service

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provider or from an alternate service provider from the enrollee's informal support system. The enrollee or enrollee's authorized representative has the final say in how (informal versus paid service provider) and when care to replace a scheduled service provider who is unavailable will be delivered.

- (8) When the Managed Care Plan is notified of a gap in services, the enrollee or enrollee's authorized representative shall receive a response acknowledging the gap.
- (9) The contingency plan shall be discussed with the enrollee or enrollee's authorized representative at least quarterly. A copy of the contingency plan shall be given to the enrollee when developed and, as updated.

3. Monitoring Activities

- a. The Managed Care Plan shall implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of enrollee assessments/service authorizations (inter-rater reliability). The Managed Care Plan shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Managed Care Plan has taken to resolve identified issues. This information shall be submitted to the Agency on a quarterly basis, thirty (30) days after the close of each quarter.
- b. The case management case file audit tool to be used by the Managed Care Plan shall be approved by the Agency prior to implementation and revision.
- c. The Managed Care Plan shall have data collection and analysis capabilities that enable the tracking of enrollee service utilization, cost and demographic information and maintain documentation of the need for all services provided to enrollees.
- d. The Managed Care Plan shall provide reports demonstrating case management monitoring and evaluation as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. These reports shall include results for the following performance measures but not limited to:
 - (1) Level of care related reassessments within three-hundred thirty-five (335) days of previous level of care determination;
 - (2) Complete and accurate level of care forms for annual re-evaluations sent to CARES within thirty (30) days of LOC due date;
 - (3) Number and percentage of staff meeting mandated abuse, neglect and exploitation training requirements;
 - (4) Plan of care audit results;
 - (5) Number and percentage of enrollee plans of care being distributed within ten (10) business days of development, or as updated, to the enrollee's PCP;

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- (6) Number and percentage of plans of care/summaries where enrollee participation is verified by signatures;
 - (7) Number and percentage of enrollee plans of care reviewed for changing needs on a face-to-face basis at least every three (3) months and updated as appropriate;
 - (8) Number and percentage of plan of care services delivered according to the plan of care as to service type, scope, amount and frequency;
 - (9) Number and percentage of enrollees with plans of care addressing all identified care needs;
 - (10) Number and percentage of critical incidents reported within twenty-four (24) hours to the appropriate agency;
 - (11) Number and percentage of case files that include evidence that advance directives were discussed with the enrollee; and
 - (12) Number and percentage of enrollees requesting a Fair Hearing and outcomes.
 - (13) Number and percentage of enrollees whose record contains a plan of care that includes a completed LTC supplemental assessment as defined in 59G-4.192, F.A.C., including the availability of family/informal support systems and the amount of assistance the existing support systems are able to provide to the enrollee.
 - (14) Number and percentage of enrollees whose record contains a plan of care that includes LTC service authorizations for time periods that are shorter than the end date of the plan of care.
- e. The Managed Care Plan shall develop an organized quality assurance and quality improvement program to enhance delivery of services through systemic identification and resolution of enrollee issues as specified in Section VII, Quality and Utilization Management.
- f. The Managed Care Plan shall develop a recording and tracking system log for enrollee complaints and resolutions and identify and resolve enrollee satisfaction issues, as specified in Core Provision, Section IV, Enrollee Services and Grievance Procedures.

4. Missed Services

The Managed Care Plan shall submit a monthly summary report of all missed facility and non-facility services in accordance with Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. For months without missed services, the Managed Care Plan shall submit a report explaining that no authorized covered services were missed during the reported month.

5. Continuity of Care During Temporary Loss of Eligibility

The Managed Care Plan shall provide covered services to enrollees who lose eligibility for up to sixty (60) days. Likewise, care coordination/case management services shall continue for such enrollees for up to sixty (60) days.

6. Behavioral Health

The Managed Care Plan is responsible for coordinating with other entities available to provide behavioral health services including:

- a. Developing and implementing a plan to ensure compliance with s. 394.4574, F.S., related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. A cooperative agreement, as defined in s. 429.02, F.S., shall be developed with the ALF if an enrollee is a resident of the ALF.
- b. Ensuring that appropriate behavioral health screening and assessment services are provided to plan enrollees and that medically necessary mental health targeted case management and behavioral health care services are available to all enrollees who reside in this type of setting.
- c. Educating Managed Care Plan staff on screening; privacy and consent regulations and procedures; referral processes; and follow-up and provider coordination requirements.
- d. Developing a systematic process for coordinating referrals to services for enrollees who request or who are identified by screening as being in need of behavior health care, by facilitating contact with the Medical Assistance managed care plan or other relevant entity or referring them to treatment providers for assessment and treatment.
- e. Documenting all efforts to coordinate services, including the following:
 - (1) Authorizations for release of information;
 - (2) Intake and referral;
 - (3) Diagnosis and evaluation;
 - (4) Needs assessment;
 - (5) Plan of care development;
 - (6) Resource assessment;
 - (7) Plan of care implementation;
 - (8) Medication management;

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- (9) Progress reports;
 - (10) Reassessment and revision of plans of care; and
 - (11) Routine monitoring of services by appropriate clinical staff.
- f. Coordinating with other entities available to ensure that a community living support plan is developed and updated for each enrollee who is a resident of an LMH-ALF. The Managed Care Plan shall ensure the community living support plan is implemented as written.
 - g. Coordinating care (including communication of medication management, treatment plans and progress among behavioral health providers, medical specialists and Long-term Care providers).
 - h. Ensure that a quarterly review of the enrollee's plan of care is conducted to determine the appropriateness and adequacy of services, and to ensure that the services furnished are consistent with the nature and severity of needs. Documentation of this quarterly review shall be maintained on file and provided at the Agency's request.
 - i. Maintaining information about the enrollee's behavioral health condition, the types of services to be furnished, the amount, frequency and duration of each service, and the provider who will furnish each service.
 - j. Provide training to the ALF staff and administrators of the procedures to follow should an urgent or emergent behavior health condition arise and ensuring that the procedures are followed; Assist the facility to develop and implement procedures for responding to urgent and emergent behavior health conditions, if none exist.
 - k. Ensuring that facilities are fully compliant with the voluntary, involuntary and transport provisions of the Baker Act (see chapters 394, 400 and 429, F.S.) for Long-term Care residents who are sent to a hospital or Baker Act receiving facility for psychiatric issues.
 - l. Ensuring through monitoring and reporting that facilities are fully compliant with Baker Act requirements (see s. 394.451, F.S.).
 - m. Provide training to ALF staff which includes:
 - (1) Signs and symptoms of mental illness;
 - (2) Behavior management strategies;
 - (3) Identification of suicide risk and management;
 - (4) Verbal de-escalation strategies for aggressive behavior;

- (5) Trauma informed care;
- (6) Documentation and reporting of behavior health concerns; and
- (7) Abuse, neglect, exploitation and incident reporting standards (as found in Core Provisions, Section VII, Quality and Utilization Management.)

E. Care Coordination / Case Management

1. Case Management Program Description

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

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

2. Contact Management Requirements

- a. General Provisions
 - (1) The Managed Care Plan shall ensure that the enrollee's authorized representative is involved in all face-to-face visits with the enrollee if the enrollee is unable to participate due to a cognitive impairment or if the authorized representative is also the enrollee's legal guardian.
 - (2) The Managed Care Plan shall ensure that all contacts (telephonic and face-to-face visits) attempted and made with, or regarding, an enrollee are

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documented in the enrollee's case file within forty-eight (48) hours of the contact.

- (3) The Managed Care Plan shall ensure access to case managers and back-up case managers as follows:
 - (a) The case manager shall be available for contact by the enrollee or the enrollee's authorized representative during business hours.
 - (b) When the enrollee's case manager is unavailable, the enrollee shall be provided the opportunity to be referred to a back-up case manager for assistance. The back-up case manager shall be available for contact by the enrollee or the enrollee's authorized representative during business hours.
 - (c) The enrollee shall be provided with access to an emergency back-up case manager through an after-hours telephone line.
 - (d) The Managed Care Plan shall ensure a mechanism to ensure enrollees, authorized representatives, and providers receive timely communication when messages are left for case managers.

b. Initial Contact

- (1) The Managed Care Plan shall conduct a face-to-face visit with the enrollee within five (5) business days of the enrollee's effective date of enrollment for enrollees in the community (including ALFs and AFCHs) and within seven (7) business days of the effective date of enrollment for those enrolled in a nursing facility. If information obtained during the initial contact or during the eligibility determination indicates the enrollee has more immediate needs for services, the face-to-face visit should be completed as soon as possible.
- (2) At the initial face-to-face visit, the Managed Care Plan shall:
 - (a) Confirm in writing the enrollee's receipt of the following items:
 - i. Enrollee handbook;
 - ii. Provider Directory; and
 - iii. Managed Care Plan ID Card.
 - (b) Review and have the enrollee or their authorized representative sign the Agency-approved Freedom of Choice Certification Form.
 - (c) Explain the enrollee's rights and responsibilities, including procedures for filing a grievance, appeals, and or Medicaid Fair Hearing including continuation of benefits during the fair hearing process.
 - (d) Conduct a comprehensive assessment of the enrollee and develop an individualized person-centered plan of care.

