FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

March 13, 2012

Mr. Mark Pahl
Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Mr. Pahl:

The Agency for Health Care Administration is submitting the enclosed Medicaid managed care policies as required by Special Term and Condition #14 of Florida's 1115 Research and Demonstration Waiver (Project No. 11-W-002064). The following is a brief description of Attachments I through VI.

- **Attachment I** - Special Term and Condition (STC) #14 as approved on December 15, 2011.

- **Attachment II STC 14.a.** – Florida Medicaid managed care policies to ensure increased stability among managed care organizations (MCO) and provider service networks (PSNs) and minimize plan turnover. The policies address the state's plan selection process and oversight criteria including: solvency requirements; evaluation of prior business operations in Florida; and financial penalties for not completing a contract term.

- **Attachment III STC 14.b.** – Florida Medicaid managed care policies to ensure provider network adequacy and access requirements which address travel time and distance, as well as the availability of routine, urgent and emergent appointments. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The policies are consistent with the requirements of 42 CFR 438.

- **Attachment IV STC 14.c.** – Florida Medicaid managed care draft policies that will require each MCO and capitated PSN to maintain an annual Medical Loss Ratio (MLR) of 85 percent for Medicaid operations in the demonstration counties with an effective date of July 1, 2012. This policy is being developed during demonstration year six. The final policy will be amended into the MCO model contract, which will be reviewed by the Centers for Medicare and Medicaid Services Regional Office.

- **Attachment V STC 14.d.** – Florida Medicaid managed care policies regarding the transition and continuity of care when enrollees are required to change plans (e.g. transition of enrollees under case management and those with complex medication needs, and maintaining existing care relationships).

- **Attachment VI STC 14.e.** – Florida Medicaid managed care policies to ensure adequate choice when there are fewer than two plans in any rural county, including contracting on a regional basis where appropriate to assure access to physicians, facilities, and services.

We appreciate your support and efforts in working with our staff on Florida's Section 1115 Research and Demonstration Waiver. Should you have any questions, please contact Linda Macdonald of my staff by phone at (850) 412-4031 or by email at Linda.Macdonald@ahca.myflorida.com.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lam
Enclosures
cc: Jackie L. Glaze, CMS-RO

Attachment I
Special Term and Condition #14

Special Term and Condition #14

14. **Managed Care Requirements**. The State must comply with the managed care regulations published at 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan services used in the rate development process.

    The State must provide for the following:

    a) Policies to ensure an increased stability among managed care organizations (MCO) and provider service networks (PSNs) and minimize plan turnover. This could include a limit on the number of participating plans in the five Demonstration counties. Plan selection and oversight criteria should include: confirmation that solvency requirements are being met; an evaluation of prior business operations in the State; and financial penalties for not completing a contract term. The State must report quarterly on the plans entering and leaving Demonstration counties, including the reasons for plans leaving. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension;

    b) Requirements contained herein are intended to be consistent with and not additional to the requirements of 42 CFR 438. Policies to ensure network adequacy and access requirements which address travel time and distance, as well as the availability of routine, urgent and emergent appointments, and which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The State must implement a thorough and consistent oversight review for determining plan compliance with these requirements and report these findings to CMS on a quarterly basis. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension;

    c) A requirement that each MCO and capitated PSN maintain an annual Medical Loss Ratio (MLR) of 85 percent for Medicaid operations in the Demonstration counties and provide documentation to the State and CMS to show ongoing compliance. The State must develop quarterly reporting of MLR during Demonstration year (DY) 6 specific to Demonstration counties. Beginning in DY 7 (July 1, 2012), plans must meet annual MLR requirements. CMS will determine the corrective action for non-compliance with this requirement;

    d) Policies that provide for an improved transition and continuity of care when enrollees are required to change plans (e.g. transition of enrollees under case management and those with complex medication needs, and maintaining existing care relationships). Policies must also address beneficiary continuity and coordination of care when a physician leaves a health plan and requests by beneficiaries to seek out of network care. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension; and,

    e) Policies to ensure adequate choice when there are fewer than two plans in any rural county, including contracting on a regional basis where appropriate to assure access to physicians, facilities, and services. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension.

Attachment II
Special Term and Condition #14a

- **Health Plan Stability/Minimize Turnover Policy**
    - Appendix A – How to become a Florida Medicaid Health Plan
    - Appendix B – MCO Application Checklist

Health Plan Stability Policy

March 2012

Agency for Health Care Administration

Health Plan Stability/Minimize Turnover Policy
Bureau of Health Systems Development

Agency Mission to Ensure Quality Care:

The Agency's mission is to ensure quality care is provided to Florida's residents. On occasion, market fluctuations result in a Medicaid health plan leaving a county, terminating its contract, or being purchased by another entity. Our primary goal is to ensure stability and minimize turnover among health plans and the following processes and requirements are performed to assist in reaching this goal.

Current Health Plan Application Review Process:

The Agency's health plan application process has been modified to include a tiered review approach that requires applicants to meet minimum financial, organizational, prior experience and network requirements in a Phase I review in order to continue with the rest of the application review process. Review requirements include but are not limited to the following:

- The applicant's legal history and dates of operation, tax identification number, corporate charter number, primary business, copies of provider certificates and articles of incorporations and certificates of good standing
- Number of full-time employees associated with the application
- Prior contract experience, with references for each
- History of default or having voluntarily withdrawn from a contract or having a contract terminated
- Experience in providing services identical or similar to the health plan services
- History of legal actions taking or pending, including letter attesting on significant business transactions and no actions or suit or claim made against the applicant resulting in litigation for disputes or damages exceeding $5,000.
- History of criminal convictions and certification regarding debarment, suspension, ineligibility, and voluntary exclusion
- Full ownership disclosure and delegation of responsibilities, including subcontractors and owners that are associated with other health plans and, as appropriate, fingerprint cards
- Detailed organizational charts, including ownership and subcontractor and affiliate relationships with detailed lines of authority
- Business plan for a minimum of 24 months after anticipated contract execution, including projected enrollment, expansion and strategy for growth and development

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Tallahassee, FL 32308

Visit AHCA online at AHCA.MyFlorida.com

- Emergency management plan
- Independently certified audited financial statements
- Pro forma financial statements broken down by line of business and prepared on an accrual basis by month for the first three years of the anticipated contract execution date
- Bank account statements for required accounts for start-up, reserves and insolvency protection and a description of how those accounts will be appropriately maintained
- Attestation that no assets have been pledged to secure personal loans
- Review of general insurance coverage for contract-required types of insurance

If applicants do not provide documentation of meeting the minimum financial, organizational, prior experience and network requirements in Phase I, they are given an opportunity to remedy the application and then, if not remedied, the application review is terminated. If the applicant does meet these requirements, they move on to a review of policies and procedures (Phase II) to ensure all contract requirements are met. If Phase I and Phase II requirements are met, a site visit be scheduled to ensure that the health plan is operationally ready for contract. This site visit includes a review of administrative functions as well as medical, behavioral health and fraud and abuse functions.

If the health plan applicant's ownership changes during the application process, the Agency may reject the application.

The Health Plan Application includes a description of the application process in order to ensure all applicants are sufficiently aware of the state's application process and criteria.

See Appendix A for links to the most current Health Plan Application, agency model documents and checklists

Agency staff reviews the health plan application using an application checklist based on application and contract requirements. See Appendix B

See current Agency Health Plan Application Phase I application review checklist attached.

Overview of Current Health Plan Oversight Requirements:

To help ensure current health plans remain stable and turnover is minimized, the Agency reviews the following areas as indicated below:

- Plan activities and performance, reviewed in monthly leadership meetings and quarterly meetings of those Agency bureau staff responsible for contract oversight. Discussion includes but is not limited to:
    - Corrective action taken or needed
    - Sanctions and appeals
    - Expansion and withdrawal requests
    - Financial, surplus and solvency issues
    - Complaints, grievances and appeals
    - Fraud and abuse issues
    - Reporting timeliness and accuracy

- Encounter data
- Systems issues
- Performance measures
- Ownership and management changes
- General plan activities and performance and whether changes are needed in Agency operations, plan processes, and the health plan contract
- Any changes that may affect plan stability and minimization of turn over

- Plan activities and performance regarding financial and organizational stability, reviewed quarterly with the Florida Department of Financial Services, Office of Insurance Regulation (OIR) and the Florida Attorney General
- Fraud and abuse activities, reviewed quarterly with the health plans, OIR, the Florida Attorney General and/or other regulatory or law enforcement agencies, as available/pertinent
- Reports required by health plans including, but not limited to, the following reports regarding:
    - Quarterly financial statements
    - Audited annual financial statements
    - Annual confirmation of the health plan's restricted insolvency protection account and required notification of any changes to authorized signatories,
    - Quarterly reporting on complaints, grievances and appeals
    - Quarterly and annual fraud and abuse reporting
- Health plan contract at least annually to determine if new requirements amendments are necessary

The Agency shall include financial penalties for not completing a contract term or withdrawing from a county or region upon receiving state statutory authority to do so. See Florida Changes that May Increase Stability and Minimize Turnover below.

The Agency shall limit plan participation upon receiving state statutory authority to do so. See Florida Changes that May Increase Stability and Minimize Turnover below.

The Agency reports monthly on plans entering and leaving each county and reasons provided for the departure.

Pertinent Model contract Cites:

Attachment II, Section II, Item D., General Responsibilities of the Health Plan
Attachment II, Section X, Item A., General Provisions
Attachment II, Section X, Item B., Staffing
Attachment II, Section X, Item E, Fraud and Abuse Prevention
Attachment II, Section XII, Item A., Health Plan Reporting Requirements
Attachment II, Section XIV, Sanctions
Attachment II, Section XV, Item A., Insolvency Protection
Attachment II, Section XV, Item C., Surplus Start-Up Account
Attachment II, Section XV, Item D., Surplus Requirement

Attachment II, Section XVI, Item Q., Termination Procedures
Attachment II, Section XVI, Item S., Withdrawing Services from a County
Attachment II, Section XVI, Item V., Ownership and Management Disclosure

See current Medicaid Health Plan Model Contract at:
http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml.

Future Policy Changes - Increase Stability and Minimize Turnover:

The legislated Statewide Medicaid Managed Care program, required to be operational for long-term care by October 1, 2013, and for acute care services by October 1, 2014, includes the following additional statutory requirements that will impact plan stability and minimize turnover:

- Requires the Agency to select a limited number of eligible health plans through an invitation to negotiate competitive procurement process instead of an open application process (see s. 409.966(2), F.S.).
- Requires managed care plan contracts to be five-years in length, with an extension allowance (see s. 409.967(1), F.S.).
- Requires financial penalties for plans that leave a region or reduce enrollment levels, including reimbursing the Agency for the cost of enrollment changes and other transition activities. Requires for departing provider service networks, a per-enrollee penalty of up to three months' payment and requires continuation of services for up to 90 days; requires all other plans to pay a penalty of 25 percent of their minimum surplus requirement pursuant to s. 641.225(1), F.S. See s. 409.967(2)(h)1., F.S.
- Requires plans to provide at least 180-days notice before withdrawing from a region. See s. 409.967(2)(h)1., F.S.
- Requires the Agency to terminate all contracts in a region if a plan leaves a region before the end of the contract term. See s. 409.967(2)(h)1., F.S.

See the Agency's website on the Statewide Medicaid Managed Care program for related law at: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#docs.

Appendix A

How to Become a Florida Medicaid Health Plan

http://ahca.myflorida.com/Medicaid/managed_care/index.shtml

March 2012

Agency for Health Care Administration

How to Become a Florida Medicaid Health Plan

Welcome, prospective health plan! We are pleased you are interested in contracting with the Agency for Health Care Administration to provide comprehensive health care services to Medicaid recipients. On these pages you will find the information you need to become a Florida Medicaid health plan, which includes health maintenance organizations, provider service networks, and specialty plans. Just follow the steps below.
Applications received after April 1, 2012, are not likely to be fully reviewed and processed prior to the release of the procurement documents for Statewide Medicaid Managed Care.

(*Note if you are an organization not authorized to do business in Florida and wish to become a licensed HMO, click here for instructions to become a licensed HMO, then follow steps 1-4 below.)

1. Review Chapter 409, Florida Statutes which is the enabling statute for the Medicaid Program:
   - Section 409.912 – Cost-effective purchasing of health care.
   - Section 409.9122 – Mandatory Medicaid managed care enrollment; programs and procedures.
   - Section 409.91211 – Medicaid managed care pilot program.
   - Section 409.91212 – Medicaid Managed Care Fraud.
   - Section 409.913 – Oversight of the integrity of the Medicaid program.
   - Section 409-9124 – Managed care reimbursement.
   - Section 409.920 – Medicaid Provider Fraud.
   - Section 409.9201 – Medicaid Fraud.
   - Section 409.9203 – Rewards for reporting Medicaid Fraud.

2. Download these materials or Application tools:
   - Medicaid Health Plan application [577KB PDF] (Updated 8/1/2011)
   - Model Health Plan contract
   - Additional required documents and resources for application submission

3. Contact the Division of Medicaid, Bureau of Health Systems Development at (850) 412-4004, to schedule a teleconference or meeting with Agency staff.

4. Attend a Medicaid Health Plan application workshop(s). Click here to see the workshop schedule.

5. Submit completed application and all required supporting documents.

Click on the following for more information about current Health Maintenance Organizations and Provider Service Networks:

- Health Maintenance Organizations (HMOs)
- Provider Service Networks (PSNs)

How to Become a Florida Medicaid Health Plan - Required Documents and Reference Materials

Required Documents for Application Submission

The documents below are required as part of your application submission. For details or specific instructions about each, please refer to the Health Plan Application.

- Behavioral Health Contract Compliance Tool [78KB Microsoft Excel]
- Behavioral Health Provider Network Spreadsheet October 2011 [82KB Microsoft Excel]
- Behavioral Health Provider Service Grid revised 2010-11 [47KB Microsoft Excel]
- Florida Medicaid Provider Enrollment Application
  - Electronic Data Interchange Agreement
  - Electronic Funds Transfer Agreement
- Fraud and Abuse Prevention Toolkit [37KB PDF]
- Member and Provider Material Checklists 09-2011 [44KB Microsoft Excel]
- Non-Institutional Provider Agreement
- Provider Network Checklist [86KB Microsoft Word]
- Provider Network Spreadsheet [86KB Microsoft Excel

Reference Materials

Below you will find additional information to help you with your application.

- Code of Federal Regulations
- County Utilization Patterns for State Fiscal Year 2008-2009
- Federal CMS Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans [331KB PDF]
- Federal CMS Guidelines for Medicaid Managed Care Organizations and Prepaid Health Plans [392KB PDF]
- Florida Medicaid External Quality Review Organization (EQRO)
- Florida Statutes
- Health Plan Rates (Scroll down to Capitation Information)
- Medicaid Fee Schedules
- Medicaid Fiscal Agent
- Medicaid Managed Care Information for Providers
- Medicaid Provider Enrollment
  - Frequent Errors in Criminal Background Screening [83KB PDF]
  - Medicaid Provider Enrollment Guide for Capitated Health Plan Applicants [36KB PDF]
  - Medicaid Provider Enrollment Guide for Fee-for-Service PSN Applicants [103KB PDF]
- Medicaid Provider Handbooks
- Model Medicaid Health Plan Contract Documents
- On-Site Survey Tool
  - Standard I - Care Management & Continuity of Care
  - Standard II - Utilization Management
  - Standard III - Eligibility, Enrollment, and Disenrollment

    - Standard IV - Enrollee Services & Enrollee Rights
    - Standard V - Provider Credentialing and Recredentialing
    - Standard VI - Provider Services
    - Standard VII - Provider Contracting
    - Standard VIII - Quality Improvement Program
    - Standard IX - Medical Records
    - Standard X - Access and Availability
    - Standard XI - Grievances and Appeals
    - Standard XII - Administration and Management
    - Standard XIII - Community Outreach
    - Standard XIV - Covered Services
    - Standard XV - Immunizations, Pregnancy, Drugs & Transportation
- Policy and Procedures Template [10KB PDF]
- RAMP Manager Information Sheet [1.28MB PDF]
- Sample Member Handbook [46KB PDF]
- Sample X12 Transactions

How to Become a Licensed HMO in Florida:

- Review Parts I and III of Chapter 641, Florida Statutes.
- Download application for a Health Care Provider Certificate from the Agency for Health Care Administration website.
- Schedule a teleconference or meeting with Division of Health Quality Assurance, Bureau of Managed Health Care at (850) 487-0640, staff to discuss licensure process.

It is recommended that the organization schedule a teleconference or meeting with the Office of Insurance Regulation to discuss its process for the issuance of a Certificate of Authority. Download application for a Certificate of Authority from the Office of Insurance Regulation website

Appendix B
MCO Application Checklist

January 2012

Agency for Health Care Administration

Agency for Health Care Administration
Internal Working Document

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
	PHASE I CONTENT REVIEW **Days 1-2** **Complete concurrently with "workplan for health plan application review"**				
	BASIC INFORMATION – See Basic Information Page of Application. If items are missing, alert and discuss with Agency Administrator				
1	Primary contact information is complete	List primary contact person as well as location in the application. Mailing address must be street address, not P.O. Box.			
2	Type of health plan is indicated	☐Provider Service Network – Fee-for-service ☐Provider Service Network – Capitated ☐Health Maintenance Organization *Check appropriate box*			
3	Target population(s) are indicated *(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.* *Check appropriate box(es)*			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
4	Service Level(s) are indicated *(Check all that apply)*	☐Reform ☐Non-Reform Medicaid State Plan Check appropriate box(es)			
5	Initial counties to be served are identified	List initial counties identified			
	GENERAL REQUIREMENTS – See Submission Requirements Page of application. If items are missing, alert and discuss with Agency Administrator				
6	Applicant submitted one hard copy with original signatures and four electronic data CDs containing all items included with the hard copy.	Confirm hard copy has original signatures and all four data CDs contain all application items.			
7	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.	Confirm files are not in locked format. Confirm narrative is in Word format.			
8	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.				
9	Policies and procedures must be appropriately branded with the applicant's health plan name.	Confirm policy and procedures have health plan applicant name/logo.			
10	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.				

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
11	The hard copy may be double-sided as long as the applicant does not include more than one policy/item response on a page.				
12	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.				
13	Application accepted for review. (Cursory/content review complete)	Review above submission items and confirm responses to each applicable question.	N/A		
	PHASE I CONCURRENT REVIEW Days 3-10				
	I. ORGANIZATIONAL INFORMATION - If inconsistencies or unusual organizational structure exist, alert and discuss with Agency Administrator.				
	A. Legal Background and Experience				
14	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:	Review response against A.1.b., B.10.e. and D.14. response for consistency and any unusual organizational structure. If inconsistencies or unusual organizational structure exist, alert and discuss with administrators.			
15	a. Dates of operation;	• If applicant has existed as a corporate entity, response should include dates of operation for each entity. • Make note of any partnerships or affiliations with other health plans or entities. • Review against D.14. of the application. • If unusual organizational structure exists, discuss with administrator.			
16	b. Type of business organization (public company, partnership, subsidiary, etc); and				
17	c. Primary business				
18	2. For this applicant, provide the following: a. Number of FTEs engaged in activities relevant to this application;	Review against X.A.163 Staffing and C.12. Criminal Background Screening for consistency.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
19	b. Total number of employees;				
20	c. Whether for profit or not for profit;				
21	d. Vendor minority status, if applicable;				
22	e. Federal Employer's Identification Number (FEIN);	• Confirm FEIN and corporate charter document # at http://www.sunbiz.org/corpweb/inquiry/search.html • If operating under DBA or fictitious name, review A.1.b. Type of business organization, B.10.e. Ownership, D.14. Organizational charts and Medicaid provider enrollment application to ensure all match appropriately. • Print website screen prints used for confirmation and keep with the checklist. • If inconsistencies or unusual organizational structure-alert and discuss with administrators.			
23	f. Florida Corporate Charter Document Number; and				

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
24	g. Copy of the following applicable documents: (1) AHCA Health Care Provider Certificate; (2) OIR Certificate of Authority; and (3) Florida Third party administrator (TPA) license (if PSN).	AHCA Health Care Provider Certificate (HCPC) • Confirm with BMHC Commercial Unit that the submitted AHCA Health Care Provider Certificate is legitimate. • PSNs are not required to have HCPCs for Medicaid. However, they are required if they serve non-Medicaid population. OIR Certificate of Authority • Confirm online at http://www.floir.com/CompanySearch/ • PSNs are not required to have an OIR Certificate of Authority. However, they are required if they serve non-Medicaid population. For PSNs: Florida third party administrator (TPA) license • If the PSN does not have a Florida TPA license, it must contract with an entity that does have one for claims processing. (See section X.D.) • Confirm online at http://www.floir.com/CompanySearch/ Print website screen prints used for confirmation and keep with the checklist.			

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25	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.	If the applicant had predecessor companies that had a Medicaid health plan contract, they should be included in the response.			
26	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.	RED FLAG: If applicant reports default/termination of a contract, discuss with administrators.			
27	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.	Review subcontractors and manager experience to determine if manage care experience is present. If no experience, make note.			
28	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.	Check documentation to confirm there are screen shots of all pertinent X12 transactions. Compare to EDI form submitted by the applicant.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
29	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.	• Conduct three separate reference checks using the Corporate Reference Questionnaire form located on the Agency shared drive in the MCO Application – New Process Development 2011 folder. The reference contact person may fax or email in pdf format the completed form. • Attempt to contact each selected reference by telephone up to four times. If the contact person cannot be reached after four attempts, request an alternate reference. • Allow five business days for submission of references.			
30	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.)	RED FLAG: If applicant reports such legal actions, discuss with administrators.			
31	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.	RED FLAG: If yes, applicant is deficient until person is removed. Alert administrators.			
	B. Ownership and Control Interest				

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
32	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.	• Confirm unduplicated list of owners, operators, and custodians. • Confirm there are no vacant contractually required positions (Review with Item C.11-13 Criminal Background Screening, D.14 Organizational Structure, X.A. Staffing and X.D. Subcontracts, staffing should be consistent, as applicable). • Review CMS-1513 legal name against operating name on Medicaid health plan application. • If inconsistencies or unclear, alert and discuss with administrators.			
33	a. List the names, addresses, and official capacities of these individuals.	Verify the listed individuals are included on the applicable organizational chart provided on D.14.			
34	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).	Confirm by reading minutes or by-laws, if applicable. If inconsistencies or unclear, alert and discuss with administrators.			
35	c. List the name and address of each corporation with a direct or indirect ownership, or controlling interest in the applicant.	Review against B.10.e., CMS-1513 Ownership. Alert administrators if ownership includes another health plan or if ownership is unclear.			
36	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 V.3. for more details on ownership interest. Confirm the subcontracted vendors are not owned by the health plan owners at http://www.sunbiz.org/corpweb/inquiry/search.html:			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
37	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.	If any owners are also involved with other health plans, ensure staffing is adequate and no inappropriate sharing of key staff, listed in X.A., Staffing, of the application exists. If inconsistencies or unclear, alert and discuss with administrators.			
38	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.	If major subcontractors appear to be owners, alert and discuss with administrator. See relative to #39 as well.			
39	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.	Confirm the subcontracted vendors are not owned by the health plan owners at http://www.sunbiz.org/corpweb/inquiry/search.html: Print website screen prints used for confirmation and keep with the checklist.			
40	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.	RED FLAG: If applicant reports such ownership, discuss with administrators.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
	C. Criminal Background Screening				
41	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. 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	Confirm the Florida Medicaid Provider Enrollment Application is complete and completed fingerprints were included for all individuals listed in Section B.10., above. Assure consistency with C.12. Assure all fields on each fingerprint card are fully completed: • Full name • Signature • Residence Address • Date of card completion • Signature of officer taking fingerprints • Employer and address • Social Security Number • Citizenship • Date of birth • Sex, race, height, weight, eyes, hair, place of birth If all fields/cards are not completed, note as deficiency. The total check for processing fees should be made out to the Agency for Healthcare Administration for $43.25 times (x) the number of fingerprints included.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
42	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 (for PSNs only); 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.	Confirm receipt of fingerprints and processing fees for all required individuals: • All listed on CMS-1513 • All listed trustees and associates • Managers identified in Question 160 of the Health Plan Application and with Officer, Director, Manager title included on the organizational charts submitted. • All listed in response to Question 28 (Records Custodians) and Questions 29 (Owner(s) and Operator(s)), of the Medicaid Provider Enrollment Application If applicant states that fingerprints were submitted to the Agency in the past 12 months, verify in FMMIS. In the Provider panel, click Related Data, then Other, then Owner. You can search by Business Name, First and Last Name, or Tax ID (FEIN or SSN). Click on a row to see detail in the Owner Data Table. The bottom of the screen will show the provider IDs with which the individual is associated. If applicant states that fingerprints were submitted to OIR in the past 12 months, verify with OIR. Contact information is Gwen.Chick@floir.com For healthcare applicants with hospital ownership, completed fingerprint cards must be submitted. No hospital exemption applies.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
43	13. For medical licensed individuals holding management positions, completed fingerprint cards are now required.	Confirm all licensed management staff are on the organizational charts and have been included on the background screening manager list. See additional information in #42.			
	D. Organizational Structure				
44	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.	• Confirm the individuals on the flow chart(s) submitted were listed in item B.10. and C.12. • Confirm contract manager, full time administrator and medical director are not employed part-time. They must be employed full-time. • Confirm all relationships and structures are consistent with response to A.1.(b.) and E.16.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
45	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.	• Confirm business plan provides an overview of operations for twenty-four (24) months after the anticipated date of the contract execution, including prospective county expansion (using Enrollment Projection template found in the forms section of the application), product expansion, and strategy for growth and development. • Confirm the enrollment projections are consistent with the applicant's business plan projections. • Confirm with BMHC that the enrollment projections are consistent with the pro forma. • Review against most recent Medicaid enrollment report for counties listed to confirm request does not exceed the current Medicaid enrollment.			
	E. Terms and Conditions				

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
46	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.	• Confirm Florida Corporate Charter numbers online at http://www.sunbiz.org/corpweb/inquiry/search.html • Print website screen prints used for confirmation and keep with the checklist. • For FFS PSNs, assure consistency with A.2. g. (3.) (TPA license) • For any management services and administrative services, confirm with D.14 (Organizational Chart) and note any discrepancies.			
47	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.	• Confirm submission of certified Articles of Incorporation and Certificate of Good Standing from Florida Department of State, Division of Corporations. • Confirm submission of pertinent licensure, such as TPA (if FFS PSN) or prepaid limited health organization license for MBHO for each subcontracted entity that will be providing administrative and management services. • Confirm the business is active. • If copies are not included in the application or they are different from what the applicant submitted, print and keep with checklist.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
48	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.	Confirm the description given addresses the following: • Implementation and maintenance of a minority recruitment and retention plan in accordance with s. 641.217, F.S. • The minority recruitment and retention plan may be company-wide for all product lines. • Detailed description of internal policies and procedures for minority recruitment and retention for the applicant, as well as for all subcontracted entities. (This is not a formal policy and procedure review)			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
49	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.	Confirm the plan procedures comply with Contract Section XVI.V(4)(5)(6). A. Annual background screening By September 1 of each Contract Year, the Health Plan shall conduct an annual background check with the Florida Department of Law Enforcement on all persons with five percent (5%) or more ownership interest in the Health Plan, or who have executive management responsibility for the Health Plan, or have the ability to exercise effective control of the Health Plan (see ss. 409.912 and 435.04, F.S.). • The Health Plan shall submit, prior to execution of this Contract, complete sets of fingerprints of principals of the Health Plan to Agency for the purpose of conducting a criminal history record check (see s. 409.907, F.S.). • Principles of the Health Plan shall be defined in s. 409.907, F.S. B. Timely submission of fingerprints • The Health Plan shall submit to the Agency Contract Manager complete sets of fingerprints of newly hired principals (officers, directors, agents, and managing employees) within thirty (30) calendar days of the hire date.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
50	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.	Confirm the plan procedures comply with Contract Section XVI.V(5): • The Health Plan shall submit to the Agency, within five (5) business days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent of the Health Plan who has been found guilty of, regardless of adjudication, or who entered a plea of *nolo contendere* or guilty to, any of the offenses listed in s. 435.04, F.S. • The Health Plan shall submit information to the Agency for such persons who have a record of illegal conduct according to the background check. • The Health Plan shall keep a record of all background checks to be available for Agency review upon request.			

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
51	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) or if the applicant has delegated major administrative functions to another entity, also provide a copy of the TPA's or applicable subcontractor's detailed emergency management plan.	Confirm applicant provided a detailed emergency management plan. • If the applicant has a delegated third party administrator (TPA) or if the applicant has delegated major administrative functions to another entity, also provide a copy of the TPA's or applicable subcontractor's detailed emergency management plan. • All disaster plans must be easy to read and follow in the event of a disaster and, at a minimum, should cover hurricanes, tornadoes and other weather related events; terrorist acts; power outages; or any other disaster that would disrupt the normal day-to-day functioning of the applicant's business or ability to provide services to enrollees.			
	F. Required State and Federal Disclosure				
52	22. The applicant must submit the following disclosures:				
53	Ensure that the signature page is included and complete which certifies the Accuracy and Authorization, Authority to Operate, Eligibility to Apply, and Confidentiality.	See certifications appendix			
54	a. HIPAA Certification form				
55	b. Certification Regarding Lobbying				
56	c. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts				

	APPLICATION ITEM	INSTRUCTIONS (if applicable)	LOCATION IN APPLICATION (Binder, Tab & Page #)	Date Deficiencies identified/Date Deficiencies resolved	INITIALS & DATE COMPLETED
57	d. Disclosure of Ownership and Control Interest Statement, CMS-1513.	Review with B.10. Ownership and Control Interest. Confirm for PSN, providers hold majority percentage of applicant ownership.			
58	e. Letter disclosing information on the applicant's significant business transactions with any party that has any interest in the profits of the applicant;	Confirm letter meets the disclosure requirements.			
59	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	Confirm letter meets the attestation requirements.			
60	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.	Confirm letter meets the attestation requirements.			
	G. Forms				
61	Enrollment Projection				
62	Background Screening Manager List				

Attachment III
Special Term and Condition #14b

- **Readiness Review Policy and Procedure**
- **Primary Care Physician Access Verification Policy and Procedure**
- **Compliance Monitoring Tool with Specific Contract Standards**
- **MCO Review Tools**
  - Administrative Staff Review Tool
  - Appeals File Review Tool
  - Child Health Check-up Review Tool
  - Case Management/Continuity of Care Review Tool
  - Physician Credentialing and Re-credentialing File Review Tool
  - Denials Record review Tool
  - Grievance File Review Tool
  - Hernandez settlement Agreement Log Checklist
  - Hernandez Settlement Agreement Report Checklist
  - Medical Record Audit Tool
  - Newborn Requirements
  - Online Provider Directory Audit Tool
  - Pregnancy Related Requirements
  - Printed Provider Directory Audit Tool
- **MCO Checklist**
  - Child Health Check-up Policy Checklist
  - Cultural Competency Plan Review Tool
  - Enrollee Handbook Audit Tool
  - Medical Record Audit Tool
  - Provider Handbook Audit Tool
  - Rights and Responsibilities Audit Tool
  - Subcontract Audit Tool
  - Transportation Audit Tool

Readiness Review Policy and Procedure

March 2012

Agency for Health Care Administration

Readiness Review Policy and Procedure
Bureau of Managed Health Care

Regulatory Authority:

Health Plan Contract Attachment II- Core Contract Provisions
Section VII

Purpose:

To ensure that a Health Plan complies with all provisions of the Medicaid Health Plan Contract requirements, including all attachments, applicable exhibits and the Health Plan Report Guide prior to contract execution.

Policy: Readiness Review

BMHC will ensure that a Health Plan complies with all provisions of the Medicaid Health Plan Contract requirements, including all attachments, applicable exhibits and the Health Plan Report Guide prior to contract execution.

Procedure:

Health Plans applying to become a managed care organization must submit an application and required supporting documentation as required by the Florida Medicaid Health Plan Application. http://ahca.myflorida.com/Medicaid/managed_care/index.shtml

Health Plan Responsibility:

1. Submit the Florida Medicaid Health Plan Application to the Agency.
2. Provide BMHC with the following documentation:
   - County(ies) and anticipated enrollment levels for each county
   - A completed provider network checklist
   - Spreadsheet of providers
   - GeoAccess maps or comparable mapping to demonstrate accessibility
   - Completed behavioral health service grids
   - First and last page of contracts for ALL provider types
   - Model subcontracts (both medical and non-medical) as appropriate

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Tallahassee, FL 32308

Medicaid Compliance Analyst Responsibilities:

1. Upon receipt of a health plan application, the analyst will document all application related activities on the Application Review Workplan. The analyst will ensure that the requests includes:
   - County(ies) and anticipated enrollment levels for each county
   - A completed provider network checklist
   - Spreadsheet of providers
   - GeoAccess maps or comparable mapping to demonstrate accessibility
   - First and last page of contracts for ALL provider types
   - Model subcontracts (both medical, non-medical and behavioral health) as appropriate

2. The analyst will review the Provider Network Checklist, the Medicaid Health Provider Network Spreadsheet, supporting contracts and GeoAccess Maps to verify the network's adequate for the requested enrollment level. All reviewed documents shall be saved on SharePoint in the Health Plan's library (document type=application). If any deficiencies are determined, the analyst shall include such in the appropriate Deficiency Log located on SharePoint.

3. Begin quality review of policies and procedures (and any accompanying documentation such as provider materials and member materials handbooks, directories, letters, provider training plan), and be in regular contact with the applicant to provide opportunity to address any concerns or areas in need of improvement. If any deficiencies are determined and have not been resolved with communication between the Agency and the applicant, include such in the appropriate Deficiency Log located on SharePoint.

4. Schedule site visit (readiness review). Coordinate with the Bureaus of HSD and MPI. Use approved letter template.

5. Schedule internal pre-survey meeting with all parties (BMHC, HSD & MPI) for agenda discussion and coordination. The final agenda is sent to the applicant two weeks prior to the on-site visit.

6. Conduct on-site readiness review.

7. The on-site readiness review will consist of:

   a. Perform review of any remaining documents (P&Ps, provider and member materials) to ensure they meet contract standards
   b. Comprehensive interviews conducted by the analyst and team members with Administrative and Clinical Staff to verify application of policies and procedures, protocols, standards and processes. (Areas of interest: Member Services, Enrollment/Disenrollment, Claims Processing, Grievances and Appeals, Provider Services, Case Management/Care Coordination, Utilization management, Quality Improvement, Behavioral Health Oversight, and Fraud and Abuse)
   c. Tour the facility
   d. Review all proprietary materials on site such as Utilization Management Program (minutes, etc) and Quality Management (minutes, etc.) Case Management and Coordination protocols and forms

e. Complete a credentialing review of a sample of the network providers using the Credentialing File Review Tool

f. Conduct an exit interview with applicable applicant staff which will outline the specific findings of the readiness review

8. Complete on-site readiness review tools as appropriate.

9. Provide completed tool from site visit to HSAG (EQRO vendor) if applicable.

10. Once HSAG provides results, issue the readiness review findings to the applicant (approval to move forward with contracting). Use approved letter template.

Primary Care Physician Access Verification Policy and Procedure

March 2012

Agency for Health Care Administration

Primary Care Providers (PCP) Access Verification
Bureau of Managed Health Care

Regulatory Authority:

Health Plan Contract Attachment II- Core Contract Provisions
Section VII
Health Plan Report Guide- Chapter 34 (PCP Wait Times Report)

Purpose:

To provide the Agency with confirmation of the health plan's examination and regular review of its participating PCP offices' average appointment wait times through a statistically valid sample, and to ensure these PCP offices are held accountable to contractually obligated standards.

Policy:

BMHC will ensure that a health plan complies with all provisions of the Medicaid health plan Contract requirements as it relates to health plan's examination and regular review of its participating PCP offices' average appointment wait times through a statistically valid sample, and to ensure these PCP offices are held accountable to contractually obligated standards.

Procedure:

Health Plan Responsibility:

1. The health plan shall submit a completed copy of the report using the template supplied in Health Plan Report Guide. This report is due to the Agency's Bureau of Managed Health Care on or before February 1st following the report year ending December 31st.

2. The health plan must file separate reports for Reform and non-Reform data and indicate on the worksheet which population is being reported.

3. The health plan must submit the methodology used to determine a "statistically valid" sample.

4. The health plan must file a report attestation. This attestation must specifically address the accuracy and completeness of both Reform and non-Reform submissions (when applicable).

