FLORIDA MEDICAID
HEALTH PLAN APPLICATION

JULY 2011

TABLE OF CONTENTS

INSTRUCTIONS AND GENERAL INFORMATION 1
Workshop 1
The Application 1
Submission Requirements 4
Basic Information 6

I. ORGANIZATIONAL INFORMATION 9
A. Legal Background and Experience 9
B. Ownership and Control Interest 10
C. Criminal Background Screening 11
D. Organizational Structure 12
E. Terms and Conditions 13
F. Required State and Federal Disclosures 13

II. FISCAL REQUIREMENTS 15
A. Financial Statements 15
B. General Insurance Requirements 16
C. Insolvency Protection 16

III. ELIGIBILITY AND ENROLLMENT 17
A. Eligibility 17
B. Enrollment 17
C. Disenrollment 17

IV. ENROLLEE SERVICES AND COMMUNITY OUTREACH 18
A. Enrollee Services 18
B. Community Outreach and Marketing 20

V. COVERED SERVICES 22
A. Covered Services 22
B. Expanded and Optional Services 22
C. Moral or Religious Objections 23
D. Special Coverage Provisions 23
E. Behavioral Health Services 24

VI. PROVIDER NETWORK 28
A. General Provisions 28
B. Provider Contracts 30
C. Provider Terminations 31
D. Provider Services 31
E. Medical Records 31

VII. QUALITY MANAGEMENT 32
A. Quality Improvement 32
B. Utilization Management 32

VIII. GRIEVANCE SYSTEM 34
A. General Requirements 34
B. Complaint Process 34
C. Grievance Process 34
D. Appeal Process 35
E. Medicaid Fair Hearings 35

IX. INFORMATION SYSTEMS 36
A. System Capacity, Availability and Performance 36
B. E-Mail System 36
C. Data and Report Validity and Completeness 36
D. Data Exchange 37
E. Reporting – System Capabilities 37
F. Companion Documents 38
G. Data Exchange 40

X. ADMINISTRATION AND MANAGEMENT 41
A. Staffing 41
B. Claims Processing and Payments 41
C. Fraud and Abuse Prevention 41
D. Subcontracts 42
E. Encounter Reporting 43
F. Corrective Actions 43

XI. REPORTING 44
A. General Requirements 44

FORMS 45
Enrollment Projection 46
Background Screening Manager List 47

CERTIFICATIONS APPENDIX 48
Accuracy and Authorization. 49
HIPAA 51
Lobbying 53
Debarment, Suspension, Ineligibility and Voluntary Exclusion 54

INSTRUCTIONS AND GENERAL INFORMATION
FLORIDA MEDICAID HEALTH PLAN APPLICATION

APPLICABILITY

This multi-purpose Health Plan Application is designed to capture detailed information that will facilitate a contract between the Agency and a Provider Service Network (PSN) or Health Maintenance Organization (HMO). The requirements in this Application are to be described by all types of organizations, unless otherwise specified. The applicant must prove it is capable of providing health care services to eligible Medicaid recipients consistent with the requirements of the applicable Contract terms and conditions.

WORKSHOP

The Agency for Health Care Administration (Agency) will schedule a workshop at least annually to meet with representatives of potential health plan applicants. At this workshop Agency staff will review the application process and provide examples of materials applicants will need in completing the application.

ONLINE TOOL KIT

Model documents and other materials to help with preparing the application are in the application tool kit on the Web site at Become a Medicaid Health Plan (http://ahca.myflorida.com/Medicaid/managed_care/index.shtml). A partial list follows:

- Model Contract Documents
  - Model Attachment I & Exhibits
  - Model Attachment II & Exhibits
  - Report Guide
- Application Review Checklists
- On-Site Review Tools
- Workshop Materials
- Links to Pertinent Laws and Regulations

THE APPLICATION

A. The Agency will accept applications each year during the established open application period. Applications must be complete and accurate when submitted.

B. The health plan application is designed to capture detailed information for review by the Agency to determine whether the applicant is prepared to meet the requirements of the Medicaid managed care Contract.

C. All information requested in the application is based on Contract requirements. Certain items specifically request policies and procedures; however, the applicant is expected to submit any and all policies and procedures to

demonstrate how it will comply with all aspects of the model Contract. For a complete listing, see the "On-Site Survey Tool" section in the application tool kit at Become a Medicaid Health Plan.

D. Fill out only those portions of the application that apply to a single health plan. For example, if the health plan is capitated, do not fill out any fee-for-service information. If the health plan will serve only non-Reform counties, do not fill out Reform information.

E. Unless otherwise specified in the Contract, the health plan will be responsible for complying with the provisions of all applicable federal and state Medicaid laws and regulations and with the current Medicaid handbooks. Links to those resources are on the Web site listed above.

F. Contact the Agency's Bureau of Health Systems Development at (850) 412-4004 for assistance with the application process. All documentation related to this health plan application process must be submitted only to the Bureau of Health Systems Development.

G. The Agency will provide technical assistance to help the health plan complete the application. Below is the sequence of application review:

1. Health plan submits completed application during established open application period
2. Agency acknowledges receipt via letter to applicant
3. Agency conducts preliminary review to determine whether all materials are included
4. Agency conducts financial, organizational, and network reviews

5.A Initial deficiencies found:
- Agency notifies applicant of any deficiencies via letter within 15 days of receipt of application
- Applicant has 10 days to submit requested material
- Agency has five days to review additional material
- If deficiencies still exist, Agency rejects application via letter to applicant
- If deficiencies satisfactorily corrected, proceed to Step 6.

5.B. No initial deficiencies. Proceed to Step 6.

6. If no initial deficiencies (or initial deficiencies corrected timely):
- Agency begins quality review of policies and procedures and will be in regular contact with the plan to provide opportunity to address any concerns or areas in need of improvement
- Agency begins review of Medicaid Provider Enrollment Application
  - Background screening begins
  - Provider file constructed
- Agency schedules site visit
- Agency begins X12 and provider network file testing with health plan

7. At day 75 of the review, the Agency will issue an official letter listing any remaining deficiencies

8.A. If remaining deficiencies exist:
- Applicant has five days to respond

- Agency has ten days to review additional material
- If deficiencies still exist, Agency rejects application via letter to applicant
- If deficiencies satisfactorily corrected, proceed to Step 9.

8.B. No remaining deficiencies. Proceed to Step 9.

9. If no remaining deficiencies (or remaining deficiencies corrected timely), Agency proceeds with on-site visit

10. Agency has 14 days to complete site visit report and provide applicant notice of any deficiencies

11. Applicant submits corrective action if necessary

12. If no deficiencies found on site visit, or when deficiencies are corrected, the Agency routes health plan contract for final signatures

13. Contract becomes effective with health plan receiving initial enrollment effective approximately two months after contract execution

H. The Agency may schedule one or more conference calls with the applicant during the review process to seek clarification or further detail. Formal notice of a deficiency will always be provided in writing.

I. The goal is to complete the process in less than 100 calendar days. Time needed for the health plan to correct deficiencies makes the process longer. If the health plan is unable to remedy deficiencies within agreed-upon timeframes, the Agency reserves the right to reject the application. To receive future consideration, the health plan would have to submit a new application.

SUBMISSION REQUIREMENTS

A. Number of Copies – The health plan must submit one hard copy with original signatures and four electronic data CDs containing all items included with the hard copy.

B. Format – Please ensure all electronic files are legible and able to be photocopied easily. The electronic files must not be in a locked format. The narrative responses should be in Word format, but the attachments (supporting documents) can be scanned as PDFs, in Excel, or any format that can be viewed electronically. Files must be logically named in accordance with application subjects and topics and easily mapped to the hard copy. Documents should be uniquely identifiable by title. Policies and procedures must be appropriately branded with the applicant's health plan name.

The narrative response shall be consecutively paginated. The attachments should be easily identifiable (tabbed and titled) and paginated within the attachment, but do not have to be consecutively paginated within the document.

The hard copy may be double-sided as long as the applicant does not include more than one policy/item response on a page.

C. Organization – The application narrative responses must be organized in the same order as the application items/questions. For example, narrative response labeled #1 should answer application item 1, which requests a description of the applicant's legal history.

D. Where to Submit – Submit the hard copy and electronic data CDs to:

Agency for Health Care Administration
Medicaid Bureau of Health Systems Development
2727 Mahan Drive, MS 50
Tallahassee, FL 32308

E. Changes in Applicant Information – If any information in the application changes after the application is submitted, the health plan must submit the new information, in writing, to the Bureau of Health Systems Development within 10 days of the effective date of the change. This includes, but is not limited to, any change in directors, officers, or address. Failure to do so may result in the rejection of the application.

F. Changes in Ownership – Any change in ownership that would necessitate a revision to the CMS-1513 while the Agency is reviewing the application requires termination of the application and resubmission under the new ownership. The official time and date of receipt will be the time and date of receipt of the new application.

G. Release of Information – Any release of information about the application or the Contract by the applicant to the media, the public or other entities requires prior written approval from the Agency.

H. Agency's Right to Discontinue – Because the application process is intended to be an opportunity for the applicant to prove to the Agency that the applicant is a suitable contracting partner, the Agency reserves the right to discontinue any application for insufficient response to any of the requirements set forth in these instructions, for any misrepresentation, or, if the Agency determines that it is in its best interest to discontinue the application process.

I. Public Record – All information submitted to the state is considered a public record unless it meets the definition of "trade secret" under s. 812.081, F.S. Information specifically identified as a trade secret will be kept confidential to the extent provided by law. If the Agency receives a public records request for information that has been identified by the applicant as a trade secret, the Agency will notify the applicant, who may take legal action to protect the confidentiality of the information. Please be sure that any documents considered proprietary are clearly labeled as a trade secret in the application submitted to the Agency.