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- (3) The Managed Care Plan shall follow up by telephone with a community-based enrollee or the enrollee's authorized representative no later than fourteen (14) days after the plan of care development or enrollment effective date, whichever is later, to ensure that services were started as authorized in the plan of care.
 - (4) If the Managed Care Plan is unable to locate/contact an enrollee via telephone, visit or letter, or through information from the enrollee's relatives, neighbors or others, another letter requesting that the enrollee contact the Managed Care Plan should be left at, or sent to, the enrollee's residence. If the Managed Care Plan is unable to locate/contact the enrollee within a continuous sixty (60)-day period, the Managed Care Plan shall report the enrollee to the Agency in accordance with Attachment II, Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.
- c. Frequency and Type of Ongoing Minimum Contact Requirements
- (1) The Managed Care Plan shall maintain, at a minimum, monthly telephone contact with the enrollee to verify satisfaction and receipt of services;
 - (2) The case manager shall meet face-to-face at least every ninety (90) days with the enrollee and/or the enrollee's authorized representative, in order to:
 - (a) Review the enrollee's plan of care and, if necessary, update the enrollee's plan of care. The Managed Care Plan shall review the plan of care in a face-to-face visit more frequently than once every ninety (90) days if the enrollee experiences a significant change;
 - (b) Discuss the frequency, duration, and amount of authorized services, and the authorized providers for each service. If the enrollee or the authorized representative reports any issues or the case manager discovers any issues during the face-to-face visit, the case manager shall document the actions taken to resolve the issues as quickly as possible;
 - (c) Assess needs, including any changes to the enrollee's informal support system;
 - (d) Discuss the enrollee's perception of his/her progress toward established goals;
 - (e) Identify any barriers to the achievement of the enrollee's goals;
 - (f) Develop new goals as needed; and
 - (g) Document the enrollee's current functional, medical, behavioral and social strengths.
 - (3) The Managed Care Plan shall have an annual face-to-face visit with the enrollee to:

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- (a) Complete the annual reassessment using Agency-required forms;
 - (b) Determine the enrollee's functional status, satisfaction with services, and changes in service needs;
 - (c) Develop a new plan of care;
 - (d) Notify an enrollee residing in an ALF or AFCH or receiving ADHC services of their right to receive waiver services in a residential or non-residential setting and to participate in his or her community, regardless of his or her living arrangement; and
 - (e) Review the enrollee handbook to ensure enrollees and their authorized representatives are familiar with the contents, especially related to covered services, enrollee rights and responsibilities, the grievance and appeals process, and reporting abuse, neglect, and exploitation.
- (4) The Managed Care Plan shall conduct a face-to-face visit with the enrollee within five (5) business days following an enrollee's change of placement type (e.g., from a community-based setting to an institutional setting, from the enrollee's own home to an ALF, or from an institutional setting to a community-based setting) or following a significant change in an enrollee's condition. This review shall be conducted to ensure that appropriate services are in place and that the enrollee agrees with the plan of care as authorized.
- (5) The Managed Care Plan shall review and have the enrollee or their authorized representative sign the Agency-approved Freedom of Choice Certification Form upon a change in the enrollee's living arrangement.
- (6) If the Managed Care Plan is unable to contact an enrollee to schedule an ongoing visit, a letter shall be sent to the enrollee or enrollee's authorized representative requesting contact within ten (10) business days from the date of the letter. If no response is received by the designated date, the Managed Care Plan shall report such inability to locate enrollees to the Agency, as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide indicating loss of contact for possible disenrollment from the LTC component of SMMC.

3. Case Management of Enrollees

The Managed Care Plan shall adhere to the following provisions.

a. Person-Centered Care Planning Approach

- (1) The Managed Care Plan shall identify the LTC service needs of enrollees in a plan of care that is developed using a person-centered care planning process described herein. The Managed Care Plan shall use a person-centered approach regarding the enrollee assessment and needs, taking into

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account not only covered services, but also other needed services and community resources, regardless of payor source, as applicable.

- (2) The Managed Care Plan shall ensure that the process:
 - (a) Provides necessary information and support to ensure that the enrollee directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. This includes allowing the enrollee to help make decisions about service options and identification of personal goals.
 - (b) Allows the enrollee to invite anyone of his or her choosing (family members, authorized representatives, friends, or others) to participate.
 - (c) Is timely in accordance with Section V.E.2.b of this Exhibit and occurs at times and locations of convenience to the enrollee.
 - (d) Offers the enrollee choice regarding the services and supports the enrollee receives and from whom.
 - (e) Includes a method for the enrollee to request updates to the plan of care, as needed.

b. Comprehensive Needs Assessment Standard

- (1) General Provisions
 - (a) The Managed Care Plan shall conduct a comprehensive assessment of the enrollee utilizing Agency-required forms.
 - (b) The Managed Care Plan shall assess the recipient's existing support systems, including the availability of family and informal support systems to assist the recipient in meeting activities of daily living and instrumental activities of daily living. Managed Care Plans shall consider the willingness, ability and availability of related caregivers to assist in meeting the enrollee's needs.
 - (c) The Managed Care Plan shall develop a supplemental LTC assessment form that includes the minimum components specified in Rule 59G-4.192, F.A.C., in order to evaluate the level of natural supports that are available to the enrollee and to capture additional information regarding the functional needs of the enrollee. The Managed Care Plan shall submit the plan-developed supplemental assessment form to the Agency for review forty-five (45) days prior to initial implementation and any substantive changes thereafter.

(2) Initial Assessment Requirement

The Managed Care Plan shall conduct a comprehensive needs assessment of the enrollee prior to the development of the initial plan of care. The

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Managed Care Plan shall review and utilize Agency-required forms and the plan-developed supplemental assessment form when completing the initial assessment of the enrollee.

(3) Reassessment Requirement

- (a) The Managed Care Plan shall conduct an annual (or more frequently if needed) reassessment of the enrollee to facilitate the plan of care update.
- (b) The Managed Care Plan shall complete the reassessment using the Agency-required forms and the plan-developed supplemental assessment form.

c. Plan of Care Standard

- (1) The Managed Care Plan shall develop a person-centered plan of care in accordance with Rule 59G-4.192, F.A.C. and 42 CFR 441.301(c)(2), within the timeframes specified within this Exhibit, that is based upon, at a minimum, the results of the comprehensive needs assessment of the enrollee and that is specific to the enrollee's needs.
- (2) Managed Care Plans shall ensure that the written plan of care:
 - (a) Reflects the setting in which the enrollee resides is chosen by the enrollee;
 - (b) Reflects the enrollee's strengths, preferences, and self-care capabilities;
 - (c) Reflects clinical and support needs as identified through the comprehensive needs assessment process;
 - (d) Establishes person-centered goals and objectives, including employment (as applicable) and integrated community living goals, and desired wellness, health, functional, and quality of life outcomes for the member, and how LTC services are intended to help the member achieve these goals;
 - (e) Reflects the services and supports (paid and unpaid) that will assist the enrollee to achieve identified goals, and the providers of those services and supports, including natural supports;
 - (f) Encourages the integration of natural supports including the development of an informal volunteer network of caregivers, family, neighbors, and others to assist the enrollee or primary caregiver with services. These services will be integrated into an enrollee's plan of care when it is determined these services would improve the enrollee's capability to live safely in the home or community setting and are agreed to and approved by the enrollee or the enrollee's authorized representative;

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- (g) Reflects risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
 - (h) Identifies the individual and/or entity responsible for monitoring the plan of care;
 - (i) Prevents the provision of unnecessary or inappropriate services and supports;
 - (j) Documents any modification of the home and community-based setting requirements are supported by a specific assessed need;
 - (k) Identifies any existing plans of care and service providers and assesses the adequacy of existing services; and
 - (l) Determines whether enrollees have advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian.
- (3) The Managed Care Plan shall develop a plan of care template that addresses the criteria specified above and includes the minimum components specified in Rule 59G-4.192, F.A.C. The Managed Care Plan shall submit the plan of care template to the Agency for review forty-five (45) days prior to initial implementation and any substantive changes thereafter.
- (4) The Managed Care Plan shall ensure that copies of the plan of care are forwarded within ten (10) business days of initial development or any subsequent updates to the enrollee's primary care provider and, if applicable, to the facility where the enrollee resides. The primary care provider shall be advised, in writing, of whom to contact with questions regarding the adequacy of the plan of care.
- (5) The enrollee or enrollee's authorized representative shall indicate whether they agree or disagree with each service authorization and review and sign the plan of care at initial development, annual review, and for any changes in services. The Managed Care Plan shall provide a copy of the plan of care to the enrollee or enrollee's authorized representative and maintain a copy in the case file. The enrollee may request additional time to review a draft plan of care prior to signing.
- d. Service Planning Standard
- (1) The Managed Care Plan shall ensure the case manager:
- (a) Provides the enrollee with information about the available providers when service needs are identified so that an informed choice of providers can be made. The entire care planning process shall be documented in the case record.
 - (b) Coordinates the services with appropriate providers upon the enrollee's or enrollee authorized representative's agreement to the plan of care.

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- (c) Identifies the enrollee's primary care provider (PCP) and specialists involved in the enrollee's treatment and obtaining the required authorizations for release of information in order to coordinate and communicate with the primary care provider and other treatment providers.
- (d) Informs the enrollee's primary care and other treatment providers that recipients should be encouraged to adopt healthy habits and maintain their personal independence.
- (e) Informs the enrollee or the enrollee's authorized representative about which Long-term Care services (such as home health nurse, home health aide or durable medical equipment) must be prescribed by the PCP.
- (f) Coordinates physician's orders for those services requiring a physician's order.
- (g) Assists the enrollee in acquiring documentation needed for requested services.
- (h) Coordinates the effort to obtain a PCP or to change the PCP if the enrollee does not have a PCP or wishes to change PCP.
- (i) Verifies that medically necessary services are available in the enrollee's community. If a service is not currently available, the case manager shall substitute a combination of other services in order to meet the enrollee's needs until such time as the desired service becomes available. A temporary alternative placement may be needed if services cannot be provided to safely meet the enrollee's needs.
- (j) Assists enrollees who reside in their own home or family home with developing a disaster/emergency plan for their household that considers the special needs of the enrollee. This plan shall be placed in the enrollee's case file. Informational materials are available at the Federal Emergency Management Agency's (FEMA) website at www.fema.gov or www.ready.gov. Enrollees should also be encouraged to register with the state's Emergency Preparedness Special Needs Shelter Registry, if applicable. For more information go to: <http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/healthcare-system-preparedness/spns-healthcare/>
- (k) Monitors the services and placement of each enrollee assigned to their caseload in order to assess the continued suitability of the services and placement in meeting the enrollee's needs as well as the quality of the care delivered by the enrollee's service providers.