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5. The health plan must assure that PCP services and referrals to participating specialists are available on a timely basis, as follows:

a. Urgent Care — within one (1) day,

b. Routine Sick Patient Care — within one (1) week,

and c. Well Care Visit — within one (1) month.

Medicaid Compliance Analyst Responsibilities:

1. The analyst must review the submitted report for completeness and accuracy.

2. The analyst must ensure that the attestation is filed along with the report.

3. The analyst must follow up with the health plan if submitted data seems questionable, i.e. Wait times exceed contractual requirements, wait times reflect unusual patterns, PCPs reflect no wait time at all

4. The analyst shall determine if the health plan requires a corrective action plan (CAP) to address issues.

5. If a CAP is deemed necessary, the analyst must follow up with the health plan to provide such within 10 business days of receiving notification of the violation or non-compliance from the Agency.

6. Upon receipt of the CAP, the analyst shall review for appropriateness and file such in the health plan's electronic library (SharePoint).

7. The analyst must notify the health plan that the CAP is accepted or work with the health plan to correct any deficiencies within 10 business days of receipt.

Compliance Monitoring Tool with Specific Contract Standards

March 2012

Agency for Health Care Administration

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard I: Care Management/Continuity of Care

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Referrals and Assistance *45 CFR 160 and 164* *CC-VIII.B.2.a*	The health plan maintains written case management and continuity of care protocols that include appropriate referral and scheduling assistance of enrollees needing specialty health care/transportation services, including those identified through Child Health Check-Up Program (CHCUP) Screenings.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Need for Services *45 CFR 160 and 164* *CC-VIII.B.2.b*	The health plan maintains written case management and continuity of care protocols that include determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting (to include referral to Women, Infants, and Children [WIC] and Healthy Start) utilizing assistance as needed by the area Medicaid office.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Follow-up for Lead Levels *45 CFR 160 and 164* *CC-VIII.B.2.c*	The health plan maintains written case management and continuity of care protocols that include case management follow-up services for children/adolescents whom the health plan identifies through blood screenings as having abnormal levels of lead.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Discharge Planning with Post-	The health plan maintains written case management and continuity of care protocols that include coordinated hospital/institutional	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard I: Care Management/Continuity of Care

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Discharge Care *45 CFR 160 and 164* *CC-VIII.B.2.d & j*	discharge planning that includes post-discharge care, including skilled short-term rehabilitation and skilled nursing facility care, as appropriate.				
5. Direct Access to Specialists *45 CFR 160 and 164* *CC-VIII.B.2.e*	The health plan maintains written case management and continuity of care protocols that include a mechanism for direct access to specialists for enrollees identified as having special health care needs, as is appropriate for their condition and identified needs.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Identificaiton of Pregnant Enrollees *45 CFR 160 and 164* *CC-VIII.B.2.f*	The health plan maintains written case management and continuity of care protocols that include an outreach program and other strategies for identifying every pregnant enrollee. This includes identification through: case management, claims analysis, and the use of a health risk assessment. The health plan requires its participating providers to notify the plan of any Medicaid enrollee who is pregnant.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A		
7. Direct Documenta-tion of Referrals *45 CFR 160 and 164* *CC-VIII.B.2.g*	The health plan maintains written case management and continuity of care protocols that include documentation of referral services in enrollee medical records, including reports resulting from the referral.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. Monitoring High Utilizers	The health plan maintains written case management and continuity of care protocols that include monitoring of enrollees with ongoing medical conditions and coordination of services for high utilizers to address the	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard I: Care Management/Continuity of Care

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
45 CFR 160 and 164 *CC-VIII.B.2.h*	following: a. Acting as a liaison between the enrollee and providers. b. Ensuring the enrollee has adequate support at home. c. Assisting enrollees who are unable to access necessary care due to their medical or emotional conditions or who do not have adequate community resources to comply with their care. d. Assisting the enrollee in developing community resources to manage a medical condition.	No ☐ d. Yes ☐ No ☐			
9. Documenting Emergency Care *45 CFR 160 and 164* *CC-VIII.B.2.i*	The health plan maintains written case management and continuity of care protocols that include documentation of emergency care encounters in enrollees' records with appropriate medically indicated follow-up.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
10. Non-duplication of Effort *45 CFR 160 and 164* *CC-VIII.B.2.k*	The health plan maintains written case management and continuity of care protocols that include sharing with other health plans serving the enrollee the results of its identification and assessment of any enrollee with special health care needs so that those activities are not duplicated.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. Protecting Enrollees' Privacy *45 CFR 160 and 164*	The health plan maintains written case management and continuity of care protocols that include ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with confidentiality requirements regarding the privacy of	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard I: Care Management/Continuity of Care

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VIII.B.2.l	individually identifiable health information.				
12. Terminating Providers *CC-VII.G.1*	The health plan has policies and procedures stating that the health plan allows enrollees in active treatment to continue care with a terminated treating provider when such care is medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or during the next Open Enrollment period – not to exceed six (6) months after the termination of the provider's contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
13. Pregnant Enrollees *CC-VII.G.2*	The health plan has policies and procedures stating that the health plan allows pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider until completion of postpartum care.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
14. Terminating Providers may Refuls to Provide Care *CC-VII.G.3*	A terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant. The health plan has policies and procedures for this requirement.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
15. Continuity of Care: Contract Provisions for Terminated Providers	For continued care under this subsection, the health plan and terminated provider continue to abide by the same terms and conditions as existed in the terminated contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard I: Care Management/Continuity of Care

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.G.4	The health plan has policies and procedures for this requirement.				
16. Continuity of Care: Providers Terminated for Cause *CC-VII.G.5*	The requirements set forth in Standard I Elements 12, 13, 14 and 15 do not apply to providers who have been terminated from the health plan for cause. The health plan has policies and procedures for this requirement.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
17. NON-REFORM: Disease Management *Exhibit 8*	The Agency encourages the health plan to develop and implement disease management programs for enrollees living with chronic conditions.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
18. REFORM except HIV/AIDS: Disease Management Programs *Exhibit 8*	The health plan develops and implements disease management programs for Reform enrollees living with chronic conditions. a. The disease management initiatives includes, but are not limited to, asthma, HIV/AIDS, diabetes, congestive heart failure and hypertension. b. The health plan may develop and implement additional disease management programs for its enrollees.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
19. REFORM except HIV/AIDS: Disease	Each disease management program has policies and procedures that follow the National Committee for Quality Assurance's (NCQA's) most recent Disease Management	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard I: Care Management/Continuity of Care					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
Management Policies and Procedures *Exhibit 8*	Standards and Guidelines, which may be accessed online at http://web.ncqa.org/tabid/381/Default.aspx. a. In addition to policies and procedures, the health plan has a disease management program description for each disease state that describes how the program fulfills the principles and functions of each of the NCQA Disease Management Standards and Guidelines categories. b. Each program description also describes how enrollees are identified for eligibility and stratified by severity and risk level. c. The health plan submits a copy of its policies and procedures and program description for each of its disease management programs to BMHC by April 1 of each Contract year.	N/A ☐ c. Yes ☐ No ☐ N/A ☐			
20. REFORM except HIV/AIDS: Transitioning Enrollees	The health plan has a policy and procedure regarding the transition of enrollees from disease management services outside the health plan to the health plan's disease management program. a. This policy and procedure includes coordination with the disease management organization (DMO) that provided services to the enrollee before	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard I: Care Management/Continuity of Care					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
Exhibit 8	enrollment in the health plan. b. Additionally, the health plan requests that the enrollee sign a limited release of information to aid the health plan in accessing the DMO's information for the enrollee.				
21. REFORM except HIV/AIDS: Plan of Treatment *Exhibit 8*	The health plan develops and uses a plan of treatment for chronic disease follow-up care that is tailored to the individual enrollee. The purpose of the plan of treatment is to assure appropriate ongoing treatment reflecting the highest standards of medical care designed to minimize further deterioration and complications. a. The plan of treatment is on file for each enrollee with a chronic disease and contains sufficient information to explain the progress of treatment. b. Medication management, the review of medications that an enrollee is currently taking, is an ongoing part of the plan of treatment to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications. c. The enrollee's ability to adhere to a treatment regimen also is monitored in the plan of treatment.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard I Care Management/Continuity of Care	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard II: Utilization Management					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
1. Over and Under Utilization *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1.a.1*	The health plan has a utilization management (UM) program that includes procedures for identifying patterns of over-utilization and under-utilization by enrollees and for addressing potential problems identified as a result of these analyses.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Reporting Fraud and Abuse *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1.a.2*	The health plan has a UM program that includes reporting fraud and abuse through the UM program to the Agency's Medicaid Program Integrity Bureau (MPI) unit.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Second Opinion *42 CFR 438.206* *42 CFR 456* *42 CFR 455.1.a.1* *641.51, F.S.* *CC-VIII.B.1.a.3*	The health plan has a UM program that includes procedures for enrollees to obtain a second medical opinion, and the health plan is responsible for authorizing claims for such services as specified in 641.51 F.S.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Protocols for Prior Authoriza-tions and Denials *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1.a.4*	The health plan has a UM program that includes protocols for prior authorization and denial of services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard II: Utilization Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
5. Evaluation of Prior and Concurrent Authoriza-tions *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1.a.4*	The health plan has a UM program that includes the process used to evaluate prior and concurrent authorizations.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Consistent Application of Review Criteria *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1.a.4*	The health plan has a UM program that includes mechanisms to ensure consistent application of review criteria for authorization decisions.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. Consultation with Requesting Providers *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1.a.4*	The health plan has a UM program that includes consultation with requesting providers when appropriate.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. Hospital Discharge Planning *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1.a.4*	The health plan has a UM program that includes hospital discharge planning.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
9. Physician Profiling *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1.a.4*	The health plan has a UM program that includes physician profiling.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard II: Utilization Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
10. Retrospective Review *42 CFR 456* *42 CFR 455.1.a.1* *CC-VIII.B.1-3.a.4*	The health plan has a UM program that includes a retrospective review of inpatient and ambulatory claims.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. BMHC Approval *CC-VIII.B.1.a.4.a*	The health plan has written approval from Bureau of Managed Health Care (BMHC) for its services authorization protocols and any changes.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. Authorization Number and Date *CC-VIII.B.1.a.4.b*	The health plan's service authorization system provides the authorization number and effective dates of authorization to providers and non-participating providers.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
13. Written Confirmation of Denials *42 CFR 438.210(c)* *CC-VIII.B.1.a.4.c*	The health plan's service authorization system provides written confirmation of all denials of authorization to providers.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
14. Notification to Health Plans *42 CFR 438.210(c)* *CC-VIII.B.1.a.4.d.i-iv*	The health plan may request to be notified, but will not deny claims payment based solely on lack of notification, for the following: a. Inpatient emergency admissions (within 10 calendar days). b. Obstetrical care (at first visit). c. Obstetrical admission exceeding forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for caesarean section. d. Transplants.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard II: Utilization Management					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
15. Denials by Appropriate Health Care Professionals *42 CFR 438.210(b)(3)* *CC-VIII.B.1.a.4.e*	The health plan ensures that all decisions to deny a service authorization request, or limit a service in amount, duration, or scope that is less than requested, are made by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
16. Emergency Shelter Medical Screenings *CC-VIII.B.1.a.4.g*	The health plan provides post authorization to County Health Departments (CHDs) for emergency shelter medical screenings provided for the Department of Children & Families (DCF) clients.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
17. Automated Authorization Systems *CC-VIII.B.1.a.4.h*	Health plans with automated authorization systems may not require paper authorization as a condition for providing treatment.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
18. Written Documentation *CC-VIII.B.1.a.4.i* *CC-IV.A.8.e*	The health plan will not delay service authorization if written documentation is not available in a timely manner.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
19. Approval for Claims Without Written Documentation *CC-VIII.B.1.a.4.i* *CC-IV.A.8.e*	The health plan is not required to approve claims for which it has not received written documentation.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard II: Utilization Management					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
20. Compensation for UM Activities *CC-VIII.B.1.b*	The health plan's compensation to individuals or entities that conduct UM activities cannot be structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
21. Notice of Action *42 CFR 438.404(a) and (c)* *42 CFR 438.10(c-d)* *CC-IV.A.16.a*	The health plan notifies the provider and gives the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
22. Standard Authorization Decisions *42 CFR 438.210(d)(1)* *CC-IV.A.16.b*	For standard authorization decisions, the health plan provides notice as expeditiously as the enrollee's health condition requires and within no more than 14 calendar days following receipt of the request for service.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
23. Extensions *CC-IV.A.16.c*	The timeframe can be extended up to 14 additional calendar days if the enrollee or the provider requests an extension, or the health plan justifies the need for additional information and how the extension is in the enrollee's interest.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
24. Expedited Authorization Decisions *42 CFR 438.210(d)(2)* *CC-IV.A.16.d*	Expedited authorization is required when a provider indicates or the health plan determines that following the standard timeline could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. An expedited decision must be made no later than 3 working days after receipt of the request for service.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard II: Utilization Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
25. Extensions for Expedited Requests *CC-IV.A.16.e*	A health plan may extend the three (3) working days for expedited cases by up to fourteen (14) calendar days if the enrollee requests an extension or if the health plan justifies the extension.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
26. Written Notice of Changes to UM *CC-VIII.B.4*	The health plan provides no less than 30 calendar days written notice to BMHC before making any changes to the administration and/or management procedures and/or authorization, denial or review procedures, including any delegations.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard II Utilization Management	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. CMSSP ONLY: Clinical Eligibility *Exhibit 3*	For purposes of determining clinical eligibility for enrollment, the health plan ensures that only those children who meet the following criteria are submitted to the Agency as children with chronic conditions: a. The child met the criteria specified through a State of Florida Department of Health clinical screening performed on an Agency-approved clinical screening tool. b. The child met the clinical criteria for enrollment in another Children's Medical Services program provided the Agency has approved the enrollment criteria as appropriate for enrollment in this health plan as children with chronic conditions.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. CMSSP ONLY: Determining Clinical Eligibility *Exhibit 3*	If a recipient is enrolled in Medicaid under a SSI eligibility assistance category, a Florida Department of Health, Children's Medical Services clinical screening is still required for purposes of determining clinical eligibility for enrollment in this health plan. This clinical screening is completed in full and cannot be waived.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
3. Accepting Medicaid Recipients *CC-III.B.1.c*	The health plan accepts Medicaid recipients without restriction and in the order in which they enroll.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Non-discrimination *CC-III.B.1.c*	The health plan does not discriminate on the basis of religion, gender, race, color, age, or national origin, health status, pre-existing condition, or need for health care services and does not use any policy or practice that has the effect of such discrimination.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
5. Maximum Enrollment Levels *CC-III.B.1.d*	The health plan accepts new enrollees throughout the contract period up to the authorized maximum enrollment levels.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Verifying the County of Residence *CC-III.B.1.e* *CC-III.C.5*	Each month the health plan reviews the X12-834 enrollment files: a. To ensure that all enrollees reside in the same county in which they were enrolled. b. To determine which enrollees were disenrolled due to moving outside the service area.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. Enrollees Changing County of Residence *CC-III.B.1.e*	The health plan updates the records for all enrollees who have moved from one county to another but are still residing in the health plan's service area and provides those enrollees with a new provider directory for that county, if necessary.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
8. Newborn Enrollment *CC-III.B.3.b*	The health plan uses the unborn activation process to facilitate enrollment and is responsible for newborns from the date their enrollment in the health plan is effective.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
9. Newborn Activation *CC-III.B.3.d*	Upon unborn activation, during the next enrollment cycle, the newborn is enrolled in the mother's health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
10. Identification of Pregnant Members *CC-III.B.3.c.1*	Unborn activation occurs upon identification of an enrollee's pregnancy through medical history, examination, testing, or claims.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. Notifying DCF of a Pregnancy *CC-III.B.3.c.1*	The health plan immediately notifies DCF of a pregnancy and any relevant information known. a. The health plan completes the DCF Excel spreadsheet, submits it via electronic mail to the appropriate DCF Customer Call Center address, and copies MPI via electronic mail. b. The health plan indicates its name and number as the entity initating the referral.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. CMSSP ONLY: Activating the Baby's Medicaid ID *Exhibit 3*	Once the health plan confirms activation of the baby's Medicaid ID, the health plan submits to the Medicaid area office a request to enroll the newborn. Newborn enrollments are effective the next available enrollment month.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
13. Assigning a Medicaid ID to the Unborn *CC-III.B.3.c.2*	DCF generates the Medicaid ID number for the unborn child. The number is transmitted to the Medicaid fiscal agent and remains inactive until the child is born and DCF is notified of the birth.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
14. Activating a Newborn's Medicaid ID *CC-III.B.3.c.3*	When a pregnant enrollee presents to the hospital for delivery, the health plan informs the hospital, the mother's attending physician, and the newborn's attending and consulting physicians that the newborn is an enrollee only if there is an unborn record in the system awaiting activation.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
15. FFS PSNs & CMSSP ONLY: Newborns not Enrolled by Unborn Activation *Exhibit 3*	Newborns not enrolled through the unborn activation process are enrolled through the Agency's choice counselor/enrollment broker.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
16. FFS PSNs & CCC ONLY: Activating the Baby's Medicaid ID *Exhibit 3*	Once the health plan confirms activation of the baby's Medicaid ID, the health plan submits to the Medicaid area office a request to enroll the newborn. Newborn enrollments are effective the next available enrollment month.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
17. FFS PSNs & CCC ONLY:	The health plan complets an ENR-Newborn Excel worksheet titled *WORKBOOK-Invol*	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Submitting Enrollment Requests *Exhibit 3*	*Disenroll–Newborn Enroll.xls* providing all the information required for the newborn's enrollment into the health plan. The Excel workbook format and naming convention is provided in the Agency's Report Guide. The health plan submits the completed workbook to the local Medicaid area office for newborn enrollment processing.				
18. FFS PSNs & CCC ONLY: Frequency of Submitting Enrollment Requests *Exhibit 3*	Newborn requests are submitted electronically to the local Medicaid area office each Wednesday using the Excel workbook template provided by the Agency. All fields are to be completed. a. Before sending the workbook by e-mail, the health plan password-protects the Excel File. b. The password is sent to the area office in a separate e-mail message. c. If there are no new cases for a week, the health plan so indicates in an e-mail to the Agency area office.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐			
19. Submitting Birth Information to DCF and MPI	The health plan completes and submits the Excel spreadsheet for unborn activation to DCF and to MPI for its information. The e-mail submission includes the password-protected spreadsheet as an attachment. The spreadsheet contains all pregnancy notifications and newborn births for the health	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-III.B.3.c.3-4	plan. Only one e-mail submission per day will be sent to each DCF customer call center region.				
20. Monitoring for a Newborn Activation *CC-III.B.3.c.6*	The health plan periodically checks Medicaid eligibility to determine if the baby's Medicaid ID has been activated.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
21. Monitoring to Find a Newborn's Medicaid ID *CC-III.B.3.c.6.a-d*	Monitoring is performed by: a. The health plan contacts the Medicaid Eligibility Vendor System (MEVS). b. The health plan contacts the Medicaid Fiscal Agent's provider inquiry line and asks a representative for assistance. c. The health plan accesses the Medicaid Automated Voice Response System (AVRS). d. The health plan completes the X12-270 transmission to the Medicaid fiscal agent.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐ d. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
22. CAPITATED PLANS: Enrollment Date of Newborn *CC-III.B.3.c.7*	If the unborn activation process is properly completed by a capitated health plan, then the newborn is enrolled in the health plan retroactive to birth.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
23. Unborn Eligibility Records	If a pregnant enrollee presents for delivery without having an unborn eligibility record that is awaiting activation, the health plan or designee submits the spreadsheet to DCF	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-III.B.3.d	immediately upon the birth of the child. The newborn will not automatically become a health plan enrollee upon birth.				
24. Health Plan's Request to Reduce Enrollment *CC-III.B.4*	The health plan may ask the Agency to halt or reduce enrollment temporarily if contined full enrollment would exceed the health plan's capacity to provide required services under the contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
25. Renewal of Contract and Enrollment Status *CC-III.C.1.a*	If the contract is renewed, the enrollment status of all enrollees continues uninterrupted.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
26. Voluntary Disenrollment *CC-III. C.1.b*	The health plan ensures that it does not restrict the enrollee's right to disenroll voluntarily in any way.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
27. CMSSP ONLY: Exceptions to Appeals for Disenrollment Rights	In addition to the exceptions for appeal of disenrollment rights listed in Attachment II, Section III, Eligibility and Enrollment, Item C.1.d., the following reasons are also included as exceptions for the CCC program: a. Aging out of the health plan at age 21. b. No longer being clinically eligible to participate in the health plan as determined pursuant to the clinical screening requirements specified	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Exhibit 3	above. c. Being a sibling of a sole beneficiary who is no longer eligible for enrollment in the health plan due to (1) or (2) above.				
28. Disenrollments by Choice Counselors or Enrollment Brokers *CC-III.C.1.c*	The health plan or its agents will not provide or assist in the completion of a disenrollment request or assist the Agency's contracted choice counselor/enrollment broker in the disenrollment process.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
29. CMSSP ONLY: Involuntary Disenrollment	The following are also reasons for which the health plan submits involuntary disenrollment requests to the Agency's choice counselor/enrollment broker. In no event will the health plan submit a disenrollment request at such a date as would cause the disenrollment to be effective later than forty-five (45) calendar days after the health plan's receipt of the reason for involuntary disenrollment. The health plan ensures that involuntary disenrollment documents are maintained in an identifiable enrollee record. a. Aging out of the health plan at age 21. b. No longer being clinically eligible to participate in the health plan as determined pursuant to the clinical screening requirements specified above.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
Exhibit 3	c. Being a sibling of a sole beneficiary who is no longer eligible for enrollment in the health plan due to a. or b. above.				
30. Disenrollment Not Subject to an Appeal *CC-III.C.1.d*	The health plan ensures that enrollees who are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees are afforded the right to file an appeal of disenrollment except for the following reasons: a. Moving out of the service area. b. Loss of Medicaid eligibility. c. Determination that an enrollee is in an excluded population. d. Enrollee death.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
31. Disenrollment for Enrollees Subject to Open Enrollment *42 CFR 438.56(c)(2)(i)* *CC-III.C.1.e*	An enrollee subject to open enrollment may submit to the Agency or its agent a request to disenroll from the health plan. Disenrollment may occur without cause during the 90 calendar day change period following the date of the enrollee's initial enrollment with the health plan, or the date the Agency or its agent sends the enrollee notice of the enrollment, whichever is later.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
32. Dissenrollment for Enrollees Not Subject to Open Enrollment *42 CFR 438.56(c)(2)(ii)* *CC-III.C.1.e*	An enrollee may request disenrollment without cause every 12 months thereafter during the annual open enrollment period. Those not subject to open enrollment may disenroll at any time.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
33. Effective Date of Approved Disenrollment *CC-III.C.1.f*	The effective date of an approved disenrollment is the last calendar day of the month in which disenrollment was made effective by the Agency or its agent.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
34. Disenrollment Date if Approved by Agency *42 CFR 438.56(e)(1)* *CC-III.C.1.f*	In no case will disenrollment be later than the first calendar day of the second month following the month in which the enrollee or the health plan files the disenrollment request.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
35. Disenrollment Date if Not Approved by Agency *42 CFR 438.56(e)(2)* *CC-III.C.1.f*	If the Agency or its agent fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
36. When Disenrollment Can Occur	An enrollee may request disenrollment at any time. The Agency or the choice counselor/ enrollment broker performs disenrollment as follows: Without cause for enrollees subject to open enrollment: a. During the 90 days following the enrollee's initial enrollment, or the date the Agency or its agent sends the enrollee notice of the enrollment, whichever is later.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ N/A ☐ f. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
42 CFR 438.56(c)(2) *CC-III.C.2*	b. At least every 12 months. c. If the temporary loss of Medicaid eligibility has caused the enrollee to miss the open enrollment period. d. When the agency or its agent grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis). e. **REFORM ONLY:** If the individual chooses to opt out and enroll in an employer-sponsored health plan. f. Without cause, for enrollees not subject to open enrollment, at any time.				
37. MANDATORY ENROLLEES: Requesting Disenrollment *42 CFR 438.56 (c)(1)* *CC-III.C.3.A*	A mandatory enrollee may request disenrollment from the health plan for cause at any time. Such request is submitted to the Agency or its agent.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
38. Cause for Disenrollment	The following reasons constitute cause for disenrollment from the health plan: a. The enrollee moves out of the county, or the enrollee's address is incorrect and the enrollee does not live in a county where the health plan is authorized to provide services. b. The provider is no longer with the health plan. c. The enrollee is excluded from enrollment. d. A substantiated marketing or community	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
	outreach violation has occurred. e. The enrollee is prevented from participating in the development of his/her treatment plan. f. The enrollee has an active relationship with a provider who is not on the health plan's panel, but is on the panel of another health plan. g. The enrollee is in the wrong health plan as determined by the Agency. h. The health plan no longer participates in the county. i. The state has imposed immediate sanctions upon the health plan. j. The enrollee needs related services to be performed concurrently, but not all related services are available within the health plan network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk. k. The health plan does not, because of moral or religious objections, cover the service the enrollee seeks. l. The enrollee missed open enrollment due to a temporary loss of eligibility, defined as 60 days or less for non-Reform populations and 180 days or less for Reform populations. m. Other reasons including, but not limited to:	g. Yes ☐ No ☐ h. Yes ☐ No ☐ i. Yes ☐ No ☐ j. Yes ☐ No ☐ k. Yes ☐ No ☐ l. Yes ☐ No ☐ m.Yes ☐ No ☐			

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
42 CFR 438.56(d)(2)(i-iv) *42 CFR 438.702(a)(3)* *CC-III.C.3.a*	i. Poor quality of care. ii. Lack of access to services covered under the contract. iii. Inordinate or inappropriate changes of PCPs. iv. Service access impairments due to significant changes in the geographic location of services. v. Lack of access to providers experienced in dealing with the enrollee's health care needs. vi. Fraudulent enrollment.				
39. Voluntary Enrollee Disenrollment *42 CFR 438.59(c)(1)* *CC-III.C.3.b*	Voluntary enrollees may disenroll from the health plan at any time.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
40. Fraudulent Use of ID Card *CC-III.C.4.a.1*	With proper written documentation, the following are acceptable reasons for which the health plan may submit involuntary disenrollment requests to the Agency or its agent: Fraudulent use of the enrollee ID card (the health plan must report the event to MPI).	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
41. Reasons for Involuntary Disenrollment	In addition to #38, with proper written documentation, the following are acceptable reasons for which the health plan may submit involuntary disenrollment requests to the Agency or its agent:	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
42 CFR 438.56(b)(1-2) *CC-III.C.4.a.2*	a. The enrollee's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the health plan seriously impairs the organization's ability to furnish services to either the enrollee or other enrollees. b. This section does not apply to enrollees with mental health diagnoses if the enrollee's behavior is attributable to the mental illness. c. An involuntary disenrollment request related to enrollee behavior must include documentation that the health plan: i. Provided the enrollee at least one oral warning and at least one written warning of the full implications of the enrollee's actions. ii. Attempted to educate the enrollee regarding rights and responsibilities. iii. Offered assistance through case management that would enable the enrollee to comply. iv. Determined that the enrollee's behavior is not related to the enrollee's medical or behavioral condition.				
42. Submitting Involuntary Disenrollment Requests	The health plan promptly submits disenrollment requests to BMHC. In no event will the health plan submit a	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
42 CFR 438.56(3) *CC-III.C.4.b*	disenrollment request at such a date as would cause the disenrollment to be effective later than 45 calendar days after the health plan's receipt of the reason for involuntary disenrollment.				
43. Involuntary Disenrollment Documents *CC-III.C.4.b*	The health plan ensures that involuntary disenrollment documents are maintained in an identifiable enrollee record.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
44. CMSSP ONLY: Involuntary Disenrollment Notice *Exhibit 3*	The health plan notifies enrollees who will be involuntarily disenrolled due to either aging out (at age 21), or due to the enrollee no longer being clinically eligible for enrollment in the health plan, of the following at least two months prior to the anticipated effective date of the involuntary disenrollment. The template for such notice must be submitted to and approved by BMHC prior to use. a. The reason for involuntary disenrollment. b. The telephone number of the choice counselor/enrollment broker. c. Transition information.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
45. Case-by-Case Review of Disenrollments *CC-III.C.4.c*	All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the Agency. Any request not approved is final and not subject to health plan dispute or appeal.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
46. Reasons Disenrollment Cannot be Requested *42 CFR 438.56(b)(2)* *42 CFR 438.56(c)(5)* *CC-III.C.4.d*	The health plan cannot request disenrollment of an enrollee due to: a. Health diagnosis. b. Adverse changes in an enrollee's health status. c. Utilization of medical services. d. Diminished mental capacity. e. Pre-existing medical conditions. f. Uncooperative or disruptive behavior resulting from the enrollee's special needs. g. Attempt to exercise rights under the health plan's grievance system. h. Request of one PCP to have an enrollee assigned to a different provider out of the health plan.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐ g. Yes ☐ No ☐ h. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
47. Notifying the Enrollee of Disenrollment *CC-III.C.4.e*	When the health plan requests an involuntary disenrollment, the plan notifies the enrollee in writing that the health plan is requesting disenrollment, the reason for the request, and an explanation that the health plan is requesting that the enrollee be disenrolled in the next contract month, or earlier if necessary. Until the enrollee is disenrolled, the health plan is responsible for the provision of services to that enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
48. REFORM: Involuntary Disenrollment	The Reform health plan submits involuntary disenrollment requests for the following reasons to the Agency's choice counselor/enrollment broker as specified in	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Exhibit 3	the Health Plan Report Guide. In no event will the health plan submit a disenrollment request at such a date as would cause the disenrollment to be effective later than forty-five (45) calendar days after the health plan's receipt of the reason for involuntary disenrollment. The health plan ensures that involuntary disenrollment documents are maintained in an identifiable enrollee record. a. Moved out of Reform health plan service area. b. Enrollee death. c. Enrollee ineligible for health plan enrollment.	No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐			
49. REFORM: Disenrollment Notice to Enrollees *Exhibit 3*	The health plan notifies enrollees who will be involuntarily disenrolled due to the reasons above of the following at least two (2) months before the anticipated effective date of the involuntary disenrollment. The template for such notice is submitted to and approved by BMHC before use. a. The reason for involuntary disenrollment. b. The telephone number of the choice counselor/enrollment broker. c. Transition information.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
50. NON-REFORM: Sending	If an enrollee was disenrolled due to moving outside the service area, a notice of disenrollment is sent to all such recipients with	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard III: Eligibility, Enrollment, and Disenrollment					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
Disenrollemnt Notices *CC-III.C.5*	instructions to contact the choice counselor/enrollment broker to make a plan choice in the new service area.				

Results for Standard III Eligibility, Enrollment, and Disenrollment	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard IV: Enrollee Services & Enrollee Rights