J. The Agency may conduct performance and compliance reviews, reviews of specific records or other data as deemed necessary. The Agency may conduct a review of a sample of analyses performed by the applicant to verify its quality. The Agency shall provide reasonable notice for all reviews conducted at the applicant's place of business. Reviews may include, but shall not be limited to, procedures, computer systems, enrollee records, accounting records, and internal quality control and staff interviews. The applicant shall work with any reviewing entity selected by the state.

K. Disclaimer – The Agency may provide information and guidance, illustrative direction, and technical assistance to assist the applicant in the managed care application process. This information is not meant to be exhaustive and neither constitutes legal or medical advice, nor does it replace any laws, rules, policies, or executed contracts. The technical assistance and guidance contained herein is for informational purposes only and the applicant's reliance upon this information does not guarantee a contract with the Agency. By providing this information, the Agency does not waive any legal right or remedy to which it may be entitled including the right to pursue corrective actions, fines or other sanctions including termination of provider contracts.

BASIC INFORMATION

Name of Health Plan Applicant: _____

Mailing Address: _____

Contact Person for Application: _____
(If this is a joint venture or limited partnership, this person must be the single point of contact for all entities. This application page must be officially updated if the applicant's primary contact changes during the course of application review.)

Title: _____

Office Telephone/Extension: _____

Cellular Telephone: _____

Fax Number: _____

E-mail Address: _____

Type of Health Plan:
☐Provider Service Network – Fee-for-service
☐Provider Service Network – Capitated
☐Health Maintenance Organization

Target Population(s):
(Check each population requested)
☐Temporary Assistance for Needy Families (TANF)
☐Supplemental Security Income (SSI)
NOTE: In non-Reform counties, a health plan must cover both populations.

Service Level(s):
(Check all that apply)
☐Reform Comprehensive and Catastrophic
☐Reform Comprehensive Only
☐Non-Reform Medicaid State Plan

Reform Counties to Be Served upon Initial Contract Execution:
(Check all that apply. Note that counties grouped in a block must be implemented at the same time. Also note that all provider network requirements must be complete at the time of application for all counties checked. See Section VI.)

	COUNTY NAME	MEDICAID AREA
	Baker Clay Nassau	4
	Broward	10
	Duval	4

Non-Reform Counties to Be Served upon Initial Contract Execution:
(Check all that apply)

	COUNTY NAME	MEDICAID AREA
	Alachua	3
	Bay	2
	Bradford	3
	Brevard	7
	Calhoun	2
	Charlotte	8
	Citrus	3
	Collier	8
	Columbia	3
	Dade	11
	Desoto	8
	Dixie	3
	Escambia	1
	Flagler	4
	Franklin	2
	Gadsden	2
	Gilchrist	3
	Glades	8
	Gulf	2
	Hamilton	3
	Hardee	6
	Hendry	8
	Hernando	3
	Highlands	6
	Hillsborough	6
	Holmes	2
	Indian River	9
	Jackson	2
	Jefferson	2
	Lafayette	3
	Lake	3
	Lee	8
	Leon	2
	Levy	3
	Liberty	2
	Madison	2
	Manatee	6
	Marion	3
	Martin	9
	Monroe	11

	Okaloosa	1
	Okeechobee	9
	Orange	7
	Osceola	7
	Palm Beach	9
	Pasco	5
	Pinellas	5
	Polk	6
	Putnam	3
	St. Johns	4
	St. Lucie	9
	Santa Rosa	1
	Sarasota	8
	Seminole	7
	Sumter	3
	Suwannee	3
	Taylor	2
	Union	3
	Volusia	4
	Wakulla	2
	Walton	1
	Washington	2

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I. ORGANIZATIONAL INFORMATION

A. Legal Background and Experience

1. In chronological order, describe the applicant's legal history. Include size and resources of all predecessor business entities, parent corporations, holding companies, subsidiaries, mergers, reorganizations and changes of ownership. Be specific as to dates and parties involved. Background details for each shall include, but not be limited to, the following information:

    a. Dates of operation;

    b. Type of business organization (public company, partnership, subsidiary, etc); and

    c. Primary business;

2. For this applicant, provide the following:

    a. Number of FTEs engaged in activities relevant to this application;

    b. Total number of employees;

    c. Whether for profit or not for profit;

    d. Vendor minority status, if applicable;

    e. Federal Employer's Identification Number (FEIN);

    f. Florida Corporate Charter Document Number; and

    g. Copy of the following applicable documents:

        (1) AHCA Health Care Provider Certificate;

        (2) OIR Certificate of Authority; and

        (3) Third party administrator (TPA) license.

3. In the past five years, has the applicant executed a contract with a federal, state, or local government entity, including current contracts? If yes, describe each contract, including the name of the government entity, name of the entity project officer (contact person for the contract), brief description of scope of work, address, telephone number, and beginning and ending dates of the contract.

4. If the applicant has ever defaulted on or voluntarily withdrawn from a contract or had a contract terminated, please describe each such contract, including the reason for the default, withdrawal or termination and the name of the government entity, name of the entity project officer, address, telephone number, and beginning and ending dates of the contract.

5. Describe, with specificity, the applicant's experience in providing services identical or similar to the services required in the model contract, if any. Identify the population served, the number of people enrolled with the applicant, and the types of services provided.

6. Submit documentation that the applicant has successfully tested all X12N transactions using Ramp Manager, which is an application that provides interactive, self-service tools for trading partners to test X12N transaction against the Florida Medicaid Companion Guides. Ramp Manager is hosted by EDIFECs in an environment customized for Florida Medicaid. Applicant must submit "Report View" test results for each type of pertinent X12 transaction. See the Ramp Manager information sheet provided in the application tool kit for more details.

7. Provide a minimum of three separate and verifiable references. The references listed must be for work similar in nature to that specified in the application. Do not include confidential references, and do not list the Agency as a client reference. Do not list the same client for more than one reference. In the event that the applicant changed names since performing work for a listed reference, provide the name under which the applicant operated in performing the work. References should be available to be contacted during normal working hours via e-mail or telephone. The Agency will attempt to contact each selected reference by telephone up to four times. If the contact person cannot be reached after four attempts, the Agency will request an alternate reference.

8. Have there been, or are there any legal actions, taken or pending, against the applicant or any of its predecessors in the past five years? If yes, give a brief explanation and the status of each action. A legal action is defined as an action taken by a government agency (such as the Centers for Medicare and Medicaid Services, the Office of Insurance Regulation or the Agency for Health Care Administration) which would have resulted in that government agency's office of General Counsel issuing a legal order resulting in a monetary or non-monetary penalty. (See Section XVI, K., Legal Action Notification, Attachment II, of the model contract.)

9. Have any of the applicant's agents or managing employees been convicted of a felony of criminal offense related to the person's involvement in any federally-funded health care program or been convicted of fraud, income tax evasion, or obstruction of justice? If yes, provide the names, positions and contact information of each one.

B. Ownership and Control Interest

10. Prepare an unduplicated list of all individuals listed on the CMS Disclosure of Ownership and Control Interest Statement (CMS-1513), all individuals listed in response to Question #28, Records Custodians and Question #29, Owner(s) and Operator(s), of the Medicaid Provider Enrollment Application and all trustees and associates of the applicant.

a. List the names, addresses, and official capacities of these individuals.

b. If the applicant's board of directors has delegated its responsibilities as governing board related to this application, provide evidence of the delegation (i.e., minutes and by-laws).

c. List the name and address of each corporation with a direct or indirect ownership, or controlling interest in the applicant.

d. List the name and address of each person or corporation with an ownership or controlling interest in any subcontractor or supplier in which the applicant has direct or indirect ownership of five percent or more. See model Contract Attachment II, Section XVI, Item V.2. and 3. for more details.

e. List the name of any person or corporation listed in any of the above paragraphs who is required to be listed on the CMS Disclosure of Ownership and Control Interest Statement because of an ownership, control or management interest in another applicant, Medicaid provider service network or Medicaid managed care organization currently contracted to provide Medicaid services in Florida. Indicate if any of the persons named are related to another named person as spouse, parent, child or sibling.

f. List any subcontractors, participating providers or suppliers owned by the applicant, its management, its owners or any members of its board of directors including the percent of financial interest.

g. List subcontractors, participating providers or suppliers, with whom the applicant has had business transactions totaling more than $25,000 during the 12 months preceding the date of the application.

h. List the name of each officer, director, agent or owner of the applicant or its affiliates, who is an employee of the State of Florida or any of its agencies. Denote the percent of financial interest in the contracting applicant held by the individual. See model Contract Attachment II, Section XVI, Item V.2. and 3. for more details.

C. Criminal Background Screening

11. Submit, as part of this health plan application, a completed Florida Medicaid Provider Enrollment Application and the Non-Institutional Medicaid Provider Agreement, including fingerprint cards and a check for the required screening fees made out to the Agency for Health Care Administration. Note that these documents are to be submitted to the Bureau of Health Systems Development as part of this health plan application and are not to be sent directly to the Medicaid fiscal agent.

The Florida Medicaid Provider Enrollment Application and the Guide for Completing a Florida Medicaid Provider Enrollment Application are available on the Web site of the Agency's Medicaid fiscal agent:

http://portal.flmmis.com/FLPublic/Provider_Enrollment/tabId/50/Default.aspx

12. Fingerprint cards must be submitted for all individuals listed below, with a completed Background Screening Manager List, as provided in the Forms section of this application:

    a. Shareholders (five percent or more ownership);

    b. Partners of your business and subcontractors, including any third party administrators;

    c. Individual officers;

    d. Directors;

    e. Managers (any person who can make or direct decisions that have an impact on services rendered to recipients);

    f. Financial records custodian;

    g. Medical records custodian; and

    h. Individuals who hold signing privileges on the depository account.

