Attachment X

- Provider Access and Availability

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Evidence of Capacity to Provide Covered Services *s. 1932(b)(7)* 1932(b)(7) Social Security Act s.4704(a) of the BBA *CC-VII.A.2.a-b*	The health plan: a. Offers an appropriate range of services and accessible preventive and primary care services to meet the needs of the maximum enrollment level in each county. b. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Submitting Network Providers to the Agency *CC-VII.A.3*	At least monthly, the health plan submits a file of all network providers to the Agency or its agent in the manner and format determined by the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Hospital Privileges *CC-VII.A.4.*	Each provider maintains hospital privileges if hospital privileges are required for the delivery of covered services. The health plan may use admitting panels to comply with this requirement.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Provider Discrimination *CC-VII.A.5*	The health plan does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
5. Establishing and Maintaining Provider	When establishing and maintaining the provider network, the health plan takes	a. Yes ☐ No ☐	☐ Met ☐ Partially Met		

Standard X: Access and Availability

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Network *42 CFR 438.206* *CC-VII.A.6.a-e*	the following into consideration: a. The anticipated number of enrollees. b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented. c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the covered services. d. The numbers of network providers who are not accepting new enrollees. e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees and whether the location provides physical access for Medicaid enrollees with disabilities.	b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐	☐ Not Met		
6. Out-of-Network Providers	If the health plan is unable to provide medically necessary services to an enrollee, the health plan covers the services in an adequate and timely manner by using providers and services that are not in the health plan's network for as long as the health	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability