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Enrollee Information *CC-IV.A.1.a*	The health plan notifies enrollees of the following: a. Enrollee rights and responsibilities. b. The role of the PCP. c. How to obtain care. d. What to do in an emergency or urgent medical situation. e. How to pursue a complaint, grievance, appeal, or Medicaid Fair Hearing. f. How to report suspected fraud and abuse. g. The procedures for obtaining behavioral health services. h. The health plan telephone numbers to use to obtain services.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐ g. Yes ☐ No ☐ h. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Capability to Answer Enrollee Inquiries *CC-IV.A.1.b*	The health plan has the capability to answer enrollee inquiries with: a. Written material. b. Telephone. c. Electronic transmission. d. Face-to-face communication.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
3. Request for Address Correction *CC-IV.A.1.c*	Mailing envelopes for enrollee materials contain a request for address correction.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Returned Mailing Envelopes *CC-IV.A.1.c.1-2*	When mailing envelopes are returned to the health plan as undeliverable, the health plan uses and maintains in a file a record of all of the following methods to contact the enrollee: a. Telephone contact at the telephone number obtained from the local telephone directory, directory assistance, city directory, or other directory. b. Routine checks (at least once a month for the first 3 months of enrollment) on services or claims authorized or denied by the health plan to determine if the enrollee has received services, and to locate updated address and telephone number information.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
5. New Enrollee Material *CC-IV.A.1.d*	New enrollee materials are not required for a former enrollee who was disenrolled because of the loss of Medicaid eligibility and who regains eligibility within sixty (60) days for a non-Reform enrollee and one-hundred and eighty (180) days for a Reform enrollee and is automatically reinstated in the health plan. Enrollees who were previously enrolled in a health plan, and who lose and regain eligibility after the specified number of days for Reform or non-Reform, will be treated as new enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Reinstated Enrollees *CC-IV.A.1.d*	Unless requested by the enrollee, new enrollee materials are not required for a former enrollee subject to open enrollment who was disenrolled because of the loss of Medicaid eligibility, regains eligibility within the time specified in this paragraph and is reinstated as a health plan enrollee. A notation of the effective date of the reinstatement is to be made on the most recent application or conspicuously identified in the enrollee's administrative file.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
7. Written Notification to Reinstated Enrollees *CC-IV.A.1.e*	The health plan notifies, in writing, each person who is to be reinstated. The written notification must identify: a. The effective date of the reinstatement. b. The assigned primary care physician.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
8. Notification of Change Procedures *C-IV.A.1.e*	The written notification of reinstatement distinguishes between enrollees subject to open enrollment and enrollees not subject to open enrollment. The notification is provided to each affected enrollee by the first calendar day of the month following the health plan's receipt of the notice of reinstatement or within 5 calendar days from receiving the enrollment file, whichever is later.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
9. Contents of Written Notification *C-IV.A.1.e*	The written notification to reinstate enrollees includes information regarding: a. Change procedures for cause. b. General health plan change procedures through the Agency's toll-free choice counselor/enrollment broker telephone number, as appropriate. c. Instructions for enrollees to contact the health plan if a new enrollee card and/or a new enrollee handbook are needed.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
10. Alternative Formats *CC-IV.A.2.a*	The health plan makes all written enrollee materials available in alternative formats and in a manner that takes into consideration the enrollee's special needs, including those who are visually impaired or have limited reading proficiency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. Access to Alternative Formats *CC-IV.A.2.a*	The health plan notifies all enrollees and potential enrollees and, upon request, that information is available in alternative formats and how to access those formats.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. Written Materials in English and Spanish *CC-IV.A.2.b*	The health plan makes all written material available in English, Spanish, and all other appropriate foreign languages (i.e., languages in the health plan service area spoken by approximately five percent of the total population).	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
13. Interpreter Services *CC-IV.A.2.b*	The health plan provides, free of charge, interpreters for potential enrollees or enrollees whose primary language is not English.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
14. Enrollee Information 42 CFR 438.10 *CC-IV.A.2.c*	The health plan provides enrollee information which addresses information requirements related to written and oral information, including: a. Languages. b. Format. c. Health plan features (i.e., benefits, cost sharing, service area, provider network and physician incentive plans). d. Enrollment and disenrollment rights and responsibilities. e. Cost sharing. f. Grievance system. g. Advance directives. h. Enrollees' right to receive information annually.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐ g. Yes ☐ No ☐ h. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
15. Reading Level *CC-IV.A.2.d*	All written materials are at or near the fourth (4^{th}) grade comprehension level. Suggested reference materials to determine whether the written materials meet this requirement include: a. Fry Readability Index. b. PROSE The Readability Analyst. c. Gunning FOG Index. d. McLaughlin SMOG Index. e. The Flesch-Kincaid Index. f. Other Agency approved software.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
16. New Enrollee Materials *CC-IV.A.3.a*	The health plan mails to the new enrollee (not later than 5 calendar days following receipt of the enrollment file from Medicaid or its agent, whichever is later): a. Enrollee handbook. b. Provider directory. c. Enrollee identification card.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
17. Additional New Enrollee Materials *CC-IV.A.3.a.1-3*	Additional new enrollee material to be mailed to the new enrollee (not later than 5 calendar days following receipt of the enrollment file from Medicaid or its agent, whichever is later): a. The date of enrollment. b. The name, telephone number, and address of the enrollee's PCP assignment. c. The enrollee's right to choose a different PCP. d. An explanation that enrollees may choose to have all family members served by the same PCP or may choose different PCPs.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
18. Additional New Enrollee Materials	Additional new enrollee material to be mailed to the new enrollee (not later than 5 calendar days following receipt of the enrollment file from Medicaid or its agent, whichever is later): a. The procedure for changing PCPs, including notice of the health plan's toll-free member services telephone number, etc. b. The enrollees' right to change their health plan selection, subject to Medicaid limitations. c. A request to update the enrollee's name, address (home and mailing), county of residence, and telephone	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC-IV.A.3.a.4, 5, 6 &8	number. d. A postage-paid, pre-addressed return envelope.				
19. New Enrollee Materials *CC-IV.A.3.a.7*	Additional new enrollee material to be mailed to the new enrollee (not later than 5 calendar days following receipt of the enrollment file from Medicaid or its agent, whichever is later): A notice that enrollees who lose eligibility and are disenrolled is automatically re-enrolled in the health plan if eligibility is regained within 60 days for non-Reform and 180 for Reform.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
20. Recording and Sending New Materials *CC-IV.A.3.b-c*	Each mailing to new enrollees is documented in the health plan's records, and materials may be sent in separate mailings.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
21. Enrollee ID Card *CC-IV.A.4*	The enrollee ID card includes: a. Enrollee's name and Medicaid ID number. b. Health plan's name, address and enrollee services number. c. A telephone number that a non-contracted provider may call for billing information.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
22. Choice of PCP *CC-IV.A.5.a*	The health plan offers each enrollee a choice of PCPs.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
23. Group or Single PCP *CC-IV.A.5.a*	Each enrollee has a single or group PCP.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
24. Assigning a PCP *CC-IV.A.5.b*	The health plan assigns a PCP to those enrollees who did not choose a PCP at the time of health plan selection. Considerations include: the enrollee's last PCP, closest PCP to the enrollee's ZIP code, keeping the family together, and age.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
25. Changing PCPs *CC-IV.A.5.c*	The health plan permits enrollees to request to change PCPs at any time. If the request is not received by the established monthly cut-off date, the PCP change will be effective the first day of the next month.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
26. Reinstated Enrollee PCP Assignment *CC-IV.A.5.d*	The health plan assigns all enrollees that are reinstated after a temporary loss of eligibility to the PCP treating them prior to the loss of eligibility unless the enrollee requests another PCP, the PCP no longer participates or is at capacity, or the enrollee changed geographic areas.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
27. REFORM: Enhanced Benefit Program *Exhibit 4*	The Agency has identified a combination of covered and non-covered services as healthy behaviors that will earn credits for an enrollee. a. The Agency assigns a specific credit to an enrollee's account for each healthy behavior service received and notifies each enrollee of the availability of the credits in the account. b. The credits in the enrollee's account are available if the enrollee enrolls in a different health plan and for a period of up to three (3) years after loss of Medicaid eligibility.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
28. REFORM: Healthy Behaviors	The Agency administers the program with assistance from the health plan. a. For covered services identified as healthy behaviors, the health plan submits a monthly report to the Medicaid Bureau of Contract Management (MCM) by the tenth calendar day of the month for the previous month's paid claims. A list of procedure codes and healthy behaviors are provided in the Agency Report Guide posted on the Agency's website. b. For non-Medicaid services, the health plan assists the enrollee in	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
Exhibit 4	obtaining and submitting documentation to MCM to verify participation in a healthy behavior without a procedure code. A universal form is available with the Agency's website and is submitted to the health plan to document participation in healthy behaviors without a procedure code.				
29. Handbooks *CC-IV.A.6.a*	The health plan has a separate enrollee handbook for Reform and non-Reform populations.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	#####	#####
30. Provider Directory *CC-IV.A.7.a*	The health plan mails a provider directory to all new enrollees, including enrollees who re-enrolled after the open enrollment period.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
31. Hospital Affiliation *CC-IV.A.7.b*	The provider directory includes information concerning how to determine a provider's hospital affiliation. The information concerning the hospital affiliation of providers is available online and through the Customer Service Department.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
32. Informing Potential Enrollees	The health plan has procedures to inform potential enrollees and enrollees, upon request, of any changes to service delivery and/or the provider network including:	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC-IV.A.7.g	a. Up-to-date information about any restrictions on access to providers, including providers who are not taking new patients. b. An explanation to all potential enrollees that an enrolled family may choose to have all family members served by the same PCP or they may choose different PCPs based on each family member's needs. c. Any restrictions on counseling and referral services based on moral or religious grounds within ninety (90) days after adopting the policy with respect to any service.				
33. Contacting New Enrollees *CC-IV.A.8.a*	The health plan contacts each new enrollee at least twice, if necessary, within ninety (90) calendar days of the enrollee's enrollment to offer to schedule the enrollee's initial appointment with the PCP, which should occur within 180 days of enrollment. This appointment is to obtain a health risk assessment and/or CHCUP screening. The "contact" is defined as mailing a notice to or telephoning an enrollee at the most recent address or telephone number available.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
34. Ongoing Covered Services *CC-IV.A.8.c*	The health plan honors any written documentation of prior authorization of ongoing covered services for a period of thirty (30) calendar days after the effective date of enrollment, or until the enrollee's PCP reviews the enrollee's treatment plan, whichever comes first.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
35. Release of Medical and Behavioral Health Records *CC-IV.A.8.b*	Within thirty (30) calendar days of enrollment, the health plan asks the enrollee to authorize release of the medical and behavioral health records to the new PCP or other appropriate provider and assists the enrollee by requesting those records from the enrollee's previous providers.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
36. Services Approved by Prior Authorization *CC-IV.A.8.d.1-3*	For all enrollees, written documentation of prior authorization of ongoing services includes the following, provided that the services were prearranged prior to enrollment with the health plan: a. Prior existing orders. b. Provider appointments, (i.e., dental appointments, surgeries, etc.). c. Prescriptions (including prescriptions at non-particiating pharmacies).	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
37. Receipt of Written Documentation *CC-VIII.B.1.a.4.i*	The health plan will not delay service authorization if written documentation is not available in a timely manner. However, the health plan is not required	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC-IV.A.8.e	to approve claims for which it has not received written documentation.				
38. Screening Pregnant Enrollees *CC- IV.A.9.a*	Within 30 calendar days of enrollment, the health plan notifies enrollees of, and ensures the availability of, a screening for all enrollees known to be pregnant or who advise the health plan that they may be pregnant. The health plan refers enrollees who are, or may be, pregnant to a provider to obtain appropriate care.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
39. CHCUP Screenings *CC- IV.A.9.b*	The health plan uses the enrollee's health risk assessments and/or release of medical records to identify enrollees who have not received CHCUP screenings in accordance with the Agency-approved periodicity schedule.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
40. Appointments for CHCUP Visits *CC- IV.A.9.c*	The health plan contacts, twice if necessary, any enrollee more than 2 months behind in the Agency-approved periodicity screening schedule to urge those enrollees, or their legal representatives, to make an appointment with the enrollee's PCP for a screening visit.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
41. Identifying Urgent Medical Needs	The health plan takes immediate action to address any identified urgent medical needs. *Urgent medical needs* means any sudden or unforeseen situation that requires immediate action to prevent	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC- IV.A.9.d	hospitalization or nursing home placement (i.e., hospitalization of spouse or caregiver or increased impairment of an enrollee living alone who suddenly cannot manage basic needs without immediate help, hospitalization or nursing home placement).				
42. Enrollee Representative *CC- IV.A.10*	The enrollee's guardian, next of kin or legally authorized responsible person is permitted to act on the enrollee's behalf in matters relating to the enrollee's enrollment, plan of care, and/or provision of services, if the enrollee: a. Was adjudicated incompetent in accordance with the law. b. Is found by the provider to be medically incapable of understanding his or her rights. c. Exhibits a significant communication barrier.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
43. Toll-free Help Line *CC- IV.A.11.a*	The health plan operates a toll-free telephone help line to respond to all areas of enrollee inquiry.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
44. Hernandez Ombudsman (HO)	If the health plan has authorization requirements for prescribed drug services and is subject to the Hernancez Settlement Agreement (HSA), the health plan allows the telephone help line staff to act as HO, so long as the health plan maintains the HO log.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC- IV.A.11.b *CC-V.H.16.f.1*	The HO log may be a part of the help-line log if the HO calls can be identified.				
45. Telephone Call Policies and Procedures *CC- IV.A.11.c*	The health plan has telephone call policies and procedures that include requirements for: a. Staffing. b. Personnel. c. Hours of operation. d. Call response times. e. Maximum hold times. f. Maximum abandonment rates. g. Monitoring of calls via recording or other means. h. Compliance with performance standards.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐ g. Yes ☐ No ☐ h. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
46. Calls from Non-English Speaking Enrollees *CC- IV.A.11.d*	The telephone help line handles calls from non-English speaking enrollee, as well as calls from enrollees who are hearing impaired.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
47. Hours for Telephone Help Line *CC- IV.A.11.e*	The telephone help line is fully staffed between the hours of 8:00 a.m. and 7:00 p.m. in the enrollee's time zone Monday through Friday, excluding state holidays.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
48. Training of Help Line Staff *CC- IV.A.11.e*	The telephone help line staff is trained to respond to enrollee questions in all areas, including but not limited to, covered services, provider network, and transportation.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
49. Help Line Performance Standards *CC- IV.A.11.f*	The health plan develops performance standards and monitors telephone help line performance by recording calls and employing other monitoring activities. Such standards are approved by BMHC before the health plan begins operation. Performance standards include: a. All calls are answered within 4 rings (these calls may be placed in a queue). b. Wait time in the queue does not exceed 3 minutes. c. Blocked call rate does not exceed 1%. d. Rate of abandoned calls does not exceed 5%.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
50. Automated Answering System *CC- IV.A.11.g*	The health plan has an automated system available between the hours of 7:00 p.m. and 8:00 a.m. in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
51. Instructions on Automated System	The automated system provides callers with clear instructions on what to do in the case of an emergency and includes a voice mailbox for callers to leave	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC- IV.A.11.g	messages.				
52. Help Line Mailbox Capacity *CC- IV.A.11.g*	The health plan ensures that the voice mailbox has adequate capacity to receive all messages.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
53. Answering Messages on Help Line *CC- IV.A.11.g*	A health plan representative responds to messages on the next business day.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
54. Translation Services *CC- IV.A.12*	The health plan is required to provide oral translation services of information to any enrollee who speaks any non-English language regardless of whether an enrollee speaks a language that meets the threshold of a prevalent non-English language.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
55. Notifying Enrollees of Translation Services *CC- IV.A.12*	The health plan notifies its enrollees of the availability of oral interpretation services and how to access such services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
56. Oral Interpretation Services *CC- IV.A.12*	Oral interpretation services are required for all health plan information provided to enrollees including notices of action. There is no charge to the enrollee for translation services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
57. Preferred Drug List *CC- IV.A.13*	If the health plan adopts the Agency's PDL, the health plan's website includes an explanation and a link to the Agency's online PDL.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
58. Use of a Pharmacy Benefits Manager *CC- IV.A.13*	If the health plan uses a pharmacy benefits manager, the health plan's website includes its PDL.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
59. Updating the Online PDL *CC- IV.A.13*	The health plan may update the online PDL by providing 30 calendar days written notice of any changes to the Bureau of Managed Health Care and Pharmacy Services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
60. Incentives for Preventive Care *CC- IV.A.14.a*	The health plan may offer incentives for enrollees to receive preventive care services. The health plan receives written approval from BMHC before offering any incentives.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
61. Incentives for All Enrollees *CC- IV.A.14.a*	The health plan makes all incentives available to all enrollees and does not use incentives to direct individuals to select a particular provider.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
62. Informing Enrollees of Incentives *CC- IV.A.14.b*	The health plan informs enrollees about specific incentives available.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
63. Restrictions on Incentives *CC- IV.A.14.c*	The health plan does not include the provision of gambling, alcohol, tobacco, or drugs (except for over-the-counter drugs) in any of its incentives and states on the incentive award that it may not be used for such purposes.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
64. Incentives Proportion to Importance of Health Service *CC- IV.A.14.d*	Incentives may have some health- or child development-related function (e.g., clothing, food, books, safety devises, etc.). Incentive dollar values are in proportion to the importance of the health service being incentivized (e.g., a tee-shirt for attending one prenatal class, but a car seat for completion of a series of classes).	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
65. Limited Value of Incentives *CC- IV.A.14.e*	Incentives are limited to a value of $20, except in the case of incentives for the completion of a series of services, health education classes, or other educational activities, in which case the incentive is limited to a value of $50. The Agency allows a special exception to the dollar value relating to infant car seats, strollers, and cloth baby carriers or slings.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
66. What Cannot Be Considered in the Dollar Limits *CC- IV.A.14.f*	The health plan does not include in the dollar limits on incentives any money spent on the transportation of enrollees to services or childcare provided during the delivery of services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
67. Goal for Pregnancy Incentives	The health plan offers an Agency-approved program for pregnant women to encourage beginning prenatal care visits in the first trimester of pregnancy. Prenatal and postpartum care incentive programs are aimed at promoting early	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC- IV.A.14.g	intervention and prenatal care to decrease infant mortality and low birth weight and to enhance health birth outcomes. The prenatal and postpartum incentives include the provisions of maternity and health-related items and education.				
68. Agency Approval for Incentives *CC- IV.A.14.h*	The health plan's request for Agency approval of all incentives contains a detailed description of the incentive and its mission.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
69. Use of Redetermination Notices *CC- IV.A.17.c*	By June 1 each year, the health plan notifies BMHC, in writing, if it wants to change the use of the redetermination date information supplied by the Agency. The health plan's participation in using the redetermination information is voluntary.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
70. Policies and Procedures for the Use of Redetermination Dates *CC- IV.A.17.c.1.*	A health plan that chooses to participate in the use of redetermination dates must provide its policies and procedures regarding this subsection to BMHC for its approval along with its response indicating that the plan will participate.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
71. Discontinuing Use of Redetermination Dates *CC- IV.A.17.c.1.a.*	A health plan that chooses to participate in the use of redetermination dates may decide to discontinue using the information at any time and must so notify BMHC in writing 30 calendar days prior to the date it will discontinue such use.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
72. Redetermination Training *CC- IV.A.17.c.1.b*	A health plan that chooses to participate in the use of redetermination dates must train all affected staff, prior to implementation, on its policies and procedures and the Agency's requirements.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
73. Documenting Redetermination Training *CC- IV.A.17.c.1.b*	The health plan must document that redetermination training occurred, including a record of those trained, for the Agency's review within 5 business days after the Agency's request.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
74. Using Redetermination Date Information *CC- IV.A.17.d*	A health plan that chooses to participate in using the redetermination date information uses the redetermination date information only in the methods listed below and uses either or both methods to communicate this information.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
75. Using Redetermination Date: One Notice per Household *CC- IV.A.17.d.1.a*	The health plan may use redetermination date information in written notices to be sent to their enrollees reminding them that their Medicaid eligibility may end soon and to reapply for Medicaid, if needed. A health plan may send one notice to the enrollee's household when there are multiple enrollees within a family who have the same Medicaid redetermination date, provided that these enrollees share the same mailing address.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
76. Using Redetermination Date: Agency-provided Notices *CC- IV.A.17.d.1.b*	The health plan uses the Agency-provided template for its redetermination date notices. The health plan puts this template on its letterhead for mailing; however, the health plan makes no other changes, additions or deletions to the letter text.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
77. Using Redetermination Date: Sending Notices *CC- IV.A.17.d.1.c*	The health plan mails the redetermination date notice to each enrollee no more than 60 calendar days and no less than 30 calendar days before the redetermination date occurs.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
78. Using Redetermination Date: Automated Voice Response *CC- IV.A.17.d.2*	The health plan may use redetermination date information in automated voice response (AVR) or integrated voice response (IVR) automated messages sent to enrollees reminding them that their Medicaid eligibility may end soon and to reapply for Medicaid, if needed.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
79. Using Redetermination Date: Automated Messages	A health plan that chooses to use this method to provide the information must adhere to the following requirements: The health plan sends the redetermination date messages to each enrollee for whom that health plan has received a redetermination date and for whom the health plan has a telephone number. The health plan may send an automated message to the enrollee's household where there are multiple	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC- IV.A.17.d.2.a	enrollees within a family who have the same Medicaid redetermination date provided that these enrollees share the same mailing address/ phone number.				
80. Using Redetermination Date: The Agency's Language *CC- IV.A.17.d.2.b*	A health plan that chooses to use this method to provide the information must adhere to the following requirements: For the voice messages, the health plan uses only the language in the Agency's redetermination date notice template provided to the health plan. The health plan may add its name to the message but makes no other changes, additions or deletions to the message text.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
81. Using Redetermination Date: When to Call Enrollees *CC- IV.A.17.d.2.c*	The health plan makes automated calls to each enrollee no more than 60 calendar days and no less than 30 calendar days before the redetermination date occurs.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
82. Using Redetermination Date: Confidentiality	The health plan does not include the redetermination date information in any file viewable by customer service or community outreach staff. The information will be used only in the letter templates and automated scripts provided by the Agency and cannot be referenced or discussed by the health plan with the enrollees, unless in response to an enrollee inquiry about the letter received, nor will it be used at a	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC- IV.A.17.d.3	future time by the health plan. If the health plan receives enrollee inquiries about the notices, such inquiries are referred to the DCF.				
83. Using Redetermination Date: Log of Mailings *CC- IV.A.17.e.1*	If the health plan chooses to participate in using the redetermination date information, it will keep the following information about each mailing made available for the Agency's review within 5 business days after the Agency's request: For each month of mailings, a dated hard copy or pdf of the monthly template used for that specific mailing: a. A list of enrollees to whom a mailing was sent. This list includes each enrollee's name and Medicaid identification number, the address to which the notice was mailed, and the date of the Agency's enrollment file used to create the mailing list. b. A log of returned, undeliverable mail received for the notices, by month, for each enrollee for whom a returned notice was received.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard IV: Enrollee Services & Enrollee Rights					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
84. Using Redetermination Date: Log of Calls *CC- IV.A.17.e.2*	For each month of automated calls made, a list of enrollees to whom a call was made, the enrollee's name, Medicaid identification number, telephone number to which the call was made, the date each call was made, and the date of the Agency's enrollment file used to create the automated call list.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
85. Using Redetermination Date: Policies and Procedures *CC- IV.A.17.f*	A health plan that chooses to participate in using the information will keep up-to-date and approved policies and procedures regarding the use, storage, and securing of this information as well as addesses all requirements of this subsection.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
86. Using Redetermination Date Information: Quarterly Report *CC- IV.A.17.g*	A health plan that participates in using the information submits to the Agency's BMHC a completed quarterly summary report.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
87. Rights and Responsibilities Policies and Procedures *42 CFR 438.100*	The health plan has written policies and procedures regarding the enrollee rights and responsibilities.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Results for Standard IV Enrollee Services and Enrollee Rights	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard V: Provider Credentialing and Recredentialing

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Credentialing and Recredentialing Criteria *CC-VII.H.2*	The health plan establishes and verifies credentialing and recredentialing criteria for all professional providers.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
2. Credentialing Policies and Procedures *CC-VII.H.4.a-f*	The health plan's credentialing and recredentialing policies and procedures are written and include the following: a. Formal delegations and approvals of the credentialing process, a designated credentialing committee, and identification of providers who fall under its scope of authority. b. A process which provides for the verification of the credentialing and recredentialing criteria. c. Approval of new providers and imposition of sanctions, termination, suspension, and restrictions on existing providers. d. Identification of quality deficiencies which result in the health plan's restriction, suspension, termination, or sanctioning of a provider.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard V: Provider Credentialing and Recredentialing

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
3. Appeal Procedures for Providers *CC-VII.H.7*	The health plan develops and implements an appeal procedure for providers against whom the health plan has imposed sanctions, restrictions, suspensions and/or terminations.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Results for Standard V Credentialing and Recredentialing	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard VI: Provider Services

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Provider Handbook *CC-VII.I.2.a*	The health plan issues a provider handbook to all providers at the time the provider's credentialing is complete.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. FFS PSNs: Provider Handbook *CC-VII.I.2.a*	In addition to other requirements specified in Attachment II, Section VI, Provider Network, Item I. Provider Services, regarding the provider handbook, the health plan includes in its provider handbook a notice that the amount paid to providers by the Agency is the Medicaid fee schedule amount less any applicable co-payments.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Distribution of Provider Handbooks *CC-VII.I.2.a*	The health plan may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains: How to obtain the handbook from the health plan's website, and how to request a hard copy from the health plan at no charge.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard VI: Provider Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
4. Updating Provider Handbook *CC-VII.I.2.a*	The health plan keeps all provider handbooks and bulletins up to date and in compliance with state and federal laws.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
5. Contract Education & Training for Providers *CC-VII.I.3.*	The health plan offers training to all providers and their staff regarding the requirements of the Health Plan Contract and special needs of enrollees. a. The health plan conducts initial training within 30 calendar days of placing a newly contracted provider, or provider group, on active status. b. The health plan also conducts ongoing training, as deemed necessary by the health plan or the Agency, in order to ensure compliance with program standards and this contract.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Toll-free Provider Help Line *CC-VII.I.4.a*	The health plan operates a toll-free telephone help line to respond to provider questions, comments and inquiries.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. Provider Help Line Staff	The help line is: • Staffed 24-hours a day, seven days a week (24/7) to respond to prior authorization requests. • Staffed to respond to provider questions in all other areas, including the provider complaint system, provider responsibilities, etc., between the hours of 8:00 am	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard VI: Provider Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC-VII.I.4.c	and 7:00 pm in the provider's time zone Monday through Friday, excluding state holidays. • The health plan's call center system has the capability to track call center statistics. • The health plan has telephone call policies and procedures that include requirements for: ➢ Staffing. ➢ Personnel. ➢ Hours of operation. ➢ Call response times. ➢ Maximum hold times. ➢ Maximum abandonment rates. ➢ Monitoring of calls via recording or other means. ➢ Compliance with performance standards.				
8. Help Line Performance Standards	The health plan develops performance standards and monitor telephone help line performance by recording calls and employing other monitoring activities. Such standards are approved by BMHC before the health plan begins operation. Performance standards include: a. All calls are answered within 4 rings (these calls may be placed in a queue). b. Wait time in the queue does not exceed 3 minutes.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard VI: Provider Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC- IV.A.11.f	c. Blocked call rate does not exceed 1%. d. Rate of abandoned calls does not exceed 5%.				
9. Answering Messages on Help Line *CC- IV.A.11.g*	A health plan representative responds to messages on the next business day.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
10. After Hours Coverage *CC-VII.I.4.e*	The health plan ensures that after regular business hours, the provider services line (not the prior authorization line) is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for an enrollee with an emergency or urgent medical condition.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. Provider Complaint System *CC-VII.I.5.a*	The health plan establishes and maintains a provider complaint system that permits a provider to dispute the health plan's policies, procedures, or any aspect of the health plan's administrative functions, including proposed actions and claims.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. Provider Complaint System	The health plan: a. Distributes the provider complaint system policies and procedures, including claims issues, to out-of-network providers upon request. b. May distribute a summary of these policies and procedures, if the	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard VI: Provider Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC-VII.I.5.c	summary includes information about how the provider may access the full policies and procedures on the health plan's website; and the summary also details how the provider can request a hard copy from the health plan at no charge.				
13. Provider Complaint System *CC-VII.I.5.d*	The provider complaint system: a. Includes a dedicated staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems. b. Identifies a staff person specifically designated to receive and process provider complaints. c. Allows providers 45 calendar days to file a written complaint for issues that are not about claims. d. Investigates each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the health plan's written policies and procedures. e. Ensures that health plan executives with the authority to require corrective action are involved in the provider complaint process.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard VI: Provider Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
14. Written Notice of Outcomes for Provider Complaints *CC-VII.I.5.e*	The health plan provides a written notice of the outcome of the review to the provider.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard VI Provider Services	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard VII: Provider Contracting

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Contract Compliance with the BBA *CC-VII.D.1.a*	All provider contracts must comply with: a. 42 CFR 438.230 (Elements 2-6), and 42 CFR 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control). b. 42 CFR 455.105 (Disclosure by providers: Information related to business transactions). c. 42 CFR 455.106 (Disclosure by providers: Information on persons convicted of crimes).	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
Reference Material: Complying with 42 CFR 438.230	All provider contracts must comply with 42 CFR 438.230: a. Each MCO oversees and is accountable for any functions or responsibilities that are delegated. b. Before delegation, each MCO evaluates the subcontractor's ability to perform the activities being delegated. c. There is a written agreement specifying the activities and reporting responsibilities of the subcontracted vendor. d. The written agreement includes provisions for revoking delegation or imposing sanctions for inadequate performance. e. The MCO monitors the subcontractor's performance on an ongoing basis according to a periodic schedule established by the State. f. The MCO requires corrective actions for any identified deficiencies or areas needing improvement.				
Reference Material: Complying with 42 CFR 455.104	All provider contracts must comply with 42 CFR 455.104, disclosure by providers and fiscal agents concerning ownership and control. A Medicaid agency must require each disclosing entity to disclose the following: a. Disclosure provided at the time of a survey. b. The MCO must provider the disclosure information to the Medicaid agency before entering into contract with the subcontractor. c. Failure to disclose requires termination of any existing agreements				

Standard VII: Provider Contracting

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Reference Material: Complying with 42 CFR 455.105	All provider contracts must comply with 42 CFR 455.105, disclosure by providers of information related to business transactions. A Medicaid agency must require each disclosing entity to disclose the following: a. Providers must submit information concerning ownership of businesses with whom the provider had had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request by the Secretary or Medicaid agency. b. Providers must submit information concerning any significant business transactions between the provider and any wholly owned supplier or subcontractor during the 5-year period ending on the date of the request by the Secretary of Medicaid agency. Federal financial participation will not be grated to providers who fail to comply with the request				
Reference Material: Complying with 42 CFR 455.106	All provider contracts must comply with 42 CFR 455.106, disclosure of providers concerning persons convicted of crimes. A Medicaid agency must require each disclosing entity to disclose the following: a. The provider must disclose any person who has ownership or control interest in the provider or is an agent or managing employee of the provider. b. The provider must disclose any person who has been convicted of a criminal offense related to involvement with Medicare, Medicaid, or the Title XX services program.				
2. Practitioners on the Federal Exclusions List *CC-VII.D.1.c*	The health plan does not employ or contract with individuals on the state or federal exclusions list.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Subcontracted Services by Providers *CC-VII.D.1.d*	The health plan identifies in its provider contract any aspect of service that may be subcontracted by the provider.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Written, Executed Agreements *CC-VII-D.2.* *CC-XVI.O.2*	All provider contracts, subcontracts and amendments executed by the health plan are in writing, signed, and dated by the health plan and the provider.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard VII: Provider Contracting

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
5. Provider Termination:Notification to BMHC *CC-VII.E.3*	In a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency, notice to both the provider and BMHC will be immediate.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Terminated Provider List to BMHC *CC-VII.E.3*	The health plan submits a list of terminated providers to BMHC once a month.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. Provider Termination: Time Frame for Notification *CC-VII.E.4*	The health plan notifies the provider, BMHC, and enrollees in active care at least sixty (60) calendar days before the effective date of the suspension or termination of a provider from the network. If the termination was for "cause," the health plan will provide to BMHC the reasons for termination.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard VII Provider Contracting	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Quality Improvement (QI) Program *42 CFR 438.204* *42 CFR 438.240* *CC-VIII.A.1.a*	The health plan has an ongoing QI Program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered to enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Written QI Plan *CC-VIII.A.1.b*	The health plan develops and submits to the Bureau of Managed Health Care (BMHC) a written quality improvement plan within 30 calendar days from execution of the initial contract and resubmits it annually by April 1 for written approval from the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Using the QI Plan to Develop Performance Improvement Projects (PIPs) *CC-VIII.A.1.b*	The QI plan includes sections defining how the QI Committee used any of the following programs to develop its PIPs: credentialing processes, case management, utilization review, peer review, review of grievances, and review and response to adverse events.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Resolving Problems not in PIPs *CC - VIII.A.1.b*	Any problems/issues identified but not included in a PIP must be addressed and resolved by the QI committee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
5. Policies and Procedures	The health plan's written policies and procedures address components of effective health care management	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VIII.A.1.c	including, but not limited to anticipation, identification, monitoring, measurement, evaluation of enrollee's health care needs, and effective action to promote quality of care.				
6. Quality Improvements *CC - VIII.A.1.d*	The health plan defines and implements improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcomes management achieving the highest level of success.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. Interventions *CC - VIII.A.1.e*	The health plan and its QI Plan demonstrate specific interventions in its care management to better manage the care and promote healthier enrollee outcomes.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. Agency Approval of the QI Plan *CC - VIII.A.1.g*	Prior to implementation, the Agency reviews the health plan's QI Plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
9. Overall Responsibility of the Governing Body *CC-X.1*	The health plan's governing body sets policy and has overall responsibility for the organization of the health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
10. Governing Body *CC-VIII.A.2.a*	The health plan's governing body oversees and evaluates the QI Program.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. Role of Governing Body *CC-VIII.A.2.a*	The role of the health plan's governing body includes providing strategic direction to the QI Program, as well as ensuring the QI Plan is incorporated into the operations throughout the health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
12. Strategic Direction in the QI Plan *CC-VIII.A.2.a*	The written QI Plan clearly describes the mechanism within the health plan for strategic direction from the governing body to be provided to the QI Program and for the QI Program committee to communicate with the governing body.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
13. QI Program Committee *CC-VIII.A.2.b*	The health plan has a QI Program Committee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
14. QI Program Committee Chairperson *CC-VIII.A.2.b*	The health plan's Medical Director serves as either the Chairman or Co-Chairman of the QI Program Committee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
15. Staff Representation on QI Program Committee *CC-VIII.A.2.b*	Appropriate health plan staff representing the various departments of the organization are members of the Committee: a. Quality Director. b. Grievance Coordinator. c. Utilization Review Manager. d. Credentialing Manager. e. Risk Manager/Infection Control. f. Advocate Representative (if applicable). g. Provider Representation (providers or a person from the network management department). Individual staff members may serve in multiple roles on the committee if they also serve in multiple positions within the health plan.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐ N/A ☐ g. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
16. Quarterly QI Program Meetings *CC-VIII.A.2.b*	The Committee meets no less than quarterly.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
17. Written QI Plan *CC-VIII.A.2.b.*	The QI Program Committee is responsible for the development and implementation of the written QI Plan, which incorporates the strategic direction provided by the governing body.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
18. Philosophy for Quality Management *CC - VIII.A.2.b.1*	The QI Plan contains the health plan's guiding philosophy for quality management and identifies any nationally recognized, standardized approach used (i.e., PDCA, Rapid Cycle Improvement, Six Sigma, etc.).	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
19. Performance Indicators *CC - VIII.A.2.b.2*	The QI Plan contains the selection of performance indicators, and the sources for benchmarking is described.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
20. QI Plan Description	The QI Plan includes a description of the following: a. Health plan positions assigned to the QI Program including why each position was chosen and the roles each positions is expected to fulfill. b. Specific training regarding quality that will be provided by the health	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VIII.A.2.b.2 *CC-VIII.A.2.b.3*	plan to staff serving on the QI Program. At a minimum, the training includes protocols developed by CMS regarding quality.				
21. QI Plan – Provider Role *CC-VIII.A.2.b.4*	The QI Plan describes the role of its providers in giving input to the QI Program, whether that is by membership on the Committee, its Sub-Committees, or other means.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
22. QI Plan-Direct and Review QI Activities	The health plan's QI Plan contains the following components: a. A standard for how the health plan assures that QI Program activities take place throughout the health plan and documents the results of the QI Program activities. Protocols for assigning tasks to the staff and timelines are included. b. A standard describing the process to review and suggest new and/or improved QI activities. c. The process for selecting and directing task forces/committees to review areas of concern in the provision of health care services to enrollees. d. The process for selecting evaluation and study design procedures. e. The process for reporting findings to appropriate executive authority, staff,	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VIII.A.2.b.5-10	and departments within the health plan as well as stakeholders, including how this communication is documented for the Agency review. f. The process to direct and analyze periodic reviews of enrollees' service utilization patterns.				
23. Committee Minutes *CC-VIII.A.2.c*	The health plan maintains: a. Minutes of all committee and sub-committee meetings and makes the minutes available upon Agency request. b. Minutes demonstrate resolution of items brought forward to the next meeting.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
24. Peer Review Process	The health plan has a peer review process that: a. Reviews a provider's practice methods and patterns, morbidity/mortality rates, and all grievances filed against the provider relating to medical treatment. b. Evaluates the appropriateness of care rendered by providers. c. Implements corrective action(s) when the health plan deems it necessary to do so. d. Develops policy recommendations to maintain or enhance the quality of	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VIII.A.2.d.1-5	care provided to enrollees. e. Conducts reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider's medical records, adherence to standards generally accepted by a provider's peers and the process and outcome of a provider's care.				
25. Peer Review Committee *CC-VIII.A.2.d.6-8*	The health plan's peer review process: a. Appoints a peer review committee, as a sub-committee to the QI program committee, to review provider performance when appropriate. The medical director or a designee chairs the peer review committee. Its membership is drawn from the provider network and includes peers of the provider being reviewed. b. Receives and reviews all written and oral allegations of inappropriate or aberrant service by a provider. c. Educates enrollees and health plan staff about the peer review process, so that enrollees and the health plan staff can notify the peer review authority of situations or problems relating to providers.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
26. QI Activities – PIPs *CC-VIII.A.3*	The health plan monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees through performance improvement projects (PIPs), medical record audits, performance measures, surveys, and related activities.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
27. Agency-Approved PIPs	The health plan performs: a. No less than four (4) Agency-approved PIPs for each population (Reform and non-Reform). There must be at least one clinical PIP and one non-clinical PIP per population. b. At least one (1) of the PIPs focuses on Language and Culture, Clinical Health Care Disparities, or Culturally and Linguistically Appropriate Services. c. At least one (1) PIP is the statewide collaborative PIP coordinated by the EQRO. d. At least one (1) of the PIPs is related to Behavioral Health Services, if the health plan covers those services. e. At least one (1) PIP is designated to address deficiencies identified by the plan through monitoring performance measure results, member satisfaction surveys, or other	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ N/A ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VIII.A.3.a.1-4	similar means. f. Each PIP includes a statistically significant sample of enrollees.				
28. REFORM: Provider Satisfaction Survey *Exhibit 8*	The health plan submits a provider satisfaction survey plan to BMHC for written approval by the end of the eighth month of this Contract. a. The plan includes the questions to be asked. b. The health plan conducts the survey at the end of the first year of this Contract. c. The results of the survey are reported to BMHC within four (4) months of the beginning of the second year of this Contract.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
29. Performance Measures (PMs) *CC-VIII.A.3.c.1*	The health plan collects data on enrollee PMs, as defined by HEDIS, or otherwise defined by the Agency. This standard may be not applicable for new plans.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
30. Consumer Assessment of Health Plans Survey (CAHPS) *CC-VIII.A.3.d*	The Agency conducts an annual CAHPS. The health plan provides an action plan to address the results of the survey within 2 months of receipt of the written request from the Agency. This standard may be not applicable for new plans.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
31. Cultural Competency Plan (CCP) *42 CFR 438.206* *CC-VIII.A.4.a.*	The health plan has a comprehensive written CCP to ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency.	Yes ☐ No ☐		#####	#####
32. Providing Cultural Services *CC-VIII.A.4.a.*	The CCP describes how providers, health plan employees, and systems effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individual enrollees and protects and preserves the dignity of each.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
33. Annual Review of CCP *42 CFR 438.206* *CC-VIII.A.4.a.*	The CCP is updated annually and submitted to BMHC by October 1 for approval for implementation by January 1 of each contract year.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
34. Distribution of CCP *42 CFR 438.206* *CC-VIII.A.4.b.*	The health plan distributes a summary of the CCP to network providers. The summary details how the provider can request a hard copy of the CCP at no charge.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
35. Annual Evaluation of CCP *42 CFR 438.206* *CC-VIII.A.4.c.*	The health plan completes an annual evaluation of the effectiveness of its CCP. A description of the evaluation, its results, the analysis of the results and interventions to be implemented are described in the annual CCP submitted to the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard VIII: Quality Improvement Program