    If an individual has submitted fingerprints to the Agency or to the Office of Insurance Regulation in the last 12 months, the applicant need only state such and does not need to include another set of fingerprints for the individual.

13. **For licensed individuals holding management positions,** include in your submittal copies of licensure screen prints from the Florida Department of Health Web site:

    http://www.doh.state.fl.us/RW_webmaster/professionals/

D. Organizational Structure

14. Provide detailed exhibits (i.e., flow charts) showing the applicant's organizational structure, including relationships and detailed lines of authority with the board of directors, parent companies, affiliated companies, subsidiaries, holding companies, subcontractors, etc. Illustrate how the relationships support the Medicaid administrative component and the health service delivery component of the applicant. Explain how the organizational structure depicted is appropriate for the provision of services under the model contract.

15. Provide the applicant's business plan, including but not limited to prospective county expansion, product expansion, and strategy for growth and development.

At a minimum, the business plan should provide an overview of operations for the entire state for 24 months after the anticipated date of the contract execution. Include Model Format for Enrollment Projection, with the business plan.

E. Terms and Conditions (See Model Contract, Attachment II, Section XVI)

16. Indicate the categories of administrative and management services obtained through subcontracts and list the name and Florida corporate charter document number of any subcontractor that will be responsible for claims processing, resolution and assistance process; data processing; management services; administrative services; and any other services.

17. Provide certified copies of the Articles of Incorporation, etc., and Certificate of Good Standing for the applicant from the Florida Department of State, Division of Corporations. Additionally, provide any pertinent licensure and documentation of such for all entities providing administrative and management services.

18. The Agency strongly encourages applicants to use certified and non-certified minority-owned businesses as subcontractors when procuring commodities or services to meet the requirement of this Contract. Describe in detail internal policies and procedures for minority recruitment and retention, as well as for all subcontracting entities.

19. Describe in detail the applicant's policies and procedures for its annual background screening for all management employees and its timely submission of fingerprint sets for all new hires.

20. Submit the applicant’s policies and procedures for ensuring that changes in management or ownership are submitted timely as required in the model Contract.

21. Provide a detailed emergency management plan that demonstrates the applicant’s ability to continue to function if normal operations are disrupted for any reason. If the applicant has a delegated third party administrator (TPA), also provide a copy of the TPA's detailed emergency management plan.

F. Required State and Federal Disclosures

22. The applicant must submit the following disclosures:

    a. HIPAA Certification form (See certifications appendix);

    b. Certification Regarding Lobbying (See certifications appendix);

    c. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts (See certifications appendix);

    d. Disclosure of Ownership and Control Interest Statement, CMS-1513, available at the following Web site:

http://ahca.myflorida.com/Medicaid/psn/pdf/cmsS1513.pdf;

e. Letter disclosing information on the applicant's significant business transactions with any party that has any interest in the profits of the applicant;

f. Letter attesting no officer, director, or agent of the applicant is an employee of the State of Florida, or any of its agencies; and

g. Letter attesting there is no action or suit filed or any claim made against the applicant by any subcontractor, vendor, or other party that results in litigation for disputes or damages exceeding the amount of $50,000.

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II. FISCAL REQUIREMENTS

(Note: The financial requirements in the model Contract are found in Attachment II, Section XV and Exhibit 15 as applicable to plan type.)

A. Financial Statements

23. Attach copies of the applicant's financial statements for the past two years. If the applicant is a new entity, without a previous or parent entity, submit financial statements for those individuals listed in response to Question #28, Records Custodians, and Question #29, Owner(s) and Operator(s) of the Medicaid Provider Enrollment Application and all trustees and associates of the applicant. The financial statements must undergo an independent certified audit. The applicant is responsible for ensuring that this audit is performed. All audits shall include:

    a. The opinion of a certified public accountant;

    b. A statement of revenue and expenses;

    c. A balance sheet;

    d. A statement of changes in financial position; and

    e. A copy of all management letters.

24 Provide the following pro forma financial statements for the applicant's Florida operation, broken down by line of business. Please separate the Medicaid line of business into Reform and non-Reform as applicable. The pro forma financial statements must be prepared on an accrual basis by month for the first three years beginning with the first month of the proposed execution date of the Contract:

    a. A statement of monthly revenue and expenses;

    b. A monthly cash flow analysis; and

    c. A balance sheet for each month.

25. The applicant must provide copies of its bank statements for the following required accounts: start-up, reserves and insolvency protection.

26. Ensure that enrollment and revenue projections, as set forth in #24 above, **correspond with the information provided in response to enrollment projections in #15**.

27. Provide a statement, signed by the applicant's president or chief executive officer, attesting that no assets of the applicant have been pledged to secure personal loans.

B. General Insurance Requirements

(Note: The General Insurance Requirements in the model Contract are found in Attachment II, Section XVI, Item Y., Terms and Conditions. The Fidelity Bond requirements are found in Attachment II, Section XV, Item F., Financial Requirements. The Third Party Resources requirements are found in Attachment II, Section XV, Item H. and Exhibit 15.)

28. Provide copies of each applicable insurance binder and include them with a list, in table format, labeled "Insurance Coverage" on the applicant's company letterhead. Information contained in the applicant's submittal must include, but is not limited to, the carrier; the entity covered; a description of coverage, including deductibles, co-insurance, minimum and maximum benefits, premium in effect, additional policies to cover these risks and other arrangements, for the following types of insurance:

    a. Medical malpractice insurance;

    b. General liability insurance;

    c. Professional liability insurance;

    d. Fire and property insurance;

    e. Fidelity bond;

    f. Workers' compensation insurance; and

    g. Directors' errors and omission insurance.

C. Insolvency Protection (See Model Contract Attachment II, Section XV, Items A. and B., and Exhibit 15)

29. **Capitated health plans and health plans capitated for behavioral health services only** – Provide documentation of a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida. The applicant must describe how it will manage the insolvency protection account. The Agency may waive this requirement if there is evidence on file with the Agency for adequate insolvency insurance. The Multiple Signature Agreement Form must be completed and submitted with original signatures of the health plan and bank representatives.

30. **Reform health plans only -** Applicants that are HMOs in counties with no managed care or capitated PSN must indicate whether they intend to accept the comprehensive premium or the comprehensive and catastrophic premium, and thus accept financial risk for catastrophic medical expenses of enrollees.

31. Submit policies and procedures for the collection and reporting of third party resources as specified in the model Contract.

III. ELIGIBILITY AND ENROLLMENT

A. Eligibility (See Model Contract Attachment II, Section III, Item A.3., and Exhibit 3 as applicable to plan type)

32. Submit policies and procedures that describe how the applicant will assist the Agency in identifying enrollees excluded from enrollment with the applicant.

B. Enrollment (See Model Contract Attachment II, Section III, Item B. and Exhibit 3, depending on plan type)

33. Submit policies and procedures that describe how the applicant will identify pregnant enrollees and comply with all requirements regarding unborn activation.

C. Disenrollment (See Model Contract Attachment II, Section III, Item C., and Exhibit 3)

34. Submit policies and procedures that describe how the applicant will comply with all aspects of model Contract Attachment II, Section III, Item C.

35. Such policies and procedures must include the process for identification and verification of instances when involuntary disenrollment is appropriate and describe how the applicant will:

    a. Document what attempts will be made to educate the enrollee about his/her rights and responsibilities, including one oral and one written warning when appropriate;

    b. Provide assistance to enable the enrollee to comply, including through case management;

    c. Determine that the enrollee's behavior is not related to the enrollee's medical or behavioral condition;

    d. Ensure an enrollee's right to appeal in cases of involuntary disenrollment; and

    e. Provide appropriate notice to enrollees.

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IV. ENROLLEE SERVICES AND COMMUNITY OUTREACH

A. Enrollee Services (See Model Contract Attachment II, Section IV, and Exhibit 4 as applicable to plan type)

36. Describe in detail the applicant's enrollee services system, including customer service centers, call centers, mail outs to members, and the type of access enrollees will have to these services.

37 Submit policies and procedures that explain how the applicant will ensure that all written enrollee materials are at or near the fourth grade comprehension level. Please specify which software the applicant will use to help meet this requirement.

38. Submit policies and procedures for assigning PCPs and reinstatements to PCPs after temporary loss of eligibility, including how the applicant will provide enrollees with a choice in the selection of a particular PCP. Describe how the applicant will ensure that each enrollee has an ongoing source of primary care, and the timeframe for changing PCPs at the enrollee's request.

39. Submit policies and procedures and draft copies of member correspondence that describe the applicant's methods to ensure that enrollees receive written notification of enrollment and reinstatement as specified in Attachment II, Section IV, of the model Contract.

40. Submit policies and procedures that explain how the applicant will ensure that enrollees are aware of:

    a. Their rights and responsibilities;

    b. The role of PCPs;

    c. How to obtain care;

    d. What to do in an emergency or urgent medical situation;

    e. How to file a complaint, grievance, or appeal and how to request a Medicaid Fair Hearing;

    f. How to report suspected fraud and/or abuse; and

    g. How to obtain behavioral health services. (Also see Application Section V, Item E., below.)

41. Submit policies and procedures that describe how the applicant will handle enrollee inquiries via written materials, telephone, electronic transmission, and face-to-face communication.

42. Submit draft new enrollee materials at the fourth grade reading level. Such materials must include at a minimum: the enrollee handbook, the provider

directory, the enrollee identification card, and other notices outlined in the model Contract. All new-enrollee materials must include all items specified in the model Contract. To document that all items are included, also submit a completed provider directory checklist and enrollee handbook checklist, both of which are available at Become a Medicaid Health Plan.

43. Submit policies and procedures that describe the mail distribution system and methods employed to ensure the applicant will deliver all materials promptly.