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- (2) The Managed Care Plan shall not require an enrollee to enter an alternative residential placement/setting because it is more cost-effective than living in his/her home.
- (3) The Managed Care Plan shall submit a summary report of the physical location/residence of all enrollees, including Medicaid Pending enrollees, as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

4. Disease Management Program

- a. In addition to the disease management program specified in Attachment II, the Managed Care Plan shall include disease management programs for:
 - (1) Dementia and Alzheimer's issues;
 - (2) Cancer;
 - (3) Diabetes;
 - (4) Chronic Obstructive Pulmonary Disease (COPD); and
 - (5) End of life issues including information on advance directives.
- b. The Managed Care Plan shall develop and implement a disease management programs to combine elements of caregiver support and disease management. The integrated program shall be aimed at providing enrollee caregivers, circles of support for enrollees and the enrollee with support and education to help care for and improve the health and quality of life for the enrollee living with chronic conditions in the home.

F. Quality Enhancements

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

1. Safety concerns in the home and fall prevention;
2. End of life issues, including information on advanced directives; and
3. Ensuring that case managers and providers screen enrollees for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.

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Section VI. Provider Network

A. Network Adequacy Standards

1. Network Capacity and Geographic Access Standards

a. In accordance with s. 409.982(4), F.S., and s. 409.98(1) - (19), F.S., the Managed Care Plan's network shall include the following types of providers: (See LTC Minimum Network Adequacy Requirements Table, for minimum waiver network standards).

- (1) Adult companion providers;
- (2) Adult day health care centers;
- (3) Adult family care homes;
- (4) Assistive care service providers;
- (5) Assisted living facilities;
- (6) Attendant nursing care providers;
- (7) Behavior management providers;
- (8) Caregiver training providers;
- (9) Case managers or case management agency;
- (10) Community care for the elderly lead agencies (CCEs);
- (11) Health care services pools;
- (12) Home adaptation accessibility providers;
- (13) Home health agencies;
- (14) Homemaker and companion service providers;
- (15) Hospices;
- (16) Medication administration providers;
- (17) Medication management providers;
- (18) Medical supplies providers;
- (19) Nurse registries;
- (20) Nursing facilities;

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- (21) Nutritional assessment and risk reduction providers;
 - (22) Personal care providers;
 - (23) Personal emergency response system providers;
 - (24) Transportation providers; and
 - (25) Therapy (occupational, speech, respiratory, and physical) providers.
- b. In accordance with s. 409.982(1), F.S., the Managed Care Plan may limit the providers in its network based on credentials, quality and price; however, during the period between October 1, 2013 and September 30, 2014, the Managed Care Plan shall, in good faith, offer a provider contract to all of the following providers in the region:
- (1) Nursing facilities;
 - (2) Hospices; and
 - (3) Aging network services providers that previously participated in home and community-based waivers serving elders or community-service programs administered by DOEA, as identified by the state.
- c. In accordance with s. 409.982(1), F.S., after twelve (12) months of active participation in the Managed Care Plan's network, the Managed Care Plan may exclude any of the providers named in b. above for failure to meet quality or performance criteria.
- d. Therapy, facility-based hospice, and adult day health care services shall be available within an average of thirty (30) minutes from an enrollee's residence or other preferred location within the region. The Agency may waive this requirement, in writing, for rural areas and for areas where there is no applicable provider within a thirty (30) minute average travel time. Travel time requirements for adult day health care and therapy services are increased to sixty (60) minutes for rural areas.
- e. Unless otherwise provided in this Contract or authorized by the Agency, the Managed Care Plan shall ensure that each county in a region has at least two (2) providers available to deliver each covered HCBS. For HCBS provided in an enrollee's place of residence, the provider does not need to be located in the county of the enrollee's residence but shall be willing and able to serve residents of that county. For adult day health care, the service provider does not have to be located in the enrollee's county of residence, but shall meet the access standards for adult day health care.
- f. Facility-based services are those services the enrollee receives from the residential facility in which they live. For purposes of this Contract ALF, AFCH, assistive care, and nursing facility care services are facility-based.

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- g. The Managed Care Plan shall contract with at least two (2) facility-based service providers per county in the region(s) it serves and meet the licensed bed ratio requirement of one (1) licensed bed for each enrollee. If the Managed Care Plan demonstrates to the Agency's satisfaction that it is not feasible to meet either or both requirements within a specific county within a contracted region, the Agency may provide written authorization to use network facilities from one or more neighboring counties within the region to meet network requirements.
- h. If the Managed Care Plan is able to demonstrate to the Agency's satisfaction that a region as a whole is unable to meet either or both network requirements for facility-based services, the Agency may waive the requirement at its discretion in writing. As soon as additional service providers become available, however, the Managed Care Plan shall augment its network to include such providers in order to meet the network adequacy requirements. Such a written waiver shall require attestation by the Managed Care Plan that it agrees to modify its network to include such providers as they become available.
- i. Facilities from neighboring counties within the region are allowed as additional network providers above and beyond the required number. No state approval is required to include these additional providers in the Managed Care Plan network as long as minimum requirements specified in Section VI.A.1.e. have been met.
- j. The Managed Care Plan may not include facility-based service providers from outside the region as network providers unless the Managed Care Plan's provider agreement or subcontract specifies that it will serve the respective region(s); however, such providers may not be used to meet the region's minimum network requirements. A waiver from the Agency will be necessary if the Managed Care Plan cannot meet network requirements for facility-based services for a region using only providers located within that region.
- k. The Managed Care Plan shall provide authorized HCBS within the timeframe prescribed in Section V, Covered Services. This includes initiating HCBS in the enrollee's plan of care within the timeframes specified in this Contract and continuing services in accordance with the enrollee's plan of care, including the amount, frequency, duration and scope of each service in accordance with the enrollee's service schedule.
- l. The Managed Care Plan shall permit enrollees in the community to choose care through participant direction for allowable services as specified in Section V, Covered Services. Such providers shall agree to all applicable terms of the Managed Care Plan's policies and procedures. Such qualification requirements shall include the minimum provider qualifications in Table 2 and all training and background screening requirements. The Managed Care Plan shall develop any necessary policies, procedures, or agreements to allow providers to provide care to enrollees where appropriate.
- m. The Managed Care Plan shall not continue to contract with providers designated as chronic poor performers, pursuant to the Managed Care Plan's policies and procedures.

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- n. The Managed Care Plan shall permit enrollees to choose from among all Managed Care Plan network residential facilities with a Medicaid-designated bed available. The Managed Care Plan shall inform the enrollee of any residential facilities that have specific cultural or religious affiliations. If the enrollee makes a choice, the Managed Care Plan shall make a reasonable effort to place the enrollee in the facility of the enrollee's choice. In the event the enrollee does not make a choice, the Managed Care Plan shall place the enrollee in a participating residential facility with a Medicaid-designated bed available within the closest geographical proximity to the enrollee's current residence. All Managed Care Plan enrollee placements into participating or non-participating residential facilities shall be appropriate to the enrollees' needs.
- o. The Managed Care Plan shall report monthly to the Agency results of its internal monitoring, ensuring that all Long-term Care providers are appropriately qualified, as specified in Table 1 - LTC Provider Qualifications & Minimum Network Adequacy Requirements, and Table 2 – PDO Provider Qualifications below. This report shall be submitted as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

B. Network Development and Management Plan

1. Regional Network Changes

The Managed Care Plan shall notify the Agency within seven (7) business days of any significant changes to its regional provider network. A significant change is defined as follows:

- a. Managed Care Plans shall report to the Agency a loss of a nursing facility, adult day health care center, AFCH or ALF in a region where another participating nursing facility, adult day health care center, AFCH or ALF of equal service ability is not available to ensure compliance with the geographic access standards specified in this Exhibit.
- b. If the Managed Care Plan excludes an Aging Network Provider, as defined by the state, the Managed Care Plan shall provide written notice to all enrollees who have chosen that provider for care, and the notice shall be provided at least thirty (30) days before the effective date of the exclusion.

2. Facility-based Services Provider Network Changes

- a. The Managed Care Plan shall notify the Agency one hundred twenty (120) days prior to the effective date of termination or exclusion of facility-based services providers.
- b. If the Managed Care Plan terminates or excludes a facility-based provider, as defined in this Contract, the Managed Care Plan shall provide written notice at least sixty (60) days before the effective date of the termination or exclusion to all enrollees who have chosen that provider for care.