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
36. Track and Trending CCP Issues *42 CFR 438.206* *CC-VIII.A.4.c.*	The health plan tracks and trends any issues identified and implements interventions to improve the provision of services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
37. Clinical Practice Guidelines (CPGs) 42 CFR 438.236(b) QAIS V.A.1. *CC-VIII.B.3*	The health plan adopted clinical practice guidelines that: a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field. b. Consider the needs of enrollees. c. Are adopted in consultation with contracting health care professionals. d. Are reviewed and updated periodically as appropriate e. Are distributed to all affected providers. f. Are distributed to enrollees and potential enrollees upon request. g. There is evidence that, at a minimum, the following areas are consistent with the guidelines: i. UM decisions ii. Enrollee education iii. Coverage of services	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐ g. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Results for Standard VIII Quality Improvement Program	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard IX: Medical Records					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
1. Maintaining a Medical Record *42 CFR 456* *CC-VII.J*	The health plan ensures the maintenance of medical records for each enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Confidentiality of Medical Records *42 CFR Part 431 Subpart F* *384.30(2), F.S.* *CC-VII.J.2.a*	The health plan has a policy to ensure the confidentiality of medical records. The policy also includes confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Medical Record Review *CC-VIII.A.3.e.1*	If the health plan is not accredited, the health plan conducts reviews of enrollees' medical records to ensure that PCPs provide high quality health care that is documented according to established standards.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Medical Record Standards *CC-VIII.A.3.e.2*	The standards, which must include all medical record documentation requirements addressed in the contract, are distributed to all providers.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
5. Sites to be Included in the Medical Records Audit *CC-VIII.A.3.e.3 & 4*	The health plan conducts medical record reviews at all PCP sites, individual offices and large group facilities, that serve 10 or more enrollees.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard IX: Medical Records

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
6. Frequency of Reviews *CC-VIII.A.3.e.5*	The health plan reviews each practice site at least once every 3 years.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. Number of Medical Records *CC-VIII.A.3.e.6*	The health plan must review at least 5–10 records at each site to determine compliance.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. Medical Record Review Strategy *CC-VIII.A.3.e.7.a-e*	The health plan submits to BMHC for written approval and maintains a written stragegy for conducting medical record reviews. The strategy includes, at a minimum: a. Designated staff to perform the duty. b. The method of case selection. c. The anticipated number of reviews by practice site. d. The tool that the health plan uses to review each site. e. How the health plan links the information compiled during the review to other health plan functions (e.g., QI, credentialing, peer review, etc.).	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐ d. Yes ☐ No ☐ N/A ☐ e. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard IX Medical Records	
Score	# Elements
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard X: Access and Availability

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

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.A.5 *s. 1932(b)(7) of the Social Security Act* *4704(a) of the BBA* *CC-VII.A.10*	particular providers that serve high-risk populations or specialize in conditions that require costly treatments. b. Does not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of the provider's license or certification.				
5. Establishing and Maintaining Provider Network	When establishing and maintaining the provider network, the health plan takes the following into consideration: a. The anticipated number of enrollees. b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented. c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the covered services. d. The numbers of network providers who are not accepting new	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
42 CFR 438.206 *CC-VII.A.6.a-e*	enrollees. e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees and whether the location provides physical access for Medicaid enrollees with disabilities.				
6. Out-of-Network Providers *42 CFR 438.206(b)(4)* *CC-VII.A.7*	If the health plan is unable to provide medically necessary services to an enrollee, the health plan covers the services in an adequate and timely manner by using providers and services that are not in the health plan's network for as long as the health plan is unable to provide the services within its network.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. Second Opinion *42 CFR 438.206* *CC-IV.G.6*	The health plan must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. Enrollee Choice of Network Providers *CC-VII.A.8*	The health plan allows each enrollee to choose among network providers to the extent possible and appropriate.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
9. Refusing to Accept Providers *CC-VII.A.10*	If the health plan declines to include individual providers or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
10. PCP Availability	The health plan ensures that PCPs agree to provide or arrange for coverage of services, consultations, or approval for referrals twenty-four (24) hours per day, seven days per week from Medicaid-enrolled providers. a. The coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. b. The chosen method of twenty-four (24) hour coverage connects the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. c. The after hour's coverage is accessible using the medical office's daytime telephone number. d. The health plan ensures that PCPs arrange for coverage of primary care services by a Medicaid-eligible primary care provider during absences due to vacation, illness, or other situations which require the PCP to be unable to provide services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard X: Access and Availability

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

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
42 CFR 438.206(b)(2) *CC-VII.B.2.c*	in addition to an enrollee's designated PCP, if that provider is not a women's health specialist.				
14. Provider Network: Certified Nurse Midwife 641.31, F.S. Chapter 467, F.S. *CC-VII.B.2.d*	The health plan ensures access to certified nurse midwife services or licensed midwife services for low risk enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
15. Agreements with County Health Departments *CC-VII.B.3.a*	The health plan makes a good faith effort to execute memoranda of agreement with the local county health departments (CHDs) to provide services which may include: family planning services, services for the treatment of sexually transmitted diseases, other public health related diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and services related to Healthy Start prenatal and postnatal screenings. The health plan provides documentation of its good faith effort upon request by the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
16. CAPITATED PLANS: Payment for Services	A capitated health plan: a. Pays, without prior authorization, at the contracted rate or the Medicaid fee-for-service rate, all valid claims initiated by any CHD for	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.B.3.b	office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis. b. Reimburses the CHD when the CHD notifies the health plan and provides the health plan with copies of the appropriate medical records and provides the enrollee's PCP with the results of any tests and associated office visits.				
17. County Health Department: Payment	The health plan authorizes all claims from a CHD, a migrant health center or a community health center, without prior authorization for the services listed below. Such providers attempt to contact the health plan before providing health care services to enrollees and provide the health plan with the results of the office visit, including test results. a. The diagnosis and treatment of sexually transmitted diseases and other reportable infectious diseases, such as tuberculosis and HIV. b. The provision of immunizations. c. Family planning services and	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
	related pharmaceuticals. d. School health services (family planning services, services for the treatment of sexually transmitted diseases, other public health related diseases, tuberculosis, immunizations, foster care emergency shelter medical screenings, and services related to Healthy Start prenatal and postnatal screenings), and for services rendered on an urgent basis by such providers. e. In the event that a vaccine-preventable disease emergency is declared, the health plan authorizes claims from the CHD for the cost of the administration of vaccines. f. Other clinic-based services provided by a CHD, migrant health center or community health center, including well-child care, dental care, and sick care services not associated with reportable infectious diseases, require prior authorization from the health plan in order to receive reimbursement. g. If prior authorization is provided, the health plan reimburses at the entity's cost-based reimbursement rate. If prior authorization for				

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Section 329 of Public Health Services Act Section 330 of Public Health Services Act *CC-VII.B.3.c and d*	prescription drugs is given and the drugs are provided, the health plan reimburses the entity at Medicaid's standard pharmacy rate.				
18. Agreements with Federally Qualified Health Centers (FQHCs) *CC-VII.B.3.e.1-2*	The health plan makes a good faith effort to execute a contract with a FQHC, and if applicable, a Rural Health Clinic (RHC).	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
19. CAPITATED PLANS: Agreements with Federally Qualified Health Centers (FQHCs) *CC-VII.B.3.e.1-2*	The capitated health plan: a. Reimburses FQHCs and RHCs at rates comparable to those rates paid for similar services in the FQHC's or RHC's community. b. Reports quarterly to BMHC, the payment rates and the payment amounts made to FQHCs and RHCs for contractual services provided by these entities.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
20. Agreements with School Districts *ss. 1011.70 and 409.908(21), F.S.* *CC-VII.B.3.f*	The health plan makes a good faith effort to execute memoranda of agreement with school districts participating in the certified match program regarding the coordinated provision of school-based services.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
21. Emergency Services *CC-VII.B.4.a*	The health plan ensures the availability of Emergency Services and Care twenty-four (24) hours a day, seven (7) days a week.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
22. General Acute Care Hospital *CC-VII.B.4.b*	The health plan provides at least one (1) fully accredited general acute care hospital bed per 275 enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
23. Birth Delivery Facility *Chapter 383, F.S.* *CC-VII.B.4.c*	The health plan provides: a. At least one (1) birth delivery facility, or a hospital with birth delivery facilities. The birth delivery facility may be a freestanding facility or part of a hospital. b. A birthing center that is accessible to low-risk enrollees.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
24. Regional Perinatal Intensive Care Centers (RPICC) *CC-VII.B.4.d*	The health plan assures access for enrollees in one (1) or more of Florida's RPICC, or a hospital licensed by the Agency for neonatal intensive care unit (NICU) Level III beds.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
25. NICU *CC-VII.B.4.e*	The health plan ensures that care for medically high-risk perinatal enrollees is provided in a facility with a NICU sufficient to meet the appropriate level of need for the enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####
26. Pharmacy *CC-VII.B.4.f*	If the health plan elects to use a more restrictive pharmacy network than the Medicaid fee-for-service network, the health plan provides at least one (1) licensed pharmacy per 2,500 enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
27. Network Changes *CC-VII.C.2.a-b* *CC-VII.C.3.a-d*	The health plan provides BMHC and HSD with documentation of compliance with access requirements at any time there has been a significant change in the health plan's operations that would affect adequate capacity and services, including, but not limited to, the following: Changes in health plan services or service area or enrollment of a new population in the health plan. The health plan notifies BMHC within seven (7) business days of any significant changes to its network. A significant change is defined as: a. A decrease in the total number of PCPs by more than five percent (5%). b. A loss of all participating specialists in a specialty where another participating specialist in that specialty is not available within sixty (60) minutes. c. A loss of a hospital in an area where another health plan hospital of equal service ability is not available within thirty (30) minutes. d. Other adverse changes to the composition of the network that impair or deny the enrollee's adequate access to providers.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

Standard X: Access and Availability

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

Standard X: Access and Availability

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

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
	mental health centers within a thirty (30) minute average travel time. c. All participating specialists and ancillary providers are within an average of sixty (60) minutes travel time from an enrollee's residence. d. For rural areas, if the health plan is unable to enter into an agreement with specialty or ancillary service providers within the required sixty (60) minute average travel time. BMHC may waive the requirement in writing. e. The health plans provide a designated emergency services facility within an average of 30 minutes travel time from an enrollee's residence, that provides care on a 24-hour a day, seven days a week (24/7) basis. f. BMHC may waive the travel time requirement, in writing, in rural areas. g. Each designated emergency service facility has one or more physicians and one or more nurses on duty in the facility at all times. BMHC may waive the travel time requirement, in writing, in rural areas.				

Standard X: Access and Availability

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-VII.F.2	h. At least one (1) pediatrician or one (1) CHD, FQHC or RHC must be available within an average of thirty (30) minutes' travel time from an enrollee's residence, provided that this requirement remains consistent with the other minimum time requirements of this Contract. In order to meet this requirement, the pediatrician(s), CHD, FQHC, and/or RHC must provide access to care on a twenty-four hour a day, seven day a week (24/7) basis. i. BMHC may waive this requirement, in writing, for rural areas and where there are no pediatricians, CHDs, FQHCs or RHCs within the thirty (30) minute average travel time.				
33. Appointment Wait Times Compliance *42 CFR 438.206(c)(1)(iv),(v) and (vi)* *CC-VII.F.6*	Annually by February 1 of each contract year, the health plan reviews a statistically valid sample of PCP offices' average appointment wait times to ensure that services are in compliance.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met	#####	#####

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

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Grievance System *42 CFR 431.200* *42 CFR 438 Subpart F* *641.511 F.S.* *CC-IX.A.1*	The health plan has internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge denial of coverage of, or payment for, medical assistance.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Fair Hearing Process *CC-IX.A.2*	The internal grievance procedures include an opportunity to file a complaint, a grievance, and/or an appeal and to seek a Medicaid Fair Hearing though the Department of Children and Families.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Grievance/Appeal Coordinator *CC-IX.A.3*	The health plan refers all enrollees and/or providers on behalf of the enrollee who are dissatisfied with the health plan or its activities to the plan's grievance/appeal coordinator for processing and documentation of the issue.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Grievance/Appeals Procedure in the Enrollee Handbook *CC-IX.A.4*	The health plan includes all necessary procedural steps for filing complaints, grievances, appeals and requests for a Medicaid Fair Hearing in the enrollee handbook.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
5. State-level Appeals *CC-IX.A.5*	The health plan's grievance system includes information for enrollees on seeking a state level appeal through either the Subscriber Assistance Panel (for HMOs) or the Beneficiary Assistance Panel (for PSNs).	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Grievance/Appeals Reports *CC-IX.A.7*	The health plan maintains a record of grievances and appeals and submit reports to BMHC.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. Log of Complaints *CC-IX.A.8*	The health plan keeps a log of complaints that do not become grievances, including date, name, nature of complaint and disposition. The plan submits the report upon request of the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. Written Acknowledgment *CC-IX.A.9*	The health plan acknowledges, in writing, receipt of each grievance and appeal, unless the enrollee requests an expedited resolution.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
9. Decision-making by People not Previously Involved *CC-IX.A.10*	The health plan ensures that none of the decision makers on a grievance or appeal were involved in any of the previous levels of review or decision-making.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
10. Personnel Involved in Grievances and Appeals	The health plan ensures that all decision makers are health care professionals with clinical expertise in treating the enrollee's condition or disease when deciding:	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-IX.A.10.a-c	a. An appeal of a denial that is based on lack of medical necessity. b. A grievance regarding the denial of an expedited resolution of an appeal. c. A grievance or appeal that involves clinical issues.	No ☐			
11. Transportation Services *CC-IX.A.11*	A health plan that covers transportation services through a subcontractor ensures that the subcontractor meets the complaint and grievance system requirements for problems related to transportation services.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. Types of Issues: Complaints *CC-IX.B.1*	A complaint is the lowest level of challenge and provides the health plan an opportunity to resolve a problem without the complaint becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
13. Types of Issues: Grievance *CC-IX.B.2*	A grievance expresses dissatisfaction about any matter other than an action by the health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
14. Types of Issues: Action *CC-IX.B.3*	An action is any denial, limitation, reduction, suspension, or termination of services; denial of payment; or failure to act in a timely manner.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
15. Types of Issues: Appeal *CC-IX.B.4*	An appeal is a request for review of an action.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
16. Written Notice of Action *CC-IX.C.1.a-g*	The health plan provides the enrollee with a written notice of action that includes the following: a. The action the health plan or its contractor has taken or intends to take. b. The reason for the action. c. The enrollee or provider's right to file an appeal with the health plan. d. The enrollee's right to request a Medicaid Fair Hearing. e. The procedures for exercising the rights specified in the notice. f. The circumstances under which expedited resolution is available and how to request it. g. The enrollee's right to have benefits continued pending resolution of an appeal, how to request a continuation of benefits, and the circumstances in which the enrollee must have to pay the cost of those benefits.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐ g. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
17. Mailing Notices: Termination, Suspension, or Reduction of Authorized Services *42 CFR 431.213-214* *CC-IX.C.2.a*	The health plan mails the notice as follows: For termination, suspension, or reduction of previously authorized Medicaid-covered services no later thatn 10 calendars before the action is to take effect.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
18. Mailing Notices: Termination/ Suspension/ Reduction of Authorized Services *42 CFR 431.213-214* *CC-IX.C.2.b*	The health plan mails the notice as follows: For denial of payment, at the time of any action affecting the claim.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
19. Mailing Notices: Deny/Limit Services *42 CFR 431.213-214* *CC-IX.C.2.c*	The health plan mails the notice as follows: For standard service authorization decisions that deny or limit services no more than 14 calendar days following the request for service or within 3 business days following an expedited service request.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
20. Mailing Notices: Extending the Timeframe	If the health plan extends the timeframe for a service authorization decision, in which case it: a. Notifies the enrollee of the reason for extending the timeframe and advises the enrollee of the right to file a grievance if the enrollee disagrees with the extension of	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
42 CFR 431.213-214 *CC-IX.C.2.d*	time. b. Issues and carries out its determination as expeditiously as possible and no later than the date the extension expires. c. Sends notice of the extension to the enrollee within 5 business days of determining the need for an extension.				
21. Mailing Notices: No Decision in the Timeframe *42 CFR 431.213-214* *CC-IX.C.2.e*	The health plan mails the notice as follows: For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse action.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
22. Mailing Notices-Standard Service Authorization *42 CFR 431.213-214* *CC-IX.C.2.f*	The health plan mails the notice as follows: For expedited service authorization decisions within the timeframes specified.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
23. Filing Grievances and Appeals: Time Limit *42 CFR 431.213-214* *CC-IX.D.1*	A grievance may be filed orally or in writing within one year of the occurrence.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
24. Filing Grievances and Appeals: Orally or in Writing *42 CFR 431.213-214* *CC-IX.D.2*	A grievance may be filed orally or in writing within 30 calendar days of the enrollee's receipt of the notice of action and, except when expedited resolution is required, must be followed with a written notice within 10 calendar days of the oral filing. The date of oral notice constitutes the date of receipt.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
25. Filing Grievances and Appeals: Reasonable Assistance to Enrollees *42 CFR 431.213-214* *CC-IX.D.3*	The health plan provides any reasonable help to the enrollee in completing forms and following the procedures for filing a grievance or appeal or requesting a Medicaid Fair Hearing. This includes interpreter services, toll-free calling, and TTY/TTD capability.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
26. Filing Grievances and Appeals: Procedures	The health plan handles grievances and appeals as follows: a. Provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. b. Ensures the enrollee understands any time limits that may apply. c. Provides opportunity before and during the process for the enrollee or an authorized representative to examine the case file, including medical records, and any other material to be considered during	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
42 CFR 431.213-214 *CC-IX.D.4.a-d*	the process. d. Considers as parties to the appeal the enrollee or an authorized representative or, if the enrollee is deceased, the legal representative of the estate.				
27. Resolution and Notification *CC-IX.E.1*	The health plan follows Agency guidelines in resolving grievances and appeals as expeditiously as possible, observing required timeframes and taking into account the enrollee's health condition.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
28. Resolution and Notification: Notice of Results *CC-IX.E.2*	A grievance must be reviewed and notice of results sent to the enrollee no later than 90 calendar days from the date the health plan receives it.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
29. Resolution and Notification: Notice of Results of an Appeal *CC-IX.E.3*	An appeal must be heard and notice of results sent to the enrollee no later than 45 calendar days from the date the health plan receives it.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
30. Resolution and Notification: Extensions	The timeframe for a grievance or appeal may be extended up to 14 calendar days if: a. The enrollee asks for an extension, or the health plan documents that additional information is needed and the delay is in the enrollee's	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-IX.E.4.a-b	interest. b. If the timeframe is extended other than at the enrollee's request, the health plan must notify the enrollee within 5 business days of the determination, in writing, of the reason for the delay.				
31. Resolution and Notification: Disenrollment *CC-IX.E.5*	The health plan completes the grievance process in time to accommodate an enrollee's disenrollment effective date, which can be no later than the first day of the second month after the filing of a request for disenrollment.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
32. Resolution and Notification: Notice of Disposition *CC-IX.E.6*	The health plan provides written notice of disposition of an appeal. In the case of an expedited appeal, the health plan also provides oral notice by close of business the day of disposition.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
33. Resolution and Notification: Contents of Notice of Results *CC-IX.E.7.a-b*	The written notice of resolution includes: a. The results of the resolution process and the date it was completed. b. If not decided in the enrollee's favor, information on the right to request a Medicaid Fair Hearing and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
34. Resolution and Notification: Contents of Notice of Results *CC-IX.E.7.c.1-3*	The written notice of resolution includes: The right to appeal an adverse decision on an appeal to the Subscriber Assistance Program (SAP) for HMOs or the Beneficiary Assistance Program (BAP) for PSNs including how to initiate such a review and: a. Before filing with the SAP or BAP, the enrollee must completed the health plan's appeal process. b. The enrollee must submit the appeal to the SAP or BAP within one year after receipt of the final decision letter from the health plan. c. Neither the SAP nor the BAP will consider an appeal that has already been to a Medicaid Fair Hearing.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
35. Resolution and Notification: Address of SAP/BAP *CC-IX.E.7.c.4*	The written notice of resolution includes: The address and toll-free telephone number of the SAP/BAP: Agency for Health Care Administration Subscriber Assistance Program/ Beneficiary Assistance Program Building 1, MS #26 2727 Mahan Drive Tallahassee, FL 32308 (805) 921-5458 (888) 419-3456 (toll free)	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
36. Resolution and Notification: Contents of Notice of Results *CC-IX.E.7.d*	The written notice of resolution includes: That the enrollee may have to pay for the cost of those benefits if the Medicaid Fair Hearing upholds the health plan's action.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
37. Expedited Appeals *CC-IX.F.1*	The health plan has an expedited review process for appeals for use when taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
38. Expedited Appeal Resolution Time Frame *CC-IX.F.2*	The health plan resolves each expedited appeal and provides notice to the enrollee, as quickly as the enrollee's health condition requires, within state-established time frames not to exceed seventy-two (72) hours after the health plan receives the appeal request, whether the appeal was made orally or in writing.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
39. Punitive Action *CC-IX.F.3*	The health plan ensures that punitive action is not taken against a provider who requests or supports a request for an expedited appeal.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
40. Denying an Expedited Appeal *CC-IX.F.4*	If the health plan denies the request for expedited appeal, it immediately transfers the appeal to the timeframe for standard resolution and so notifies the enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
41. Medicaid Fair Hearing System *CC-IX.G.1*	An enrollee may seek a Medicaid Fair Hearing without having first exhausted the health plan's grievance and appeal process.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
42. Timing of Filing for a Medicaid Fair Hearing with the Health Plan's Appeal Process *CC-IX.G.2*	An enrollee who chooses to exhaust the health plan's grievance and appeal process may still file for a Medicaid Fair Hearing within 90 calendar days of receipt of the health plan's notice of resolution.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
43. Timing of Filing for a Medicaid Fair Hearing without Health Plan's Appeal Process *CC-IX.G.3*	An enrollee who chooses to seek a Medicaid Fair Hearing without pursuing the health plan's process must do so within 90 days of receipt of the health plan's notice of action.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
44. Parties to the Medicaid Fair Hearing *CC-IX.G.4*	Parties to the Medicaid Fair Hearing include the health plan as well as the enrollee or that person's authorized representative.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
45. Address to Request a Medicaid Fair Hearing *CC-IX.G.5*	The address at DCF for the Medicaid Fair Hearing Office is: Office of Public Assistance Appeals Hearings, 1317 Winewood Boulevard, Building 5, Room 203 Tallahassee, FL 32399-0700	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
46. Continuation of Benefits *CC-IX. H.1.a.1-2*	The health plan continues the enrollee's benefits if the enrollee or the enrollee's authorized representative files an appeal with the health plan regarding the health plan's decision: a. Within 10 business days after the notice of the adverse action is mailed. b. Within 10 business days after the intended effective date of the action, whichever is later.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
47. Continuation of Benefits *CC-IX. H.1.b-e*	The health plan continues the enrollee's benefits if: a. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. b. The services were ordered by an authorized provider. c. The original period covered by the original authorization has not expired. d. The enrollee requests an extension of benefits.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
48. Continuation or Reinstatement of Benefits	If, at the enrollee's request, the health plan continues or reinstates the benefits while the appeal is pending, benefits must continue until one of the following occurs:	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-IX. H.2.a-d	a. The enrollee withdraws the appeal. b. Ten business days pass after the health plan sends the enrollee the notice of resolution of the appeal against the enrollee, unless the enrollee within those 10 days has requested a Medicaid Fair Hearing with continuation of benefits. c. The Medicaid Fair Hearing office issues a hearing decision adverse to the enrollee. d. The time period or service limits of a previously authorized service have been met.	d. Yes ☐ No ☐			
49. Recovering the Cost of Services *CC-IX. H.3*	If the final resolution of the appeal is adverse to the enrollee and the health plan's action is upheld, the health plan may recover the cost of services furnished to the enrollee while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
50. Reversal of Health Plan's Action *CC-IX. H.4*	If the Medicaid Fair Hearing officer reverses the health plan's action and services were not furnished while the appeal was pending, the health plan must authorize or provide the disputed services promptly.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XI: Grievances and Appeals

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
51. Reversal of Health Plan's Action: Paying for Services *CC-IX. H.5*	If the Medicaid Fair Hearing officer reverses the health plan's action and the enrollee received the disputed services while the appeal was pending, the health plan must pay for those services in accordance with this contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard XI Grievances and Appeals	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Accuracy of Information *CC-II.D.2*	The health plan verifies that information it submits to the Agency or its agents is accurate.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Submitting Documents to the BMHC *CC-II.D.3-4*	The health plan submits all policies and procedures, model provider agreements and amendments, all subcontracts (including behavioral health, if applicable), and all other materials related to this Contract to the Bureau of Managed Health Care (BMHC) for approval before implementation.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Prior Approval of Documents and Notification to Enrollees *CC-II.D.4.a-b*	To obtain BMHC approval: a. The health plan provides written materials to BMHC at least forty-five (45) calendar days before the effective date of the change. b. The health plan provides written notice of such changes affecting enrollees to those enrollees at least thirty (30) calendar days before the effective date of change.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Website Documents *CC-II.D.6*	The health plan makes enrollee materials, including the preferred drug list, provider directory and enrollee handbook(s), available online at the health plan's website without requiring enrollee log-in.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
5. Providing Covered Services without Regard to Usage *CC-II.D.17*	The health plan provides covered services to enrollees as required for each enrollee without regard to the frequency or cost of services relative to the amount paid pursuant to the Contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. CMSSP ONLY: Screening Tools *Exhibit 2*	The health plan's policies and procedures include both the clinical screening tool and the administration of the clinical screening tool performed by the State of Florida Department of Health to determine beneficiary clinical-eligibility for the specialty plan for children with chronic conditions.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
7. CMSSP ONLY: Updates to Policies and Procedures Concerning the Screening Tools *Exhibit 2*	Any revisions to policies and procedures concerning both the clinical screening tool and the administration of the clinical screening tool is approved by the Agency prior to use.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. ALL PLANS EXCEPT REFORM HMOs: Furnishing Services *Exhibit 2*	The health plan furnishes services in an amount, duration and scope that are no more restrictive than the services provided in the Medicaid fee-for-service program and may reasonably be expected to achieve the purpose for which the services are furnished.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
9. CAPITATED REFORM PLANS: Compliance with Florida Medicaid Handbooks *Exhibit 2*	The health plan complies with all current Florida Medicaid Handbooks (Handbooks) pursuant to Attachment II, Section II, General Overview, unless a customized benefit package has been certified by the Agency. a. In no instance may the limitations or exclusions imposed by the health plan be more stringent than those specified in the Handbooks, unless authorized in the customized benefit package by the Agency. b. The health plan may exceed limits in the Handbooks by offering expanded services, as described elsewhere in this Contract or through its approved customized benefit package.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
10. FFS PSNs and CAPITATED REFORM: Catastrophic Component Threshold *Exhibit 2*	A health plan that accepts only the comprehensive component of the capitation rate continues to provide all covered services to each enrollee who reaches the catastrophic component threshold. a. The health plan continues to apply its QM and UM program components, as well as other administrative policies and protocols to the delivery of care and services to the enrollees who meet the threshold. b. The health plan submits documentation for reimbursement for covered services costs as outlined in Attachment II, Exhibit 13.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
11. REFORM: Benefit Maximum *Exhibit 2*	When the cost of an enrollee's covered services reaches the benefit maximum of $550,000 in a fiscal year, the health plan assists the enrollee in obtaining necessary health care services in the community. a. The health plan continues to coordinate the care received by the enrollee in the community, and the health plan continues to be responsible for emergency services and care. b. In addition, the health plan provides benefit reporting to BMHC, monthly, and HSD in accordance with Attachment II, Section XII, Reporting Requirements, once the cost of covered services reaches $450,000.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. Responsibilities of the Health Plan *CC-X.A.2*	The health plan is responsible for the administration and management of all aspects of this Contract, including, but not limited to, delivery of services, provider network, provider education, claims resolution and assistance, and all subcontracts, employees, agents, and services performed by anyone acting for or on behalf of the health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
13. Centralized Executive Administration *CC-X.A.3*	The health plan has a centralized executive administration, which serves as the contact point for the Agency, except as otherwise specified in this Contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
14. Staffing the Health Plan *CC-X.B.1*	The health plan educates its staff about its policies and procedures and all applicable provisions of the Contract, including advance directives, and situations in which advance directives may be of benefit to enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
15. Performance Metrics *CC-X.C.1*	The health plan has performance metrics, including those for quality, accuracy and timeliness, and include a process for measurement and monitoring, and for the development and implementation of interventions for improvement in regards to claims processing and claims payment. The health plan keeps documentation of the above and has the documentation available for Agency review.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
16. Electronic Transmissions *CC-X.C.2.3*	The health plan is able to accept electronically-transmitted claims from providers in HIPAA-compliant formats. The health plan uses electronic transmission of claims, HIPAA-compliant transactions, notices, documents, forms, and payments to the greatest extent possible by the health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
17. Federal and State Requirements for Processing Claims *42CFR 447.45* *42 CFR 447.46* *Chapter 641,F.S.* *CC-X.C.4*	The health plan ensures that claims are processed and comply with the federal and state requirements, which is more stringent.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
18. CAPITATED: Date of Claim Receipt *Exhibit 10*	The date of claim receipt is the date the health plan receives the claim at its designated claims receipt location.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
19. CAPITATED: Date of Payment *Exhibit 10*	The date of health plan claims payment is the date of the check or other form of payment.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
20. CAPITATED: Electronically Submitted Claims *Exhibit 10*	For all electronically submitted claims for capitated services, the health plan: a. Within twenty-four (24) hours after the beginning of the next business day after receipt of the claim, provides electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim. b. Within twenty (20) calendar days after receipt of the claim, pays the claim or notifies the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim includes an itemized list of additional information or documents necessary to process the claim. c. Pays or denies the claim within ninety (90) calendar days after receipt of the claim. Failure to pay or deny the claim within one hundred and twenty (120) calendar days after receipt of the claim creates an uncontestable obligation for the health plan to pay the claim.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
21. CAPITATED: Claims Submitted Non-electronically *Exhibit 10*	For all non-electronically submitted claims for capitated services, the health plan: a. Within fifteen (15) calendar days after receipt of the claim, provides acknowledgment of receipt of the claim to the provider or designee or provides the provider or designee with electronic access to the status of a submitted claim. b Within forty (40) calendar days after receipt of the claim, pays the claim or notifies the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim includes an itemized list of additional information or documents necessary to process the claim. c. Pays or denies the claim within one hundred and twenty (120) calendar days after receipt of the claim. Failure to pay or deny the claim within one hundred and forty (140) calendar days after receipt of the claim creates an uncontestable obligation for the health plan to pay the claim.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
22. CAPITATED: Payment for Services	The health plan reimburses providers for the delivery of authorized services as described in s. 641.3155, F.S., including, but not limited to: a. The provider must mail or electronically transfer (submit) the claim to the health plan within six (6) months after: i. The date of service or discharge from an inpatient setting.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Exhibit 10	ii. The date that the provider was furnished with the correct name and address of the health plan. b. When the health plan is the secondary payer, the provider must submit the claim to the health plan within ninety (90) calendar days after the final determination of the primary payer.				
23. CAPITATED: Reimbursing Providers Out of Service Area *Exhibit 10*	In accordance with s. 409.912, F.S., the health plan reimburses any hospital or physician that is outside the health plan's authorized geographic service area for health plan authorized services provided by the hospital or physician to enrollees: a. At a rate negotiated with the hospital or physician. b. The lesser of the following: i. The usual and customary charge made to the general public by the hospital or physician. ii. The Florida Medicaid reimbursement rate established for the hospital or physician.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
24. Resolution of Claim Complaints by Providers *s. 641.3155 F.S.* *CC-X.C.5*	The health plan has a process for handling and addressing the resolution of provider complaints concerning claims issues.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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25. Claims Submitted by Out-of-Network Providers *CC-X.C.6*	The health plan does not deny claims submitted by an out-of-network provider, including provision of emergency services and care, solely based on the period between the date of service and the date of clean claim submission, unless the period exceeds 365 days.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
26. Aging Claims Summary *CC-X.C.7*	Each quarter the health plan submits an aging claims summary.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
27. Encounter Data Collection *CC-X.D.1*	Encounter data collection and submission is required for all capitated health plans for all health care services rendered to their enrollees (services for which the health plan is reimbursed by the Agency on a capitated basis) and from all fee-for-service PSNs for all capitated services.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
28. Encounter Data Submission *CC-X.D.1*	The health plan submits encounter data that meets established Agency data quality standards to ensure receipt of complete and accurate data for program administration.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
29. Revising Encounter Data Standards *CC-X.D.1*	The Agency will revise and amend the encounter data standards with 90 calendar days advance notice to the health plan to ensure continuous quality improvement. The health plan makes changes or corrections to any systems, processes, or data transmission formats as needed to comply with Agency data quality standards as originally defined or subsequently amended.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

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30. Submitting Historical Encounters *CC-X.D.3.a*	The health plan submits the historical encounters for all typical and atypical services with health plan paid dates of January 1, 2007 for Reform populations, and July 1, 2008 for non-Reform populations, up to the submission start date. The health plan retains submitted historical encounter data for a period not less than 5 years.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
31. Submitting Ongoing Encounters *CC-X.D.3.b*	The health plan submits encounters for all typical and atypical services with health plan paid dates on or after the submission start date on an ongoing basis within 60 calendar days following the end of the month in which the health plan paid the claims for services.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
32. Encounters Failing EDI *CC-X.D.3.c*	For all encounters submitted after the submission start date, including historical and ongoing claims, if the Agency or its fiscal agent notifies the health plan of encounters facility X112 electronic data interface (EDI) compliance edits or FMMIS threshold and repairable compliance edits, the health plan remediates all such encounters within 60 calendar days after such notice.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
33. Automated and Integrated Encounter Data Systems	All health plan encounters are submitted to the Agency in the standard HIPAA transaction formats: the ANSI X12N 837 transaction formats for P, Professional; I, Institutional, and D, Dental; and for pharmacy services in the National Council for Prescription Drug Program (NCPDP) format. Health plan paid amounts are provided for non-	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CC-X.D.4.a	capitated network providers.				
34. Submitting Service-level Encounter Data *CC-X.D.b*	The health plan collects and submits, to the Agency's fiscal agent, enrollee service-level encounter data for all covered services. The health plan is responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on their behalf.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
35. Converting Paper Claims to Encounter Data *CC-X.D.c*	The health plan converts all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
36. Complete and Accurate Encounters *CC-X.D.4.d.1-3*	The health plan provides complete and accurate encounters to the Agency. The health plan implements review procedures to validate encounter data submitted by providers. a. Complete: Submitting at least 95% of the covered services provided by health plan providers and non-participating providers. b. Accurate (X12): Ninety-five percent of the records in a health plan's encounter batch submission pass X12 EDI compliance edits and the FMMIS threshold and repairable compliance edits. c. Accurate (NCPDP): Ninety-five percent of the records in a health plan's encounter batch submission pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

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37. Sufficient IT Staff *CC-X.D.5*	The health plan designates sufficient IT and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
38. Timely Submission from Providers *CC-X.D.6*	Where a health plan has entered into capitation reimbursement arrangements with providers, the health plan requires timely submissions from its providers as a condition of the capitation payment.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
39. Agency-sponsored Workgroups *CC-X.D.7*	The health plan participates in Agency-sponsored workgroups directed at continuous improvements in encounter data quality and operations.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
40. Conflict of Interest	The health plan discloses to HSD within ten (10) business days of discovery the name of any officer, director, or agent who is an employee of the State of Florida, or any of its agencies. a. The health plan discloses the name of any state employee who owns, directly or indirectly, an interest of five percent (5%) or more in the health plan or any of its affiliates. b. The health plan covenants that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of the services hereunder. c. The health plan further covenants that in the performance of the Contract no person having any such known interest will be	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CC-XVI.E	employed. d. No official or employee of the Agency and no other public official of the State of Florida or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking of carrying out the Contract will, prior to completion of this Contract, voluntarily acquire any personal interest, direct or indirect, in this Contract or proposed Contract.				
41. Minority Participation Report *CC-XVI.O.1.c.1*	By the 15th day after the reporting month, the health plan provides a monthly Minority Participation Report to BMHC summarizing the business it does with minority subcontractors or vendors.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
42. Waiving Minority Participation Report *CC-XVI.O.1.c.2.a-d*	The submission of a Minority Participation Report may be waived in writing if: a. The health plan demonstrates that it is at least fifty-one percent (51%) minority-owned. b. At least fifty-one percent (51%) of its board of directors belong to a minority. c. At least fifty-one percent (51%) of its officers belong to a minority. d. The health plan is a not-for-profit corporation ***and*** at least fifty-one percent (51%) of the population it serves belongs to a minority.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐ d. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
43. Continuing to be Waived from Submitting the	If the health plan has been approved by the Agency for a waiver of this report requirement, it must submit a request for waiver renewal	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