44. Submit policies and procedures for follow-up with enrollees whose new enrollee materials are returned to the applicant for any reason. Submit draft copies of all other member correspondence required by the model Contract.

45. Submit policies and procedures and draft copies of member correspondence for making all written materials available in alternative formats and in all appropriate foreign languages. Such policies and procedures should include how the applicant will notify all enrollees and potential enrollees that information is available in alternative formats and foreign languages, as required in Section IV of the model Contract, and how to access those formats, how the applicant will notify enrollees on at least an annual basis of their right to request and obtain information; and how the applicant will ensure that enrollees receive a 30-day notice of any change in benefits.

46. Submit policies and procedures that describe how the applicant will inform enrollees about open enrollment and of the enrollees' right to disenroll or change health plans without cause during the 90-day change window, and to disenroll with cause thereafter. Submit draft copies of member correspondence.

47. Describe how the applicant will meet all requirements for the enrollee toll-free help line. Include help line policy and procedure guides and a description of how the applicant will monitor the help line to ensure that all help line requirements are continuously met, how the applicant will route calls among help line staff to ensure timely and accurate response to enrollee inquiries, what the after-hours procedures are and what staff positions will answer the phone after hours; and how the applicant will ensure that the telephone help line can handle calls from non-English speaking callers and from enrollees who are hearing impaired, including the number of help line staff that are fluent in one of the state-identified prevalent non-English languages.

48. Submit policies and procedures that describe any incentive programs and/or provisions the applicant intends to offer to enrollees (see Model Contract Attachment II, Section IV, Item A.14.). Submit draft copies of member correspondence.

49. Submit policies and procedures that describe how the applicant will ensure that enrollees and potential enrollees, upon request, will be informed of any changes to service delivery and/or the provider network including the following:

    a. Latest information on any restrictions on access to providers, including providers not taking new patients;

b. Information for potential enrollees that they may have all family members served by the same PCP or choose different PCPs based on each family member's needs; and

c. Any restrictions by a provider on counseling/referral services based on moral or religious grounds within 90 days after such a policy is adopted.

50. Submit policies and procedures that describe how the applicant will meet the new enrollee procedure requirements specified in Section IV, 8., New Enrollee Procedures, and 9., Enrollee Assessments, of the model Contract.

51. Submit policies and procedures that describe how the applicant will ensure that its member handbook, provider directory and preferred drug list will be available on the applicant's Web site within the requirements specified in the model Contract.

52. Indicate if the applicant will participate in the use of Medicaid redetermination information according to Attachment II, Section IV, A.17., Medicaid Redetermination Notices of the model Contract. If the applicant will participate, submit Medicaid redetermination policies and procedures for approval along with the statement indicating participation.

53. **Reform health plans only -** Submit policies and procedures that describe how the applicant will ensure that it will assist the enrollee of the enhanced benefit program specified in Exhibit 4.

B. Community Outreach and Marketing (See Model Contract Attachment II, Section IV, Item B.)

54. Provide a statement specifying whether or not the applicant intends to engage in community outreach and marketing activities.

55. If the applicant intends to conduct community outreach, it must submit a community outreach plan. The plan must contain logically developed strategies for reaching Medicaid recipients, and it must comply with the measures set forth in Model Contract Attachment II, Section IV, Item B., Community Outreach and Marketing. At a minimum, the plan shall include, but not be limited to, the following:

a. Specific strategies that the applicant will use for community outreach; and

b. An explanation, including policies and procedures, showing how the applicant will provide Medicaid recipients with the state's choice counselor/enrollment broker's toll-free telephone number for inquiries regarding enrollment options, health plan benefits and the opportunity to raise questions and discuss potential enrollment. Submit draft copies of member correspondence.

56. Submit community outreach policies and procedures. Such policies and procedures shall comply with all state, federal, and model Contract requirements

and detail how the applicant will monitor its community outreach representatives to ensure they or other staff do not engage in prohibited outreach and marketing activities. In addition, the applicant must describe how it trains its staff and providers to ensure full compliance with all community outreach requirements set forth in the model Contract. Submit draft copies of community outreach materials.

57. Submit policies and procedures that describe how the applicant's community outreach materials are developed for the Medicaid population, including materials available in alternative formats and foreign languages.

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V. COVERED SERVICES (See Model Contract Attachment I and Attachment II, Sections II and V and Exhibit 5)

A. Covered Services

58. Submit policies and procedures detailing how all services covered under the model Contract will be met. The health plan must cover all Medicaid-covered services listed in Attachment I and Attachment II, Section V, Covered Services, and Exhibit 5, of the model Contract. All services must be provided in the same amount, duration and scope as services provided to fee-for-service Medicaid recipients and as outlined in the Medicaid Coverage and Limitations Handbook, unless (for capitated Reform health plans) otherwise specified in Attachment I.

59. **Fee-for-Service Plans only** – The fee-for-service applicant must use the Agency's pharmacy benefits manager (PBM) rather than its own.

60. **Reform Capitated Plans only –** Capitated health plans in Medicaid Reform counties have the flexibility to provide all Medicaid-covered services, as outlined in the Medicaid Coverage and Limitations Handbooks, or to design a customized benefit package (CBP) in accordance with state-established standards for a target population. Fee-for-service plans must provide all Medicaid-covered services, as outlined in the Medicaid Coverage and Limitations Handbooks, but have the option to waive copayments or provide expanded services. Regardless of which option the applicant chooses, it must provide all medically necessary services to children and pregnant women. Reform applicants must complete a benefit grid for each targeted population, following the benefit grid specifications in model Contract Attachment I (an electronic version for submission may be found in the application tool kit at Become a Medicaid Health Plan. To be approved, the benefit grid must meet actuarial equivalency and sufficiency standards for the population(s) to be covered. Policies and procedures must correspond to the covered services the applicant will provide.

    The grid template is part of the application tool kit at Become a Medicaid Health Plan. It displays the services to be covered and the areas the applicant may customize, whether that is co-pays, or the amount, duration or scope of the services. The shaded areas indicate that no changes can be made to the services in that part of the grid.

    If the CBP includes expanded services, the applicant must submit additional information with the grid including projected per member per month (PMPM) costs for the target population, as well as the actuarial rationale for developing the PMPM for that service. This rationale shall include utilization and unit cost expectations for services provided in the benefit.

B. Expanded and Optional Services

61. Health plans may choose to offer expanded services, which are services for which the health plan receives no direct payment from the Agency and are beyond the scope of FFS Medicaid. The applicant must describe any expanded services (as detailed in the model Contract) it will provide. The description must fully describe the service, setting,

and type of health professional expected to provide the service. The description should include the expected health-related benefit to the enrollee of obtaining the service.

62. Non-Reform health plans may choose to offer optional services that would otherwise be available to recipients through regular (or FFS) Medicaid. For these optional services, such as dental, the health plan receives an increased capitation rate (or, for FFS health plans, an increased benchmark rate). Submit policies and procedures that describe any optional services (as detailed in the model Contract) the applicant will provide. The policies and procedures must fully describe the service, setting, and type of health professional expected to provide the service. The description should include the expected health-related benefit to the enrollee obtaining the service. The description should also include any outreach and education provided to enrollees to encourage access to dental screenings and services for children/adolescents. Submit draft copies of member correspondence.

C. Moral or Religious Objections

63. Describe any required service the applicant does not intend to provide on the basis of a moral or religious objection.

D. Special Coverage Provisions

64. Submit policies and procedures that address advance directives, including how the applicant will train and educate its staff about advance directives and how it will educate enrollees about their ability to direct their care using advance directives. Submit draft copies of member correspondence.

65. The applicant must submit specific policies and procedures related to the provision of Child Health Check-Up (CHCUP) services. Such policies and procedures must include how the applicant will identify children/adolescents who have not received all required screenings, and how the applicant will ensure that children/adolescents receive all required screenings and treatment for conditions found at CHCUP screenings, including blood lead screenings and follow up and case management in cases where an enrollee has elevated blood lead levels. The applicant must describe how it will ensure that appointments are scheduled for enrollees to obtain screenings. In addition, the applicant must provide strategies for attaining the 60% screening requirement specified in Florida Statutes. Submit draft copies of member materials and case management policies and procedures.

66. Submit policies and procedures and all documentation used to explain the process by which enrollees can obtain emergency medical services. The applicant must describe how it will educate all enrollees and network providers of the provisions related to emergency medical services. Submit draft copies of member correspondence.

67 Submit and address in policies and procedures for family planning, how the applicant will ensure confidentiality for all enrollees unless the applicant does not intend to provide these services on the basis of moral or religious objections.

68. Submit policies and procedures that describe how the applicant will maintain a log of all hysterectomy, sterilization and abortion procedures performed for all enrollees unless

the applicant does not intend to provide these services on the basis of moral or religious objections. Submit draft log.

69. Submit policies and procedures that address how the applicant will ensure that its providers are enrolled in the Vaccines for Children (VFC) program, and how it will ensure that providers differentiate Title XXI MediKids in order to bill for their immunizations separately.

70. Submit policies and procedures that ensure all screening and coordination requirements for pregnant women, including Healthy Start screening and referral, Women, Infants and Children (WIC) referral, and HIV and Hepatitis B counseling and testing are provided. The policies and procedures must also address the comprehensive prenatal care, delivery, newborn and postpartum care requirements. Submit draft copies of member correspondence.

71. Submit policies and procedures that describe how the applicant will comply with the settlement agreement relating to *Hernandez et. al. v. Medows,* case number 02-20964 Civ-Gold/Simonton. (See requirements for prescription drug services in Attachment II, Section V, H.,16., model Contract.)

72. Submit policies and procedures used to ensure that all enrollees under the age of 18 who are taken into protective custody or foster care are physically screened within 72 hours, or immediately if required.