C. Provider Credentialing and Contracting

1. Credentialing and Recredentialing

- a. The Managed Care Plan shall establish and verify provider credentialing and recredentialing criteria that includes a determination of whether the provider, or employee or volunteer of the provider, meets the definition of “direct service provider” and completion of a Level II criminal history background screening on each direct service provider to determine whether any have disqualifying offenses as provided for in s. 430.0402, F.S., and s. 435.04, F.S. Any provider, or employee or volunteer of the provider, meeting the definition of “direct service provider” who has a disqualifying offense is prohibited from providing services to enrollees. No additional Level II screening is required of the provider if the provider is a Limited Enrolled or Fully Enrolled Medicaid provider. No additional Level II screening is required of an employee or volunteer of the provider who is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.).
 - (1) The Managed Care Plan shall maintain a signed affidavit from each provider attesting to its compliance with this requirement, or with the requirements of its licensing agency if the licensing agency requires Level II screening of direct services providers.
 - (2) The Managed Care Plan shall include compliance with this requirement in its provider contracts and subcontracts and verify compliance as part of its subcontractor and provider monitoring activity.
- b. The Managed Care Plan shall establish and verify provider credentialing and recredentialing criteria as directed by the Agency to ensure that ALFs, AFCHs, and ADHC providers meet the minimum HCB Settings Requirements.
 - (1) Verification shall include on-site review of the facilities by the Managed Care Plan staff prior to the Managed Care Plan offering the provider as a provider choice to enrollees.
 - (2) The Managed Care Plan shall include language provided by the Agency pursuant to HCB Settings Requirements in its provider contract agreements with ALF, AFCH, and ADHC providers, and shall require ALFs to be in compliance with the Assisted Care Communities Resident Bill of Rights per s. 429.28, F.S.
 - (3) The Managed Care Plan shall include and maintain documentation of all ALF, AFCH, and ADHC’s compliance with HCB Settings Requirements.
- c. When recredentialing a participating nursing facility provider, the Managed Care Plan shall, at a minimum, review the facility’s performance using the following measures as provided on the federal CMS Nursing Home Compare website at: <http://www.medicare.gov/nursinghomecompare/>:

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- (1) If the nursing facility has an overall rating of two (2) or more stars, the nursing facility has met this measure. If the nursing facility has less than two (2) overall stars, proceed with the review.
 - (2) If the nursing facility has a rating of less than two (2) stars in the Quality Measures category within the Long-Stay Residents section, the nursing facility has not met this measure. If the nursing facility has a rating of two (2) or more stars in the Quality Measures category within the Long-Stay Residents section, proceed with the review.
 - (3) Determine under the Quality Measures category within the Long-Stay Residents section, if the percentage of long-stay residents who receive an antipsychotic medication at the nursing facility is the same as the statewide average or less. If the percentage is more than the statewide average percentage, the nursing facility has not met this measure. If the percentage is the same or less than the statewide average percentage, the facility has met this measure.
- d. The Managed Care Plan's credentialing and recredentialing process shall include ensuring that all Long-term Care providers are appropriately qualified, as specified in Rule 59G-4.192, F.A.C. and Table 2 – PDO Provider Qualifications below. Network adequacy requirements for LTC are listed in Table 1 - LTC Minimum Network Adequacy Requirements.
- e. The Managed Care Plan shall provide reports demonstrating provider network qualifications as specified in Attachment II, Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

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Table 1

LTC Minimum Network Adequacy Requirements Table*

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

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Long-term Care Plan Benefit	Minimum Network Adequacy Requirements Urban Counties	Minimum Network Adequacy Requirements Rural Counties
Intermittent and Skilled Nursing	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Medication Administration	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Medication Management	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Medical Equipment & Supplies	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Nutritional Assessment and Risk Reduction	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Nursing Facility Care	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.	At least two (2) providers serving each county of the region and one (1) licensed bed for each enrollee in the applicable max enrollment.
Personal Care	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Personal Emergency Response System	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Respite Care	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Transportation	At least two (2) providers serving each county of the region.	At least two (2) providers serving each county of the region.
Occupational Therapy	At least two (2) providers serving each county of the region AND at least (1) provider within 30 minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within 60 minutes travel time.
Physical Therapy	At least two (2) providers serving each county of the region AND at least (1) provider within 30 minutes travel time.	At least two (2) providers serving each county of the region AND at least (1) provider within 60 minutes travel time.
Respiratory Therapy	At least two (2) providers serving each county of the region AND at least one (1) provider within 30 minutes travel time.	At least two (2) providers serving each county of the region AND at least one (1) provider within 60 minutes travel time.

Long-term Care Plan Benefit	Minimum Network Adequacy Requirements Urban Counties	Minimum Network Adequacy Requirements Rural Counties
Speech Therapy	At least two (2) providers serving each county of the region AND at least one (1) provider within 30 minutes travel time.	At least two (2) providers serving each county of the region AND at least one (1) provider within 60 minutes travel time.

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

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Table 2
PDO Provider Qualifications

Long-term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications
Adult Companion	Individual	None *
Attendant Nursing Care	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Homemaker	Individual	None *
Intermittent/ Skilled Nursing	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Personal Care	Individual	None*

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

2. Provider Contract Requirements

- a. The Managed Care Plan shall include the following provisions in its provider contracts:
 - (1) Require that each provider develop and maintain policies and procedures for back-up plans in the event of absent employees, and that each provider maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees;
 - (2) Include requirements for residential facilities regarding collection of patient responsibility, including prohibiting the assessment of late fees; and
 - (3) For ALFs and AFCHs, that they shall conform to the HCB Settings Requirements. The Managed Care Plan shall include the following statement verbatim in its provider contracts with ALF and AFCH providers:

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

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

Choice of:

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

Ability to have:

- Unrestricted visitation; and
- Snacks as desired.

Ability to:

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

- (4) The Managed Care Plan shall include the following statement in its provider contract with ALF providers:

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

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

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

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

Choice of:

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

Ability to have:

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

- (6) The Managed Care Plan shall include the following provision in its provider contract with nursing facilities and hospices: The provider shall maintain active Medicaid enrollment and submit required cost reports to the Agency for the duration of this agreement.

D. Provider Services

1. Provisions for Providers Subject to HCB Settings Requirements

- a. The Managed Care Plan shall assure all direct service professionals providing LTC waiver services have the requisite responsibility to encourage enrollee independence, inclusion, and integration in the community in accordance with HCB Settings Requirements.
- b. As directed by the Agency, the Managed Care Plan shall monitor provider compliance with Contract requirements and take corrective action as necessary if the Managed Care Plan or the Agency concludes an ALF, AFCH, or ADHC provider does not meet the HCB Settings Requirements.
- (1) Upon discovery of non-compliance with the HCB Settings Requirements by an ALF, AFCH, or ADHC provider, the Managed Care Plan shall require the provider to remediate all areas of non-compliance within ten (10) business days of discovery. The Managed Care Plan must submit documentation of the remediation to the Agency in a format and timeframe specified by the Agency.
- (2) The Managed Care Plan shall not place, continue to place, and/or receive reimbursement for enrollees residing in an ALF or AFCH, or receiving services from an ADHC provider that does not meet the HCB Settings Requirements and/or does not have a provider agreement as specified in Section VI.C.2.a. of this Exhibit.

- c. The Managed Care Plan must terminate providers that are in continuous non-compliance with HCB Settings Requirements.

2. Provider Handbook and Bulletin Requirements

- a. The Managed Care Plan shall include the following information in its provider handbooks:
 - (1) The role of case managers;
 - (2) Requirements for HCBS providers regarding critical incident reporting and management; and
 - (3) Requirements for residential facilities regarding patient responsibility.

E. Medical/ Case Records Requirements

1. Standards for Medical/Case Records

- a. The Managed Care Plan shall ensure the adherence to the following provisions.
- b. The enrollee's case record documents all activities and interactions with the enrollee and any other provider(s) involved in the support and care of the enrollee. The record shall include, at a minimum, the following information:
 - (1) Enrollee demographic data including emergency contact information, guardian contact data, if applicable, permission forms and copies of assessments, evaluations, and medical and medication information;
 - (2) Legal data such as guardianship papers, court orders and release forms;
 - (3) Copies of eligibility documentations, including level of care determinations by CARES;
 - (4) Identification of the enrollee's PCP;
 - (5) Information from quarterly onsite assessments that addresses at least the following:
 - (a) Enrollee's current medical/functional/behavioral health status, including strengths and needs;
 - (b) Identification of family/informal support system or community resources and their availability to assist the enrollee, including barriers to assistance;
 - (c) Enrollee's ability to participate in the review and/or who case manager discusses service needs and goals with if the enrollee was unable to participate, and

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- (d) Environmental and/or other special needs (e.g., safety risks, sanitation, need for physical adaptations, general condition of the home, amount of space, adequacy of sleeping area, access to the bathroom, temperature, availability of food, etc.).
- (6) Needs assessments, including all physician referrals;
- (7) Documentation of enrollee's responses to HCB Settings Requirements queries and enrollee limitations for enrollees in ALFs and AFCHs or receiving ADHC services;
- (8) Documentation of interaction and contacts (including telephone contacts) with enrollee, family of enrollees, service providers or others related to services;
- (9) Documentation of issues relevant to the enrollee remaining in the community with supports and services consistent with his or her capacities and abilities. This includes monitoring achievement of goals and objectives as set forth in the plan of care;
- (10) Residential agreements between facilities and the enrollee;
- (11) Problems with service providers shall be addressed in the narrative with a planned course of action noted;
- (12) Copies of eligibility documents, including LOC determinations;
- (13) Record of Service authorizations;
- (14) CARES assessment documents;
- (15) Documentation that the enrollee has received and signed, if applicable, all required plan and program information (including copies of the enrollee handbook, provider directory, etc.);
- (16) Documentation of the discussion of Advanced Directives and Do Not Resuscitate orders;
- (17) Documentation of the discussion with the enrollee on the procedures for filing complaints and grievances;
- (18) Documentation of the choice of a participant-directed care option;
- (19) Notices of Action sent to the enrollee regarding denial or changes to services (discontinuance, termination, reduction or suspension);
- (20) Enrollee-specific correspondence;
- (21) Physician's orders for Long-term Care services and equipment;

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- (22) Provider evaluations/assessments and/or progress reports (e.g., home health, therapy, behavioral health);
 - (23) Case notes including documentation of the type of contact made with the enrollee and/or all other persons who may be involved with the enrollee's care (e.g., providers);
 - (24) Other documentation as required by the Managed Care Plan;
 - (25) Copy of the contingency plan and other documentation that indicates the enrollee/authorized representative has been advised regarding how to report unplanned gaps in authorized service delivery; and
 - (26) Documentation of choice between institutional and home and community-based services.
- c. Case management enrollee file information shall be maintained by the Managed Care Plan in compliance with state regulations for record retention. Per 42 CFR 441.303(c)(3), written and electronically retrievable documentation of all evaluations and re-evaluations shall be maintained as required in 45 CFR 92.42. The Managed Care Plan shall specify in policy where records of evaluation and re-evaluations of level of care are maintained and exchanged with the CARES unit.
 - d. The Managed Care Plan shall adhere to the confidentiality standards under the Health Insurance Portability and Accountability Act (HIPAA).
 - e. Case files shall be kept secured.
 - f. All narratives in case records shall be electronically signed and dated by the case manager. Electronic signatures with date stamps are allowable for electronic case records.