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Minority Participation Report *CC-XVI.O.3*	annually, in writing, to HSD by September 1 of each Contract year.				
44. Emergency Management Plan *CC-XVI.BB*	Annually by May 31 of each Contract year, the health plan submits to BMHC for approval an emergency management plan specifying what actions the health plan conducts to ensure the ongoing provision of health services in a disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. If the emergency management plan is unchanged from the previous year, the health plan submits a certification to BMHC that the prior year's plan is still in place.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
45. Notification of Legal Actions *CC-XVI.K*	The health plan gives HSD, by certified mail, immediate written notification (no later than thirty [30] calendar days after service of process) of any action or suit filed or of any claim made against the health plan by any subcontractor, vendor, or other party that results in litigation related to this Contract for disputes or damages exceeding the amount of $50,000. In addition, the health plan immediately advises HSD of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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46. Misuse of Symbols, Emblems, or Names *CC-XVI.M*	No person or health plan may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Medicaid," or "Agency for Health Care Administration," except as required in the Agency's Standard Contract, Section I., Item N., Sponsorship, unless prior written approval is obtained from the Agency. a. Specific written authorization from the Agency is required to reproduce, reprint, or distribute any Agency form, application, or publication for a fee. State and local governments are exempt from this prohibition. b. A disclaimer that accompanies the inappropriate use of program or Agency terms does not provide a defense. c. Each piece of mail or information constitutes a violation.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
47. Disclosure of Ownership and Management Forms *CC-XVI.V.1*	Disclosure is made on forms prescribed by the Agency: a. For the areas of ownership and control interest (42 CFR 455.104, Form CMS 1513). b. Business transactions (42 CFR 455.105). c. Conviction of crimes (42 CFR 455.106). d. Public entity crimes (s. 287.133(3)(a), F.S.). e. Disbarment and suspension (52 Fed. Reg., pages 20360-20369, and Section 4707 of the Balanced Budget Act of 1997).	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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48. Required Submission of Disclosure of Ownership and Management Forms *CC-XVI.V.1*	The forms are available through the Agency. a. Submission to HSD is required with the initial application for a Medicaid health plan and annually to HSD and BMHC by September 1 of each Contract year thereafter. b. In addition, the health plan submits to the BMHC and HSD full disclosure of ownership and control of the health plan and any changes in management within five calendar days of knowing the change will occur and at least sixty (60) calendar days before any change in the health plan's ownership or control takes effect.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
49. Definition of Ownership Requiring Disclosure: Part I *CC-XVI.V.2*	The following definitions apply to ownership disclosure: A person with an ownership interest or control interest means a person or corporation that: a. Owns, indirectly or directly, five percent (5%) or more of the health plan's capital or stock, or receives five percent (5%) or more of its profits. b. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the health plan or by its property or assets and that interest is equal to or exceeds five percent (5%) of the total property or assets. c. Is an officer or director of the health plan, if organized as a corporation, or is a partner in the health plan, if organized as a partnership.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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50. Definition of Ownership Requiring Disclosure: Part II *CC-XVI.V.2*	The following definitions apply to ownership disclosure: The percentage of direct ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the health plan's assets used to secure the obligation. Thus, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of the health plan's assets, the person owns six percent (6%) of the health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
51. Definition of Ownership Requiring Disclosure: Part III *CC-XVI.V.2*	The following definitions apply to ownership disclosure: The percent of indirect ownership or control is calculated by multiplying the percentage of ownership in each organization. Thus, if a person owns ten percent (10%) of the stock in a corporation, which owns eighty percent (80%) of the health plan's stock, the person owns eight percent (8%) of the health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
52. Management Disclosure	The following definitions apply to management disclosure: a. Changes in management are defined as any change in the management control of the health plan. b. Changes in the board of directors or officers of the health plan, medical director, chief executive officer, administrator, and chief	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CC-XVI.V *CC-XVI.V.3*	financial officer. c. Changes in the management of the health plan where the health plan has decided to contract out the operation of the health plan to a management corporation. The health plan discloses such changes in management control and provides a copy of the contract to the Agency for approval at least sixty (60) calendar days prior to the management contract start date.				
53. Annual Background Checks *CC-XVI.V*	By September 1 of each Contract Year, the health plan conducts an annual background check with the Florida Department of Law Enforcement on all persons with five percent (5%) or more ownership interest in the health plan, or who have executive management responsibility for the health plan, or have the ability to exercise effective control of the health plan (see ss. 409.912 and 435.03, F.S.). The health plan keeps a record of all background checks to be made available for Agency review upon request.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
54. Fingerprints of Newly Hired Principals *CC-XVI.V*	The health plan submits to the Agency Contract Manager complete sets of fingerprints of newly hired principals (officers, directors, agents, and managing employees) within thirty (30) days of the hire date.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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55. Requied Notifications *CC-XVI.V*	The health plan submits to the Agency: a. Within five (5) business days, any information on any officer, director, agent, manageing employee, or owner of stock or beneficial interest in excess of 5% of the health plan who has been found guilty of or enter a plea of nolo contendere or guilty to offenses listed in s. 435.03, F.S. b. Any officer, director, agent, manageing employee, or owner of stock or beneficial interest in excess of 5% of the health plan who has a record of illegal conduct according to the background check. c. To avoid termination, the health plan submits a corrective action plan to ensure that the person is divested of all interest and/or control and has no role in the operation and/or management of the health plan.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
56. Non-contracting with Health Plans whose Officials have Committed Offenses *CC-XVI.V*	The Agency will not contract with a health plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the health plan, who has committed any of the above listed offenses (see ss. 409.912 and 435.03, F.S.).	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Reference: 435.03 Level 1 screening standards

(1) All employees required by law to be screened shall be required to undergo background screening as a condition of employment and continued employment. For the purposes of this subsection, level 1 screenings shall include, but not be limited to, employment history checks and statewide criminal correspondence checks through the Florida

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Department of Law Enforcement, and may include local criminal records checks through local law enforcement agencies.

(2) Any person for whom employment screening is required by statute must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to abuse, neglect, or exploitation of a vulnerable adult.

(d) Section 782.04, relating to murder.

(e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, relating to vehicular homicide.

(g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(h) Section 784.011, relating to assault, if the victim of the offense was a minor.

(i) Section 784.021, relating to aggravated assault.

(j) Section 784.03, relating to battery, if the victim of the offense was a minor.

(k) Section 784.045, relating to aggravated battery.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 794.011, relating to sexual battery.

(o) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(p) Chapter 796, relating to prostitution.

(q) Section 798.02, relating to lewd and lascivious behavior.

(r) Chapter 800, relating to lewdness and indecent exposure.

(s) Section 806.01, relating to arson.

(t) Chapter 812, relating to theft, robbery, and related crimes, if the offense was a felony.

(u) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

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(v) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult. (w) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult. (x) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony. (y) Section 826.04, relating to incest. (z) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child. (aa) Section 827.04, relating to contributing to the delinquency or dependency of a child. (bb) Former s. 827.05, relating to negligent treatment of children. (cc) Section 827.071, relating to sexual performance by a child. (dd) Chapter 847, relating to obscene literature. (ee) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor. (ff) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct. (3) Standards must also ensure that the person: (a) For employees and employers licensed or registered pursuant to chapter 400 or chapter 429, and for employees and employers of developmental disabilities centers as defined in s. 393.063, intermediate care facilities for the developmentally disabled as defined in s. 400.960, and mental health treatment facilities as defined in s. 394.455, meets the requirements of this chapter. (b) Has not committed an act that constitutes domestic violence as defined in s. 741.28.					
57. Minority Recruitment and Retention *CC-XVI.W*	The health plan implements and maintains a minority recruitment and retention plan. a. The health plan has policies and procedures for the implementation and maintenance of such a plan. b. The minority recruitment and retention plan may be company-wide for all product lines.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
58. REFORM CAPITATED: Customized Benefit Package	The capitated health plan submits a customized benefit package (CBP). The CBP may vary the co-pays or the amount,	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐	☐ Met ☐ Partially Met ☐ Not Met		

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(CBP) *Exhibit 5*	duration and scope of the following services for non-pregnant adults: hospital outpatient not otherwise specified (NOS) and hospital outpatient physical, occupational, respiratory, and speech therapy services; and home health, dental, pharmacy, chiropractic, podiatry, vision, hearing and durable medical equipment as specified below. a. Amount, duration and scope may vary for durable medical supplies (DME) with the exception of any prosthetic/orthotic supply priced over $3,000 on the Medicaid fee schedule and except for motorized wheelchairs, which must be covered up to the Medicaid State Plan (State Plan) limit. b. Dialysis services, contraceptives, and chemotherapy-related medical and pharmaceutical services must be covered up to the State Plan limit. c. Hearing services for non-pregnant adults may vary in amount, duration and scope except for hearing aid services, which must be covered up to the State Plan limit. d. The health plan provides all medically necessary services up to the State Plan limit in accordance with the Medicaid Handbook requirements for pregnant women, children/adolescents, and enrollees with a HIV/AIDS diagnoses as identified by the Agency.	No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐ d. Yes ☐ No ☐ N/A ☐			

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59. REFORM CAPITATED: Approved CBPs *Exhibit 5*	Approved CBPs must comply with the benefit grid plan evaluation tool and instructions available from HSD. The Agency tests the health plan's CBP for actuarial equivalency and sufficiency of benefits, before approving the CBP. Actuarial equivalency is tested by using a benefit plan evaluation tool that: a. Compares the value of the level of benefits in the proposed package to the value of the current Medicaid State Plan package for the average member of the covered population. b. Ensures that the overall level of benefits is appropriate.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
60. REFORM CAPITATED: Sufficiency Testing the CBP *Exhibit 5*	Sufficiency is tested by comparing the proposed CBP to state-established standards. The standards are based on the covered population's historical use of Medicaid State Plan services. These standards are used to ensure that the proposed CBP is adequate to cover the needs of the vast majority of the enrollees.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
61. REFORM CAPITATED: Maximum Annual Dollar Value of the CBP *Exhibit 5*	If, in its CBP, the health plan limits a service to a maximum annual dollar value, the health plan must calculate the dollar value of the service using the Medicaid fee schedule.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
62. REFORM CAPITATED: Changing the CBPs	The CBPs may change on a Contract year basis and only if approved by the Agency in writing. The health plan submits to HSD its CBP for recertification of actuarial equivalency and	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

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Exhibit 5	sufficiency standards no later than June 15th of each year.				
63. REFORM CAPITATED: Exhaustion of Benefits Letters	The health plan incorporates a requirement into its policies and procedures stating that it will send letters of notification to enrollees regarding exhaustion of benefits for services restricted by unit amount if the amount is more restrictive than Medicaid for the following services: pharmacy; DME; hospital outpatient services not otherwise specified (NOS) and hospital outpatient physical, occupational, respiratory, and speech therapy services; hearing services; vision services; chiropractic; podiatry; and home health services. The health plan sends an exhaustion of benefits letter for any service restricted by a dollar amount. The health plan implements said letters upon the written approval of the Agency. The letters of notification include the following: a. A letter notifying an enrollee when he/she has reached fifty percent (50%) of any maximum annual dollar limit established by the health plan for a benefit. b. A follow-up letter notifying the enrollee when he/she has reached seventy-five (75%) of any maximum annual dollar limit established by the health plan for a benefit. c. A final letter notifying the enrollee that	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

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Exhibit 5	he/she has reached the maximum dollar limit established by the health plan for a benefit.				
64. Background Checks for Subcontractors *CC-XVI.O.1.d*	Subcontractors are subject to background checks. The health plan considers the nature of the work a subcontractor or agent will perform in determining the level and scope of the background checks.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
65. Subcontractor Compliance with HIPAA *CC-XVI.O.1.e*	The health plan documents compliance certification (business-to-business) testing of transaction compliance with HIPAA for any subcontractor receiving enrollee data.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
66. Health Plan Retaining Responsibility for the Contract *CC-XVI.O.1.f*	No subcontract that the health plan enters into with respect to performance under the Contract in any way relieves the health plan of any responsibility for the performance of duties under this Contract. a. The health plan assures that all tasks related to the subcontract are performed in accordance with the terms of this Contract and are provide BMHC with its monitoring schedule annually by December 1 of each Contract year. b. The health plan identifies in its subcontracts any aspect of service that may be further subcontracted by the subcontractor.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
67. Withdrawing Services from a County	If the health plan intends to withdraw services from a county, the health plan provides the Agency with one-hundred and twenty (120)	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-XVI.S	calendar days' notice and works with the Agency to develop a transition plan.				
68. Written Notice of Withdrawing Services from a County *CC-XVI.S*	The health plan provides written notice to all enrollees in that county at least sixty (60) calendar days before the last day of service. The health plan also provides written notice of the withdrawal to all providers and subcontractors in the county.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
69. Notice of Terminations *CC-XVI.Q.1*	The health plan agrees to extend the thirty (30) calendar-day notice found in the Standard Contract, Section III., Item B.1., Termination at Will, to one-hundred and twenty (120) calendar days' notice.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
70. Transition Planning *CC-XVI.Q.1*	The health plan works with the Agency to create a transition plan, including the orderly and reasonable transfer of enrollee care and progress whether or not they are hospitalized. Depending on the volume of health plan enrollees affected, the Agency may require an extension of the termination date.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
71. Termination Notice	The party initiating the termination renders written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination specifies the nature of	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-XVI.Q	termination, the extent to which performance of work under the Contract is terminated, and the date on which such termination becomes effective.				
72. Termination Hearings *CC-XVI.Q.1*	The Agency provides the health plan with an opportunity for a hearing prior to termination for cause. This does not preclude the Agency from terminating without cause.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
73. Receipt of Final Notice of Termination	Upon receipt of final notice of termination, on the date and to the extent specified in the notice of termination, the health plan: a. Continues work under the Contract until the termination date unless otherwise required by the Agency. b. Ceases enrollment of new enrollees under the Contract. c. Terminates all community outreach activities and subcontracts relating to community outreach. d. Assigns to the state those subcontracts as directed by the Agency's contracting officer including all the rights, title and interest of the health plan for performance of those subcontracts. e. In the event the Agency has terminated this Contract in one or more Agency areas of the state, completes the performance of this Contract in all other areas in which the health plan's Contract was not terminated.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐ d. Yes ☐ No ☐ N/A ☐ e. Yes ☐ No ☐ N/A ☐ f. Yes ☐ No ☐ N/A ☐ g. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XII: Administration and Management

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-XVI.Q.2.a-g	f. Takes such action as may be necessary, or as the Agency's contracting officer may direct, for the protection of property related to the Contract that is in the possession of the health plan and in which the Agency has been granted or may acquire an interest. g. Not accept any payment after the Contract ends, unless the payment is for the time period covered under the Contract. Any payments due under the terms of this Contract may be withheld until the Agency receives from the health plan all written and properly executed documents as required by the written instructions of the Agency.				
74. Written Notice of Termination for Enrollees *CC-XVI.Q.2.h*	At least sixty (60) calendar days before the termination effective date, provide written notification to all enrollees of the following information: The date on which the health plan will no longer participate in the state's Medicaid program and instructions on contacting the Agency's choice counselor/enrollment broker help line to obtain information on enrollment options and to request a change in health plans.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard XII Administration and Management	
Score	# Elements
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Community Outreach Events *CC-IV.B.1.a*	The health plan's community outreach representatives may provide community outreach materials at health fairs/public events as noticed by the health plan to the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Approval of Outreach Material *CC-IV.B.1.b*	For each new Contract period, the health plan submits to BMHC for written approval all community outreach material no later than 60 calendar days before the start of the next Contract period, and, for any changes in the community outreach material, no later than 30 calendar days before implementation.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Announcing Participation in Events *CC-IV.B.1.c*	To announce participation at a health fair/public event, the health plan submits a notice to BMHC.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. Plan to Control the Action of Outreach Representa-tives *CC-IV.B.1.d*	The health plan is responsible for developing and implementing a written plan designed to control the actions of its community outreach representatives.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
5. Application of Policies *CC-IV.B.1.e*	All community outreach policies apply to staff, subcontractors, health plan volunteers, and all persons acting for or on behalf of the health plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
6. Health Plan Liability for Violations *CC-IV.B.1.f*	The health plan is vicariously liable for any outreach and marketing violations of its employees, agents or subcontractors.	☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met		
7. Donating to or Sponsoring an Event *CC.VI.B.1.g*	Nothing precludes the health plan from donating to or sponsoring an event with a community organization where time, money or expertise is provided for the benefit of the community.	☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met		
8. Sponsoring Other Community Evemts *CC-IV.B.1.g*	If events are not health fairs/public events, no community outreach materials or marketing materials will be distributed by the health plan, but the health plan may engage in brand-awareness activities, including the display of health plan or product logos. Inquiries at such events from prospective enrollees are referred to the health plan's member services section or the Agency's choice counselor/enrollment broker.	☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met		
9. Prohibited: Marketing for Enrollment *CC-IV.B.2.a*	The health plan is prohibited from engaging in marketing for enrollment to any potential members or conducting any pre-enrollment activities not expressly allowed under the contract.	☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met		
10. Prohibited: Recruitment or Enrollment Activities *CC-IV.B.2.c*	The health plan is prohibited from engaging in activities not expressly allowed under this contract for the purpose of recruitment or enrollment.	☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
11. Prohibited: Discouraging Enrollment *ss. 409.912 and 409.91211, F. S.* *CC-IV.B.2.d*	The health plan is prohibited from engaging in practices that are discriminatory, including, but not limited to, attempts to discourage enrollment or re-enrollment on the basis of actual or perceived health status.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. Prohibited: Solicitation and Cold Calling *Section 4707 BBA* *s.409.912, F. S.* *CC-IV.B.2.e*	The health plan is prohibited from engaging in direct or indirect cold call marketing or other solicitation of Medicaid recipients, either door-to-door, telephone, or other means.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
13. Prohibited: Misleading or Confusing the Recipients	The health plan is prohibited from engaging in activities that could mislead or confuse Medicaid recipients or misrepresent the health plan, its community outreach representatives or the Agency. No fraudulent, misleading, or misrepresentative information is used in community outreach, including information about other government programs. Statements that could mislead or confuse include, but are not limited to, any assertion, statement or claim (whether written or oral) that: a. The Medicaid recipient must enroll in the health plan to obtain Medicaid or to avoid losing Medicaid benefits. b. The health plan is endorsed by any federal, state, or county government, the Agency, CMS, or any other organization that has not	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
s. 409.912, F. S. *CC-IV.B.2.f.1–5*	certified its endorsement in writing to the health plan. c. Community outreach representatives are employees or representatives of the federal, state, or county government, or of anyone other than the health plan or the organization by whom they are reimbursed. d. The state or county recommends that a Medicaid recipient enroll with the health plan. e. A Medicaid recipient will lose benefits under the Medicaid program or any other health or welfare benefits to which the person is legally entitled if the recipient does not enroll with the health plan.				
14. Prohibited: Offering Valuables *CC-IV.B.2.g*	The health plan is prohibited from engaging in granting or offering any monetary or other valuable consideration for enrollment.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
15. Prohibited: Offering Other Insurance *CC-IV.B.2.h*	The health plan is prohibited from engaging in offering insurance, such as but not limited to, accidental death, dismemberment, disability or life insurance.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
16. Prohibited: Enlisting Assistance from State Employees *CC-IV.B.2.i*	The health plan is prohibited from engaging in enlisting assistance of any employee, officer, elected official, or agency of the state in recruitment of Medicaid recipients except as authorized in writing by the Agency.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
17. Prohibited: Offering Financial Gain to Any Person *CC-IV.B.2.j*	The health plan is prohibited from engaging in offering material or financial gain to any persons soliciting, referring or otherwise facilitating Medicaid recipient enrollment.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
18. Prohibited: Marketing at State Offices *CC-IV.B.2.j*	The health plan ensures that its staff do not market the health plan to Medicaid recipients at any location including state offices or DCF ACCESS centers.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
19. Prohibited: Promotional Items Over $5.00 *CC-IV.B.2.k*	The health plan is prohibited from engaging in giving away promotional items in excess of $5.00 retail value. Items to be given away have the health plan's name and are given away only at health fairs/public events. In addition, such promotional items are offered to the general public and are not limited to Medicaid recipients.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
20. Prohibited: Offering Gifts or Jobs to Choice Counselors or Enrollment Brokers *CC-IV.B.2.l*	The health plan is prohibited from engaging in providing any gift, commission, or any form of compensation to the choice counselor/enrollment broker, including its full-time, part-time or temporary employees and subcontractors.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
21. Prohibited: Providing Information Before	The health plan is prohibited from engaging in providing information before enrollment about the incentives to be offered an enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Enrollment about Incentives *CC-IV.B.2.m*	The health plan may inform enrollees on or after their enrollment effective date about the specific incentives or programs available.				
22. Prohibited: Giving Potential Members Health-Plan Specific Information *CC-IV.B.2.n*	The health plan is prohibited from engaging in discussing, explaining or speaking to a potential member about health-plan specific information other than to refer all health plan inquiries to the member services section of the health plan or the Agency's choice counselor/enrollment broker.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
23. Prohibited: Distributing Material Without BMHC Approval *CC-IV.B.2.o*	The health plan is prohibited from engaging in distributing any community outreach materials without prior written notice to BMHC except as otherwise allowed under Permitted Activities and Provider Compliance subsections.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
24. Prohibited: Marketing Materials Not Mentioned in Contract *CC-IV.B.2.p*	The health plan is prohibited from engaging in distributing any marketing materials not expressly allowed under this Contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
25. Prohibited: Subcontracting with Independent Agents or Brokers Chapters 624-651 F. S. *CC-IV.B.2.q*	The health plan is prohibited from engaging in subcontracting with any brokerage firm or independent agent for purposes of marketing or community outreach.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
26. Prohibited: Paying Commission Related to Enrollment *CC-IV.B.2.r*	The health plan is prohibited from engaging in paying commission compensation to community outreach representatives for new enrollees. The payment of a bonus to a community outreach representative is not considered a commission if such bonus is not related to enrollment or membership growth.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
27. Prohibited: Activities Listed in s. 641.3909. F.S. s.641.3903, F. S. *CC-IV.B.2.s*	The health plan is prohibited from engaging in all activities included in: a. Misrepresentation and false advertising of health maintenance contracts. b. Providing false information or false advertising. c. Defamation. d. Making false statements and entries. e. Unfair claims settlement practices. f. Failure to maintain complaint-handling procedures. g. Operation without a subsisting certificate of authority. h. Misrepresnetation in HMO applications. i. Twisting. j. Illegal dealings in premiums and excess or reduced charges for HMO coverage. k. False claims and obtaining or retaining money dishonestly. l. Prohibited discriminatory practices. m. Misrepresentation concering the availability of HMO providers. n. Adverse actions against a provider.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐ g. Yes ☐ No ☐ h. Yes ☐ No ☐ i. Yes ☐ No ☐ j. Yes ☐ No ☐ k. Yes ☐ No ☐ l. Yes ☐ No ☐ m. Yes ☐ No ☐ n. Yes ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
		No ☐			
28. Permitted: Attending Health Fairs/ Public Events *CC-IV.B.3.a*	The health plan may engage in the following activities upon prior written notice to BMHC: The health plan may attend health fairs/public events upon request by the sponsor and after written notification to BMHC.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
29. Permitted: Leaving Outreach Materials at Health Fairs/ Public Events *CC-IV.B.3.b*	The health plan may engage in the following activities upon prior written notice to BMHC: The health plan may leave community outreach materials at health fairs/public events at which the health plan participates.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
30. Permitted: Providing Community Outreach Materials *CC-IV.B.3.c*	The health plan may engage in the following activities upon prior written notice to BMHC: The health plan can provide BMHC-approved community outreath materials. Such materials may include Medicaid enrollment and eligibility information and information related to other health care projects and health, welfare, and social services provided by the State of Florida or local communities. The health plan staff, including community outreach representatives, refers all health plan inquiries to the member services section of the health plan or the Agency's choice counselor/enrollment broker. BMHC approval of the script used by the health plan's member services section must be obtained before usage.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
31. Permitted: Distributing Outreach Materials to Community Agencies *CC-IV.B.3.d*	The health plan may engage in the following activities upon prior written notice to BMHC: The health plan may distribute community outreach materials to community agencies.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
32. Written Notice of Attending Events *CC-IV.B.4.a*	The health plan submits to BMHC a written notice of its intent to attend and provide community outreach materials at health fairs/public events.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
33. Requirements for Attending Events *CC-IV.B.4.a.1.a–f*	The Agency requires the following health fair/public event information: a. The event announcement to be given to the public. b. Date, time, and location of the event. c. Name and type of sponsoring organization. d. Event contact person and contact information. e. Health plan contact person and contact information. f. Names of participating community outreach representatives, their contact information and services they will provide at the event.	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
34. Complete Disclosure	If the health plan is the primary organizer of the event, the health plan submits in its community outreach health fairs/public events notification report to BMHC, complete disclosure information from each organization participating. Information includes the name of the	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-IV.B.4.a.2	organization, contact person information, and confirmation of participation.				
35. Letter of Invitation to Attend an Event *CC-IV.B.4.a.3*	If the health plan has been invited by a community organization to be a sponsor or attendee of an event, the health plan submits in its community outreach health fairs/public events notification report to BMHC, a copy of the letter of invitation from the event sponsor(s) requesting the health plan's participation.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
36. Community Outreach Health Fairs/ Public Events Notification *CC-IV.B.4.b*	The health plan reports health fair/public event notices to BMHC by submitting a community outreach health fairs/public events notification report by the 20th calendar day of the month prior to the event month. Amendments to the report are due no later than two weeks prior to the event.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
37. Attending Force Majeure Events *CC-IV.B.4.c*	The monthly and two-week advance notice requirements are waived in cases of force majeure provided the health plan notices BMHC by the time of the event. Force majeure events include destruction due to hurricanes, fires, war, riots, and other similar acts. When providing the Agency with notice of attendance at such events, the health plan includes a description of the force majeure event requiring waiver of notice.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
38. Provider Compliance: Displaying Material *CC-IV.B.5.a*	The health plan ensures, through provider education and outreach, that its health care providers are aware of and comply with the following: Health care providers may display health-plan-specific materials in their own offices.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
39. Provider Compliance: Comparing Health Plans *CC-IV.B.5.b*	The health plan ensures, through provider education and outreach, that its health care providers are aware of and comply with the following: Health care providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
40. Provider Compliance: Providing Patients a List of Health Plans *CC-IV.B.5.c*	The health plan ensures, through provider education and outreach, that its health care providers are aware of and comply with the following: Health care providers may announce a new affiliation with a health plan and give their patients a list of health plans with which they contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
41. Provider Compliance: Co-sponsoring Events *CC-IV.B.5.d*	The health plan ensures, through provider education and outreach, that its health care providers are aware of and comply with the following: Health care providers may co-sponsor events, such as health fairs, and advertise with the health plan in indirect ways such as television, radio, posters, fliers, and print advertisement.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
42. Provider Compliance: Cannot Provide a List of	The health plan ensures, through provider education and outreach, that its health care providers are aware of and comply with the following:	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Medicaid Patients or Participate in Plan Enrollment *CC-IV.B.5.e*	Health care providers will not furnish lists of their Medicaid patients to the health plan with which they contract, or any other entity, nor can providers furnish other health plans' membership lists to the health plan, nor can providers assist with health plan enrollment.				
43. Provider Compliance: Referring Inquiries to Choice Counselors or the Enrollment Broker *CC-IV.B.5.f*	The health plan ensures, through provider education and outreach, that its health care providers are aware of and comply with the following: For the health plan, health care providers may distribute information about non-health-plan-specific health care services and the provision of health, welfare, and social services by the State of Florida or local communities as long as any inquiries from prospective enrollees are referred to the member services section of the health plan or the Agency's choice counselor/enrollment broker and to the Department of Health, for clinical eligibility screening for children with chronic conditions.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
44. Registering Community Outreach Representa-tives	The health plan registers each community outreach representative that represents the health plan with BMHC . a. The health plan submits its registration file to BMHC and uses the Agency-supplied template. b. The health plan submits changes to the community outreach representative's initial	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIII: Community Outreach

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-IV.B.6.a	registration to BMHC and uses the Agency-supplied template.				
45. Identification at Events *CC-IV.B.6.b*	While attending health fairs/public events, community outreach representatives wear picture identification that shows the health plan represented.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
46. Inform Medicaid Recipients of Representing the Health Plan *CC-IV.B.6.c*	If asked, the community outreach representative informs the Medicaid recipient that the representative is not a state employee and is not a choice counseling specialist, but is a representative of the health plan, unless the representative is a Department of Health employee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
47. Training for Representatives *CC-IV.B.6.d*	The health plan instructs and provides initial and periodic training to its community outreach representatives about the outreach and marketing provisions of the contract.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
48. Background and Reference Checks *CC-IV.B.6.e*	The health plan implements procedures for background and reference checks for use in hiring community outreach representatives.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
49. Reporting Violations *CC-IV.B.6.f*	The health plan reports to BMHC any health plan staff or community outreach representative who violates any requirements of this contract within 15 calendar days of knowledge of such violation.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard XIII Community Outreach	
Score	# Elements
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard XIV: Covered Services

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Expanded Services: Drugs *CC-V.C.1.c*	The health plan may offer, upon written Agency approval, an over-the-counter expanded drug benefit, not to exceed $25.00 per household, per month. a. Such benefits are limited to nonprescription drugs containing a national drug code (NDC) number, first aid supplies and birth control supplies. b. Such benefits are offered directly through the health plan's fulfillment house or through a subcontractor. c. The health plan makes payments for the over-the-counter drug benefit directly to the subcontractor, if applicable.	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐ c. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Expanded Services: Adult Dental Services *CC-V.C.1.d*	Adult Dental Services may include routine preventive services, diagnostic and restorative services, radiology services and discounts on dental services.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
3. Covering Dental	For enrollees under age 21, the health plan covers: a. Diagnostic services, preventive treatment, CHCUP dental screening (including a direct referral to a dentist for enrollees beginning at 3 years of age or earlier as indicated); and restorative treatment, endodontic treatment,	a. Yes ☐ No ☐ N/A ☐ b. Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIV: Covered Services

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Exhibit 5	periodontal treatment, surgical procedures and/or extractions, orthodontic treatment, complete and partial dentures, complete and partial denture relines and repairs, and adjunctive and emergency services. b. Adult services include adult full and partial denture services and medically necessary emergency dental procedures to alleviate pain or infection; and emergency dental care is limited to emergency oral examinations, necessary x-rays, extractions, and incision and drainage of abscess.				
4. Expanded Services: Adult Vision Services *CC-V.C.1.e*	Adult Vision Services may include eye exams, eyeglasses and contact lenses.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
5. Expanded Services: Adult Hearing Services *CC-V.C.1.f*	Adult Hearing Services may include hearing evaluations, hearing aid devices and hearing aid repairs.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Excluded Services	The health plan consults the DCF office to identify appropriate methods of assessment and referral for enrollees requiring long-term care institutional services, institutional services for persons with developmental disabilities or state hospital services. The health plan is responsible for transition and referral of these enrollees to appropriate service	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CC-V.E.2	providers, including helping the enrollees obtain an attending physician; and the health plan disenrolls all enrollees requiring these services.				
7. Moral or Religious Objections *42 CFR 438.102* *CC-V.F*	The health plan provides or arranges for all covered services. If, during the course of the Contract period the health plan elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the health plan notifies: The Agency within one-hundred and twenty (120) calendar days before implementing the policy with respect to any service; and enrollees within thirty (30) calendar days before implementing the policy with respect to any service.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. NON-REFORM CAPITATED: Co-payments *Exhibit 5*	The health plan will not require a copayment or cost sharing for services listed in Attachment I or Attachment II, Section V, Covered Services, Item A., Covered Services, including optional services, and Attachment II, Section V, Covered Services, Item B., Optional Services, and Attachment II, Section V, Covered Services, Item C., Expanded Services. The health plan may not charge enrollees for missed appointments.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
9. Child Health Check-Up Program (CHCUP) *CC-V.H.2.a*	The health plan has a CHCUP that encompasses all federal requirements.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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10. Transportation for CHCUP *CC-V.H.2.f*	The health plan provides the following services: CHCUP If the health plan Contract covers transportation, the health plan offers transportation to enrollees in order to assist them to keep, and travel to, medical appointments. If the Contract does not cover transportation services, the health plan offers to help enrollees schedule transportation.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. Coordination and Training of Providers *CC-V.H.2.g*	The health plan provides the following services: CHCUP The CHCUP program includes the maintenance of a coordinated system to follow the enrollee through the entire range of screening and treatment, as well as supplying CHCUP training to medical care providers.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
12. CHCUP Screening Rates	The health plan achieves a CHCUP screening rate of at least sixty percent (60%) for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1 – September 30). a. This screening compliance rate is based on the CHCUP screening data reported by the health plan and due to the Agency by January 15 following the end of each federal fiscal year as specified in Attachment II, Section XII, Reporting Requirements. b. The data are monitored by the Agency for accuracy, and, if the health plan does not	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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s. 409.912, F.S. *CC-V.H.2.h*	achieve the sixty percent (60%) screening rate for the federal fiscal year reported, the health plan will file a corrective action plan (CAP) with the Agency no later than February 15, following the fiscal year reported.				
13. Participation Rate for CHCUP *CC-V.H.2.i*	The health plan adopts annual screening and participation goals to achieve at least an eighty percent (80%) CHCUP screening and participation rate, as required by the Centers for Medicare and Medicaid Services. For each federal fiscal year that the health plan does not meet the eighty percent (80%) screening and participation rate, it must file a CAP with the Agency no later than February 15 following the federal fiscal year being reported.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
14. Diabetes *s. 641.31, F.S.* *CC-V.H.6*	The health plan provides the following services: Diabetes. The health plan provides coverage for medically necessary equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services, if the enrollee's PCP, or the physician to whom the enrollee has been referred who specializes in treating diabetes, certifies that the equipment, supplies and services are medically necessary.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
15. Provisions Governing Emergency Services	The health plan advises all enrollees of the provisions governing emergency services and care. a. The health plan does not deny claims for	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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s. 743.064, F.S. *CC-V.H.7.a*	emergency services and care received at a hospital due to lack of parental consent. b. In addition, the health plan does not deny payment for treatment obtained when a representative of the health plan instructs the enrollee to seek emergency services and care.				
16. Emergency Services *CC-V.H.7.b*	The health plan does not: Require prior authorization for an enrollee to receive pre-hospital transport or treatment for emergency services and care; specify or imply that emergency services and care are covered by the health plan only if secured within a certain period of time; use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; nor does the plan deny payment based on a failure by the enrollee or the hospital to notify the health plan before, or within a certain period of time after, emergency services and care were given.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
17. Trauma Services *ss. 395.1041* *ss. 395.4045* *401.45, F.S.* *CC-V.H.7.c*	The health plan provides pre-hospital and hospital-based trauma services and emergency services and care to enrollees.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
18. Screenings for Emergency Treatment	When an enrollee presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists will be made, for the purposes of treatment, by a physician of the hospital or, to the extent	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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ss. 409.9128 409.901, F.S. 641.513, F.S. *CC-V.H.7.d*	permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. The physician, or the appropriate personnel, indicates on the enrollee's chart the results of all screenings, examinations and evaluations; and the health plan covers all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the enrollee's condition is an emergency medical condition.				
19. Emergency Services in a Non-contracted Hospital *42 CFR 438.114(b)* *CC-V.H.7.i*	The health plan covers any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as the health plan can safely transport the enrollee to a participating facility. The health plan may transfer the enrollee, in accordance with state and federal law, to a participating hospital that has the service capability to treat the enrollee's emergency medical condition; and the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified as responsible for coverage and payment.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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20. Post-stabilization Care *42 CFR 438.114 42 CFR 422.113(c) CC-V.H.7.k*	The health plan covers post-stabilization care services without authorization, regardless of whether the enrollee obtains a service within or outside the health plan's network for the following situations: Post-stabilization care services that were pre-approved by the health plan; post-stabilization care services that were not pre-approved by the health plan because the health plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request; the treating provider could not contact the health plan for pre-approval; and those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The health plan can choose not to cover them if they are provided by a non-participating provider, except in those circumstances detailed above.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
21. Payment of Emergency Claims to Non-participating Providers *CC-V.H.7.l*	The health plan does not deny claims for the provision of emergency services and care submitted by a nonparticipating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred and sixty-five (365) days.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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22. CAPITATED PLANS: Payment of Emergency Services *CC-V.H.7.m*	For capitated health plans, reimbursement for services provided to an enrollee under this section by a non-participating provider is the lesser of: The non-participating provider's charges; the usual and customary provider charges for similar services in the community where the services were provided; the amount mutually agreed to by the health plan and the non-participating provider within sixty (60) calendar days after the non-participating provider submits a claim; and the Florida Medicaid reimbursement rate established for the hospital or provider.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
23. Out of Plan Non-Emergency Services *CC-V.H.8*	The health plan provides timely approval or denial of authorization of out-of-network use through the assignment of a prior authorization number, which refers to and documents the approval. The health plan does not require paper authorization as a condition of receiving treatment if the health plan has an automated authorization system; and written follow-up documentation of the approval is provided to the out-of-network provider within one (1) business day from the request for approval.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
24. Using Non-Participating Providers	Unless otherwise specified in this Contract, where an enrollee uses non-emergency services available under the health plan from a non-participating provider, the health plan is not	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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Exhibit 5	liable for the cost of such services unless the health plan referred the enrollee to the non-participating provider or authorized the out-of-network service.				
25. Out-of-Network Emergency Services s. 409.912, F. S., *Exhibit 5 H. 8. c*	In accordance with s. 409.912, F. S., the health plan reimburses any hospital or physician that is outside the health plan's authorized service area for health-plan-authorized services at a rate negotiated with the hospital or physician or according to the lesser of the following: The usual and customary charge made to the general public by the hospital or provider; and the FL Medicaid reimbursement rate established for the hospital or provider.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
26. Paying Non-participating Providers s. 641.3155, F. S. *Exhibit 5*	The health plan reimburses all out-of-network providers as described in s. 641.3155, F. S.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Reference: 641.3155 Prompt payment of claims.--

(1) As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

(2) All claims for payment or overpayment, whether electronic or nonelectronic:

(a) Are considered received on the date the claim is received by the organization at its designated claims-receipt location or the date a claim for overpayment is received by

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the provider at its designated location.