73. Submit policies and procedures related to the applicant's quality enhancements as outlined in Attachment II, Section V, Covered Services, Item H. Coverage Provisions, 17., Quality Enhancements, of the model Contract and provide a list of such services. Submit draft copies of member correspondence.

74. Submit policies and procedures relative to referring recipients for transportation services. For Reform county applicants, submit policies and procedures relative to coordinating and providing transportation services.

75. Submit policies and procedures relative to implementing and maintaining a drug utilization review program designed to encourage coordination between an enrollee's primary care physician and a prescriber of psychotropic or similar prescription drugs for behavioral health problems. (Also see Application Section V, Item E., below.)

76. Indicate if the applicant will use a pharmacy lock-in program according to Attachment II, Section V, A.16., Medicaid Redetermination Notices of the model Contract. If the applicant will participate, submit Medicaid redetermination policies and procedures for approval along with the statement indicating participation. Submit

77. The applicant must submit its policies and procedures relative to referring recipients for Medicaid services not covered by this Contract.

E. Behavioral Health Services –(See Model Contract Attachment II, Section VI)

78. The applicant must cover the services specified in Attachment II, Section VI, Behavioral Health Services, of the model Contract. Before submitting the application, visit the

application tool kit online at Become a Medicaid Health Plan to download the Behavioral Health Policy and Procedure Review Tool, the Policy and Procedure Template, and instructions. The applicant must use the provided template to submit its policies and procedures for the provision of behavioral health services and targeted case management to be covered under the Contract and all administrative functions required by the Contract. The policies and procedures must document the applicant's ability to provide the full range of behavioral health services.

79. The applicant must indicate if it intends to subcontract with a managed behavioral health organization (MBHO) for the performance of work required under the Contract with the Agency. Identify the MBHO with which the applicant will subcontract and specify which services they will be subcontracted to provide. Include in the application a copy of the draft contract with the MBHO. Provide the MBHO's contact information for the staff to communicate with, including name, phone number, and e-mail address.

80. Submit copies of draft model contracts for behavioral health providers, groups, facilities, and community mental health centers as appropriate.

81. Submit an enrollee handbook that has a separate behavioral health section that includes the following information:

    a. Description of behavioral health services provided, including limitations and general restrictions on provider access (including for counseling and referral services the applicant will not cover because of moral and religious objections), exclusions and out-of-network use;

    b. Procedures for obtaining required services, including second opinions, and authorization requirements, including those services available without prior authorization;

    c. Description of behavioral health emergency services and procedures for obtaining services both in and out of the applicant's service area, including explanation that prior authorization is not required for emergency services, the locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization care services;

    d. The extent to which, and how, after-hours and emergency coverage is provided, and that the enrollee has a right to use any hospital or other setting for emergency care;

    e. A notice that clearly states that the enrollee may select an alternative behavioral health case manager or direct service provider within the health plan, if one is available; and

    f. Information to assist the enrollee in assessing a potential behavioral health problem.

    Note: Contact BMHC Behavioral Health Unit for a sample member handbook.

82. Submit a behavioral health provider network that demonstrates that the applicant has sufficient facilities, service locations, service sites and personnel to provide the Covered Services described in Attachment II, Section VI, Behavioral Health Care, of the model

Contract. Separate the network by counties, grouping together the community mental health centers, psychiatrists, licensed mental health professionals, and hospitals/CSU's with inpatient psychiatric beds. Specify the number of child and adult beds.

83. As additional documentation of the behavioral health provider network, submit a completed and signed "Behavioral Health Provider Service Grid," which is available in the application tool kit online at Become a Medicaid Health Plan.

84. Submit GeoAccess or other mapping software reporting approved by the Agency report/map that reflects the location of each full service community mental health center, CSU (capitated plans only) and inpatient psychiatric hospital by county.

85. Submit a behavioral health-specific quality improvement program description that details how the applicant will objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered.

86. Submit a behavioral health-specific utilization management program description that addresses:

    a. Procedures for identifying patterns of over- and under-utilization by enrollees and for addressing potential problems identified as a result of these analyses;

    b. Procedures for handling suspected and/or confirmed fraud and abuse information identified through the utilization management program;

    c. A procedure for enrollees to obtain a second medical/psychiatric opinion and how the applicant will handle claims for such services;

    d. Service authorization protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting provider when appropriate, hospital discharge planning, and a retrospective review of both inpatient and ambulatory claims, meeting the predefined criteria; and

    e. Medical necessity criteria for determining behavioral health services that meets model Contract requirements.

87. Submit a provider handbook that is specific to behavioral health and includes the following information:

    a. Description of the program;

    b. Covered Services;

    c. Emergency Service responsibilities;

    d. Policies and procedures that cover the provider complaint system, including specific instructions on how to contact the applicant's provider services unit to file a provider complaint and a description of the staff position(s) with authority to address a provider complaint;

e. Information about the Medicaid Fair Hearing process and the applicant's complaint, grievance, and appeal process, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the enrollee's right to request continuation of benefits while utilizing the system;

f. Medical necessity standards and clinical practice guidelines;

g. Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

h. PCP responsibilities;

i. Other provider or subcontractor responsibilities;

j. Prior authorization protocols and referral procedures;

k. Clinical records and targeted case management standards;

l. Claims submission protocols and standards, including instructions and all information necessary for a clean or complete claim;

m. The health plan's and the MBHO's cultural competency plan;

n. Enrollee rights and responsibilities; and

o. Behavioral health specific disaster plan that will include, but not be limited to, how the plan will address covering psychotropic medications, crisis services, and inpatient services.

88. Submit a training plan, training manual and training schedule specific to behavioral health that will address how the plan will train behavioral health providers on its authorization protocols, medical necessity standards and clinical practice guidelines, contact information, etc.

89. Submit an organization chart that represents the applicant's oversight and structure of the behavioral health services component. If the plan is subcontracting the behavioral health services to an MBHO, the organization chart shall demonstrate who has the contractual oversight of the MBHO. Include who will be the designated behavioral health contact for the plan and/or the MBHO along with all relevant contact information.

90. Describe the applicant's clinical practice guidelines for each service (based on those behavioral health services/codes in the Contract) to be provided and how the applicant will ensure that the frequency, duration, and content of services is consistent with the age, developmental level and level of functioning of the enrollee.

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VI. PROVIDER NETWORK (See Model Contract Attachment II, Section VII and Exhibit 7 as appropriate by plan type)

A. General Provisions

91. The applicant must demonstrate that it has sufficient facilities, service locations, service sites and personnel to provide the covered services described in Attachments I and II, Section V and Section VI of the model Contract.

92. Specify in which Medicaid counties the applicant intends to operate during the Contract period, and if the applicant anticipates a phase-in period. The applicant must describe how it will increase and adapt its network as it expands to additional counties. The applicant must provide network information in a geo-access format.

    NOTE: The Agency may require the applicant to provide services in an Agency-predetermined service area.

93. The applicant must demonstrate that it has the capacity to provide covered services to all enrollees up to the maximum enrollment level in each county, including assurances that the applicant:

    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; and

    b. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients.

94. List, by county, the name, address, specialty, license number, hours of operation, and staffing of locations where the applicant plans to provide all covered services, including ancillary and hospital services, and whether the provider's panel is open or closed to new Medicaid enrollees enrolled with the applicant. The Excel spreadsheet template for this information is available in the application tool kit online at Become a Medicaid Health Plan. See the link titled "Provider Network Spreadsheet."

95. Submit a separate list of primary care providers (PCPs) located in adjacent counties who may provide services to enrollees. For enrollees who select a PCP or access providers in an adjacent county, the health plan is responsible for all services in the Contract including transportation to the provider in an adjacent county.

96. Submit GeoAccess or other mapping software reporting approved by the Agency to show, by county, the location of all contracted providers listed below, including travel times within the county. Submit a GeoAccess report that documents that the applicant's network meets all access standards for pharmacies and hospitals. These maps/reports are required to demonstrate that the access requirement of thirty (30) minutes travel time to PCPs and hospitals and sixty (60) minutes travel time to specialists and ancillary providers have been met.

    a. Dentists;

b. Pedodonists;
c. Primary care physicians, by specialty;
d. County Health Departments;
e. Federally Qualified Health Centers;
f. Rural Health Clinics;
g. Pharmacies;
h. Hospitals; and
i. Specialists.

97. Provide the cover page and signature page from the executed contracts of all participating providers in each county.

98. Submit policies and procedures regarding newborn assignment to pediatricians or other appropriate PCPs.

99. Submit policies and procedures used to ensure the applicant's providers offer emergency services, urgent care, routine sick patient care, and well care visits within the time frames specified in the model Contract.

100. Submit policies and procedures, documents and checklists the applicant intends to use in conducting an annual review of each primary care physician's active patient load and ensuring that additional enrollees are not assigned to physicians with appointment waiting times and geographic access standards out of compliance with Attachment II, Section VII, Provider Network, of the model Contract.

101. Submit policies and procedures, documents and checklists detailing how the applicant will conduct an onsite review of providers' office prior to contracting to ensure compliance with the model Contract.

102. Submit policies and procedures for notifying the Agency any time there has been a significant change in the applicant's operations that would affect adequate capacity and services, as outlined in Attachment II, Section VII, Item C. of the model Contract.

103. Submit policies and procedures for informing potential enrollees and enrollees of any changes to service delivery and/or the provider network as outlined in Attachment II, Section VII, C., of the model Contract. Such policies and procedures must also address changes in the applicant's network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network. Submit draft member and provider correspondence.