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Section VII. Quality and Utilization Management

A. Quality Improvement

1. Comprehensive LTC Managed Care Plans shall appoint a Geriatrician to the QI program committee. The Geriatrician shall be a qualified geriatrician with five (5) or more years of experience and/or training in working with elders and a current active unencumbered Florida license under Chapter 458 or 459, F.S. The Geriatrician shall be responsible for establishing and monitoring the implementation and administration of geriatric management protocols to support long-term care requiring geriatric practice.
2. The Managed Care Plan shall establish and maintain an enrollee advisory committee to consider issues for LTC enrollees and obtain periodic feedback from LTC enrollees on satisfaction with care, problem identification, and suggestions for improving the service delivery system. (42 CFR 438.110(a)).
 - (a) The advisory committee shall meet at least twice annually.
 - (b) The Managed Care Plan shall submit to the Agency by October 1st of each year documentation in the form of advisory committee meeting agendas, meeting minutes, and any other documentation that demonstrates the Managed Care Plan’s response to concerns raised by advisory committee participants.

B. Performance Measures (PMs)

1. Required Performance Measures (PMs)

- a. The Managed Care Plan shall collect and report the following performance measures, certified via qualified auditor, as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

HEDIS/Agency-defined	
1	Care for Older Adults (COA): – included components: advance care planning; medication review; and functional status assessment. Add age bands: 18 to 60 years as of December 31 of the measurement year* 61 to 65 years as of December 31 of the measurement year* 66 years and older as of December 31 of the measurement year
Agency-defined	
2	Required Record Documentation (RRD)
3	Face-To-Face Encounters (F2F)
4	Case Manager Training (CMT)
5	Timeliness of Services (TOS)
6	Prevalence of Antipsychotic Drug Use in Long-Stay Dementia Residents
7	Caregiver Support
8	Service Authorization Length

*Agency addition to HEDIS

Section VII. Quality and Utilization Management

- b. The Agency, at its sole discretion, may add and/or change required performance measures based on state and federal quality initiatives. These measures may include, but are not limited to, Medicare measures related to nursing home care and home-based care. Examples of measures that may be included are avoidable hospitalizations; hospital readmissions; prevalence of pressure ulcers; prevalence of use of restraints; rates of antipsychotic drug use; prevalence of dehydration among enrollees; and prevalence of Baker Act-related hospitalizations.
- c. For Required Record Documentation (RRD), the Freedom of Choice form component will not be reported until the July 1, 2016 performance measure report and subsequent performance measure reports.
- d. For the Prevalence of Antipsychotic Drug Use in Long-stay Dementia Residents measure, Managed Care Plans will be notified when they are required to begin reporting this measure and will be provided with measure specifications.

3. Quality Assessment and Performance Improvement Program

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

C. Performance Improvement Projects (PIPs)

The Managed Care Plan shall perform two (2) Agency-approved statewide performance improvement projects (PIPs), one (1) clinical PIP and one (1) non-clinical PIP.

1. The collaborative PIP topic for the long-term care plans is Medication Review. This is a clinical PIP.
2. The Managed Care Plan shall submit a proposed non-clinical PIP topic to the Agency contract manager no later than March 21, 2014.
3. PIP proposals (including activities I through VI of the EQRO PIP validation form) for both the collaborative PIP and the non-clinical PIP are due to the Agency no later than August 1, 2014.

D. Satisfaction and Experience Surveys

1. Enrollee Satisfaction Survey

- a. The Managed Care Plan shall conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for a time period specified by the Agency, using the Home and Community-Based CAHPS Survey 1.0, available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html>.
- b. The Managed Care Plan shall follow the Survey Administration Guidelines below:

Section VII. Quality and Utilization Management

- (1) The Managed Care Plan must contract with an Agency-approved survey vendor certified by the National Committee for Quality Assurance (NCQA) to administer the HCBS CAHPS Survey.
 - (2) The survey must be administered telephonically or in-person.
 - (3) The minimum sample size is 2,000, with a target of 411 completed surveys. The Managed Care Plan shall have its sample validated by an NCQA-certified HEDIS Auditor.
 - (4) To be included in the survey sample, enrollees must have been enrolled in the LTC plan and receiving home and community-based services for at least three (3) consecutive months.
 - (5) The Managed Care Plan must submit an Excel file of the survey results (including the responses to each survey item for each respondent) as well as an Excel file report of the tabulated response rates for the plan for each survey item. Both of these files must be attested to by the Managed Care Plan's survey vendor, and the Managed Care Plan shall submit an attestation regarding the accuracy and completeness of the files.
 - (6) Survey results are due to the Agency by September 1 of each year beginning with the 2018 survey.
- c. The Managed Care Plan shall submit to the Agency, by March 15 of each Contract year, a written proposal for survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a CAHPS survey vendor; sampling methodology; administration protocol; analysis plan; and reporting description. The survey tool and script to be used in administering the survey must also be submitted by March 15 of each Contract year.
- d. The Managed Care Plan shall submit a corrective action plan, as required by the Agency, within sixty (60) days of the request from the Agency to address any deficiencies the annual enrollee satisfaction survey.
- e. The Managed Care Plan shall use the results of the annual member satisfaction survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities conducted by the Managed Care Plan pertaining to improving member satisfaction resulting from the annual enrollee satisfaction survey must be reported to the Agency on a quarterly basis.

E. Provider- Specific Performance Monitoring

1. Medical/Case Record Review

- a. The Managed Care Plan shall conduct medical/case record reviews at the following provider sites:
 - (1) Adult Family Care Homes at least once every two (2) years; and

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- (2) Assisted Living Facilities at least once every two (2) years.

F. Other Quality Management Requirements

1. Abuse/Neglect and Critical Incident Reporting Standard

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

- a. Suspected cases of abuse, neglect and/or exploitation must be reported to the Florida Abuse Hotline (1-800-96A-BUSE) (see s. 415.1034, F.S.). The DCF Adult Protective Services Program has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities, once a report has been accepted by the Abuse Hotline. Abuse Hotline assigns reports of abuse, neglect and/or exploitation to the appropriate Adult Protective Services Unit. If the investigation requires the enrollee to move from his/her current location(s), the Managed Care Plan shall assist the investigator in finding a safe living environment or another participating provider of the enrollee's choice.
 - b. After receiving an intake from the Florida Abuse Hotline, the Adult Protective Investigator assigns a risk-level designation of "low," "intermediate" or "high" for each referral. If the enrollee needs immediate protection from further harm, which can be accomplished completely or in part with the provision of home and community-based services, the referral is designated "high" risk. The Managed Care Plan shall serve enrollees who have been designated "high" risk within seventy-two (72) hours after being referred to the Managed Care Plan from the Florida Adult Protective Services Unit or designee, as mandated by Florida Statute. To ensure that Adult Protective Investigators can easily contact the Managed Care Plan, the Managed Care Plan shall provide Adult Protective Services a primary and back-up contact person, including a telephone number, for "high" risk referrals. The Managed Care Plan's contacts shall return calls from Adult Protective Services within twenty-four (24) hours of initial contact.
 - c. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee's case file, that is designated as confidential. This documentation will consist of only the necessary elements for the treatment of, and service delivery to a vulnerable adult. Such file shall be made available to the Agency upon request.
 - d. Enrollee quality of care issues must be reported to and a resolution coordinated with the Managed Care Plan's Quality Management Department.
2. The Managed Care Plan shall develop and implement a critical incident reporting and management system for incidents that occur in a home and community-based Long-term Care service delivery setting, including: community-based residential alternatives other than assisted living facilities; other HCBS provider sites; and an enrollee's home, if the incident is related to the provision of covered HCBS.
 3. The Managed Care Plan shall require HCBS providers to report critical incidents to the Managed Care Plans within twenty-four (24) hours of the incident. The Managed Care Plan shall not require nursing facilities or assisted living facilities to report

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critical incidents or provide incident reports to the Managed Care Plan. Critical incidents occurring in nursing facilities and assisted living facilities will be addressed in accordance with Florida law, including but not limited to ss. 400.147, 429.23, Chapter 39 and Chapter 415, F.S.

4. If the event involves a health and safety issue for an enrollee with LTC benefits, the Comprehensive LTC Managed Care Plan and case manager shall arrange for the enrollee to move from his/her current location or change providers to accommodate a safe environment and participating or direct service provider of the enrollee's choice.
5. If an investigation of suspected abuse, neglect or exploitation requires the enrollee to move from his/her current locations, the Comprehensive LTC Managed Care Plan shall coordinate with the investigator to find a safe living environment or another participating provider of the enrollee's choice.

G. Utilization Management

1. General Provisions

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

- a. Protocols for ensuring that entities reviewing service authorization requests for LTC services have access to the enrollees' plan of care and information obtained from the comprehensive assessment;
- b. Protocols for evaluating service authorization requests utilizing objective long-term care evidence based criteria;
- c. A description of the responsibilities and scope of authority of case managers in authorizing LTC services and in submitting service authorization requests (when applicable);
- d. A description of the process for authorizing and implementing services based on an incomplete plan of care.
- e. Procedures for ensuring service authorization decisions are consistent with the goals documented on the plan of care;
- f. Mechanisms to assess the quality and appropriateness of care furnished to enrollees (42 CFR 438.330(b)(5)(i));
- g. A description of the process to prevent, detect, and remediate critical incidents (42 CFR 438.330(b)(5)(ii)); and
- h. Protocols for ensuring that there are no gaps in service authorization for enrollees requiring ongoing services.