(b) Must be mailed or electronically transferred to the primary organization within 6 months after the following have occurred:

1. Discharge for inpatient services or the date of service for outpatient services; and

2. The provider has been furnished with the correct name and address of the patient's health maintenance organization.

All claims for payment, whether electronic or nonelectronic, must be mailed or electronically transferred to the secondary organization within 90 days after final determination by the primary organization. A provider's claim is considered submitted on the date it is electronically transferred or mailed.

(c) Must not duplicate a claim previously submitted unless it is determined that the original claim was not received or is otherwise lost.

(3) For all electronically submitted claims, a health maintenance organization shall:

(a) Within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim.

(b) Within 20 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(c)1. Notification of the health maintenance organization's determination of a contested claim must be accompanied by an itemized list of additional information or documents the insurer can reasonably determine are necessary to process the claim.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Additional information is considered submitted on the date it is electronically transferred or mailed. The health maintenance organization may not request duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment shall be used to the greatest extent possible by the health maintenance organization and the provider.

(e) A claim must be paid or denied within 90 days after receipt of the claim. Failure to pay or deny a claim within 120 days after receipt of the claim creates an uncontestable

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obligation to pay the claim.

(4) For all nonelectronically submitted claims, a health maintenance organization shall:

(a) Effective November 1, 2003, provide acknowledgment of receipt of the claim within 15 days after receipt of the claim to the provider or designee or provide a provider or designee within 15 days after receipt with electronic access to the status of a submitted claim.

(b) Within 40 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health maintenance organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(c)1. Notification of the health maintenance organization's determination of a contested claim must be accompanied by an itemized list of additional information or documents the organization can reasonably determine are necessary to process the claim.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Additional information is considered submitted on the date it is electronically transferred or mailed. The health maintenance organization may not request duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payments shall be used to the greatest extent possible by the health maintenance organization and the provider.

(e) A claim must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny a claim within 140 days after receipt of the claim creates an uncontestable obligation to pay the claim.

(5) If a health maintenance organization determines that it has made an overpayment to a provider for services rendered to a subscriber, the health maintenance organization must make a claim for such overpayment to the provider's designated location. A health maintenance organization that makes a claim for overpayment to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. The health maintenance organization must identify the claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

(a) If an overpayment determination is the result of retroactive review or audit of coverage decisions or payment levels not related to fraud, a health maintenance organization shall adhere to the following procedures:

1. All claims for overpayment must be submitted to a provider within 30 months after the health maintenance organization's payment of the claim. A provider must pay, deny, or contest the health maintenance organization's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the

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claim.

2. A provider that denies or contests a health maintenance organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information. The notice is considered made on the date the notice is mailed or electronically transferred by the provider.

3. The health maintenance organization may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health maintenance organization's overpayment claim as required by this paragraph.

4. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment for a claim for an overpayment payment begins to accrue when the claim should have been paid, denied, or contested.

(b) A claim for overpayment shall not be permitted beyond 30 months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(6) **Payment of a claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest of 12 percent per year. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested. The interest is payable with the payment of the claim.**

(7)(a) For all contracts entered into or renewed on or after October 1, 2002, a health maintenance organization's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity must be finalized within 60 days after the receipt of the provider's request for review or appeal.

(b) All claims to a health maintenance organization begun after October 1, 2000, not under active review by a mediator, arbitrator, or third-party dispute entity, shall result in a final decision on the claim by the health maintenance organization by January 2, 2003, for the purpose of the statewide provider and health plan claim dispute resolution program pursuant to s. 408.7057.

(8) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber for payment of covered services for which the health

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maintenance organization contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to the health maintenance organization for payment of the services or internal dispute resolution process to determine whether the health maintenance organization is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health maintenance organization's internal dispute resolution process, not to exceed 60 days. This subsection does not prohibit collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

(9) The provisions of this section may not be waived, voided, or nullified by contract.

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility more than 1 year after the date of payment of the claim.

(11) A health maintenance organization shall pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to a subscriber if such services are determined by the health maintenance organization to be medically necessary and covered services under the health maintenance organization's contract with the contract holder.

(12) A permissible error ratio of 5 percent is established for health maintenance organizations' claims payment violations of paragraphs (3)(a), (b), (c), and (e) and (4)(a), (b), (c), and (e). If the error ratio of a particular insurer does not exceed the permissible error ratio of 5 percent for an audit period, no fine shall be assessed for the noted claims violations for the audit period. The error ratio shall be determined by dividing the number of claims with violations found on a statistically valid sample of claims for the audit period by the total number of claims in the sample. If the error ratio exceeds the permissible error ratio of 5 percent, a fine may be assessed according to s. 624.4211 for those claims payment violations which exceed the error ratio. Notwithstanding the provisions of this section, the office may fine a health maintenance organization for claims payment violations of paragraphs (3)(e) and (4)(e) which create an uncontestable obligation to pay the claim. The office shall not fine organizations for violations which the office determines were due to circumstances beyond the organization's control.

(13) This section shall apply to all claims or any portion of a claim submitted by a health maintenance organization subscriber under a health maintenance organization subscriber contract to the organization for payment.

(14) Notwithstanding paragraph (3)(b), where an electronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health maintenance organization, the pharmacy benefits manager shall, within 30 days of receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(15) Notwithstanding paragraph (4)(a), effective November 1, 2003, where a nonelectronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health maintenance organization, the pharmacy benefits manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the

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claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

(16) Notwithstanding the 30-month period provided in subsection (5), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. A claim for overpayment may not be permitted beyond 12 months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(17) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the health maintenance organization within 12 months after the health maintenance organization's payment of the claim. A claim for underpayment may not be permitted beyond 12 months after the health maintenance organization's payment of a claim.

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All Health Plans					
27. Family Planning Services	The health plan: • Provides family planning services to help enrollees make comprehensive and informed decisions about family size and/or spacing of births. • Provides the following services: planning and referral, education and counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care. • Furnishes family planning services on a voluntary and confidential basis. • Allows enrollees freedom of choice of family planning methods covered under the Medicaid program, including Medicaid-covered implants, where there are no medical contra-indications. • Renders the services to enrollees under the age of 18 provided the enrollee is married, a parent, pregnant, has written consent by a parent or legal guardian, or, in the opinion of a physician, the enrollee may suffer health hazards if the services are not provided. • Allows each enrollee to obtain family planning services from any provider and requires no prior authorization for	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CC-V.H.9. a–f	such services. • Makes available and encourages all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, including discussion of all appropriate methods of contraception, counseling and services for family planning to all women and their partners. • Directs providers to maintain documentation in the enrollee's medical records to reflect this provision • The provisions of this subsection are not to be interpreted so as to prevent a health care provider or other person from refusing to furnish any contraceptive or family planning service, supplies or information for medical or religious reasons. A health care provider or other person will not be held liable for such refusal.				
28. CAPITATED PLANS: Paying for Non-network Providers *CC-V.H. 9.d*	For capitated health plans, if the enrollee receives services from a non-network Medicaid provider, then the health plan reimburses at the Medicaid reimbursement rate, unless another payment rate is negotiated.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
29. Inpatient Hospital Services: TB and Renal	Inpatient services also include inpatient care for any diagnosis including tuberculosis and renal failure when provided by general acute	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CC-V.H.10.a.2	care hospitals in both emergent and non-emergent conditions.				
30. Inpatient Hospital Services: PT *CC-V.H.10.a.3*	The health plan will cover physical therapy (PT) services when medically necessary and when provided during an enrollee's inpatient stay.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
31. Inpatient Hospital Services: Deliveries	The health plan: • Provides for no less than a forty-eight (48) hour hospital length of stay following a normal vaginal delivery, and at least a ninety-six (96) hour hospital length of stay following a Cesarean section. In connection with coverage for maternity care, the hospital length of stay is required to be decided by the attending physician in consultation with the mother. • Prohibits denying the mother or newborn child eligibility, or continued eligibility, to enroll or renew coverage under the terms of the health plan, solely for the purpose of avoiding the Newborns and Mothers Health Protection Act (NMHPA) requirements. • Prohibits providing monetary payments or rebates to mothers to encourage them to accept less than the minimum protections available under NMHPA.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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Newborns and Mothers Health Protection Act (NMHPA) of 1996 *CC-V.H.10.a.7* *CC-V.H.10.a.8.a, b, c, d*	• Penalizing or otherwise reducing or limiting the reimbursement of an attending physician because the physician provided care in a manner consistent with NMHPA. • Prohibits providing incentives (monetary or otherwise) to an attending physician to induce the physician to provide care in a manner inconsistent with NMHPA. • Prohibits restricting any portion of the forty-eight (48) hour, or ninety-six (96) hour, period prescribed by NMHPA in a manner that is less favorable than the benefits provided for any preceding portion of the hospital stay.				
32. REFORM: Inpatient Hospital Services	In Reform, for all child/adolescent enrollees (up to age 21) and pregnant adults, the health plan is responsible for providing up to three-hundred and sixty-five (365) days of health-related inpatient care, including behavioral health (if behavioral health is covered by the health plan as specified in Attachment I), for each state fiscal year. For all non-pregnant adults in Reform, the health plan is responsible for up to forty-five (45) days of inpatient coverage and up to three-hundred and sixty-five (365) days of emergency inpatient care, including behavioral	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CC-V.H.10.a.10	health (if behavioral health is covered by the health plan as specified in Attachment I), in accordance with the Medicaid Hospital Services Coverage & Limitations Handbook, for each state fiscal year.				
33. NON- REFORM: Inpatient Hospital Services: 45 Days of Inpatient Coverage *CC-V.H.10.a.10*	For non-Reform populations, the health plan provides up to forty-five (45) days of inpatient coverage per enrollee, including behavioral health (if behavioral health is covered by the health plan as specified in Attachment I), for each state fiscal year.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
34. CAPITATED: Nursing Home Services vs. Inpatient Services *Exhibit 5*	The health plan may provide services in a nursing home as downward substitution for inpatient services. Such services are not counted as inpatient hospital days.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
35. REFORM CAPITATED PLANS: Transplants *CC-V.H.10.a.6* *CC-V.H.10.b.1*	For transplant services of the heart, liver, or lung, Reform capitated health plans are paid by the Agency through kick payments. (See Summary of Responsibility Table Section 5.H.10.a.6)	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
36. NON-REFORM: Transplants: Payments to Plans	Transplant services for non-reformed health plans of the heart, liver, or lung as well as pre- and post-transplant follow-up care, are covered through fee-for-service Medicaid and not by the health plan. All other transplants are paid by the health plan. If at the conclusion of the transplant evaluation the enrollee is listed with the United Network for Organ Sharing (UNOS) as a level 1A, 1B,	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIV: Covered Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC-V.H.10.a.6 *CC-V.H.10.b.2*	or 2 candidate for a heart or lung transplant, or with a Model End State Liver Disease (MELD) score of 11-25 for a liver transplant, the health plan submits a copy of the UNOS to BMHC requesting disenrollment for the member. The recipient cannot re-enroll with the health plan until at least 1 year post transplant. The re-enrollment is not automatic. (See Summary of Responsibility Table Section 5.H.10.a.6)				
37. Outpatient Services	Outpatient hospital services: • Consist of medically necessary preventive, diagnostic, therapeutic or palliative care under the direction of a physician or dentist at a licensed acute care hospital. • Include medically necessary emergency room services, dressings, splints, oxygen and physician-ordered services and supplies for the clinical treatment of a specific diagnosis or treatment. • Include emergency services and care without any specified dollar limitations. • Include a procedure for the authorization of dental care and associated ancillary medical services provided in an outpatient hospital setting if that care meets the following requirements: ➢ Is provided under the direction of	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIV: Covered Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC-V.H.11.a *CC-V.H.11.b.1-2*	a dentist at a licensed hospital. ➢ Although not usually considered medically necessary, is considered medically necessary to the extent that the outpatient hospital services must be provided in a hospital due to the enrollee's disability, behavioral health condition or abnormal behavior due to emotional instability or a developmental disability.				
38. CAPITATED PLANS: Providing Ancillary Hospital Services *CC-V.H.12.a.1*	When the capitated health plan or its authorized physician authorizes ancillary hospital services (either inpatient or outpatient), the health plan reimburses the provider of the service at the Medicaid line item rate, unless the health plan and the hospital have negotiated another reimbursement rate.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
39. Emergency Ancillary Hospital Services *CC-V.H.12.a.2* *CC-V.H.12.b*	The health plan authorizes payment for non-network physicians for emergency ancillary services provided in a hospital setting. If the health plan covers dental services, as specified in Attachment I, it has a procedure for the authorization of medically necessary dental care and associated ancillary services provided in licensed ambulatory surgical center settings if that care is provided under the direction of a dentist as described in the State Plan.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIV: Covered Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
40. Hysterectomies, Sterilizations, and Abortions *CC-V.H.13*	The health plan: • Maintains a log of all hysterectomy, sterilization and abortion procedures performed for its enrollees. The log includes, at a minimum, the enrollee's name and identifying information, date of procedure, and type of procedure. • Provides abortions only in the following situations: • If the pregnancy is a result of an act of rape or incest. • The physician certifies that the woman is in danger of death unless an abortion is performed.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
41. Quality Enhancements (QE)	The health plan: • Offers QEs in community settings accessible to enrollees. • Provides information in the enrollee and provider handbooks on the QEs and how to access related services. • The health plan develops and maintains written policies and procedures to implement QEs. • May co-sponsor the annual training of providers, provided that the training meets the provider training requirements for the programs. The health plan is encouraged to actively collaborate with community agencies and organizations, including CHDs, local Early Intervention Programs, Healthy Start Coalitions and local	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIV: Covered Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
	school districts in offering these services. • Involves the enrollee in an existing community program for purposes of meeting the QE requirement, the health plan ensures documentation in the enrollee's medical record of referrals to the community program and follow up on the enrollee's receipt of services from the community program. • Ensures that PCPs screen enrollees for signs of domestic violence and offers referral services to applicable domestic violence prevention community agencies. • Conducts regularly scheduled pregnancy prevention programs, or makes a good faith effort to involve enrollees in existing community pregnancy prevention programs, such as the Abstinence Education Program. The programs is targeted towards teen enrollees, but is open to all enrollees, regardless of age, gender, pregnancy status or parental consent. • Provides regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the health plan's prenatal and				

Standard XIV: Covered Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
	postpartum programs. The health plan coordinates its efforts with the local Healthy Start care coordinator to prevent duplication of services. • Conducts regularly scheduled smoking cessation programs as an option for all enrollees, or the health plan makes a good faith effort to involve enrollees in existing community smoking cessation programs. • Provides smoking cessation counseling to enrollees. • Provides participating PCPs with the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions. • Offers annual substance abuse screening training to its providers. • Has all PCPs screen enrollees for signs of substance abuse as part of prevention evaluation at the following times: ➢ Initial contact with a new enrollee. ➢ Routine physical examinations. ➢ Initial prenatal contact. ➢ When the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services. ➢ When documentation of emergency				

Standard XIV: Covered Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
CC-V.H.17.a–e *CC-V.H.17.f.2-5* *CC-V.H.17.f.6.a.i-v* *CC-V.H.17.b*	room visits suggests the need. • Offers targeted enrollees either community or health plan-sponsored substance abuse programs. • Provides regular general wellness programs targeted specifically toward enrollees from birth to age of five (5), or the health plan makes a good faith effort to involve enrollees in existing community children's programs. Children's programs promote increased use of prevention and early intervention services for at-risk enrollees. The health plan approves claims for services recommended by the Early Intervention Program when they are covered services and medically necessary; and the health plan offers annual training to providers that promotes proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.				
42. Protective Custody: Physical Screenings	The health plan provides: • A physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter or the foster care program by DCF. • These required examinations, or, if unable to do so within the required	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIV: Covered Services					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
65C-29.008, FAC. *CC-V.H.18.a-c*	time frames, approves the out-of-network claim and forwards it to the Agency and/or its fiscal agent. • Approves the claims and forwards them to the Agency and/or the fiscal agent for all CHCUP screenings for children/ adolescents whose enrollment and Medicaid eligibility are undetermined at the time of entry into the care and custody of DCF, and who are later determined to be enrollees at the time the examinations took place.				
43. Covered Therapy Services *CC-V.H.19*	Medicaid therapy services are physical, speech-language (including augmentative and alternative communication systems), occupational and respiratory therapies. a. The health plan covers therapy services consistent with the Medicaid Therapy Services Coverage and Limitations Handbook requirements; therapy services are limited to children/adolescents under age 21; and the provision of school-based therapy services to an enrollee does not replace, substitute or fulfill a service prescription or doctors' orders for therapy services covered by the health plan. . b. Adults are covered for physical and respiratory therapy services under the outpatient hospital services program.	a. Yes ☐ No ☐ b. Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XIV: Covered Services

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
44. Referrals for Additional Services *CC-V.H.19.a-c*	The health plan: • Refers enrollees to appropriate providers for further assessment and treatment of conditions. • Offers enrollees scheduling assistance in making treatment appointments and arranging transportation. • Provides for care management in order to follow the enrollee's progress from screening through the course of treatment.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
45. CMSSP ONLY: Prescribed Pediatric Extended Care (PPEC) Services s. 400.901-.917, F.S., Chapters 59A-13 and 59G-4.260, FAC *Exhibit 5*	PPEC services are provided at licensed non-residential facilities that serve three (3) or more children under the age of 21 who require medically necessary short- or long-term medical care due to medically complex conditions. Such services are designed to meet the child's physiological, developmental, nutritional, and social needs.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Results for Standard XIV Covered Services	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

FLORIDA MEDICAID

AGENCY FOR HEALTHCARE ADMINISTRATION
MANAGED CARE ORGANIZATIONS
Compliance Monitoring Tool with Specific Contract Standards

MCO Health Plan:_____ Contract Number:_____

Contract Manager:_____ Date(s) of Monitoring:_____

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
1. Immunization Schedule *CC-V.H.14.a–c*	The health plan: • Provides immunizations in accordance with the Recommended Childhood Immunization Schedule for the United States, or when medically necessary for the enrollee's health. • Provides for the simultaneous administration of all vaccines for which an enrollee under the age of 21 is eligible at the time of each visit. • Follows only contraindications established by the Advisory Committee on Immunization Practices (ACIP), unless: ➢ In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate ➢ The particular requirement is not in compliance with Florida law, including Florida law relating to religious or other exemptions.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
2. Vaccines for Children (VFC)	The health plan: • Participates, or directs its providers to participate, in the VFC Program. • Advises providers to bill Medicaid fee-for-service directly for immunizations provided to Title XXI MediKids participants. • Provides documentation annually by October	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-V.H.14.d–g	1 of each Contract year to BMHC that the health plan, or its participating providers, are enrolled in the VFC program. • Provides coverage and reimbursement to the participating provider for immunizations covered by Medicaid, but not provided through VFC. • Ensures that providers have a sufficient supply of vaccines if the health plan is enrolled in the VFC program. The health plan directs those providers that are directly enrolled in the VFC program to maintain adequate vaccine supplies.				
3. CAPITATED PLANS: Vaccine Administration Fee *CC-V.H.14.h*	The health plan will pay no more than the Medicaid program vaccine administration fee of $10 per administration, unless another rate is negotiated with the participating provider.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
4. CAPITATED PLANS: Paying the Vaccine Administration Fee	The health plan will pay the immunization administration fee at no less than the Medicaid rate when an enrollee receives immunizations from a non-participating provider so long as: • The non-participating provider contacts the health plan at the time of service delivery. • The health plan is unable to document to the non-participating provider that the enrollee has already received the immunization. • The non-participating provider submits a claim for the administration of immunization	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-V.H.14.i.1-3	services and provides medical records documenting the immunization to the health plan.				
5. Immunizations for Enrollees Requesting Temp. Cash Assistance *CC-V.H.14.j*	The health plan encourages PCPs to provide immunization information for enrollees requesting temporary cash assistance from DCF, upon request by DCF and receipt of the enrollee's written permission, in order to document that the enrollee has met the immunization requirements for enrollees receiving temporary cash assistance.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
6. Pregnancy-related Requirements: Prenatal Risk Screenings	The health plan provides the most appropriate and highest level of quality care for pregnant enrollees. Required care includes the following: *Florida's Healthy Start Prenatal Risk Screening:* The health plan ensures that the provider offers Florida's Healthy Start prenatal risk screening to each pregnant enrollee as part of her first prenatal visit. The health plan: • Ensures that the provider uses the DOH prenatal risk form (DH Form 3134), which can be obtained from the local CHD. • Ensures that the PCP maintains all documentation of Healthy Start screenings, assessments, findings and referrals in the enrollees' medical records. • Ensures that the provider submits the completed DH Form 3134 to the CHD in the county where the prenatal screen was	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
s. 383.14, F.S. *s. 381.004, F.S.* *64C-7.009, F.A.C.* *CC-V.H.15.a.1-4* *CC-V.H.15.i*	completed within ten (10) business days of completion of the screening. • Collaborates with the Healthy Start care coordinator within the enrollee's county of residence to assure delivery of risk-appropriate care.				
7. Pregnancy-related Requirements: Infant Risk Screenings *CC-V.H.15.b*	*Florida's Healthy Start Infant (Postnatal) Risk Screening Instrument:* The health plan ensures that the provider completes the Florida Healthy Start Infant (Postnatal) Risk Screening Instrument (DH Form 3135) with the Certificate of Live Birth and transmits the documents to the CHD in the county where the infant was born within ten (10) business days of the birth. The health plan ensures that the provider keeps a copy of the completed DH Form 3135 in the enrollee's medical record and provides a copy to the enrollee.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
8. Pregnancy-related Requirements: Healthy Start Risk Screenings	Pregnant enrollees or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways: • If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the enrollee or infant is invited to participate based on factors other than score. • If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-V.H.15.c.1-2	care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance abuse or domestic violence.				
9. Pregnancy-related Requirements: WIC Referrals *CC-V.H.15.d.1.a-c*	The health plan refers all infants, children up to age five (5), and pregnant, breast-feeding and postpartum women to the local WIC office. The health plan ensurs providers provide: • A completed Florida WIC program medical referral form with the current height or length and weight (taken within sixty [60] calendar days of the WIC appointment). • Hemoglobin or hematocrit. • Any identified medical/nutritional problems.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
10. Pregnancy-related Requirements: Coordinate the most recent CHCUP with WIC *CC-V.H.15.d.2-3*	For subsequent WIC certifications, the health plan ensures that providers coordinate with the local WIC office to provide the above referral data from the most recent CHCUP. Each time the provider completes a WIC referral form, the health plan ensures that the provider gives a copy of the form to the enrollee and keeps a copy in the enrollee's medical record.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
11. Pregnancy-related Requirements: HIV Testing and Counseling	The health plan ensures that providers give all women of childbearing age HIV counseling and offer them HIV testing. • The health plan ensures that its providers offer	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Chapter 381, F.S. *s. 384.31, F.S.* *64D-3.019, F.A.C.* *CC-V.H.15.e.1-3*	all pregnant women counseling and HIV testing at the initial prenatal care visit and again at twenty-eight (28) and thirty-two (32) weeks. • The health plan ensures that its providers attempt to obtain a signed objection if a pregnant woman declines an HIV test. • The health plan ensures that all pregnant women who are infected with HIV are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (Public Health Service Task Force Report entitled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States).				
12. Pregnancy-related Requirements: Hepatitis B Screenings	The health plan ensures that its providers screen all pregnant enrollees receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit. • The health plan ensures that the providers perform a second HBsAg test between twenty-eight (28) and thirty-two (32) weeks of pregnancy for all pregnant enrollees who tested negative at the first prenatal visit and are considered high-risk for Hepatitis B infection. This test is performed at the same time that other routine prenatal screenings are ordered.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-V.H.15.f.1-2	• All HBsAg-positive women are to be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.				
13. Pregnancy-related Requirements: HBIG and HepB Vaccines *CC-V.H.15.g.1-3*	The health plan ensures that infants born to HBsAg-positive enrollees receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable, preferably within twelve (12) hours of birth, and completes the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States. • The health plan ensures that its providers test infants born to HBsAg-positive enrollees for HBsAg and Hepatitis B surface antibodies (anti-HBs) six (6) months after the completion of the vaccine series to monitor the success or failure of the therapy. • The health plan ensures that providers report to the local CHD a positive HBsAg result in any child age 24 months or less within twenty-four (24) hours of receipt of the positive test results. • The health plan ensures that infants born to enrollees who are HBsAg-positive are referred to Healthy Start regardless of their Healthy Start screening score.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
14. Pregnancy-related Requirements:	The health plan reports to the Perinatal Hepatitis B Prevention Coordinator at the local CHD all prenatal or postpartum enrollees who test HBsAg-positive. The	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Testing Positive for Hepatitis B *CC-V.H.15.h.1-2*	health plan also reports said enrollees' infants and contacts to the Perinatal Hepatitis B Prevention Coordinator. • The health plan reports the following information: name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or estimated date of confinement, whether the enrollee received prenatal care, and immunization dates for infants and contacts. • The health plan uses the Perinatal Hepatitis B Case and Contact Report (DH Form 1876) for reporting purposes.				
15. Pregnancy-related Requirements: Health Plan Requirements to Monitor Prenatal Care	Prenatal Care: The health plan: • Requires a pregnancy test and a nursing assessment with referrals to a physician, PA or ARNP for comprehensive evaluation. • Requires case management through the gestational period according to the needs of the enrollee. • Requires any necessary referrals and follow-up. • Schedules return prenatal visits at least every four (4) weeks until week thirty-two (32), every two (2) weeks until week thirty-six (36), and every week thereafter until delivery, unless the enrollee's condition requires more frequent visits.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-V.H.15.j.1-7	• Contacts those enrollees who fail to keep their prenatal appointments as soon as possible, and arranges for their continued prenatal care. • Assists enrollees in making delivery arrangements, if necessary. • Ensures that all providers screen all pregnant enrollees for tobacco use and make certain that the providers make available to pregnant enrollees smoking cessation counseling and appropriate treatment as needed.				
16. Pregnancy-related Requirements: Nutritional Assessment/ Counseling *CC-V.H.15.k.1-4*	The health plan ensures that its providers supply nutritional assessment and counseling to all pregnant enrollees. The health plan: • Ensures the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes. • Offers a mid-level nutrition assessment. • Provides individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment. • Ensures documentation of the nutrition care plan in the medical record by the person providing counseling.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
17. Pregnancy-related Requirements: OB Deliveries	The health plan develops and uses generally accepted and approved protocols for both low-risk and high-risk deliveries reflecting the highest standards of the medical profession, including Healthy Start and prenatal screening, and ensure that all providers use these protocols.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-V.H.15.l.1-2	• The health plan ensures that all providers document preterm delivery risk assessments in the enrollee's medical record by week twenty-eight (28). • If the provider determines that the enrollee's pregnancy is high risk, the health plan ensures that the provider's obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and that the enrollee progresses through the final stages of labor and immediate postpartum care.				
18. Pregnancy-related Requirements: Newborn Care	The health plan makes certain that its providers supply the highest level of care for the newborn beginning immediately after birth. Such level of care includes, but is not limited to, the following: • Instilling of prophylactic eye medications into each eye of the newborn. • When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test. • Weighing and measuring of the newborn. • Inspecting the newborn for abnormalities and/or complications. • Administering one half (.5) milligram of vitamin K. • APGAR scoring. • Any other necessary and immediate need for referral in consultation from a specialty	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Chapter 468, F.S. Chapters 458 or 459, F.S. *CC-V.H.15.m.1-8*	physician, such as the Healthy Start (postnatal) infant screen. • Any necessary newborn and infant hearing screenings (to be conducted by a licensed audiologist pursuant to Chapter 468, F.S., a physician licensed under Chapters 458 or 459, F.S., or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or a licensed audiologist).				
19. Pregnancy-related Requirements: Postpartum Care *CC-V.H.15.n.1-3*	The health plan: • Provides a postpartum examination for the enrollee within six (6) weeks after delivery. • Ensures that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate. • Ensures that continuing care of the newborn is provided through the CHCUP program component.	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		
20. Prescribed Drugs	The health plan: • Provides those products and services associated with the dispensing of medicinal drugs pursuant to a valid prescription, as defined in Chapter 465, F.S. Prescribed drug services generally include all prescription drugs listed in the Agency's Preferred Drug List (PDL). • Has a PDL that includes at least two (2) products, when available, in each therapeutic	Yes ☐ No ☐	☐ Met ☐ Partially Met ☐ Not Met		

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CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Chapter 465, F.S. *s. 409.91195, F.S.* *CC-V.H.16.a* *CC-V.H.16.a.1–16.a.5*	class. • Makes available those drugs and dosage forms listed in its PDL. • Does not arbitrarily deny or reduce the amount, duration or scope of prescriptions solely based on the enrollee's diagnosis, type of illness or condition. • May place appropriate limits on prescriptions based on criteria such as medical necessity, or for the purpose of utilization control, provided the health plan reasonably expects said limits to achieve the purpose of the prescribed drug services set forth in the Medicaid State Plan. • Makes available those drugs not on its PDL, when requested and approved, if the drugs on the PDL have been used in a step therapy sequence or when other medical documentation is provided. • Submits an updated PDL to BMHC and the Bureau of Pharmacy Services by October 1 of each Contract year, and provides thirty (30) days' written notice of any changes. If the health plan adopts the Medicaid PDL, the health plan is exempt from such reporting. Antiretroviral agents are not subject to the PDL.				
21. Prescribed Drugs: PBA *CC-V.H.16.b*	The health plan may delegate any or all functions to one (1) or more pharmacy benefits administrators (PBA). Before entering into a subcontract, the health plan works with the Agency's fiscal agent.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
22. Prescribed Drugs: Functional Equivalents	The health plan: • Ensures that its enrollees are receiving the functional equivalent of those goods and services received by fee-for-service Medicaid recipients in accordance with the HSA. • Conducts annual HSA surveys of no less than five percent (5%) of all participating pharmacy locations to ensure compliance with the HSA. • May annually survey less than five percent (5%), with written approval from the Agency, if the health plan can show that the number of participating pharmacies it surveys is a statistically significant sample that adequately represents the pharmacies that have contracted with the health plan to provide pharmacy services. • Does not include in the annual HSA survey any participating pharmacy location that the health plan found to be in complete compliance with the HSA requirements within the past twelve (12) months. • Requires all participating pharmacy locations that fail any aspect of the annual HSA survey to undergo mandatory training within six (6) months and then be re-evaluated within one (1) month of the training to ensure that the pharmacy location is in compliance with the HSA. • Ensures that it complies with all aspects and surveying requirements set forth in Policy Transmittal 06-01, Hernandez Settlement	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
CC-V.H.16.f *CC-V.H.16.f.3* *CC-V.H.16.f.3.a* *CC-V.H.16.f.3.b* *CC-V.H.16.f.3.c* *CC-V.H.16.f.3.d* *CC-V.H.16.f.3.e* *CC-V.H.16.f.4*	Requirements. • Submits a report annually, by August 1 of each Contract year to BMHC, providing survey results. • Offers training to all new and existing participating pharmacy locations about the HSA requirements.				
23. Prescribed Drugs: Providing Brand-Name Drugs *s. 465.025, F.S.* *CC-V.H.16.g*	The health plan covers the cost of a brand-name drug if the prescriber: Writes in his/her own handwriting on the valid prescription that the "Brand Name is Medically Necessary;" and submits a completed "Multisource Drug and Miscellaneous Prior Authorization" form to the health plan indicating that the enrollee has had an adverse reaction to a generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
24. PSNs ONLY: Hemophilia Factor-Related Drugs *CC-V.H.16.h*	Hemophilia factor-related drugs identified by the Agency for distribution through the Comprehensive Hemophilia Disease Management Program are reimbursed on a fee-for-service basis. During operation of the Comprehensive Hemophilia Disease Management Program, the health plan coordinates the care of its enrollees with Agency-approved organizations and will not be responsible for the distribution of hemophilia-related drugs	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
25. Prescribed Drugs: HMOs-Hemophilia	For HMOs, hemophilia factor-related drugs are reimbursed by Medicaid on a fee-for-service basis. The HMO coordinates the care of its enrollees	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation

CONTRACT SECTION	CONTRACT REQUIREMENT	COMPLIANT	SCORING	DOCUMENTS REVIEWED	FINDINGS
Factor-related Drugs *CC-V.H.16.i*	with hemophilia and will not be responsible for the distribution of hemophilia factor-related drugs.				
26. CAPITATED PLANS: Transportation Services *CC-V.H. 20.a–20.c*	Transportation services • Transportation services include the arrangement and provision of an appropriate mode of transportation for enrollees to receive medical services. • If the health plan provides transportation, it may do so through its own network of transportation providers or through a contractual relationship, which may include the Commission for the Transportation Disadvantaged. • If the health plan does not provide transportation services, it must assist enrollees in arranging transportation to and from medical appointments for Medicaid-covered services.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
27. NON-REFORM PLANS not Covering Transportation: CTD Providers *Exhibit 5*	The health plan refers enrollees needing transportation to the Agency's contracted Commission for the Transportation Disadvantaged (CTD) provider in order to assist them to keep and travel to medical appointments.	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		
28. CMSSP ONLY: Insurance, Safety Requirements and Standards	Instead of the minimal liability insurance requirements specified for Reform health plans in this exhibit, the health plan, as a unit of state government operated by the Department of Health, Children's Medical Services, is insured under the state's Comprehensive Risk Management Program as set	Yes ☐ No ☐ N/A ☐	☐ Met ☐ Partially Met ☐ Not Met		

Standard XV: Immunizations, Pregnancy, Drugs & Transportation					
CONTRACT SECTION	**CONTRACT REQUIREMENT**	**COMPLIANT**	**SCORING**	**DOCUMENTS REVIEWED**	**FINDINGS**
Chapter 284, F.S *Exhibit 5*	forth in chapter 284, F.S. The health plan may act as a transportation provider, in which case it must follow all requirements set forth in the Medicaid Non-Emergency Transportation Services Coverage and Limitations Handbook. However, if the health plan subcontracts for transportation services, the health plan ensures the subcontractor's compliance with the minimum liability insurance requirement of $100,000 per person and $200,000 per incident for all transportation services purchased or provided for the transportation disadvantaged through the health plan. (See s. 768.28(5), F.S.)				