104. Submit policies and procedures for continuity of care following a provider termination. Such policies and procedures must address how, in the event a PCP ceases participation in the network, the applicant will notify enrollees who have chosen the provider as their PCP no less than 60 calendar days before the effective date of the termination and no more than 15 calendar days after receipt or issuance of the termination notice.

105. Submit policies and procedures the applicant will use in notifying the Agency within seven business days of any significant changes to the applicant's network.

106. Submit policies and procedures that demonstrate a good faith effort to enter into a memorandum of agreement with the local CHDs, FQHCs and school districts participating in the certified match program.

107. Submit policies and procedures for authorizing claims from CHDs, migrant health centers, and FQHCs.

108. Submit an attestation that each provider in the applicant's network has a unique Florida Medicaid provider number. The procedure is as follows:

a. **Capitated health plans only** – The applicant shall register all network providers who are not verified as Medicaid-enrolled providers with the Agency's Medicaid fiscal agent. A network provider who does not have a Florida Medicaid provider number and who does not intend to become a Medicaid provider on his/her own shall complete the two-page "Managed Care Treating Provider Registration Form" which may be accessed at the Web site of the Agency's Medicaid fiscal agent or at the following link:

http://portal.flmmis.com/FLPublic/Provider_Enrollment/tabId/50/Default.aspx

b. **FFS health plans only** – If the FFS health plan will be capitated for a particular service (i.e., transportation), then the applicant shall register all network providers who are not verified as Medicaid-enrolled providers with the Agency's Medicaid fiscal agent. A network provider who does not have a Florida Medicaid provider number and who does not intend to become a Medicaid provider on his/her own shall complete the two-page "Managed Care Treating Provider Registration Form" which may be accessed at the Web site of the Agency's Medicaid fiscal agent or at the following link:

http://portal.flmmis.com/FLPublic/Provider_Enrollment/tabId/50/Default.aspx

109. Submit policies and procedures that identify how the applicant will require each provider to have a National Provider Identifier (NPI) in accordance with Attachment II, Section VII, A.9., of the model Contract. The applicant must submit the provider's NPI as part of the Provider Network Report.

B. Provider Contracts

110. Submit the applicant's model provider contracts and a completed checklist for each of the following:

a. Primary care physicians;

b. Specialty physicians;

c. Hospitals; and

d. Ancillary providers.

The model subcontract checklist is available in the application tool kit at Become a Medicaid Health Plan.

C. Provider Terminations

111. Submit policies and procedures that cover provider termination and appeal rights and processes to ensure continuity of care for enrollees in active treatment as specified in Attachment II, Section VII, G., Continuity of Care. Submit draft provider notification letters (including notices to enrollees as required by the model Contract).

D. Provider Services

112. Submit policies and procedures that cover the applicant's responsibilities to ensure its providers are compliant with the model Contract and pertinent federal and state regulations.

113. Submit policies and procedures for distributing provider materials. Submit a draft provider handbook that meets the model Contract requirements and a completed provider handbook checklist. The checklist is available in the application tool kit at Become a Medicaid Health Plan.

114. Submit policies and procedures that describe the provider orientation process and orientation materials the applicant will present to new providers, as well as the schedule and content of any continuing training for current providers.

115. Describe the staffing plan for provider relations, the provider complaint system and the provider telephone help line, including an organizational chart and job descriptions. Include staff resumes, if available, that describe pertinent experience and certification/licensure.

116. Submit the policies and procedures that cover the functions of the provider relations unit to ensure that all provider requirements, specified in the model Contract are met.

117. Submit the policies and procedures that cover the provider complaint system, including the toll-free provider help line system.

E. Medical Records

118. Submit policies and procedures that describe how the applicant will ensure that providers are compliant with the enrollee medical record requirements, including the confidentiality of enrollee medical records.

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VII. QUALITY MANAGEMENT (See Model Contract Attachment II, Section VIII and Exhibit 8)

A. Quality Improvement

119. Submit the Quality Improvement Program (QIP), including an organizational chart and job descriptions. Include available staff resumes that describe pertinent experience and certification/licensure.

120. The QIP should include committee membership (and whether members are applicant staff or external to the applicant), the members' qualifications and certifications/licensure, and the responsibilities, reporting relationships and communication requirements for the committees. The communication process should be depicted in a flow chart.

121. Provide the policies and procedures that cover required quality improvement (QI) activities, including but not limited to, the development of the QI plan and its maintenance, the process by which the applicant tracks and trends data and information from internal and external sources and then incorporates the results of its analysis into the QIP, the performance improvement projects, performance measures, quality of care projects, satisfaction surveys, medical record reviews, peer review, credentialing/recredentialing, mechanisms for reporting quality deficiencies, and the relationship with a local advisory group. The description should include the anticipated timelines for the development and implementation of the activities.

122. Provide a copy of the applicant's written Cultural Competency Plan as described in Attachment II, Section VIII, A., of the model Contract, and policies and procedures to keep it up-to-date in accordance with the model Contract. Cultural competence in health care is defined as the ability of health care providers to understand patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs that are brought to the encounter.

B. Utilization Management

123. Describe the Utilization Management Program, including an organizational chart and job descriptions. Include staff resumes, if available, which describe pertinent experience and certification/licensure.

124. Submit policies and procedures that include:

    a. Service authorization protocols, including those that cover new enrollees.

    b. Procedures for identifying patterns of over- and under-utilization.

    c. The process by which enrollees can obtain a second medical opinion.

125. Submit policies and procedures describing care management activities.

126. For Reform plans only - Submit policies and procedures that describe the process for the development and implementation of disease management programs.

127. Submit policies and procedures that describe treatment plans for those with chronic diseases.

128. Submit policies and procedures for adopting practice guidelines.

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VIII. GRIEVANCE SYSTEM (See Model Contract Attachment II, Section IX)

A. General Requirements

129. Submit policies and procedures for the complaint, grievance, and appeal processes, including an organizational chart and job descriptions for grievance system staff. Include staff resumes, if available, that describe pertinent experience and certification/licensure.

130. Submit the training to be given to the applicant's staff who interact with enrollees and providers regarding the recognition and handling of enrollee complaints, grievances, and appeals, and how continuation of benefits will be handled.

131. Submit policies and procedures that describe the process for ensuring grievance and appeal decision makers have not been involved in previous levels of review involving the matter under consideration.

132. Submit policies and procedures for utilizing appropriate health care professionals, when deciding a grievance or appeal involving clinical issues, an appeal of a denial based on lack of medical necessity or a grievance regarding the denial of an expedited resolution of an appeal.

133. Submit draft materials to be provided to enrollees that describe the grievance process, including the Beneficiary Assistance Panel (PSNs) or the Subscriber Assistance Panel (HMOs), and Medicaid Fair Hearings.

134. Submit policies and procedures that describe the assistance to be provided to enrollees in completing the procedural steps of the grievance process.

135. Submit policies and procedures that describe how the applicant will ensure that no punitive action will be taken against a provider who supports the submission of an appeal, a request for a Medicaid Fair Hearing or a request for the continuation of benefits by an enrollee or a provider who submits an appeal, a request for a Medicaid Fair Hearing or a request for a continuation of benefits on an enrollee's behalf.

136. Submit policies and procedures that describe how the analysis of complaints and grievances information will be used for quality improvement.

B. Complaint Process

137. Submit policies and procedures that describe how the applicant will handle enrollee complaints and what steps it will take if a complaint is not resolved by close of business the day following receipt of the complaint. Submit draft member correspondence.

C. Grievance Process

138. Submit policies and procedures that describe the filing and resolution of enrollee grievances. Submit draft member correspondence.

139. Submit policies and procedures that describe the expedited review process. Submit draft member correspondence.

D. Appeal Process

140. Submit policies and procedures that describe the filing and resolution of appeals, as well as the continuation of benefits during an appeal. Submit draft member correspondence.

141. Submit policies and procedures that describe the applicant's activities once an appeal is resolved. Submit draft member correspondence.

E. Medicaid Fair Hearings

142. Submit policies and procedures for filing a request for a Medicaid Fair Hearing. Submit draft member correspondence.

143. Submit policies and procedures for the continuation of benefits during a Medicaid Fair Hearing. Submit draft member correspondence.

144. Submit policies and procedures that cover the applicant's responsibilities once a Medicaid Fair Hearing decision is delivered. Submit draft member correspondence.

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IX. INFORMATION SYSTEMS (See Model Contract Attachment II, Section XI)

A. System Capacity, Availability and Performance

145. Submit policies and procedures that describe in detail how the applicant will ensure that the capacity, availability and performance of its systems will meet the requirements set forth in the Contract. The description should address technologies, including those that support system scalability and flexibility, as well as policies and procedures. The description should, at a minimum, encompass:

    a. Information and telecommunications systems architecture (for information and telecommunications systems within the applicant's span of control),

    b. Data and voice communications network architecture,

    c. Business continuity and disaster recovery strategies,

    d. Monitoring tools and resources.

146. Identify the timing of implementation of the mix of technology and management (policies and procedures) strategies outlined in the response to question #143, above.

147. State the projected recovery times and data loss for each mission-critical system identified in the applicant's business continuity-disaster recovery (BC-DR) plan (these projections are pertinent only in the event of a declared disaster).

B. E-Mail System

148. Describe the applicant's proposed solution for a continuously available electronic mail communication link (e-mail system) with the Agency to ensure the Agency is able to communicate with the health plan via e-mail at any time. In the description address:

    a. Availability from the workstations of the designated applicant staff;

    b. Capabilities to attach and send documents created using software products other than the vendor's systems, including the Agency's currently installed version of Microsoft Office and any subsequent upgrades as adopted; and

    c. Capabilities to, as needed, encrypt and/or otherwise secure the content of electronic messages.