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42 CFR 438.206(b)(4) *CC-VII.A.7*	plan is unable to provide the services within its network.				
7. Second Opinion *42 CFR 438.206* *CC-IV.G.6*	The health plan must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. Enrollee Choice of Network Providers *CC-VII.A.8*	The health plan allows each enrollee to choose among network providers to the extent possible and appropriate.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
9.Provider Discrimination *s. 1932(b)(7) of the Social Security Act* *4704(a) of the BBA* *CC-VII.A.10*	The health plan does not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of the provider's license or certification.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
10. Refusing to Accept Providers *CC-VII.A.10*	If the health plan declines to include individual providers or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. Provider Relations *CC-VII.A.11*	The health plan establishes and maintains a formal provider relations function to timely and adequately respond to inquiries, questions and concerns from network providers.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. Provider Network: PCPs	The health plan enters into written agreements with a sufficient number of	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability					
CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.B.1.a	PCPs to ensure adequate accessibility for enrollees of all ages.				
13. PCP Availability *CC-VII.B.1.a.1*	The health plan ensures that PCPs agree to provide or arrange for coverage of services, consultations, or approval for referrals twenty-four (24) hours per day, seven days per week from Medicaid-enrolled providers. The coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
14. PCP 24-Hour Coverage Requirements *CC-VII.B.1.a.1*	The chosen method of twenty-four (24) hour coverage connects the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after hour's coverage is accessible using the medical office's daytime telephone number.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
15. PCP Coverage *CC-VII.B.1.a.2*	The health plan ensures that PCPs arrange for coverage of primary care services by a Medicaid-eligible primary care provider during absences due to vacation, illness, or other situations which require the PCP to be unable to provide services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
16. Provider to Enrollee	The health plan provides at least one	Yes ☐	☐ Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Ratio *CC-VII.B.1.b.2*	(1) FTE PCP per 1,500 enrollees. The health plan may increase the ratio by 750 Enrollees for each FTE ARNP or FTE PA affiliated with a PCP.	No ☐	☐ Partially Met ☐ Not Met		
17. Obstetricians as PCPs *CC-VII.B.1.b.3*	The health plan allows pregnant enrollees to choose the health plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
18. Newborn PCP Assignment *CC-VII.B.1.c*	If the enrollee has not selected a provider for a newborn, the health plan assigns a pediatrician or other appropriate PCP to all pregnant enrollees for the care of their newborn babies no later than the beginning of the last trimester of gestation.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
19. Provider Network: HIV Expertise *CC-VII.B.2.b*	If the infectious disease specialist does not have expertise in HIV and its treatment and care, then the health plan has another provider with such expertise.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
20. Direct Access to Women's Health Specialists 42 CFR 438.206(b)(2) *CC-VII.B.2.c*	The health plan permits female enrollees to have direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to an enrollee's designated PCP, if that provider is not a women's health specialist.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
21. Provider Network: Certified Nurse Midwife 641.31, F.S. Chapter 467, F.S. *CC-VII.B.2.d*	The health plan ensures access to certified nurse midwife services or licensed midwife services for low risk enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
22. Agreements with County Health Departments *CC-VII.B.3.a*	The health plan makes a good faith effort to execute memoranda of agreement with the local county health departments (CHDs) to provide services which may include: family planning services, services for the treatment of sexually transmitted diseases, other public health related diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and services related to Healthy Start prenatal and postnatal screenings. The health plan provides documentation of its good faith effort upon request by the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
23. CAPITATED PLANS: Payment for Services *CC-VII.B.3.b*	A capitated health plan pays, without prior authorization, at the contracted rate or the Medicaid fee-for-service rate, all valid claims initiated by any CHD for office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
24. CAPITATED	A capitated health plan reimburses the	Yes ☐	☐ Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
PLANS: Reimbursing CHD *CC-VII.B.3.b*	CHD when the CHD notifies the health plan and provides the health plan with copies of the appropriate medical records and provides the enrollee's PCP with the results of any tests and associated office visits.	No ☐ N/A ☐	☐ Partially Met ☐ Not Met		
25. County Health Department: Payment	The health plan authorizes all claims from a CHD, a migrant health center or a community health center, without prior authorization for the services listed below. Such providers attempt to contact the health plan before providing health care services to enrollees and provide the health plan with the results of the office visit, including test results. a. The diagnosis and treatment of sexually transmitted diseases and other reportable infectious diseases, such as tuberculosis and HIV. b. The provision of immunizations. c. Family planning services and related pharmaceuticals. d. School health services (family planning services, services for the treatment of sexually transmitted diseases, other public health	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Section 329 of Public Health Services Act Section 330 of Public Health Services Act *CC-VII.B.3.c*	related diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and services related to Healthy Start prenatal and postnatal screenings), and for services rendered on an urgent basis by such providers. e. In the event that a vaccine-preventable disease emergency is declared, the health plan authorizes claims from the CHD for the cost of the administration of vaccines.				
26. County Health Department: Payment *CC-VII.B.3.d*	Other clinic-based services provided by a CHD, migrant health center or community health center, including well-child care, dental care, and sick care services not associated with reportable infectious diseases, require prior authorization from the health plan in order to receive reimbursement. If prior authorization is provided, the health plan reimburses at the entity's cost-based reimbursement rate. If prior authorization for prescription drugs is given and the drugs are provided, the health plan reimburses the entity at Medicaid's standard pharmacy rate.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
27. Agreements with	The health plan makes a good faith	Yes ☐	☐ Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Federally Qualified Health Centers (FQHCs) *CC-VII.B.3.e.1-2*	effort to execute a contract with a FQHC, and if applicable, a Rural Health Clinic (RHC).	No ☐	☐ Partially Met ☐ Not Met		
28. CAPITATED PLANS: Agreements with Federally Qualified Health Centers (FQHCs) *CC-VII.B.3.e.1-2*	The capitated health plan: a. Reimburses FQHCs and RHCs at rates comparable to those rates paid for similar services in the FQHC's or RHC's community. b. Reports quarterly to BMHC, the payment rates and the payment amounts made to FQHCs and RHCs for contractual services provided by these entities.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
29. Agreements with School Districts *ss. 1011.70 and 409.908(21), F.S.* *CC-VII.B.3.f*	The health plan makes a good faith effort to execute memoranda of agreement with school districts participating in the certified match program regarding the coordinated provision of school-based services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
30. Emergency Services *CC-VII.B.4.a*	The health plan ensures the availability of Emergency Services and Care twenty-four (24) hours a day, seven (7) days a week.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
31. General Acute Care Hospital *CC-VII.B.4.b*	The health plan provides at least one (1) fully accredited general acute care hospital bed per 275 enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
32. Birth Delivery	The health plan provides:	a. Yes ☐	☐ Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Facility *Chapter 383, F.S.* *CC-VII.B.4.c*	a. At least one (1) birth delivery facility, or a hospital with birth delivery facilities. The birth delivery facility may be a freestanding facility or part of a hospital. b. A birthing center that is accessible to low-risk enrollees.	No ☐ b. Yes ☐ No ☐	☐ Partially Met ☐ Not Met		
33. Regional Perinatal Intensive Care Centers (RPICC) *CC-VII.B.4.d*	The health plan assures access for enrollees in one (1) or more of Florida's RPICC, or a hospital licensed by the Agency for neonatal intensive care unit (NICU) Level III beds.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
34. NICU *CC-VII.B.4.e*	The health plan ensures that care for medically high-risk perinatal enrollees is provided in a facility with a NICU sufficient to meet the appropriate level of need for the enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
35. Pharmacy *CC-VII.B.4.f*	If the health plan elects to use a more restrictive pharmacy network than the Medicaid fee-for-service network, the health plan provides at least one (1) licensed pharmacy per 2,500 enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
36. Compliance with Hernandez et al. vs. Meadows *CC-VII.B.4.f*	The health plan ensures that its contracted pharmacies comply with the Settlement Agreement to *Hernandez et al. v. Medows* (case number 02-20964 Civ-Gold/Simonton) (HSA).	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
37. Network Changes	The health plan provides BMHC and	a. Yes ☐ No ☐	☐ Met ☐ Partially Met		