Results for Standard XV Immunizations, Pregnancy, Drugs & Transportation	
Score	**# Elements**
Met	
Partially Met	
Not Met	
Not Applicable	
Total # Elements	
Total # Applicable Elements	
Percent of Elements Met	

MCO Review Tools

March 2012

Agency for Health Care Administration

Agency For Health Care Administration
Managed Care Organizations
Administrative Staff File Review Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

		1	2	3	4	5	6
File #	**Title**	**Initials**	**License**	**Resume**	**Position Description**	**Training**	**Experience**
1	Contract Manager		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
2	Full-time Administrator		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
3	Medical Director		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
4	Medical Record Review Coordinator		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
5	Data Reporting & Processing Director		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
6	Community Outreach Coordinator		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
7	Utilization Management Director		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
8	Grievance System Coordinator		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
9	Compliance Officer		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
10	Claims/Encounter Manager		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
11	Behavioral Health Director		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
12	Medical/Professional Support Staff		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
13	Medical/Professional Support Staff		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
14	Medical/Professional Support Staff		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
15	Case Management		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
16	Case Management		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐

Agency For Health Care Administration
Managed Care Organizations
Administrative Staff File Review Tool

		1	2	3	4	5	6	7
File #	Title	Initials	License	Resume	Position Description	Job Duties	Training	Experience
17	Case Management		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
18	QI Professional		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
	# Applicable Files							
	# Compliant Files							
	Percent Compliant							

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

FLORIDA MEDICAID

Agency For Health Care Administration
Managed Care Organizations
Appeals File Review Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

		1	2	3	4	5	6	7
File #	Case ID #	Date Appeal Received	Standard or Expedited	Appeal Acknowledged in Writing	Assistance Given, if Requested (List type of assistance in comments)	Enrollee Given Chance to Present Evidence	Decision Maker Involved in Initial Determination*	Decision Maker Has Appropriate Clinical Expertise
1			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
2			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
3			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
4			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
5			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
6			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
7			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
8			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
9			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
10			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
11			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
12			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
13			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
14			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
15			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
16			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
17			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
18			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
19			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
20			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
21			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

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Managed Care Organizations
Appeals File Review Tool

		1	2	3	4	5	6	7
File #	Case ID #	Date Appeal Received	Standard or Expedited	Appeal Acknowledged in Writing	Assistance Given if Requested (List type of assistance in comments)	Enrollee Given Chance to Present Evidence	Decision Maker Involved in Initial Determination*	Decision Maker Had Appropriate Clinical Expertise
22			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
23			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
24			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
25			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
26			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
27			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
28			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
29			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
30			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	# Applicable Files							
	# Compliant Files							
	Percent Compliant							

* The compliant answer is “No” for element 6

		8	9	10	11	12	13	14	15
		Complete this section for all Appeals							
File #	Case ID #	Written Notice Includes Results and Date of Resolution	Written Notice Includes Enrollee's Right to a Fair Hearing	Written Notice Includes How to Request a Fair Hearing	Written Notice Includes SAP and BAP Information	Written Notice Includes Enrollee's Right to Continuance of Benefits	Written Notice Includes How to Request a Continuance of Benefits	Written Notice Includes Enrollee Liability for Cost of Continued Benefits if Plan's Action Upheld	Benefits Continued, if Applicable
1		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
2		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
3		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
4		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
5		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
6		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
7		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
8		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
9		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
10		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
11		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
12		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
13		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
14		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
15		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
16		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
17		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
18		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
19		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
20		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
21		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
22		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
23		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
24		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
25		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
26		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐

		8	9	10	11	12	13	14	15
		Complete this section for all Appeals							
File #	Case ID #	Written Notice Includes Results and Date of Resolution	Written Notice Includes Enrollee's Right to a Fair Hearing	Written Notice Includes How to Request a Fair Hearing	Written Notice Includes SAP and BAP Information	Written Notice Includes Enrollee's Right to Continuance of Benefits	Written Notice Includes How to Request a Continuance of Benefits	Written Notice Includes Enrollee Liability for Cost of Continued Benefits if Plan's Action Upheld	Benefits Continued if Applicable
28		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
29		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
30		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐
# Applicable Files									
# Compliant Files									
Percent Compliant									

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Managed Care Organizations
Appeals File Review Tool

		16	17	18	19	20	21	22	23	24
		Complete this Section for Standard Appeals				Complete this Section for Expedited Appeals				
File #	Case ID #	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved w/in 45 Days of Receipt or w/in 14 Days of Date of Extension	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Reasonable Effort Oral Notice	Written Resolution Notice w/in 72 Hours or w/in 14 Days of Date of Extension
1				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
2				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
3				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
4				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
5				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
6				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
7				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
8				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
9				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
10				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
11				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
12				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
13				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
14				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
15				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
16				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
17				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
18				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
19				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
20				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
21				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
22				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
23				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
24				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
25				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
26				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐

		16	17	18	19	20	21	22	23	24
		Complete this section for Standard Appeals				Complete this Section for Expedited Appeals				
File #	Case ID #	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Written Resolution Notice w/in 45 Days of Receipt or w/in 14 Days of Date of Extension	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Reasonable Effort Oral Notice	Written Resolution Notice w/in 72 Hours or w/in 14 Days of Date of Extension
27				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
28				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
29				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
30				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
# Applicable Elements										
# Compliant Elements										
Percent Compliant										

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

File #	Case ID #	Comments
1		
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FLORIDA MEDICAID

Agency For Health Care Administration
Managed Care Organizations
Child Health Check-Up Review Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	REQUIREMENTS FOR CHILD HEALTH CHECK-UP					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
1	Comprehensive health and developmental history including a. Past medical history	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. Developmental history	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	c. Behavioral health status	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
2	Nutritional assessment	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
3	Developmental assessment	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
4	Comprehensive unclothed physical examination	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
5	Dental screening	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	a. Dental referral, when required	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
6	Laboratory Tests	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	a. Blood lead testing, when required	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
7	Sensory screening: Vision	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	a. Sensory screening included objective vision test, when required	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
8	Sensory screening: Hearing	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	a. Sensory screening included objective hearing test, when required	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐

	REQUIREMENTS FOR CHILD HEALTH CHECK-UP					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
9	Appropriate immunizations	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
10	Health education/anticipatory guidance	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
11	Diagnosis and treatment	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
12	Referral and follow-up, as appropriate	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐

If a component was provided within 90 days before the Child Health Check-Up and the results were documented, the provider does not need to repeat the component. An exception should be made if the recipient's environment or medical condition indicates that the component should be repeated. Or if, based on medical discretion, a component has not been performed within approximately 90 days, but within reasonable time based on the recipient's age and with documentation of medically appropriate rationale, i.e., 2-year old participants in the Early Intervention Program. AHCA-Medicaid 2003

Total # Applicable Elements					
Total # Compliant Elements					
Total Percent Compliant					

FLORIDA MEDICAID

Agency For Health Care Administration
Managed Care Organizations
Case Management/Continuity of Care Review Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	REQUIREMENTS FOR CASE MANAGEMENT/CONTINUITY OF CARE					
	Requirement	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
1	Specialty Health Needs members received assistance with referral and scheduling	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
2	Case management monitoring of members with developmental services	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
3	For non-covered services, the member received assistance with referrals and appointments from Healthy Start	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
4	Child Health Check Up referral if member is more than 2 months behind in periodic screening	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
5	Children placed by the Department of Children and Family Services into protective custody, ER shelter, foster care with a 72-hour evaluation	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
6	WIC referral for pregnant, breast feeding and post partum women, infant children under 5 years of age	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
7	Provide referral for out-of-plan Exceptional Services	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
8	Case Management follow-up services for children with abnormal levels of lead	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
9	Pregnant members receiving CM through gestational period	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
10	HIV infected pregnant women are receiving counseling and are offered treatment	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
11	WIC referral for HIV-infected women, infants and children	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
12	Documentation of referral services in enrollee medical records, including reports resulting from the referral	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐

	REQUIREMENTS FOR CASE MANAGEMENT/CONTINUITY OF CARE					
	Requirement	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
13	Following diagnosis: Behavioral health, HIV-related, disease management, pregnancy or developmental/Specialty Healthcare Needs	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
14	Evidence of communication/coordination between case management PCP and patient/facility	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
15	Evidence of member receiving appropriate DME, supplies and services for diagnosis	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
16	Evidence of appropriate referrals scheduled and received	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
17	Evidence of appropriate out-of-plan referrals scheduled and received, if applicable	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
18	Case coordinator identified all special needs of the member	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
19	Evidence of timeliness of coordinated care	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
20	Evidence of follow up is documented	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
21	Non-compliance of member was identified and addressed	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
22	Linguistic/cultural barriers identified and addressed	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
23	Other barriers to health care provision for members were identified and addressed	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
24	Monitoring of enrollees with ongoing medical conditions and coordination of services for high utilizers to address the following, ensuring the enrollee has adequate support at home, assisting enrollees who are unable to access necessary care due to their medical or emotional conditions or who do not have adequate community resources to comply with their care, and assisting the enrollee in developing community resources to manage a medical condition.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐

Total # Applicable Elements					
Total # Compliant Elements					
Total Percent Compliant					

Agency For Health Care Administration
Managed Care Organizations
Physician Credentialing and Recredentialing File Review Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

File Number	1	2	3	4	5	6	7
Physician Initials							
1. An individual credentialing/recredentialing file is maintained for each physician.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
2. There is a completed credentialing/ recredentialing **application** signed and dated by the physician.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
3. There is primary source verification to validate that the physician has a valid Florida **medical license** pursuant to s. 641.495, F.S. that has not been revoked or suspended by the Division of Medical Quality Assurance, Department of Health	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
4. There is a **DEA** certificate included in the file, if applicable.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
5. There is evidence of primary source verification of the physician' **education and training** (also satisfied by verification of Board Certification) **for providers in initial credentialing**.	Y ☐ N ☐ **N/A** ☐	Y ☐ N ☐ **N/A** ☐	Y ☐ N ☐ **N/A** ☐	Y ☐ N ☐ **N/A** ☐	Y ☐ N ☐ **N/A** ☐	Y ☐ N ☐ **N/A** ☐	Y ☐ N ☐ **N/A** ☐
6. There is evidence of primary source verification of the physician's **Board Certification**.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
7. There is evidence of primary source verification of an **NPDB** query to validate the physician's professional liability **claims history**.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
8. There is evidence of the **Medicaid ID Number**, Medicaid provider registration number, or proof of submission of Medicaid registration form; or the provider is Medicaid eligible.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

File Number	1	2	3	4	5	6	7
Physician Initials							
9. If the physician is not currently enrolled in the Medicaid fee-for-service program: a. There is evidence of a **background check** with the Florida Department of Law Enforcement (FDLE); or b. The individual already was screened within the past 12 months by another FL agency or department. If so, the provider is not required to submit fingerprint cards, but there is documentation of the results of the previous screening in the physician's file.	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐
10. There is evidence of primary source verification of Medicaid/Medicare/State **sanctions.**	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

N/A ☐

11. The file contains a current curriculum vitae with at least 5 years of **work history for providers in initial credentialing.**	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
12. **Gaps in work history** of greater than 6 months are explained **for providers in initial credentialing.**	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
13. In a PCP's file, there is evidence of **hospital privileges** in good standing at the hospital designated as the primary admitting facility by the PCP, or there is evidence of an arrangement with another PCP for hospital coverage.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
14. There is an attestation that the total active **patient load** for all populations and all plans is no more than 3,000 patients per PCP. An *active patient* is one that is seen by the physician a minimum of 3 times per year.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
15. There is evidence of the physician's disclosure related to ownership and management and business transactions.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
16. For PCPs, there is evidence of the results from an office site visit .	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
17. The site visit includes an assessment of:							
a. Physical accessibility for persons with disabilities	a. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐	a. Y ☐ N ☐ N/A ☐
b. Adequate space, supplies, proper sanitation, smoke-free facilities c. Evidence of proper fire and safety procedures	b. Y ☐ N ☐ N/A ☐	b. Y ☐ N ☐ N/A ☐	b. Y ☐ N ☐ N/A ☐	b. Y ☐ N ☐ N/A ☐	b. Y ☐ N ☐ N/A ☐	b. Y ☐ N ☐ N/A ☐	b. Y ☐ N ☐ N/A ☐
d. Medical record keeping practices	c. Y ☐ N ☐ N/A ☐	c. Y ☐ N ☐ N/A ☐	c. Y ☐ N ☐ N/A ☐	c. Y ☐ N ☐ N/A ☐	c. Y ☐ N ☐ N/A ☐	c. Y ☐ N ☐ N/A ☐	c. Y ☐ N ☐ N/A ☐
e. Posting of the Agency's statewide consumer call center telephone number including the hours of operation in the waiting room/ reception area	d. Y ☐ N ☐	d .Y ☐ N ☐	d. Y ☐ N ☐	d. Y ☐ N ☐	d. Y ☐ N ☐	d. Y ☐ N ☐	d. Y ☐ N ☐

f. Posting of the Agency Summary of Florida's Patient's Bill of Rights and Responsibilities g. The availability of a copy of the Florid a Patient's Bill of Rights and Responsibilities for enrollee's who request a copy of the document.	N/A ☐ e. Y ☐ N ☐ N/A ☐ f. Y ☐ N ☐ N/A ☐ g. Y ☐ N ☐ N/A ☐	N/A ☐ e. Y ☐ N ☐ N/A ☐ f. Y ☐ N ☐ N/A ☐ g. Y ☐ N ☐ N/A ☐	N/A ☐ e. Y ☐ N ☐ N/A ☐ f. Y ☐ N ☐ N/A ☐ g. Y ☐ N ☐ N/A ☐	N/A ☐ e. Y ☐ N ☐ N/A ☐ f. Y ☐ N ☐ N/A ☐ g. Y ☐ N ☐ N/A ☐	N/A ☐ e. Y ☐ N ☐ N/A ☐ f. Y ☐ N ☐ N/A ☐ g. Y ☐ N ☐ N/A ☐	N/A ☐ e. Y ☐ N ☐ N/A ☐ f. Y ☐ N ☐ N/A ☐ g. Y ☐ N ☐ N/A ☐	N/A ☐ e. Y ☐ N ☐ N/A ☐ f. Y ☐ N ☐ N/A ☐ g. Y ☐ N ☐ N/A ☐
18. Verification occurs within 180 days of receipt of credentialing/recredentialing application.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
19. There is a signed and dated attestation statement concerning the correctness and completeness of the application.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
20. The attestation statement includes: a. Physical or mental problems that may impact the ability to provide mental health care; b. History of chemical dependency/substance abuse. c. History of loss of license and/or felony convictions. d. History of loss or restriction of privileges or disciplinary actions.	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐
21. There is evidence that a Medical Director or other qualified individual reviews and approves "clean" credentialing/recredentialing files.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
22. There is evidence that a peer review body reviews and approves/disapproves files not	Y ☐	Y ☐	Y ☐	Y ☐	Y ☐	Y ☐	Y ☐

meeting established thresholds.	N ☐ N/A ☐	N ☐ N/A ☐	N ☐ N/A ☐	N ☐ N/A ☐	N ☐ N/A ☐	N ☐ N/A ☐	N ☐ N/A ☐
23. There is evidence that recredentialing occurs at least every 36 months.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
24. There is evidence that the recredentialing process includes a review of complaints and results of QI activities.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

HEALTH PLAN NAME
Denials Record Review Tool

Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Staff Member:	

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision	Notice Sent per Requirement?	Date Notice Sent	Notice Sent per Requirement?	Notice Includes Reasons	Decision Made by Qualified Clinician	Comments
1					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
2					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
3					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
4					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
5					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
6					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
7					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
8					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
9					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
10					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
11					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
12					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
13					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
14					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
15					Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	
# Applicable Elements										**Total # Applicable Elements**
# Compliant Elements										**Total # Compliant Elements**
Percent Compliant										**Total Percent Compliant**

FLORIDA MEDICAID

Agency For Health Care Administration
Managed Care Organizations
Grievance File Review Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

		1	2	3	4	5	6	7
File #	Case ID #	Date Grievance Received	Standard or Expedited	Grievance Acknowledged in Writing	Assistance Given if Requested (List type of assistance in comments)	Enrollee Given Chance to Present Evidence	Decision Maker Involved in Initial Determination*	Decision Maker Has Appropriate Clinical Expertise
1			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
2			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
3			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
4			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
5			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
6			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
7			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
8			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
9			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
10			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
11			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
12			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
13			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
14			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
15			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
16			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
17			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
18			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
19			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

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Agency For Health Care Administration
Managed Care Organizations
Grievance File Review Tool

		1	2	3	4	5	6	7
File #	Case ID #	Date Grievance Received	Standard or Expedited	Grievance Acknowledged in Writing	Assistance Given if Requested (List type of assistance in comments)	Enrollee Given Chance to Present Evidence	Decision Maker Involved in Initial Determination*	Decision Maker Had Appropriate Clinical Expertise
20			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
21			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
22			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
23			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
24			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
25			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
26			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
27			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
28			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
29			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
30			S ☐ E ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	# Applicable Files							
	# Compliant Files							
	Percent Compliant							

* The compliant answer is “No” for element 6

		8	9	10	11
File #	Case ID #	Written Notice Includes Results and Date of Resolution	Written Notice Includes Enrollee's Right to a Fair Hearing	Written Notice Includes How to Request a Fair Hearing	Written Notice Includes SAP/BAP Information
1		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
2		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
3		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
4		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
5		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
6		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
7		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
8		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
9		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
10		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
11		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
12		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
13		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
14		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
15		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
16		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
17		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
18		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
19		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
20		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
21		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
22		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
23		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
24		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
25		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
26		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

Agency For Health Care Administration
Managed Care Organizations
Grievance File Review Tool

		8	9	10	11	
File #	Case ID #	Written Notice Includes Results and Date of Resolution	Written Notice Includes Enrollee's Right to a Fair Hearing	Written Notice Includes How to Request a Fair Hearing	Written Notice Includes SAP/BAP Information	
28		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
29		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
30		Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
# Applicable Files						
# Compliant Files						
Percent Compliant						

		12	13	14	15	16	17	18	19	20
		Complete this Section for Standard Grievances				Complete this Section for Expedited Grievances				
File #	Case ID #	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Written Resolution Notice w/in 90 Days of Receipt or w/in 14 Days of Date of Extension	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Reasonable Effort Oral Notice	Written Resolution Notice w/in 72 Hours or w/in 14 Days of Date of Extension
1				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
2				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
3				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
4				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
5				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
6				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
7				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
8				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
9				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
10				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
11				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
12				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
13				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
14				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
15				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
16				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
17				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
18				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
19				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
20				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
21				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
22				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
23				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
24				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
25				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐

		12	13	14	15	16	17	18	19	20
		Complete this section for Standard Grievances				Complete this Section for Expedited Grievances				
File #	Case ID #	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Written Resolution Notice w/in 45 Days of Receipt or w/in 14 Days of Date of Extension	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Reasonable Effort Oral Notice	Written Resolution Notice w/in 72 Hours or w/in 14 Days of Date of Extension
26				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
27				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
28				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
29				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
30				Y ☐ N ☐ N/A ☐	Y ☐ N ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐
# Applicable Elements										
# Compliant Elements										
Percent Compliant										

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

File #	Case ID #	Comments
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FLORIDA MEDICAID

Agency For Health Care Administration
Managed Care Organizations
Hernandez Settlement Agreement Log Checklist

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Date Log Received from Plan:	

	Hernandez Settlement Agreement Log					
Item Number	**Standard** **The HSA Log contains:**	**Found on the Log Q1**	**Found on the Log Q2**	**Found on the Log Q3**	**Found on the Log Q4**	**Comments**
1	The enrollee's name	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
2	The enrollee's address	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
3	The enrollee's telephone number	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
4	The reason for the denial	Y ☐ N ☐N/A ☐	Y ☐ N/A ☐	Y ☐ N/A ☐	Y ☐ N/A ☐	
5	The reason for the delay	Y ☐ N ☐N/A ☐	Y ☐ N/A ☐	Y ☐ N/A ☐	Y ☐ N/A ☐	
6	The termination of the prescription	Y ☐ N ☐N/A ☐	Y ☐ N/A ☐	Y ☐ N/A ☐	Y ☐ N/A ☐	
7	Name of pharmacy listed on the log	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
8	Store number of pharmacy listed on log	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	
9	The date of the call	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	

	Hernandez Settlement Agreement Log					
Item Number	Standard The HSA Log contains:	Found on the Log Q1	Found on the Log Q2	Found on the Log Q3	Found on the Log Q4	Comments
10	The explanation of the resolution	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
11	The name of the prescribed good/service	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	
12	Trends and patterns If the answer is Yes, explain in comments	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Hernandez Settlement Agreement Report Checklist

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Date Report Received from Plan:	

	Hernandez Settlement Agreement Report		
Item Number	**Standard**	**Answer to Standard**	**Comments**
	The HSA Report contains:		
1	Total number of participating pharmacy locations surveyed are entered on the form Enter number of pharmacies: _____	Y ☐ N ☐	
2	Process used to select the pharmacies is explained	Y ☐ N ☐	
3	HSA areas surveyed are listed Enter counties surveyed: _____	Y ☐ N ☐	
4	HSA delinquencies are noted on the form	Y ☐ N ☐ If NO, none of the answers for 6-15 should be checked	
5	If the prior question was answered YES, check the area where the HSA delinquencies are noted on the report. If delinquencies were found, the number of delinquencies needs to be completed to meet the element		
6	a. Rejection signs posted	☐ If checked, enter number of delinquencies _____	
7	b. Printed computer screen rejection distributed to recipient	☐ If checked, enter number of delinquencies _____	
8	c. Pamphlet distributed to recipient	☐ If checked, enter number of delinquencies _____	

	Hernandez Settlement Agreement Report		
Item Number	Standard	Answer to Standard	Comments
	The HSA Report contains:		
9	d. Ombudsman available	☐ If checked, enter number of delinquencies _____	
10	e. Toll-free number & voicemail	☐ If checked, enter number of delinquencies _____	
11	f. Two-way fax available _____	☐ If checked, enter number of delinquencies _____	
12	g. E-mail address available	☐ If checked, enter number of delinquencies _____	
13	h. Computer Link available	☐ If checked, enter number of delinquencies _____	
14	i. Non-English speaking personnel	☐ If checked, enter number of delinquencies _____	
15	j. Hearing impaired facilities available	☐ If checked, enter number of delinquencies _____	
16	Total number of delinquencies are completed on the report	Y ☐ N ☐ N/A ☐	
17	If delinquencies are noted, the schedule for the health plan's retraining and reevaluation are attached	Y ☐ N ☐ N/A ☐	
18	If delinquencies are noted, the date of the reevaluation is noted on the report	Y ☐ N ☐ N/A ☐	
19	The health plan submitted the HSA log with the report	Y ☐ N ☐	

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Medical Record Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Enrollee Identifier:	

	Medical Record Review Tool			
Item Number	**Contents of the Medical Record:**	**Found in Record**	**Reference**	**Comments**
1	Contains member identifying information: a. Name	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.a*	
	b. Member identification number	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.a*	
	c. Date of birth	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.a*	
	d. Sex	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.a*	
	e. Legal guardianship, if any	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.a*	
2.	Is legible and maintained in detail		*42 CFR 456* *CC-VII.J.1.b*	
3	Contains: a. A summary of significant surgical procedures	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.c*	
	b. Past and current diagnoses or problems	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.c*	
	c. Allergies	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.c*	
	d. Untoward reaction to drugs	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.c*	
	e. Current medications	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.c*	
4	Contains entries that are: a. Dated	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.d*	
	b. Signed by the appropriate party	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.d*	

Medical Record Review Tool				
Item Number	**Contents of the Medical Record:**	**Found in Record**	**Reference**	**Comments**
5	Contains: a. Entries that indicate a chief complaint or purpose of the visit	Y ☐ N ☐ Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.e*	
	b. Objective findings of the practitioner	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.e*	
	c. Diagnosis or medical impression	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.e*	
6	Contains entries that indicate: a. Studies ordered (lab, x-ray, etc.)	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.f*	
	b. Therapies administered and prescribed	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.g*	
7	Contains entries showing the name and profession of the provider rendering services, including the signature or initials of the provider.	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.h*	
8	Contains entries showing: a. Disposition	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
	b. Recommendations	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
	c. Instructions to the member	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
	d. Evidence of follow-up	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
	e. Outcomes of services	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
9	Contains an immunization history	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.j*	
10	Contains information relating to the member's use of tobacco products, alcohol or substance abuse	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.k*	
11	Contains summaries of all emergency care and hospital discharge summaries with appropriate medically indicated follow-up	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J1.l*	

	Medical Record Review Tool			
Item Number	Contents of the Medical Record:	Found in Record	Reference	Comments
12	Contains: a. Documented referrals	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.m*	
	b. Referral reports	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.f*	
13	Contains the primary language spoken by the member and any translation needs of the enrollee	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.o*	
14	Identifies members needing communication assistance in the delivery of health care services	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.p*	
15	Advanced Directives and: a. Contains documentation that the member was provided written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the member has executed an advance directive	Y ☐ N ☐ N/A ☐	*42 CFR 489.102* *CC-VII.J.1.q*	
	b. Contains copies of any Advanced Directives executed by the member	Y ☐ N ☐ N/A ☐	*42 CFR 489.102* *CC-VII.J.1.q*	
16	Contains services provided (i.e., family planning, preventive services, treatment of sexually transmitted diseases, etc.)	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.n*	
17	Sufficient documentation was provided for the file review	Y ☐ N ☐		

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

FLORIDA MEDICAID

Agency For Health Care Administration
Managed Care Organizations
Newborn Requirements

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	CONTRACT SECTION V.H.15 REQUIREMENTS FOR NEWBORN REVIEWS					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
1.	A copy of the completed Florida Healthy Start Infant (Postnatal) Risk Screening Instrument (DH Form 3135) was:					
	a. In the enrollee's medical record.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. Provided to the enrollee.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
2.	Infants who did not score high enough to be eligible for Healthy Start care coordination were referred for services, regardless of their score on the Healthy Start risk screen.	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	a. If the referral was made at the same time the Healthy Start risk screen was administered, the provider may have indicated on the risk screening form that the enrollee or infant is invited to participate based on factors other than score.	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	b. If the determination was made subsequent to risk screening, the provider may have referred the enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance abuse or domestic violence.	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
3.	At initial referral, the provider:					
	a. Completed Florida WIC program medical referral form with the current height or length and weight (taken within sixty [60] calendar days of the WIC appointment).	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	b. Completed a hemoglobin or hematocrit.	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	c. Identified any medical/nutritional problems.	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
4.	For subsequent WIC certifications, the provider coordinated with the					

	CONTRACT SECTION V.H.15 REQUIREMENTS FOR NEWBORN REVIEWS					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
	local WIC office to provide:					
	a. The current height or length and weight (taken within sixty [60] calendar days of the WIC appointment);	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	b. Hemoglobin or hematocrit.	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	c. Any identified medical/nutritional problems from the most recent CHCUP.	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
5.	Each time the provider completed a WIC referral form, the provider gave a copy of the form to the enrollee and kept a copy in the enrollee's medical record.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
6.	Infants born to HBsAg-positive enrollees completed the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
7.	The provider tested infants born to HBsAg-positive enrollees for HBsAg and Hepatitis B surface antibodies (anti-HBs) six (6) months after the completion of the vaccine series to monitor the success or failure of the therapy.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
8.	Reported to the local CHD a positive HBsAg result in any child age 24 months or less within twenty-four (24) hours of receipt of the positive test results.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
9.	Infants born to enrollees who were HBsAg-positive were referred to Healthy Start regardless of their Healthy Start screening score.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐

Agency For Health Care Administration
Managed Care Organizations
Online Provider Directory Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

Online Provider Directory Review Tool				
Item Number	**Standard**	**Found in Directory**	**Reference**	**Comments**
1	The health plan arranges the Provider Directory as follows: a. Providers are listed in alphabetical order, showing the provider's name and specialty. b. Providers are listed by specialty, in alphabetical order.	a. Y ☐ N ☐ b. Y ☐ N ☐	*CC-IV.A.7.f.1-2*	
	The online provider directory includes:			
2	Information relating to: a. The names of the providers b. The locations of the providers c. The office hours d. The telephone numbers e. The non-English languages spoken by the current health plan providers	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐ e. Y ☐ N ☐	*CC-IV.A.7.b*	
3	Information relating to: a. Primary Care Providers (PCPs) b. Specialists c. Pharmacies d. Hospitals e. Certified nurse midwives f. Licensed midwives g. Ancillary providers	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐ e. Y ☐ N ☐ f. Y ☐ N ☐ g. Y ☐ N ☐	*CC-IV.A.7.b*	
4	Identification of providers who are not accepting new patients.	Y ☐ N ☐	*CC-IV.A.7.b*	

	Online Provider Directory Review Tool			
Item Number	Standard	Found in Directory	Reference	Comments
5	Information concerning how to determine a provider's hospital affiliation	Y ☐ N ☐	*CC-IV.A.7.b*	
6	Pharmacy network requirements: a. If a health plan elects to use a more restrictive pharmacy network than the network available to people enrolled in the Medicaid fee-for-service program, the provider directory includes the names of the participating pharmacies. b. If all pharmacies are part of a chain and all within the health plan's service area are under contract with the health plan, the provider directory need list only the chain name.	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	*CC-IV.A.7.d*	
7	The provider directory includes a statement that some providers may choose not to perform certain services based on religious or moral beliefs.	Y ☐ N ☐	*CC-IV.A.7.e*	
8	The health plan provides: a. The most recently printed provider directory and appends to it a list of the providers who have left the network and those who have been added since the directory was printed. b. In lieu of the appendix, to the provider directory, the health plan may enclose a letter stating that the most current listing of providers is available by calling the health plan at its toll-free telephone number and the Internet address that will take the enrollee directly to the online provider directory.	a. Y ☐ N ☐ N/A ☐ a. Y ☐ N ☐ N/A ☐		
9	Have terminated provider on the health plan's Provider Termination and New Provider Notification Report been removed from the on-line provider directory?	Y ☐ N ☐		
10	Have new providers on the health plan's Provider Termination and New Provider Notification Report been added to the on-line provider directory?	Y ☐ N ☐		

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Pregnancy Related Requirements

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	CONTRACT SECTION V.H.15 REQUIREMENTS FOR PREGNANCY-RELATED REVIEWS					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
The health plan provides the most appropriate and highest level of quality care for pregnant enrollees.						
1.	Providers offer Florida's Healthy Start prenatal risk screening to pregnant enrollees during the first prenatal visit as required by s. 383.14, F.S., s. 381.004, F.S., and 64C-7.009, F.A.C.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	a. The provider used the DOH prenatal risk form (DH Form 3134)	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. The provider kept a copy of the completed screening instrument in the enrollee's medical record and provided a copy to the enrollee	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
2.	Pregnant enrollees who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:					
	a. If the referral was made at the same time the Healthy Start risk screen was administered, the provider indicated on the risk screening form that the enrollee was invited to participate based on factors other than score; or	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	b. If the determination was made subsequent to risk screening, the provider referred the enrollee directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, Substance abuse, or domestic violence	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
3.	The health plan referred all pregnant, breast-feeding and postpartum women to the local WIC office. Each time the provider completed a WIC referral form, the provider gave a copy to the enrollee and kept a copy in the enrollee's medical record	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐

	CONTRACT SECTION V.H.15 REQUIREMENTS FOR PREGNANCY-RELATED REVIEWS					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
4.	The health plan ensures that practitioners provided:					
	a. A completed Florida WIC program medical referral form with the current height or length and weight	Y ☐ N ☐	Y ☐ N ☐ ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. Hemoglobin or hematocrit	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	c. Any identified medical/nutritional problems	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
5.	The health plan:					
	a. Ensures that providers offered all pregnant women counseling and HIV testing at the initial prenatal care visit	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. Ensures that providers offered all pregnant women counseling and HIV testing at 28 weeks	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
	c. Ensures that providers offered all pregnant women counseling and HIV testing at 32 weeks	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
	d. Ensures that providers attempted to obtain a signed objection if a pregnant woman declined an HIV test (s. 384.31, F.S. and 64-D-3.019, F.A.C.)	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
	e. Ensures that all pregnant women who were infected with HIV were counseled about and offered the latest antiretroviral regime recommended by the USDHHS (Public Health Service Task Force Report: Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States)	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
6.	The health plan ensures that providers screened all pregnant enrollees receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
7.	The health plan ensures that providers performed a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant enrollees who tested negative at the first prenatal visit and were considered high-risk for Hepatitis B infection. This test was performed at the same time as other routine prenatal screenings.	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
8.	All HBsAg-positive women were reported to the local CHD and to Healthy Start, regardless of the Healthy Start screening score	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
9.	The health plan ensures that the PCP maintained all documentation of Healthy Start screenings, assessments, findings, and referrals in	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

	CONTRACT SECTION V.H.15 REQUIREMENTS FOR PREGNANCY-RELATED REVIEWS					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
	the enrollee's medical record					
10	The health plan required a pregnancy test and a nursing assessment with referrals to a physician, PA, or ARNP for comprehensive evaluation	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A
11	The health plan:					
12	a. Required case management through the gestations period according to the needs of the enrollee	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. Required any necessary referrals and follow-up	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	c. Scheduled return prenatal visits at least every four weeks until week 32, every two weeks until week 36, and every week thereafter until delivery, unless the enrollee's condition required more frequent visits	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	d. Contacted enrollees who failed to keep prenatal appointments as soon as possible, and arranged for continued prenatal care	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
	e. Assisted enrollees in making delivery arrangements, if necessary	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	f. Ensured that providers screened all pregnant enrollees for tobacco use and made available smoking cessation counseling and appropriate treatment as needed	Y ☐ N ☐	Y ☐ N ☐☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
13	Concerning nutritional assessment/counseling , the health plan:					
	a. Ensured that providers supplied nutritional assessment/counseling to all pregnant enrollees	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. Ensured the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	c. Offered a mid-level nutrition assessment	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	d. Provided individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or physician following the nutrition assessment	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	e. Ensured documentation of the nutrition care plan in the medical record by the person providing counseling	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

	CONTRACT SECTION V.H.15 REQUIREMENTS FOR PREGNANCY-RELATED REVIEWS					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
14	The health plan ensured that all providers document preterm delivery risk assessments in the enrollee's medical record by week 28	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
15	The health plan:					
	a. Provided a postpartum examination for the enrollees within 6 weeks after delivery	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	b. Reported to the Perinatal Hepatitis B Prevention Coordinator at the local CHD all postpartum enrollees who tested HBsAg-positive	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐
	c. Ensures that providers supplied voluntary family planning, including a discussion of all methods of contraception, as appropriate	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐	Y ☐ N ☐ N/A☐

Total # Applicable Elements					
Total # Compliant Elements					
Total Percent Compliant					

Agency For Health Care Administration
Managed Care Organizations
Printed Provider Directory Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

Item Number	Printed Provider Directory Review Tool Standard	Found in Directory	Reference	Comments
1	The health plan arranges the Provider Directory as follows: a. Providers are listed in alphabetical order, showing the provider's name and specialty. b. Providers are listed by specialty, in alphabetical order.	a. Y ☐ N ☐ b. Y ☐ N ☐	*CC-IV.A.7.f.1-2*	
	The provider directory includes:			
2	Information relating to: a. The names of the providers b. The locations of the providers c. The office hours d. The telephone numbers e. The non-English languages spoken by the current health plan providers	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐ e. Y ☐ N ☐	*CC-IV.A.7.b*	
3	Information relating to: a. Primary Care Providers (PCPs) b. Specialists c. Pharmacies d. Hospitals e. Certified nurse midwives f. Licensed midwives g. Ancillary providers	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐ e. Y ☐ N ☐ f. Y ☐ N ☐ g. Y ☐ N ☐	*CC-IV.A.7.b*	
4	Identification of providers who are not accepting new patients. The information concerning the providers not accepting new patients is available through the Customer Service Department.	Y ☐ N ☐ Y ☐ N ☐	*CC-IV.A.7.b*	

Printed Provider Directory Review Tool				
Item Number	Standard	Found in Directory	Reference	Comments
5	Information concerning how to determine a provider's hospital affiliation The information concerning the hospital affiliation of providers is available through the Customer Service Department.	Y ☐ N ☐ Y ☐ N ☐	*CC-IV.A.7.b*	
6	Pharmacy network requirements: a. If a health plan elects to use a more restrictive pharmacy network than the network available to people enrolled in the Medicaid fee-for-service program, the provider directory includes the names of the participating pharmacies. b. If all pharmacies are part of a chain and all within the health plan's service area are under contract with the health plan, the provider directory need list only the chain name.	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	*CC-IV.A.7.d*	
7	The provider directory includes a statement that some providers may choose not to perform certain services based on religious or moral beliefs.	Y ☐ N ☐	*CC-IV.A.7.e*	
8	The health plan provides: a. The most recently printed provider directory and appends to it a list of the providers who have left the network and those who have been added since the directory was printed. b. In lieu of the appendix, to the provider directory, the health plan may enclose a letter stating that the most current listing of providers is available by calling the health plan at its toll-free telephone number and the Internet address that will take the enrollee directly to the online provider directory.	a. Y ☐ N ☐ N/A ☐ a. Y ☐ N ☐ N/A ☐		