2. Service Authorizations

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- a. The Managed Care Plan shall ensure service authorizations are consistent with the services documented on enrollee's plan of care, including the frequency and duration necessary to adequately and safely support the enrollee in the setting of his or her choice.
- b. The Managed Care Plan shall not deny covered services based on an incomplete plan of care.
- c. The Managed Care Plan shall authorize ongoing services within the timeframes specified in the enrollee's plan of care.
- d. The Managed Care Plan shall process service authorization requests for respite services that are requested on an emergent basis within the expedited timeframes specified in Attachment II, Section VII.G.2.e.(4).
- e. The Managed Care Plan may determine the duration for which services shall be authorized, except as follows:
 - (1) Maintenance therapies, as defined in Rule 59G-4.192, F.A.C., shall be authorized for no less six (6) months on the enrollee's plan of care. This must be supported by the results from the comprehensive assessment or objective long-term care evidence-based criteria.
 - (2) All other covered services that are authorized for a duration of less than six (6) months must be for the treatment of an acute illness or a condition that will be resolved within six (6) months. The decision must be supported by the PCP's prescription of the service for a shorter duration or, in the case of services that do not require a PCP's prescription, the decision must be supported by objective evidence-based criteria.
 - (3) The authorization time period shall be consistent with the end date of the services as specified in the plan of care.
- f. The Managed Care Plan shall not deny authorization for a service solely because a caregiver is at work or is unable to participate in the enrollee's care because of their own medical, physical or cognitive impairments.
- g. The Managed Care Plan shall not deny medically necessary services required for the enrollee to safely remain in the community because of cost.
- h. The Managed Care Plan shall authorize and initiate services identified on the enrollee's plan of care no later than fourteen (14) days after the plan of care has been developed or updated and ensure services are implemented with reasonable promptness, consistent with the needs of the enrollee and as medically necessary.
- i. The enrollee or enrollee's authorized representative shall be notified in writing of any denial, reduction, termination or suspension of services, that varies from the type, amount, or frequency of services detailed on the plan of care that the

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enrollee or enrollee's authorized representative has signed. Refer to Section IV, Enrollee Services and Grievance Procedures.

- j. If the enrollee disagrees with authorization of services (including the amount and/or frequency of a service), and has the right to file a grievance, appeal or fair hearing in accordance with Attachment II, Section IV.C., Grievance System, and applicable law, the Managed Care Plan shall provide the enrollee with a written notice of action that explains the enrollee's right to file an appeal regarding the placement or plan of care determination.
- k. If the case manager and PCP or attending physician do not agree regarding the need for a change in level of care, placement or physician's orders for medical services, the case manager shall refer the case to the Managed Care Plan's Medical Director for review. The Medical Director is responsible for reviewing the case, discussing it with the PCP and/or attending physician if necessary, and making a determination in order to resolve the issue. The Managed Care Plan shall maintain documentation of any conversations with the PCP and/or attending physician in the enrollee's case record.
- l. In addition to the requirements in Attachment II, Section VII.G., the Managed Care Plan shall ensure a notice of action is provided to enrollees receiving LTC services in each instance during a course of treatment where the Managed Care Plan authorizes fewer units or days subsequent to the initial authorization for the service.
- m. The Managed Care Plan shall submit a monthly summary report of all enrollees whose services have been denied, reduced, or terminated for any reason as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

H. Continuity of Care in Enrollment

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

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Section VIII. Administration and Management

A. Organizational Governance and Staffing

1. Case Management Staff Qualifications and Experience

- a. Case managers shall meet one of the following qualifications:
 - (1) Case Managers with the following qualifications shall also have a minimum of two (2) years of relevant experience:
 - (a) Bachelor's degree in social work, sociology, psychology, gerontology or a related social services field;
 - (b) Registered nurse, licensed to practice in the state;
 - (c) Bachelor's degree in a field other than social science; or
 - (2) Case Managers with the following qualifications shall also have a minimum of four (4) years of relevant experience: Licensed Practical Nurse, licensed to practice in the state.
 - (3) Case Managers with a master's degree in social work, sociology, psychology, gerontology, or a related social services field may substitute experience obtained through a practicum, internship, or clinical rotation on an equivalent basis for up to one (1) year of the experience requirements.
 - (4) Case Managers without the aforementioned qualifications may substitute professional human service experience on a year-for-year basis for the educational requirement. Case Managers without a bachelor's degree shall have a minimum of six (6) years of relevant experience.
- b. All case managers are required to obtain a successful Level II criminal history and/or background investigation.
- c. All Case Managers shall have at least four (4) hours of in-service training in the identification of abuse, neglect and exploitation and shall complete this training requirement annually.
- d. The Managed Care Plan shall ensure that a staff person(s) is designated as the expert(s) on housing, education, behavioral health, and employment issues and resources within the Managed Care Plan's Contract region(s). This individual shall be available to assist case managers with up-to-date information designed to aid enrollees in making informed decisions about their independent living options.

2. Case Management Supervision

- a. Supervision of case managers:

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

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

3. Training

- a. The Managed Care Plan shall provide case managers with adequate orientation and ongoing training on subjects relevant to the population served. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained. The Managed Care Plan shall ensure that there is a training plan in place to provide uniform training to all case managers. This plan should include formal training classes as well as practicum observation and instruction for newly hired case managers.
- b. The training plan and any resources, power points, handouts, or notes shall be submitted to the Agency's FTP site annually by November 1 for the upcoming year.
- c. Newly hired case managers shall be provided orientation and training in a minimum of the following areas:
 - (1) The role of the case manager in utilizing a person-centered approach to Long-term Care case management, including allowing the enrollee to direct the care planning to the maximum extent possible;

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- (2) The role of the case manager in advocating on behalf of the enrollee;
 - (3) Enrollee rights and responsibilities;
 - (4) Enrollee safety and infection control;
 - (5) Participant Direction Option (overview);
 - (6) Case management responsibilities as outlined in this Exhibit;
 - (7) Case management procedures specific to the Managed Care Plan;
 - (8) The Long-term Care component of SMMC and the continuum of Long-term Care services, including available service settings and service restrictions/limitations;
 - (9) The Managed Care Plan's provider network by location, service type, and capacity;
 - (10) Information on local resources for housing, education and employment services/program that could help enrollees gain greater self-sufficiency in these areas;
 - (11) Responsibilities related to monitoring for and reporting of regulatory issues and quality of care concerns, including but not limited to suspected abuse/neglect and/or exploitation and critical incidents (see Chapters 39 and 415, F.S.);
 - (12) Information on Alzheimer's disease and related disorders, and continuing education and training, including risk factors, signs and symptoms, treatment options, and new developments in the field;
 - (13) General medical information, such as symptoms, medications and treatments for diagnostic categories common to the Long-term Care population serviced by the Managed Care Plan;
 - (14) Behavioral health information, including identification of the enrollee's behavioral health needs and how to refer the enrollee to behavioral health services;
 - (15) Reassessment processes using the Agency's required forms.
- d. In addition to review of areas covered in orientation, all case managers shall also be provided with regular ongoing training on topics relevant to the population(s) served. The following are examples of topics that could be covered:
- (1) In-service training on issues affecting the aged and disabled population;
 - (2) Abuse, neglect, and exploitation training;

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- (3) Policy updates and new procedures;
 - (4) Refresher training for areas found deficient through the Managed Care Plan;
 - (5) Interviewing skills;
 - (6) Assessment/observation skills;
 - (7) Cultural competency;
 - (8) Enrollee rights;
 - (9) Participant Direction Option (extensive);
 - (10) Critical incident reporting;
 - (11) Medical/behavioral health issues;
 - (12) Medication awareness (including identifying barriers to compliance and side effects); and/or
- e. The Managed Care Plan shall ensure all case management staff hold current CPR certification.
 - f. The Managed Care Plan shall submit reports to the Agency on case manager training as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.

4. Caseload Requirements

- a. The Managed Care Plan shall have an adequate number of qualified and trained case managers to meet the needs of enrollees.
- b. Caseload Ratio Requirements:
 - (1) The Managed Care Plan shall ensure that case manager caseloads do not exceed:
 - (a) A ratio of sixty (60) enrollees to one (1) case manager for enrollees that reside in the community, except as follows: no more than a ratio of forty (40) enrollees to one (1) case manager for enrollees under age twenty-one (21) years receiving private duty nursing services in their family home or other community-based setting;
 - (b) No more than a ratio of one hundred (100) enrollees to one (1) case manager for enrollees age twenty-one (21) years or older that reside in a nursing facility; or

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- (c) No more than a ratio of fifteen (15) enrollees to one (1) case manager for enrollees under age twenty-one (21) years who reside in a skilled nursing facility.
- c. The Managed Care Plan may implement a mixed caseload of enrollees.
- d. Where the case manager's caseload consists of enrollees who reside in the community and enrollees who reside in nursing facilities (mixed caseload), and if none of the enrollees who reside in a nursing facility are under the age of twenty-one (21) years, the Managed Care Plan shall ensure that the ratio does not exceed sixty (60) enrollees to one (1) case manager, except as follows: no more than a ratio of forty (40) enrollees to one (1) case manager for enrollees under age twenty-one (21) years receiving private duty nursing services in their family home or other community-based setting.
- e. If the mixed caseload includes any enrollees residing in nursing facilities who are under the age of twenty-one (21) years, the Managed Care Plan shall ensure that the ratio does not exceed fifteen (15) enrollees to one (1) case manager.
- f. The Managed Care Plan may submit a request to the Agency to implement a mixed caseload of enrollees. The Managed Care Plan shall receive authorization from the Agency prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established by the Managed Care Plan and do not require authorization. The Managed Care Plan shall submit any caseload exception requests to the Agency. The Agency may, at any time, revoke the Managed Care Plan's authorization to exceed caseload ratios.
 - (1) The Managed Care Plan shall have written protocols to ensure newly enrolled enrollees are assigned to a case manager immediately upon enrollment. The case manager assigned to special subpopulations (e.g., individuals with AIDS, dementia, behavioral health issues or traumatic brain injury) shall have experience or training in case management techniques for such populations.
 - (2) The Managed Care Plan shall ensure that case managers are not assigned duties unrelated to enrollee-specific case management for more than fifteen percent (15%) of their time if they carry a full caseload.
 - (3) The Managed Care Plan shall report to the Agency monthly on its case manager caseloads as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

B. Subcontracts

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

C. Information Management and Systems

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

Section VIII. Administration and Management

D. Claims and Provider Payment

For Medicaid only enrollees residing in a nursing facility and receiving hospice services, the Managed Care Plan shall pay the hospice provider the per diem rate set by the Agency for hospice services.