Standard X: Access and Availability					
CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.C.2.a-b	HSD with documentation of compliance with access requirements at any time there has been a significant change in the health plan's operations that would affect adequate capacity and services, including, but not limited to, the following: a. Changes in health plan services or service area. b. Enrollment of a new population in the health plan.	b. Yes ☐ No ☐	☐ Not Met		
38. Significant Changes in Network	The health plan notifies BMHC within seven (7) business days of any significant changes to its network. A significant change is defined as: a. A decrease in the total number of PCPs by more than five percent (5%). b. A loss of all participating specialists in a specialty where another participating specialist in that specialty is not available within sixty (60) minutes. c. A loss of a hospital in an area where another health plan hospital of equal service ability is not available within thirty (30) minutes. d. Other adverse changes to the composition of the network that impair or deny the enrollee's	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.C.3.a-d	adequate access to providers.				
39. Negative Affect on Enrollees' Access to Services *CC-VII.C.4*	The health plan has procedures to address changes in the health plan network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
40. PCP Leaving Network	If a PCP ceases participation in the health plan's network, the health plan sends written notice to BMHC and to the enrollees who have chosen the provider as their PCP. This notice is be issued no less than fifteen (15) calendar days after receipt of the termination notice. a. If an enrollee is in a prior authorized ongoing course of treatment with any other provider who becomes unavailable to continue to provide services, the health plan notifies the enrollee in writing within ten (10) calendar days from the date the health plan becomes aware of such unavailability. b. These requirements to provide notice prior to the effective dates of termination will be waived in instances where a provider becomes physically unable to care for enrollees due to illness, death, or	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability					
CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.C.5.a-b	leaving the service area and fails to notify the health plan, or when a provider fails credentialing. Under these circumstances, notice will be issued immediately upon the health plan's becoming aware of the circumstances.				
41. New Providers *CC-VII.C.6*	The health plan notifies BMHC of any new network providers by the 15th of the month following execution of the provider agreement.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
42. Appointment Waiting Times *42 CFR 438.206(c)(1)(i)* *CC-VII.F.1.a-c*	The health plan assures that PCP services and referrals to participating specialists are available on a timely basis, as follows: a. Urgent Care: within one (1) day, b. Routine Sick Patient Care: within one (1) week, and c. Well Care Visit: within one (1) month.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐			
43. Geographic Standards for Providers	All PCPs, hospital and community mental health services are available within an average of thirty (30) minutes travel time from an enrollee's residence. BMHC may waive this requirement, in writing, for rural areas and for areas where there are no PCPs, hospitals or community mental health centers within a thirty (30) minute average	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.F.2	travel time.				
44. Geographic Standards for Specialists and Ancillary Services *CC-VII.F.2 and 4*	All participating specialists and ancillary providers are within an average of sixty (60) minutes travel time from an enrollee's residence. For rural areas, if the health plan is unable to enter into an agreement with specialty or ancillary service providers within the required sixty (60) minute average travel time. BMHC may waivethe requirement in writing.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
45. Emergency Services Facilities *CC-VII.F.3*	The health plans provide a designated emergency services facility within an average of 30 minutes travel time from an enrollee's residence, that provides care on a 24-hour a day, seven days a week (24/7) basis. BMHC may waive the travel time requirement, in writing, in rural areas.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
46. Staffing Emergency Services Facilities *CC-VII.F.3*	Each designated emergency service facility has one or more physicians and one or more nurses on duty in the facility at all times. BMHC may waive the travel time requirement, in writing, in rural areas.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
47. Pediatrician, CHD, FQHC, or RHC	At least one (1) pediatrician or one (1) CHD, FQHC or RHC must be available within an average of thirty (30) minutes' travel time from an enrollee's residence, provided that this	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.F. 5	requirement remains consistent with the other minimum time requirements of this Contract. In order to meet this requirement, the pediatrician(s), CHD, FQHC, and/or RHC must provide access to care on a twenty-four hour a day, seven day a week (24/7) basis. BMHC may waive this requirement, in writing, for rural areas and where there are no pediatricians, CHDs, FQHCs or RHCs within the thirty (30) minute average travel time.				
48. Appointment Wait Times Compliance *42 CFR 438.206(c)(1)(iv),(v) and (vi)* *CC-VII.F.6*	Annually by February 1 of each contract year, the health plan reviews a statistically valid sample of PCP offices' average appointment wait times to ensure that services are in compliance.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard X Access and Availability	
Score	# Elements
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	