149. Identify the timing of implementation of the e-mail solution outlined in the response to question #149, above.

C. Data and Report Validity and Completeness

150. Describe the processes the applicant shall institute to ensure the validity and completeness of the data, including reports, it will submit to the Agency. At a minimum

the response should address data validity and completeness audits and the use of relevant statistical techniques.

D. Data Exchange

151. Cite at least two currently-live instances where the applicant is successfully:

a. Providing claims electronically to a state's MMIS or third party in accordance with HIPAA-compliant or agency-specific coding, data exchange format and transmission standards and specifications, as required in the model Contract; and

b. Receiving, processing and updating enrollment data from a state's MMIS or third party in accordance with HIPAA-compliant or agency-specific coding, data exchange format and transmission standards and specifications, as required in the model Contract.

152. If the applicant is not able at present to meet a data exchange requirement contained in the model Contract, identify the applicable requirement and discuss the effort and time needed to meet said requirement.

E. Reporting – System Capabilities

153. Describe how the applicant will extract and upload data sets to a secure FTP site such that authorized Agency staff, on a secure and read-only basis, can retrieve and/or utilize data to build and generate reports for Agency management use.

154. Submit policies and procedures to ensure that the applicant will report systems problems to the Agency within the required time frames specified in Attachment II, Section XI, of the model Contract.

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F. Companion Documents

155. Provide a detailed profile of the information systems (refer to the Reference Table; below):

SYSTEMS PROFILE

	APPLICATION						OPERATING ENVIRONMENT					
System Information Management Function:	App. Mgt. Outsourced? (Yes/No)	If Yes, to Whom?	Dedicated or Multi Client?	If Multi-Client, Indicate Other Users	Name of Application(s):	App. Version/Release Level:	Optg. Env. Mgt. Outsourced? (Yes/No)	If Yes, to Whom?	Operating Hardware Vendor	Optg. Hardware Model/Series ID	Operating System Vendor	Optg. System Model/Series ID
1 Maintenance of Member enrollment and other Information, both current and historical												
2 Maintenance of Claims Information, both current and historical												
3 Maintenance of authorization and care coordination Information, both current and historical												
4 Maintenance of Provider Network and other Information												
5 Maintenance of EPSDT-specific Information												
6 Maintenance of Information related to Member health status and outcomes												
7 Maintenance of vendor financial data												
8 Maintenance of Information related to interactions with Members and Providers, including Grievances, Appeals and Complaints												
9 Maintenance of internal operations data, e.g. call center statistics and system availability												
10 Maintenance of Information related to reported incidents that may have compromised patient safety												
11 Maintenance of data collected via client satisfaction surveys												
12 Maintenance of Information related to program integrity and compliance activities												
13 Generation of the reports stipulated in the Contract												
14 Processing of Claims including electronic submission and, where applicable, automated and/or rules-based adjudication												
15 Processing of transactions between the contractor and its members and between the contractor and providers including but not limited to: provider applications for network participation; enrollee and/or provider inquiries, suggestions, complaints etc.) - "workflow"												
PREPAID HEALTH PLANS ONLY:												
16 Maintenance of Encounter Information for Providers with whom the vendor does not have a fee-for-service reimbursement arrangement, both current and historical												

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In the systems profile, please indicate whether systems will be:

- Used solely for the administration and management of Florida Medicaid activities, or
- Multi-client systems, where information and transactions related to Florida Medicaid will be captured and/or processed along with information and transactions of other clients.

Additionally, as part of the systems profile indicate:

- Name and version/release level of each application (e.g., MS Word 2003)
- Operating hardware vendor and model/series ID (e.g., SUN Microsystems Sunfire 4800 Series)
- Operating system vendor and ID along with version/release level (e.g., SUN Microsystems Solaris version 8)
- Whether operation of the application and/or operating hardware is being outsourced to a third party; if so, indicate the third party to which the operation is or will be outsourced.

156. Identify whether any of the applications identified in the systems profile will be replaced (and by what application, if known), or undergo a major upgrade or release/version update, in the next 18 months. Submit policies and procedures for the applicant to notify the Agency about systems changes within the required time frames specified in Attachment II, Section XI, of the model Contract.

157. Provide diagrams that illustrate point-to-point interfaces, information flows and the networking arrangement (a.k.a. "network diagram") associated with the information systems included in the systems profile. These diagrams should provide insight into how the applicant's systems will be organized and interact with Agency systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with Florida Medicaid.

158. Provide a sample system availability and performance report from a current customer.

159. Provide a profile of the applicant's information systems (IS) organization – in-house or outsourced operation within the applicant's span of control - that includes an organizational chart and a roster by job type/class (using the applicant's job classification scheme) of: number of in-house and/or outsourced IS staff, average years of experience in the IS field, and average number of years working in the applicant's IS organization. Following is a sample profile:

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IS ORGANIZATIONAL PROFILE - PERSONNEL ROSTER TABLE EXAMPLE

Job Class:	# In-House FTEs	Avg. Years of Experience in Field	Avg. Years in Org.	# Outsourced FTEs	Avg. Years of Experience in Field	Avg. Years in Org.
System Analysis						
Application Programming						
Network Administration						
Data Comm. Analysis/Engineering						
Job Control/Computer Operations						
etc.						

Capitated Plans and FFS Plans with a Capitated Component Only

G. Data Exchange (See Model Contract Attachment II, Section XI)

160. Cite at least two currently-live instances where the applicant is successfully providing encounter data to a state's MMIS, DSS or other third party in accordance with HIPAA-compliant or agency-specific coding, data exchange format and transmission standards and specifications, as required in the model Contract.

161. If the applicant is not able at present to meet a particular encounter data submission requirement contained in the model Contract, identify the applicable requirement and discuss the effort and time needed to meet said requirement.

H. Social Networking (See Model Contract Attachment II, Section XI)

162. Submit a statement regarding Attachment II, Section XI, K., Social Networking, of the model Contract, indicating participation in social networking. If the applicant will use social networking in the Medicaid line of business, submit policies and procedures as required in the model Contract. If social networking is not to be used, the applicant shall include in the above statement how it will ensure that other policies and procedures are reviewed to ensure compliance with the model Contract.

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X. ADMINISTRATION AND MANAGEMENT (See Model Contract Attachment II, Section X and Exhibits 10 and 13)

A. Staffing

163 Submit the job descriptions for each of the minimum staffing positions listed in Attachment II, Section X, Item A., Health Plan Reporting Requirements. Include the resumes showing pertinent experience and certification/licensure of the current staff, if available.

B. Claims Processing and Payments

164. Describe the staffing plan for the claims unit, including an organizational chart and job descriptions. Include staff resumes, if available, that describe pertinent experience and certification/licensure.

165. Describe the applicant's provider claims complaint resolution process.

166. **Capitated health plans and FFS health plans receiving a capitation payment for at least one service -** Submit policies and procedures that cover the submission, processing and payment of provider claims. For capitated health plans that intend to serve Medicaid Reform populations, such policies and procedures should also cover the submission of claims for kick payments as specified in Attachment II, Exhibit 13.

167. **Capitated health plans only and FFS health plans receiving a capitation payment for at least one service -** Describe the applicant's claims processing and payment performance metrics, including quality, accuracy and timeliness. Include a description of how they will be monitored to ensure compliance with model Contract requirements.

168. **FFS health plans only -** Submit policies and procedures that cover the submission, authorization and forwarding of provider claims to the Agency or its Medicaid fiscal agent.

169. **FFS health plans only -** Describe the applicant's role in coordination with the Medicaid fiscal agent and when acting as an intermediary between a provider and the Medicaid fiscal agent when there is a disagreement.

C. Fraud and Abuse Prevention

170. Submit policies and procedures that delineate procedures for detecting and reporting potential/suspected fraud and abuse information gained from UM activities. Include policies and procedures that demonstrate methodology, assigns roles, and responsibilities.

171. Submit policies and procedures and an organizational chart that delineate the staffing organizational arrangement of compliance/anti-fraud/abuse personnel, their roles and responsibilities, including investigational methodology and reporting protocols for fraud and abuse prevention. Also include a comprehensive health plan organizational chart

starting with the Board of Directors and include all plan positions listing position titles and individual staff names. Provide a functional committee organizational chart that includes committee names and composition of each by listing position titles. Provide job descriptions for the compliance officer, staff subordinate to the compliance officer, and for any other positions involved in compliance and anti-fraud/abuse activity. Include available staff resumes, list pertinent experience, and certification/licensure.

172. Submit the compliance plan, anti-fraud plan, code of conduct, ethics, and policies and procedures that cover program integrity processes reasonably designed, implemented, and enforced to be generally effective to prevent and detect criminal conduct, govern compliance-related activities, and describe the compliance committee, including, but not limited to internal controls and processes that support communication and the plan's due diligence to prevent, reduce, detect, investigate, correct, educate, and report known or suspected fraud and abuse in compliance with the model Contract and in keeping with requirements of federal and state regulations. Also include policies and procedures that delineate internal monitoring, auditing protocols, and corrective action.

173. Submit the policies, procedures, and training programs that describe the orientation and ongoing education about program integrity, compliance, and fraud and abuse prevention that will be provided to the applicant's staff, providers, subcontractors, and enrollees, including requirements by s. 6032 of the federal Deficit Reduction Act of 2005. Include the methodology of training delivery, how fraud and abuse\compliance training will be documented, validated, and training cycles maintained. Also include how the fraud and abuse training's effectiveness will be evaluated.

D. Subcontracts

(Note: the Subcontract requirements in the model Contract are found in Attachment II, Section XVI, Terms and Conditions, Item O., Subcontracts, and Exhibit 16)

174. Provide model subcontracts for all major service providers (that are in addition to provider contracts referenced above in question #108) who are not salaried employees of the applicant. Such entities include but are not limited to:

    a. Any applicant-delegated administrative functions;

    b. Pharmacy benefits managers (PBM);

    c. Administrative service organizations;

    d. Management service organizations; and

    e. Third party administrators (TPA).