E. Encounter Data Requirements

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

F. Fraud and Abuse Prevention

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

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Section IX. Method of Payment

A. Fixed Price Unit Contract

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

B. Payment Provisions

1. Capitation Rates

- a. The Agency will prospectively adjust the base capitation rates included in Attachment I, Scope of Services to reflect the Managed Care Plan's enrolled risk.
- b. The Agency will develop a pre-enrollment benchmark case mix for each region based on analysis of the most recent twelve (12) months of historical data that allows for three (3) months of claims run out. The enrollment distribution will be calculated using population segmentation logic consistent with that used in rate development. Recipients whose last care setting prior to the start of the capitation rate period was nursing facility will be classified as Non-HCBS. Recipients who become program-eligible after the start of the capitation rate period will be classified as Non-HCBS based on program codes that indicate Institutional Care Program eligibility. Enrollees not meeting the Non-HCBS classification criteria will be classified as HCBS. For rate purposes, for both the transitioned and new enrollees, the recipient's initial classification will remain valid through the duration of the capitation rate period.
- c. Month 1: In each region, the Agency will pay the Managed Care Plan a blended capitation rate that reflects the regional pre-enrollment benchmark case mix, adjusted for the Agency-required transition percentage, which is included as Attachment I, Scope of Services, Exhibit I-C. AHCA will later perform a reconciliation based on month one (1) actual enrollment and case mix for each plan.
- d. Subsequent months: For the second month and each subsequent month of the contract payment period, AHCA will develop a blended capitation rate for the Managed Care Plan, adjusted for the new enrollments and disenrollments that occurred in the previous month, and adjusted for the Agency-required transition percentage.
- e. From August 1, 2013 to August 31, 2014 only, once ninety-five percent (95%) of regional eligible recipients are enrolled in managed care plans, the Agency will ensure that the recalibrated rates are budget neutral to the State on a PMPM basis. The benchmark against which budget neutrality will be measured is the region-wide rate based on the pre-enrollment case mix with the Agency-required transition percentage.

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2. Rate Adjustments and Reconciliations

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

Section IX. Method of Payment

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

Section IX. Method of Payment

- i. The Agency will annually reconcile between the hospice per diem and room and board payment rates used in the capitation rates paid and the actual published payment rates. This hospice-specific reconciliation will be performed using the Managed Care Plan's own utilization, as reflected through encounter data that covers the capitation rate period dates of services with at least four (4) months of claims run out.
 - ii. The Managed Care Plan shall review and provide written comments or a letter of concurrence to the Agency within forty-five (45) days after receipt of the reconciliation results. This reconciliation is considered final if the Managed Care Plan concurs with the result.
 - iii. Comments and errors identified are limited to the published rates reviewed and related Managed Care Plan hospice payments, and methodology, and/or calculations.
 - iv. If the Managed Care Plan or the Agency comments that such an error has occurred, a new forty-five (45) day review period shall start on the date the Managed Care Plan receives the Agency's final determination of the reconciliation results. The Agency's final determination of the reconciliation results shall be final and conclusive. The Managed Care Plan may dispute the Agency's decision as per Attachment II, Core Contract Provisions, Section XII. Special Terms and Conditions, if it does not concur with the results.
 - v. If the Managed Care Plan does not provide comments within the forty-five (45) day period, no further opportunity for review consideration will be provided.
- (3) Patient Responsibility Reconciliation. The Managed Care Plan shall have its annual patient responsibility collections and HCBS waiver service costs report reviewed annually to verify the patient responsibility collections on a per capita basis did not exceed the cost of HCBS services. If the per capita patient responsibility collections exceed the HCBS waiver costs, the Agency will adjust the capitation to correct the Managed Care Plan overpayment.
 - (4) Nursing Facility, Hospice and Patient Responsibility Collection Reconciliation Schedule. The Agency will announce the reconciliation schedule after the close of each capitation rate period. The Managed Care Plan shall respond to any Agency requests for additional information concerning the reconciliation within fifteen (15) days of notification.
 - (5) Actual hospice payments shall be reconciled by the Agency to ensure actual claim payments are, at a minimum, the same as Medicaid fee-for-service (FFS) claim payments. Any Managed Care Plan provider payments to hospices in excess of FFS claim payment will not be reimbursed by the agency or in any way increase per member per month payment to the Managed Care Plan in any current or future capitation rate setting period.

Section IX. Method of Payment

The Managed Care Plan accepts and assumes all risks of excess payments as a cost of doing business and cannot seek additional Medicaid payments for such business decisions. Any inadvertent payments made by the Agency to a Managed Care Plan in excess of the FFS amount shall be overpayments and shall be recouped.

3. Community High Risk Pool (CHRP)

- a. The Community High Risk Pool (CHRP) for the SMMC Long-term Care (LTC) program, implemented July 1, 2014, recognizes the disproportionate enrollment of high cost home and community-based (HCBS) recipients. The CHRP operates as a revenue neutral redistribution of plan reimbursement associated with community enrollees. The risk pool is funded through a small withhold amount applied to the pre-transition adjusted HCBS enrollment for the LTC contractor. Encounter data submissions are required in accordance with **Attachment II**, Core Contract Provisions, Section VIII, Administration and Management, E., Encounter Data Requirements. The Agency shall analyze the LTC encounter data submitted by the LTC plans.
 - (1) Only HCBS services will be used to evaluate the SMMC LTC risk pool for an enrolled recipient.
 - (2) Costs associated with nursing home services and hospice services are explicitly excluded from the distribution of the risk pool.
- b. Effective July 1, 2014, the Agency will establish a withhold per-member-per-month (PMPM) on a quarterly basis.
 - (1) The withhold PMPM will use only state-plan or waiver approved services and exclude nursing facility and hospice services.
 - (2) The CHRP will be established by SMMC LTC region.
 - (3) The Agency may adjust the PMPM withhold value on a quarterly basis as necessary.
 - (4) The Agency shall communicate the terms of the CHRP including the threshold and coinsurance amount each quarter.
 - (5) The established CHRP withhold will be applied to the pre-transition HCBS enrollment on a monthly basis.
- c. The Agency will distribute the funds in the CHRP in proportion to each LTC Plan's reported or Agency adjusted expenditures in excess of the CHRP threshold average PMPM for HCBS recipients for the quarterly period.
 - (1) The Agency will utilize encounter data submitted by the LTC Plan and the enrollment maintained by the Agency to evaluate LTC plan expenditures for the purpose of distributing the CHRP funds. Encounter data shall be submitted in accordance with Attachment, II, Core Contract Provisions,

Section IX. Method of Payment

Section VIII, Administration and Management, E., Encounter Data Requirements.

- (2) The Agency shall aggregate the qualified service expenditures from the encounter data by LTC Plan for the quarter based on incurred date reported on the encounter data for HCBS recipients who were eligible on the date of service. The Agency, at its discretion, may reprice encounter data based on what the Agency would have paid for the same services under fee-for-service.
 - (3) The first CHRP distribution will cover the months of July and August 2014, for incurred dates paid through November 2014, with payment in March 2015, after which distributions will occur every three (3) months) using the following schedule:
 - (a) May Disbursement – Claims incurred September – November, paid and submitted through February;
 - (b) August Disbursement – Claims incurred December – February, paid and submitted through May;
 - (c) November Disbursement – Claims incurred March – May, paid and submitted through August; and
 - (d) February Disbursement – Claims incurred June – August, paid and submitted through November.
 - (4) At the end of each twelve (12) month period, in the event the eligible expenditures for the CHRP are less than the total amount withheld the balance of the withheld amount less any disbursement for eligible expenditures will be refunded to the LTC Plans participating in the region.
 - (5) At the end of each twelve (12) month period, in the event the LTC Plan(s) in a region do not have any HCBS recipients whose expenditures meet the threshold the withheld amounts will be refunded to the LTC Plans participating in the region.
 - (6) At the end of each twelve (12) month period, the Agency will close the funds, eliminating any carry over balances, and return any unused portion of each regional fund to the LTC Plans operating in that region on a per member basis. The Agency, at its discretion, may distribute any unused portion of the funds from the pool before the end of the twelve (12) month period.
- d. The Agency may adjust prior CHRP distributions if the encounter data used for the original CHRP distribution has changed through adjustments submitted in the encounter data that may include but are not limited to voided and replaced encounters submitted by the LTC Plans or a recipients retro-active disenrollment from the SMMC LTC program. Twelve (12) months after the end of the quarter, the Agency will make no further post-payment adjustments.