175. Submit a completed checklist of the required terms and conditions for each of the applicant's proposed model subcontracts. Such checklist may be obtained from the application tool kit at Become a Medicaid Health Plan.

176. Submit policies and procedures that describe how the applicant will ensure that all subcontracts, including provider contracts, comply with all state and federal requirements.

E. Encounter Reporting – Capitated health plans and any capitated unit of a fee-for-service health plan

177. Describe the staffing plan for a data unit, if different from claims, including an organizational chart and job descriptions. Include staff resumes, if available, that describe pertinent experience and certification/licensure.

178. Submit policies and procedures that describe the generation and submission of encounters, including but not limited to, how the applicant will ensure the completeness, accuracy and timeliness of its encounters as required in Attachment II, Section X, D., Encounter Data, of the model Contract.

179. Submit policies and procedures that describe the physician incentive program, if any.

F. Corrective Actions

180. Submit policies and procedures to ensure that the applicant will timely provide any corrective action plan and performance measure action plan required under Attachment II, Section XIV, Sanctions, of the model Contract.

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XI. REPORTING (See Model Contract Attachment II, Section XII)

A. General Requirements

181. Submit a chart of the responsible positions within the organization for each report listed in Attachment II, Sec. XII, Table 1, of the model Contract. These positions will be the applicant's liaison to the Agency.

182. Submit policies and procedures and the position(s) within the organization responsible for the compilation and submission of each report listed in Attachment II, Sec. XII, Table 1, of the model Contract in accordance with the specifications detailed in the Agency's Health Plan Report Guide. Also include the position, and contact information for the person holding this position, that will assure and certify the timeliness, accuracy and completeness of the reports.

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FORMS

Enrollment Projection

Provide information for one (1) full year, starting with the quarter in which the applicant anticipates initial enrollment.

Year	Quarter	Area	County	Estimated # Eligible	Projected Numbers	
					New Members this Quarter	***Total Members To-Date**
		Example: One	*Example: Broward*			
Total						
Total						
Total						
Total						

*"Total Members To-Date" is derived by adding the "New Members this Quarter" to the prior "Total Members To-Date."

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Background Screening Manager List

List of individuals who must complete a background screen: Submit a detailed list of all individuals who must complete a background screen (regardless of whether they have already completed a screen for a different state agency/department, already been submitted to AHCA or the fiscal agent, are exempt, etc.). The list of positions for which a screening is required is provided below. Your list must include the individual's full legal name (first name, middle initial, last name); title; position (relative to the applicant/health plan; such as, plan employee, owner, subcontractor, etc.); date of birth; Social Security number and indicate that a fingerprint card is being submitted or the state agency name to which fingerprints were submitted within the prior twelve (12) months; e.g., AHCA/HSD or DFS/OIR..

Manager Type	Full Name	Health Plan Title (if different than manager type)	Position (Plan Employee, Subcontractor, etc.)	Date of Birth	SSN	Fingerprint (FP) Or Agency Name/Unit
Contract Manager						
Full-Time Administrator						
Medical Director						
Medical Records Review Coordinator						
Data Processing and Data Reporting Coordinator						
Community Outreach Oversight Coordinator						
QI Manager						
UM Manager						
Grievance System Coordinator						
Compliance Officer						
Case Management Manager/Coordinator						
Behavioral Health Oversight Manager						
Board Certified or Board Eligible, Licensed Staff Psychiatrist						
Financial Records Custodian						
Medical Records Custodian						
Claims/Encounter Manager						
Individuals w/signing privileges on depository account						
Any other with direct decisions or have impact on services rendered to beneficiaries						

If an individual has submitted fingerprints to the Agency or to the Office of Insurance Regulation in the last 12 months, the applicant need only state such and does not need to include another set of fingerprints for the individual.

CERTIFICATIONS APPENDIX

Accuracy and Authorization: I certify that all information in this application is true, complete, and current and provided in good faith. I further certify that I am a duly authorized representative of this organization with full signatory authority.

Authority to Operate: I certify that this organization is authorized to do business in Florida, and all its subcontractors, if any, are registered with the state in accordance with Florida law. Copies of appropriate licenses/certifications are attached to this application.

Eligibility to Apply: I certify that this organization, including its subsidiaries and affiliates, has not unilaterally and willfully terminated any previous contract prior to the end of the contract period with a state or federal government entity and has not had a contract terminated by a state or federal government entity for cause prior to the end of the contract term within the past five years.

Confidentiality: I certify that this organization has the capacity to maintain the confidentiality of enrollee data and will abide by all confidentiality provisions of state and federal law as they pertain to any contract that may result from this application.

Signature: _____

Printed Name: _____

Title: _____

_____

Date:

If the CEO or Executive Director is different from the person named above, provide that information below. If the organization is a joint venture or limited partnership, provide the information for each entity in the organization.

Name: _____

Title: _____

Mailing Address: _____

Office Telephone/Extension: _____

Cellular Telephone: _____

Fax Number: _____

E-mail Address: _____

If the payee name and address is different from above, provide that information below.

Name: _____

Title: _____

Mailing Address: _____

Office Telephone/Extension: _____

Cellular Telephone: _____

Fax Number: _____

E-mail Address: _____

If the financial records contact is different from above, provide that information below.

Name: _____

Title: _____

Mailing Address: _____

Office Telephone/Extension: _____

Cellular Telephone: _____

Fax Number: _____

E-mail Address: _____

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CERTIFICATION REGARDING
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 COMPLIANCE

This certification is required for compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The undersigned Vendor certifies and agrees as to abide by the following:

1. Protected Health Information. For purposes of this Certification, Protected Health Information shall have the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by the Vendor from or on behalf of the Agency.

2. Limits on Use and Disclosure of Protected Health Information. The Vendor shall not use or disclose Protected Health Information other than as permitted by this Contract or by federal and state law. The Vendor will use appropriate safeguards to prevent the use or disclosure of Protected Health Information for any purpose not in conformity with this Contract and federal and state law. The Vendor will not divulge, disclose, or communicate Protected Health Information to any third party for any purpose not in conformity with this contract without prior written approval from the Agency. The Vendor will report to the Agency, within ten (10) business days of discovery, any use or disclosure of Protected Health Information not provided for in this Contract of which the Vendor is aware. A violation of this paragraph shall be a material violation of this Contract.

3. Use and Disclosure of Information for Management, Administration, and Legal Responsibilities. The Vendor is permitted to use and disclose Protected Health Information received from the Agency for the proper management and administration of the Vendor or to carry out the legal responsibilities of the Vendor, in accordance with 45 C.F.R. 164.504(e)(4). Such disclosure is only permissible where required by law, or where the Vendor obtains reasonable assurances from the person to whom the Protected Health Information is disclosed that: (1) the Protected Health Information will be held confidentially, (2) the Protected Health Information will be used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and (3) the person notifies the Vendor of any instance of which it is aware in which the confidentiality of the Protected Health Information has been breached.

4. Disclosure to Agents. The Vendor agrees to enter into an agreement with any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by the Vendor on behalf of, the Agency. Such agreement shall contain the same terms, conditions, and restrictions that apply to the Vendor with respect to Protected Health Information.

5. Access to Information. The Vendor shall make Protected Health Information available in accordance with federal and state law, including providing a right of access to persons who are the subjects of the Protected Health Information.

6. Amendment and Incorporation of Amendments. The Vendor shall make Protected Health Information available for amendment and to incorporate any amendments to the Protected Health Information in accordance with 45 C.F.R. § 164.526.

7. Accounting for Disclosures. The Vendor shall make Protected Health Information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528. The Vendor shall document all disclosures of Protected Health Information as needed for the Agency to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

8. Access to Books and Records. The Vendor shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by the Vendor on behalf of the Agency, available to the Secretary of the Department of Health and Human Services or the Secretary's designee for purposes of determining compliance with the Department of Health and Human Services Privacy Regulations.

9. Termination. At the termination of this contract, the Vendor shall return all Protected Health Information that the Vendor still maintains in any form, including any copies or hybrid or merged databases made by the Vendor; or with prior written approval of the Agency, the Protected Health Information may be destroyed by the Vendor after its use. If the Protected Health Information is destroyed pursuant to the Agency's prior written approval, the Vendor must provide a written confirmation of such destruction to the Agency. If return or destruction of the Protected Health Information is determined not feasible by the Agency, the Vendor agrees to protect the Protected Health Information and treat it as strictly confidential.

CERTIFICATION

The Vendor has caused this Certification to be signed and delivered by its duly authorized representative, as of the date set forth below.

Vendor Name:

_____ _____

Signature Date

_____

Name and Title of Authorized Signer

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CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____ _____

Signature Date

_____ _____

Name of Authorized Individual Application or Contract Number

_____

Name and Address of Organization

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CERTIFICATION REGARDING
DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION

CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each Vendor whose contract/subcontract equals or exceeds $25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, Vendors who audit federal programs must also sign, regardless of the contract amount. The Agency for Health Care Administration cannot contract with these types of Vendors if they are debarred or suspended by the federal government.

2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.

3. The Vendor shall provide immediate written notice to the contract manager at any time the Vendor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.

5. The Vendor agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.

6. The Vendor further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal monies, to submit a signed copy of this certification.

7. The Agency for Health Care Administration may rely upon a certification of a Vendor that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.

8. This signed certification must be kept in the contract manager's contract file. Subcontractor's certifications must be kept at the contractor's business location.

CERTIFICATION

(1) The prospective Vendor certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective Vendor is unable to certify to any of the statements in this certification, such prospective Vendor shall attach an explanation to this certification.

_____ _____

Signature Date

_____