Section X. Financial Requirements

A. Insolvency Protection

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

B. Surplus

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

C. Interest

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

D. Third Party Resources

1. Patient Responsibility

- a. The Managed Care Plan is responsible for collecting patient responsibility as determined by DCF and shall have policies and procedures to ensure that, where applicable, enrollees are assessed for and pay their patient responsibility. Some enrollees have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility.
- b. The Managed Care Plan may transfer the responsibility for collecting its enrollees' patient responsibility to residential providers and compensate these providers net of the patient responsibility amount. If the Managed Care Plan transfers collection of patient responsibility to the provider, the provider contract shall specify complete details of both parties' obligations in the collection of patient responsibility. The Managed Care Plan shall either collect patient responsibility from all of its residential providers or transfer collection to all of its residential providers.
- c. The Managed Care Plan shall have a system in place to track the receipt of patient responsibility at the enrollee level irrespective of which entity collects the patient responsibility. This data shall be available upon request by the Agency. The Managed Care Plan or its providers shall not assess late fees for the collection of patient responsibility from enrollees.
- d. The Managed Care Plan shall submit a Patient Responsibility Report annually, in accordance with Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide. If an enrollee's patient responsibility exceeds the reported Medicaid Home and Community Based service expenditure, the Agency will employ the reconciliation process detailed in Section IX.B., Payment Provisions, to determine if a payment adjustment is required.

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Section X. Financial Requirements

E. Assignment

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

F. Financial Reporting

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

G. Inspection and Audit of Financial Records

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

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Section XI. Sanctions

A. Contract Violations and Non-Compliance

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

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

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

C. Performance Measure Sanctions

1. The Agency may sanction the Managed Care Plan for failure to achieve minimum performance scores on performance measures specified by the Agency after the first year of poor performance. The HEDIS measure will be compared to the National Committee for Quality Assurance HEDIS National Means and Percentiles. The Agency-defined measures have threshold rates (percentages) that may trigger a sanction. The Survey-based measures have threshold average ratings (from 0-10) that may trigger a sanction.

Performance Measure Sanction Table – Effective 8/01/2013 – 8/31/2018	
HEDIS Measures	Rate and applicable sanction
Care for Older Adults	Rate < 25 th percentile - immediate monetary sanction and PMAP may be imposed Rate < 50 th percentile - PMAP may be required
Agency-defined Measures	Rate and applicable sanction
Required Record Documentation – numerators 1-4	Rate < 85% - immediate monetary sanction and PMAP may be imposed Rate < 90% - PMAP may be required
Face-to-Face Encounters	
Case Manager Training	
Timeliness of Service	
Survey-based Measures	Average rating and applicable sanction
Satisfaction with Long-term Care Plan	Rate 4.0 or lower – immediate monetary sanction and PMAP may be imposed Rate 5.0 or lower – PMAP may be required
Satisfaction with Care Manager	
Rating of Quality of Services	

2. Monetary sanctions: The Managed Care Plan may receive a monetary sanction for measures for which their scores meet the thresholds given in the above table for the first offense. Managed Care Plans shall receive a monetary sanction for measures for which their scores meet the thresholds given in the above table for the second offense and subsequent offenses. For the HEDIS and Agency-defined measures, if the Health Plan has a score/rate that triggers an immediate monetary sanction, the Health Plan may be sanctioned \$500 for each case in the denominator not present in the numerator. If the Health Plan fails to improve these performance measures in subsequent years, the Agency will impose a sanction of \$1,000 per case. For each

Section XI. Sanctions

Survey-based measure in the table above for which the Health Plan has an average rate that triggers an immediate monetary sanction, the Health Plan may be sanctioned \$10,000.

3. The Agency may amend the performance measure thresholds and sanctions and will notice the Managed Care Plans prior to the start of the applicable measurement year or with an amount of notice mutually agreed upon by the Agency and the Managed Care Plans. Amendments to the performance measure thresholds and sanctions may include, but are not limited to, adding and removing performance measures from the sanction strategy, changing thresholds for sanctions, and changing the monetary amounts of sanctions.

D. Other Sanctions

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

E. Notice of Sanctions

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

F. Dispute of Sanctions

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

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Section XII. Special Terms and Conditions

A. Conflict of Interest

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

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Section XIII. Liquidated Damages

A. Damages

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

B. Issues and Amounts

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

Liquidated Damages Issues and Amounts		
#	LTC PROGRAM ISSUE	DAMAGES
1	Failure to comply with the medical/case records documentation requirements pursuant to the Contract.	\$500 per plan of care for HCBS enrollees that does not include all of the required elements. \$500 per enrollee file that does not include all of the required elements. \$500 per face-to-face visit where the care coordinator fails to document the specified observations. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the caseload and staffing requirements
2	Failure to comply with the timeframes for developing and approving a plan of care for transitioning or initiating home and community-based services as described in the Contract.	\$500 per day, per occurrence.
3	Failure to have a face-to-face contact between the Managed Care Plan case manager and each enrollee at least every ninety (90) days or following a significant change as described in the Contract.	\$5,000 for each occurrence.
4	Failure to complete in a timely manner minimum care coordination contacts required for persons transitioned from a nursing facility to a community placement as described in the Contract.	\$500 per day, per occurrence.
5	Failure to meet the performance standards established by the Agency regarding missed visits for personal care, attendant nursing care, homemaker, or home-delivered meals for enrollees (referred to herein as "specified HCBS") pursuant to the Contract.	\$500 per occurrence.

Section XIII. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	LTC PROGRAM ISSUE	DAMAGES
6	Failure to develop a person-centered plan of care for an enrollee that includes all of the required elements, and which has been reviewed with and signed and dated by the enrollee or enrollee’s authorized representative, unless the enrollee or enrollee’s authorized representative refuses to sign, which shall be documented in writing as described in the Contract.	\$500 per deficient plan of care. These amounts shall be multiplied by two (2) when the Managed Care Plan has not complied with the caseload and staffing requirements specified in the Contract.
7	Failure to meet any timeframe regarding care coordination for enrollees as described in the Contract.	\$250 per day, per occurrence.
8	Failure to follow-up no later than fourteen (14) days after the plan of care has been developed or updated, to ensure that services are in place as described in the Contract.	\$500 for each occurrence.
9	Failure to provide a copy of the plan of care to each enrollee's PCP and residential facility in the timeframes as described in the Contract.	\$500 per day.
10	Failure to report enrollees that do not receive any Long-term Care services listed in the approved plan of care for a month, as described in the Contract.	For each enrollee, an amount equal to the capitation rate for the month in which the enrollee did not receive Long- term Care services.
11	Failure to comply with obligations and time frames in the delivery of annual face-to-face reassessments for level of care as described in the Contract.	\$1,000 per occurrence.
12	Failure to ensure that for each enrollee all necessary paperwork is submitted to DCF within the timeframes included in the Contract.	\$100 assessed for each enrollee who temporarily loses eligibility (for less than sixty (60) days) pursuant to a redetermination.
13	Failure to follow-up within twenty-four (24) hours of initial contact by the Florida Adult Protective Services Unit for “high risk” referrals pursuant to Attachment II, Exhibit II-B, Section V.D.2.b. of this Contract.	\$5,000 per occurrence
14	Failure to serve enrollees who have been designated as “high risk” within seventy-two (72) hours after being referred to the Managed Care Plan from the Florida Adult Protective Services Unit or designee, as mandated by Florida Statute.	\$5,000 per occurrence

Section XIII. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	LTC PROGRAM ISSUE	DAMAGES
16	Failure to report suspected cases of abuse, neglect, and/or exploitation of elders and individuals with disabilities to the Florida Abuse Hotline (1-800-96A-BUSE) (see s. 415.1034, F.S.)	\$5,000 per occurrence
17	Performance Measure: Care for Older Adults	Failure to achieve a rate at the 25 th percentile (per the NCQA National Means and Percentiles, Medicare) or higher will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 25 th percentile rate.
18	Performance Measure: Required Record Documentation – numerators 1-4	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 90% target rate.
19	Performance Measure: Face-to-Face Encounters	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 90% target rate.
20	Performance Measure: Case Manager Training	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 90% target rate.
21	Performance Measure: Timeliness of Service	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 90% target rate.

Section XIII. Liquidated Damages

Liquidated Damages Issues and Amounts		
#	LTC PROGRAM ISSUE	DAMAGES
22	Performance Measure: Satisfaction with Care Manager and LTC Managed Care Plan	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 90% target rate.
23	Performance Measure: Rating of Quality of Services	Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$100 per each case in the denominator not present in the numerator for the measure up to the 90% target rate.

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Section XIV. Reporting Requirements

A. Managed Care Plan Reporting Requirements

1. Required Reports

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

Summary of Reporting Requirements		
Report Name	Plan Type	Frequency
Case Manager and Provider Training Report	All Comprehensive LTC Plans	Monthly
Case Manager Caseload Report	All Comprehensive LTC Plans	
Case Management File Audit Report	All Comprehensive LTC Plans	Quarterly
Case Management Monitoring and Evaluation Report	All Comprehensive LTC Plans	Quarterly and Annually
Critical Incident Report	All Comprehensive LTC Plans	Immediately upon occurrence and no less than within twenty-four (24) hours of detection or notification
Denial, Reduction, Termination or Suspension of Services Report	All Comprehensive LTC Plans	Monthly
Enrollee Roster and Facility Residence Report	All Comprehensive LTC Plans	Monthly
Missed Services Report	All Comprehensive LTC Plans	Monthly
Participant Direction (PDO) Roster Report	All Comprehensive LTC Plans	Quarterly
Patient Responsibility Report	All Comprehensive LTC Plans	Annually
Provider Network and Qualifications Report	All Comprehensive LTC Plans	Quarterly
Unable to Locate Report	All Comprehensive LTC Plans	Monthly

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