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

MCO Checklist

March 2012

Agency for Health Care Administration

FLORIDA MEDICAID

Agency For Health Care Administration
Managed Care Organizations
Child Health Check-Up Policy Checklist

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	REQUIREMENTS FOR CHILD HEALTH CHECK-UP					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
1	Comprehensive health and developmental history including:	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	a. Past medical history	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. Developmental history	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	c. Behavioral health status	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	d. Comprehensive unclothed physical examination	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	e. Developmental assessment	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	f. Nutritional assessment	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	g. Immunizations according to the Recommended Childhood Immunizations Schedule for the United States	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	h. Health education/anticipatory guidance	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	i. Dental screening	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	j. A direct referral to a dentist for enrollees beginning at age three or earlier as indicated	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
	k. Vision screening, including objective testing as required	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	l. Hearing screening included objective testing as required	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

	REQUIREMENTS FOR CHILD HEALTH CHECK-UP					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
	m. Diagnosis and treatment	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	n. Referral and follow-up, as appropriate	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
2	For children/adolescents whom the health plan identified through blood lead screenings as having abnormal levels of lead, the health plan provided case management follow-up services as required in Chapter Two of the Child Health Check-Up Services Coverage and Limitations Handbook. Screening for lead poisoning is a required component of the Contract					
	a. The health plan required all providers to screen all enrolled children for lead poisoning at ages 12 months and 24 months	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	b. Children between the ages of 12 months and 72 months received a screening blood lead test if there was no record of a previous test	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A
	c. The health plan provided additional diagnostic and treatment services determined to be medically necessary to a child/ adolescent diagnosed with an elevated blood lead level	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A
	d. The health plan recommended, but did not required, the use of paper filter tests as part of the lead screening requirement	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A	Y ☐ N ☐ N/A
3	The health plan informed enrollees of all testing/screenings due in accordance with the periodicity schedule specified in the Medicaid Child Health Check-Up Services Coverage and Limitations Handbook	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
4	The health plan contacted enrollees to encourages enrollees to obtain health assessments and preventive care	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
5	The health plan covered fluoride treatments by a physician or a dentist for children/adolescents even if the health plan does not provide dental coverage	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
6	If the health plan contract covers transportation, the health plan offers transportation to enrollees in order to assist them to keep, and travel to, medical appointments. If the contract does not cover transportation services, the health plan offered to help enrollees schedule transportation	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
7	The CHCU program included the maintenance of a coordinated system to follow the enrollees through the entire range of screening and treatment, as well as supplying CHCUP training to medical care	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

	REQUIREMENTS FOR CHILD HEALTH CHECK-UP					
	Required Components	**File #1**	**File #2**	**File #3**	**File #4**	**File #5**
	providers					
8	The health plan achieved a CHCUP screening rate of at least sixty percent (60%) for those enrollees who were continuously enrolled for at least eight months during the federal fiscal years (October 1–September 30).	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
	a. *This screening compliance rate is based on the CHCUP screening data reported by the health plan and due to the Agency by January 15 following the end of each federal fiscal years as specified in Attachment II, Section XII, Reporting Requirements.*					
	b. The data is monitored by the Agency for accuracy, and if the health plan does not achieve the 60% screening rate for the federal fiscal year reported, the health plan will file a corrective action plan (CAP) with the Agency no later than February 15, following the fiscal year report.					
	c. The health plan adopted annual screening and participation goals to achieve at least an 80% CHCUP screening and participation rates, as required by the Centers for Medicare and Medicaid Services. For each federal fiscal year that the health plan does not meet the 80% screening and participation rates, it must file a CAP with the Agency no later than February 15 following the federal fiscal year being reported. Any data reported by the health plan that is found to be inaccurate will be disallowed by the Agency, and the Agency will considers such findings as being in violation of the Contract and may sanction the health plan accordingly. (See s. 1902(a)(43)(D)(iv) of the Social Security Act)					

Total # Applicable Elements					
Total # Compliant Elements					
Total Percent Compliant					

Agency For Health Care Administration
Managed Care Organizations
Cultural Competency Plan Review Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

CULTURAL COMPETENCY PLAN				
File #	**Title**	**Yes or No**	**Reference**	**Comments**
1	The Cultural Competency Plan (CCP) is updated annually and submitted to BMHC by October 1.	Y ☐ N ☐	*42 CFR 438.206* *CC-VIII.A.4.a.*	
2	The CCP includes a mission statement which defines the purpose and rationale for implementing a CCP (statement to include the Plan's values and principles).	Y ☐ N ☐		
3	The CCP describes how providers will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of individual enrollees and protects and preserves the dignity of each.	Y ☐ N ☐	*CC-VIII.A.4.a.*	
4	The CCP describes how health plan employees effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of individual enrollees and protects and preserves the dignity of each.	Y ☐ N ☐	*CC-VIII.A.4.a.*	
5	The CCP describes how health plan systems effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of individual enrollees and protects and preserves the dignity of each.	Y ☐ N ☐	*CC-VIII.A.4.a.*	
6	If the health plan distributes a summary of the CCP to network providers, the summary includes information on how the provider may access the full CCP on the website. The summary also details how the provider can request a hard copy of the CCP from the health plan at no charge to the provider.	Y ☐ N ☐ N/A ☐	*42 CFR 438.206* *CC-VIII.A.4.b.*	

CULTURAL COMPETENCY PLAN				
File #	**Title**	**Yes or No**	**Reference**	**Comments**
7	The CCP includes a description of the evaluation, its results, the analysis of the results and interventions to be implemented are described in the annual CCP submitted to the Agency.	Y ☐ N ☐	*42 CFR 438.206 CC-VIII.A.4.c.*	
8	The CCP states how the HMO plans to track and trend any issues identified in the evaluation and lists interventions to be implemented for improvement in the provision of services.	Y ☐ N ☐	*42 CFR 438.206 CC-VIII.A.4.c.*	
9	The CCP includes an annual evaluation of the effectiveness of the CCP. The evaluation may include results from the CAHPS or other comparative member satisfaction surveys, outcomes for certain cultural groups, member grievances, member appeals, provider feedback and health plan employee surveys.	Y ☐ N ☐	*42 CFR 438.206 CC-VIII.A.4.c.*	

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Enrollee Handbook Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	Enrollee Handbook Review Tool			
Item Number	**Standard**	**Found in Handbook**	**Reference**	**Comments**
	The enrollee handbook contains:			
1	Table of Contents	Y ☐ N ☐	*CC-IV.A.6.a.1*	
2	Terms, conditions, and procedures for enrollment including the reinstatement process and enrollee rights and protections.	Y ☐ N ☐	*CC-IV.A.6.a.2*	
3	A description of the 90-day change period and the open enrollment process.	Y ☐ N ☐	*CC-IV.A.6.a.3*	
4	Information about how to change PCPs.	Y ☐ N ☐	*CC-IV.A.6.a.4*	
5	Description of services provided, including: a. Limitations and general restrictions on provider access b. Exclusions c. Out-of-network use d. Any restrictions on enrollee freedom of choice among network providers	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	*CC-IV.A.6.a.5*	
6	Procedures for obtaining required services including: a. Second opinions b. Authorization requirements c. Services available without prior authorization	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐	*CC-IV.A.6.a.6*	
7	Information regarding newborn enrollment, including the mother's responsibility to notify the health plan and DCF of the pregnancy and the newborn's birth.	Y ☐ N ☐	*CC-IV.A.6.a.7*	
8	Information concerning how to select the newborn's PCP.	Y ☐ N ☐	*CC-IV.A.6.a.8*	

Enrollee Handbook Review Tool				
Item Number	Standard **The enrollee handbook contains:**	Found in Handbook	Reference	Comments
9	Emergency services and procedures for obtaining services both in and out of the health plan's service area including: a. An explanation that prior authorization is not required for emergency or post-stabilization services b. Locations of emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization care services c. Use of 911 or its local equivalent d. Post-stabilization requirements	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	*42 CFR 422.133(c)* *CC-IV.A.6.a.1*	
10	The extent to which, and how, after-hours and emergency coverage is provided, and that the enrollee has the right to use any hospital or other setting for emergency care.	Y ☐ N ☐	*CC-IV.A.6.a.10*	
11	Information concerning the: a. Extent to which and how enrollees may obtain services from out-of-network providers b. Right to obtain family planning services from any participating Medicaid provider without prior authorization	a. Y ☐ N ☐ b. Y ☐ N ☐	*42 CFR 438.100* *CC-IV.A.6.a.11*	
12	Information about the Subscriber Assistance Program (SAP, for HMOs only) and the Beneficiary Assistance Program (BAP, for PSNs only), and the Medicaid Fair Hearing Process, including an explanation that a review by the SAP must be requested within 1 year after the date of the occurrence that initiated the appeal, how to initiate a review by the SAP and the SAP address and telephone number: Agency for Health Care Administration SAP/BAP Building 1, MS #26, 2727 Mahan Drive Tallahassee, FL 32308 (805) 921-5458 or (888) 419-3456 (toll free)	Y ☐ N ☐	*CC-IV.A.6.a.12*	
13	Clear specifications about the grievance process including: a. Address. b. Telephone number. c. Office hours of the grievance staff	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	*CC-IV.A.6.a.13*	

	Enrollee Handbook Review Tool			
Item Number	**Standard**	**Found in Handbook**	**Reference**	**Comments**
	The enrollee handbook contains:			
14	Information that services will continue upon appeal of a denied authorization and that the enrollee may have to pay in case of an adverse ruling.	Y ☐ N ☐	*CC-IV.A.6.a.14*	
15	The enrollee handbooks include enrollee rights and procedures for enrollment including the toll-free telephone number for the Agency's contracted choice counselor/enrollment broker. The following language (verbatim) is in the handbook: <u>*Enrollment:*</u> *If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in (INSERT HEALTH PLAN NAME) or the state enrolls you in a plan, you will have 90 days from the date of your first enrollment to try the health plan. During the first 90 days you can change health plans for any reason. After the 90 days, if you are still eligible for Medicaid, you will be enrolled in the plan for the next nine months. This is called "lock-in."*	Y ☐ N ☐	*CC-IV.A.6.a.15*	
16	The enrollee handbooks include the following language verbatim: <u>*Open Enrollment:*</u> *If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called "open enrollment." You do not have to change health plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next 12 months. Every year you can change health plans during your 60-day open enrollment period.*	Y ☐ N ☐	*CC-IV.A.6.a.15*	
17	Enrollee rights and procedures for enrollment including the toll-free telephone number for the Agency's contracted choice counselor/ enrollment broker.	Y ☐ N ☐	*42CFR438.56(d)(2)* *CC-IV.A.6.a.16*	
18	The following language (verbatim): <u>*Disenrollment:*</u>	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	*42 CFR 438.56(d)(2)* *CC-IV.A.6.a.16* *CC-III.4.C.3.a*	

	Enrollee Handbook Review Tool			
Item Number	Standard	Found in Handbook	Reference	Comments
	The enrollee handbook contains:			
	If you are a mandatory enrollee and you want to change plans after the initial 90 day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change health plans. *The following are state-approved cause reasons to change health plans:* *a. The enrollee moves out of the county, or the enrollee's address is incorrect and the enrollee does not live in a county where the health plan is authorized to provide services.* *b. The provider is no longer with the health plan.* *c. The enrollee is excluded from enrollment.* *d. A substantiated marketing or community outreach violation has occurred.* *e. The enrollee is prevented from participating in the development of his/her treatment plan.* *f. The enrollee has an active relationship with a provider who is not on the health plan's panel, but is on the panel of another health plan.* *g. The enrollee is in the wrong health plan as determined by the Agency.* *h. The health plan no longer participates in the county.* *i. The state has imposed immediate sanctions upon the health plan as specified in 42 CFR 438.702(a)(3).* *j. The enrollee needs related services to be performed concurrently, but not all related services are available within the health plan network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.* *k. The health plan does not, because of moral or religious objections, cover the service the enrollee seeks.* *l. The enrollee missed open enrollment due to a temporary loss of eligibility, defined as 60 days or less for non-Reform populations and 180 days or less for Reform populations.* *m. Poor quality of care.* *n. Lack of access to services covered under the contract.* *o. Inordinate or inappropriate changes of PCPs.* *p. Service access impairments due to significant changes in the*	e. Y ☐ N ☐ f. Y ☐ N ☐ g. Y ☐ N ☐ h. Y ☐ N ☐ i. Y ☐ N ☐ j. Y ☐ N ☐ k. Y ☐ N ☐ l. Y ☐ N ☐ m. Y ☐ N ☐ n. Y ☐ N ☐ o. Y ☐ N ☐ p. Y ☐ N ☐ q. Y ☐ N ☐ r. Y ☐ N ☐		

Item Number	Enrollee Handbook Review Tool Standard The enrollee handbook contains:	Found in Handbook	Reference	Comments
	geographic location of services. *q. Lack of access to providers experienced in dealing with the enrollee's health care needs.* *r. Fraudulent enrollment.*			
19	The following statement (verbatim) in the disenrollment section of the handbook: *Some Medicaid recipients can change health plans whenever they choose, for any reason. For example, people who are eligible for both Medicaid and Medicare benefits and children who receive SSI benefits can change plans at any time for any reason. To find out if you can change plans, call the (INSERT EITHER "CHOICE COUNSELOR" OR "ENROLLMENT BROKER" AND APPROPRIATE TELEPHONE NUMBER).*	Y ☐ N ☐	*CC-IV.A.6.a.1*	
20	Information that interpretation services and alternative communication systems are available, free of charge, including for all foreign languages and vision and hearing impairment, and how to access these services.	Y ☐ N ☐	*CC-IV.A.6.a.17*	
21	Information regarding health care Advance Directives. The health plan provides policies and procedures for Advance Directives to all enrollee's age 18 and older and advises enrollees of: a. Their rights under state law, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. b. The health plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.	a. Y ☐ N ☐ b. Y ☐ N ☐	*42 CFR 438.6(i)(1-2)* *42 CFR 422.128* *76.309 F.S.* *CC-IV.A.6.a.18.a*	
22	Information regarding health care Advance Directives. The information about advance directives includes a description of state law and must reflect changes in state law as soon as possible, but no later than 90 calendar days after the effective change.	Y ☐ N ☐	*42 CFR 438.6(i)(1-2)* *42 CFR 422.128* *765 F.S.* *CC-IV.A.6.a.18.b*	

Enrollee Handbook Review Tool				
Item Number	Standard The enrollee handbook contains:	Found in Handbook	Reference	Comments
23	Information regarding health care Advance Directives. The health plan's information informs enrollees that complaints about non-compliance with advance directive laws and regulations may be filed with the state's complaint hotline.	Y ☐ N ☐	*42 CFR 438.6(i)(1-2)* *42 CFR 422.128* *76.309 F.S.* *CC-IV.A.6.a.18.c*	
24	Information regarding health care Advance Directives: a. The health plan educates enrollees about the enrollees' ability to direct their care using this mechanism. b. The health plan specifically designates which staff and/or network providers are responsible for providing Advance Directive education.	a. Y ☐ N ☐ b. Y ☐ N ☐	*42 CFR 438.6(i)(1-2)* *42 CFR 422.128* *765 F.S.* *CC-IV.A.6.a.18.d*	
25	Information about cost sharing for the enrollee, if any.	Y ☐ N ☐ N/A ☐	*CC-IV.A.6.a.19*	
26	Information about how and where to access any benefits that are available under the Medicaid State Plan but are not covered under this contract, including any cost sharing.	Y ☐ N ☐	*CC-IV.A.6.a.20*	
27	Information concerning how to obtain information from the health plan about how it rates on performance measures in specific areas of service.	Y ☐ N ☐	*CC-IV.A.6.a.21*	
28	Information concerning how to obtain information about quality enhancements.	Y ☐ N ☐	*CC-IV.A.6.a.22*	
29	Information concerning procedures for reporting fraud, abuse, and overpayment that includes the following specific language: To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form which is available online at https://ahcaxnet.fdhc.state.fl.us/InspectorGeneral/fraud_complaintform.aspx.	Y ☐ N ☐	*CC-IV.A.6.a.23*	
30	Information regarding HIPAA relative to the enrollee's personal health information (PHI).	Y ☐ N ☐	*CC-IV.A.6.a.24*	
31	The toll-free telephone number of the appropriate Area Medicaid Office.	Y ☐ N ☐	*CC-IV.A.6.a.25*	

	Enrollee Handbook Review Tool			
Item Number	Standard The enrollee handbook contains:	Found in Handbook	Reference	Comments
32	Instructions concerning how to get information to help the enrollee assess a potential behavioral health problem.	Y ☐ N ☐	*42 CFR 438.10(g)(3)* *CC-IV.A.6.a.26*	
33	Information concerning behavioral health. a. 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. b. Information that post-stabilization services are provided without prior authorization and other post stabilization care services rules. c. A clear statement that the enrollee may select an alternative behavioral health care manager or direct service provider within the health plan, if one is available. d. A description of behavioral health services provided, including limitations, exclusions and out-of-network use. e. A description of emergency behavioral health services procedures both in and out of the health plan's service area.	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐ c. Y ☐ N ☐ N/A ☐ d. Y ☐ N ☐ N/A ☐ e. Y ☐ N ☐ N/A ☐	*CC-IV.A.6.a.28*	
34	Instructions concerning how to get information about the structure and operation of the health plan and any physician incentive plans.	Y ☐ N ☐	*42 CFR 438.10(g)(3)* *CC-IV.A.6.a.27*	

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Medical Record Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	Medical Record Review Tool			
Item Number	**Contents of the Medical Record:**	**Found in Record**	**Reference**	**Comments**
1	Contains member identifying information: a. Name	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.a*	
	b. Member identification number	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.a*	
	c. Date of birth	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.a*	
	d. Sex	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.a*	
	e. Legal guardianship, if any	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.a*	
2.	Is legible and maintained in detail		*42 CFR 456* *CC-VII.J.1.b*	
3	Contains: a. A summary of significant surgical procedures	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.c*	
	b. Past and current diagnoses or problems	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.c*	
	c. Allergies	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.c*	
	d. Untoward reaction to drugs	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.c*	
	e. Current medications	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.c*	
4	Contains entries that are: a. Dated	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.d*	
	b. Signed by the appropriate party	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.d*	

Medical Record Review Tool				
Item Number	**Contents of the Medical Record:**	**Found in Record**	**Reference**	**Comments**
5	Contains: a. Entries that indicate a chief complaint or purpose of the visit	Y ☐ N ☐ Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.e*	
	b. Objective findings of the practitioner	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.e*	
	c. Diagnosis or medical impression	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.e*	
6	Contains entries that indicate: a. Studies ordered (lab, x-ray, etc.)	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.f*	
	b. Therapies administered and prescribed	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.g*	
7	Contains entries showing the name and profession of the provider rendering services, including the signature or initials of the provider.	Y ☐ N ☐	*42 CFR 456* *CC-VII.J.1.h*	
8	Contains entries showing: a. Disposition	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
	b. Recommendations	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
	c. Instructions to the member	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
	d. Evidence of follow-up	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
	e. Outcomes of services	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.i*	
9	Contains an immunization history	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.j*	
10	Contains information relating to the member's use of tobacco products, alcohol or substance abuse		*42 CFR 456* *CC-VII.J.1.k*	
11	Contains summaries of all emergency care and hospital discharge summaries with appropriate medically indicated follow-up	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J1.l*	

	Medical Record Review Tool			
Item Number	Contents of the Medical Record:	Found in Record	Reference	Comments
12	Contains: a. Documented referrals	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.m*	
	b. Referral reports	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.f*	
13	Contains the primary language spoken by the member and any translation needs of the enrollee	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.o*	
14	Identifies members needing communication assistance in the delivery of health care services	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.p*	
15	Advanced Directives and: a. Contains documentation that the member was provided written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the member has executed an advance directive	Y ☐ N ☐ N/A ☐	*42 CFR 489.102* *CC-VII.J.1.q*	
	b. Contains copies of any Advanced Directives executed by the member	Y ☐ N ☐ N/A ☐	*42 CFR 489.102* *CC-VII.J.1.q*	
16	Contains services provided (i.e., family planning, preventive services, treatment of sexually transmitted diseases, etc.)	Y ☐ N ☐ N/A ☐	*42 CFR 456* *CC-VII.J.1.n*	
17	Sufficient documentation was provided for the file review	Y ☐ N ☐		

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Provider Contract Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

Item Number	Provider Contracts Review Tool Standard The provider contracts:	Standard Met	Reference	Comments
1	Prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of the Contract.	Y ☐ N ☐	*CC-VII.D.2.a.*	
2	CAPITATED PLANS: Require the provider to look solely to the capitated health plan for compensation of services rendered with the exception of nominal cost sharing.	Y ☐ N ☐	*CC-VII.D.2.b.1*	
3	State that if there is a health plan physician incentive plan, all provider contracts include a statement that the health plan makes no specific payment directly or indirectly under a physician incentive plan to a provider as an inducement to reduce or limit, medically necessary services to an enrollee, and that incentive plans do not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care.	Y ☐ N ☐ N/A ☐	*CC-VII.D.2.c*	
4	State that any contracts, agreements, or subcontracts entered into by the provider for purposes of carrying out any aspect of this Contract include assurances that the individuals who are signing are authorized and that it includes all the requirements of this Contract.	Y ☐ N ☐	*CC-VII.D.2.d*	
5	Require the provider to cooperate with the health plan's peer review, grievance, QIP and UM activities, and provide for monitoring and oversight, including monitoring of services rendered to enrollees, by the health plan or its subcontractor.	Y ☐ N ☐	*CC-VII.D.2.e*	
6	State if the health plan delegates credentialing, the agreement ensures that all licensed providers are credentialed in accordance with the health plan's and Agency's credentialing requirements.	Y ☐ N ☐	*CC-VII.D.2.e*	
7	Include provisions for the immediate transfer to another PCP or health plan if the enrollee's health or safety is in jeopardy.	Y ☐ N ☐	*CC-VII.D.2.f*	

	Provider Contracts Review Tool			
Item Number	Standard The provider contracts:	Standard Met	Reference	Comments
8	Do not prohibit a provider from discussing treatment or non-treatment options with enrollees that may not reflect the health plan's position or may not be covered by the health plan.	Y ☐ N ☐	*CC-VII.D.2.g*	
9	Will not prohibit a provider from acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee for the enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered.	Y ☐ N ☐	*CC-VII.D.2.h*	
10	Do not prohibit a provider from advocating on behalf of the enrollee in any grievance system or UM process, or individual authorization process to obtain necessary services.	Y ☐ N ☐	*CC-VII.D.2.i*	
11	Require providers to meet appointment waiting time standards pursuant to this Contract.	Y ☐ N ☐	*CC-VII.D.2.j*	
12	Provide for continuity of treatment in the event a provider contract terminates during the course of an enrollee's treatment by that provider.	Y ☐ N ☐	*CC-VII.D.2.k*	
13	Prohibit discrimination with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of such license or certification. This provision is not to be construed as a willing provider law, as it does not prohibit the health plan from limiting provider participation.	Y ☐ N ☐	*CC-VII.D.2.l*	
14	Prohibit discrimination against providers serving high-risk populations or those that specialize in conditions requiring costly treatments.	Y ☐ N ☐	*CC-VII.D.2.m*	
15	Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the health plan.	Y ☐ N ☐	*CC-VII.D.2.n*	
16	Require that records be maintained for a period not less than 5 years from the close of the Contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the health plan if the provider contract is continuous.	Y ☐ N ☐	*CC-VII.D.2.o*	

Provider Contracts Review Tool				
Item Number	**Standard**	**Standard Met**	**Reference**	**Comments**
	The provider contracts:			
17	Specify that DHHS, the Agency, Medicaid Program Integrity (MPI), and MFCU has the right to inspect, evaluate and audit all of the following related to this Contract: a. Pertinent books. b. Financial records. c. Medical records. d. Documents, papers, and records of any provider involving financial transactions.	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	*CC-VII.D.2.p*	
18	Specify the covered services and populations to be served under the provider contract.	Y ☐ N ☐	*CC-VII.D.2.q*	
19	Require that providers comply with the health plan's cultural competency plan.	Y ☐ N ☐	*CC-VII.D.2.r*	
20	Require that any community outreach materials related to this Contract that are displayed by the provider be submitted to the BMHC for written approval before use.	Y ☐ N ☐	*CC-VII.D.2.s*	
21	Require submission of all reports and clinical information required by the health plan, including CHCU reporting, if applicable.	Y ☐ N ☐	*CC-VII.D.2.t*	
22	Require providers of transitioning enrollees to cooperate in all respects with providers of other health plans to assure maximum health outcomes for enrollees.	Y ☐ N ☐	*CC-VII.D.2.u*	
23	Require providers to submit notice of withdrawal from the network at least 90 calendars days before the effective date of such withdrawal.	Y ☐ N ☐	*CC-VII.D.2.v*	
24	Require that all providers agreeing to participate in the network as PCPs fully accept and agree to responsibilities and duties associated with the PCP designation.	Y ☐ N ☐	*CC-VII.D.2.w*	
25	Requires providers to submit all NPIs to the health plan within 15 business days of receipt.	Y ☐ N ☐	*m. 1173(b) Social Security Act s, 4707(a) BBA CC-VII.A.9.a-b*	
26	Require all providers to notify the health plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida statutes.	Y ☐ N ☐	*CC-VII.D.2.x*	

	Provider Contracts Review Tool			
Item Number	Standard	Standard Met	Reference	Comments
	The provider contracts:			
27	Require providers to offer hours of operation that are no less than the hours of operation offered to commercial health plan members or comparable non-Reform Medicaid recipients if the provider serves only Medicaid recipients.	Y ☐ N ☐	*42 CFR 438.206* *CC-VII.D.2.y*	
28	Require safeguarding of information about enrollees as required in 42 CFR 438.224.	Y ☐ N ☐	*42 CFR 438.224* *CC-VII.D.2.z*	
29	Require compliance with HIPAA privacy and security provisions.	Y ☐ N ☐	*Public Law 104-191 (HIPAA)* *45 CFR 160* *45 CFR 164* *CC-VII.D.2.aa*	
30	Require an exculpatory clause, which survives provider agreement termination, including breach of provider contract due to insolvency, which assures that neither Medicaid recipients nor the Agency are held liable for any debts of the provider.	Y ☐ N ☐	*CC-VII.D.2.bb*	
31	Require that the provider secure and maintain during the life of the provider contract worker compensation insurance (complying with the FL worker compensation law) for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the health plan.	Y ☐ N ☐	*CC-VII.D.2.cc*	
32	Make provisions for a waiver of those terms of the provider contract that, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract.	Y ☐ N ☐	*CC-VII.D.2.dd*	
33	Contain no provision that in any way prohibits or restricts the provider from entering into a commercial contract with any other health plan.	Y ☐ N ☐	*s. 641.315 F.S.* *CC-VII.D.2.ee*	
34	Do not contain any provisions requiring the provider to contract for more than one health plan product or otherwise be excluded.	Y ☐ N ☐	*s. 641.315 F.S.* *CC-VII.D.2.ff*	
35	Do not contain provisions that prohibit the provider from providing inpatient services in a contracted hospital to an enrollee if such services are determined to be medically necessary and covered services under this Contract.	Y ☐ N ☐	*s. 641.315 F.S.* *CC-VII.D.2.gg*	
36	Require providers to cooperate fully in any investigation by the Agency, MPI, MFCU or other state or federal entity and in any subsequent legal action that may result from such an investigation involving this Contract.	Y ☐ N ☐	*CC-VII.D.2.hh*	

	Provider Contracts Review Tool			
Item Number	Standard	Standard Met	Reference	Comments
	The provider contracts:			
37	Require providers to submit timely, complete, and accurate encounter data to the health plan.	Y ☐ N ☐	*CC-VII.D.2.ii*	
38	Contain a clause indemnifying, defending, and holding the Agency and the health plan's enrollees harmless from and against all claims, damages, cause of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the provider agreement. This clause will survive the termination of the agreement, including breach due to insolvency.	Y ☐ N ☐	*s. 768.28, F.S.* *CC-VII.D.2.jj*	
39	Require physician to immediately notify the health plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims, or otherwise.	Y ☐ N ☐	*CC-VII.D.2.kk*	
40	Specify that in addition to any other right to terminate the provider contract, and notwithstanding any other provision of this Contract, the Agency or the health plan may request immediate termination of a provider contract if, as determined by the Agency, a provider fails to abide by the terms and conditions of the provider contract, or in the sole discretion of the Agency, the provider fails to come into compliance with the provider contract within 15 calendar days after receipt of notice from the health plan specifying such failure and requesting such provider abide by the terms and conditions thereof.	Y ☐ N ☐	*CC-VII.D.2.ll*	
41	Specify that any provider whose participation is terminated pursuant to the provider contract for any reason can utilize the applicable appeals procedures outlined in the provider contract. No additional or separate right of appeal to the Agency of the health plan is created as a result of the health plan's act of terminating, or decision to terminate, any provider under this Contract. Notwithstanding the termination of the provider contract with respect to any particular provider, the Contract will remain in full force and effect with respect to all other providers.	Y ☐ N ☐	*CC-VII.D.2.mm*	
42	Require that the hospitals notify the health plan of enrollee pregnancies and births where the mother is a health plan enrollee.	Y ☐ N ☐	*CC-XVI.P*	

Provider Contracts Review Tool				
Item Number	Standard	Standard Met	Reference	Comments
	The provider contracts:			
43	The health plan's contracts with hospitals: a. Include a clause that states whether the health plan or the hospital will complete the DCF Excel spreadsheet for unborn activation and submit it to the appropriate DCF Customer Call Center. b. Indicate that the health plan's name is indicated as the referring agency when the DCF Excel spreadsheet is completed.	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐	*CC-III.B.5* *CC-XVI.P*	

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Provider Handbook Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	Provider Handbook Review Tool			
Item Number	**Standard**	**Found in Handbook**	**Reference**	**Comments**
	The provider handbook contains:			
1	A description of the Medicaid program	Y ☐ N ☐	*CC-VII.I.2.a.1*	
2	A description of the covered services	Y ☐ N ☐	*CC-VII.I.2.a.2*	
3	A description of emergency services and the responsibilities	Y ☐ N ☐	*CC-VII.I.2.a.3*	
4	The Child Health Check-Up (CHCUP) Program services and standards	Y ☐ N ☐	*CC-VII.I.2.a.4*	
5	Policies and procedures covering the provider complaint system to include: a. Specific instructions regarding how to file a provider complaint, including complaints about claims issues b. Which individual(s) has authority to review a provider complaint	a. Y ☐ N ☐ b. Y ☐ N ☐	*CC-VII.I.2.a.5* *CC-VII.I.5.b*	
6	The procedural steps in the enrollee grievance process, including: a. Address, toll-free telephone number, and office hours of the grievance staff b. The enrollee's right to request continuation of benefits while utilizing the grievance system c. Information about the Subscriber Assistance Program (SAP, for HMOs only) and the Beneficiary Assistance Program (BAP, for PSNs only) d. Toll-free telephone number to call to present a complaint, grievance, or appeal	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	*CC-VII.I.2.a.6*	
7	Medical necessity standards and practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions	Y ☐ N ☐	*CC-VII.I.2.a.7*	
8	An explanation of PCP responsibilities	Y ☐ N ☐	*CC-VII.I.2.a.8*	
9	Other provider or subcontractor responsibilities	Y ☐ N ☐	*CC-VII.I.2.a.9*	

	Provider Handbook Review Tool			
Item Number	Standard The provider handbook contains:	Found in Handbook	Reference	Comments
10	Prior authorization and referral procedures, including the required forms.	Y ☐ N ☐	*CC-VII.I.2.a.10*	
11	Medical records standards	Y ☐ N ☐	*CC-VII.I.2.a.11*	
12	Claims submission protocols and standards, including instructions and all information necessary to file a clean or complete claim	Y ☐ N ☐	*CC-VII.I.2.a.12*	
13	Protocols for submitting encounter data	Y ☐ N ☐	*CC-VII.I.2.a.13*	
14	A summary of the health plan's cultural competency plan and explains how to get a full copy of the cultural competency plan at no cost to the provider	Y ☐ N ☐	*CC-VII.I.2.a.14*	
15	Information on the health plan's quality enhancement programs	Y ☐ N ☐	*CC-VII.I.2.a.15*	
16	The enrollee rights and responsibilities.	Y ☐ N ☐	*42 CFR 438.100* *CC-VII.I.2.a.16*	
17	Information notifying providers that the health plan is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including: a. Its choice counseling/ enrollment broker contractors as a participating provider of the health plan b. The provider's submission of encounter data is accepted by the FL MMIS and/or the state's encounter data warehouse	a. Y ☐ N ☐ b. Y ☐ N ☐	*CC-VII.I.2.a.17*	
18	The health plan disseminates bulletins as needed to incorporate changes to the provider handbook	Y ☐ N ☐	*CC-VII.I.2.b*	
19 CMSSP ONLY	The health plan includes in its provider handbook a notice that the amount paid to providers by the Agency is the Medicaid fee schedule amount less any applicable co-payments.	Y ☐ N ☐ N/A ☐	*Exhibit 7*	

Total # Applicable Elements	24
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Rights and Responsibilities Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	Rights and Responsibilities Review Tool			
Item Number	**Standard**	**Found in Handbook**	**Reference**	**Comments**
1	Enrollees have the right to be treated with respect and with due consideration for his or her dignity and privacy.	Y ☐ N ☐	*42 CFR 438.100*	
2	Enrollees have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.	Y ☐ N ☐	*42 CFR 438.100*	
3	Enrollees have the right to participate in decision regarding his or her health care, including the right to refuse treatment.	Y ☐ N ☐	*42 CFR 438.100*	
4	Enrollees have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Y ☐ N ☐	*42 CFR 438.100*	
5	Enrollees have the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.	Y ☐ N ☐	*42 CFR 438.100* *45 CFR 164.524* *45 CFR 164.526*	
6	Enrollees have the right to be furnished health care services in accordance with federal and state regulations.	Y ☐ N ☐	*42 CFR 438.100* *42 CFR 438.206* *through* *42 CFR 438.210*	
7	The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.	Y ☐ N ☐	*42 CFR 438.100*	

Agency For Health Care Administration
Managed Care Organizations
Subcontract Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

	Subcontract Review Tool			
Item Number	**Standard**	**Standard Met**	**Reference**	**Comments**
1	All provider subcontracts prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of the Contract.	Y ☐ N ☐	*CC-XVI.O.2*	
2	All provider subcontracts contain termination procedures.	Y ☐ N ☐	*CC-XVI.Q.1*	
	In subcontracts, the health plan agrees to:			
3	Make payment to all subcontractors pursuant to all state and federal laws.	Y ☐ N ☐	*CC-XVI.O.2.a.1* *s. 641.3115, F.S.* *42 CFR 447.46* *42 CFR 447.45(d)(2), (3), (d)(5), & (d)(6)*	
4	Provide for prompt submission of information needed to make payment.	Y ☐ N ☐	*CC-XVI.O.2.a.2*	
5	Provide for full disclosure of the method and amount of compensation or other consideration to be received from the health plan.	Y ☐ N ☐	*CC-XVI.O.2.a.3*	
6	Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the health plan.	Y ☐ N ☐	*CC-XVI.O.2.a.4*	
7	Specify that the health plan assumes responsibility for cost avoidance measures for third party collections.	Y ☐ N ☐	*CC-XVI.O.2.a.5*	
8	Provide that the Agency and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed.	Y ☐ N ☐	*CC-XVI.O.2.b.1*	
9	Provide for inspections of any records pertinent to the Contract by the Agency and DHHS.	Y ☐ N ☐	*CC-XVI.O.2.b.2*	

Subcontract Review Tool				
Item Number	Standard	Standard Met	Reference	Comments
10	Require that records be maintained for a period not less than five years from the close of the Contract and retained further if the records are under review or audit until the review or audit is complete (prior approval for the disposition of records must be requested and approved by the health plan if the subcontract is continuous).	Y ☐ N ☐	*CC-XVI.O.2.b.3*	
11	Provide for monitoring and oversight by the health plan and the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the health plan's and the Agency's credentialing requirements and recredentialing, if the health plan has delegated the credentialing to a subcontractor.	Y ☐ N ☐	*CC-XVI.O.2.b.4*	
12	Provide for monitoring of services rendered to health plan enrollees through the subcontractor.	Y ☐ N ☐	*CC-XVI.O.2.b.5*	
13	Identify the population covered by the subcontract.	Y ☐ N ☐	*CC-XVI.O.2.c*	
14	Provide for submission of all reports and clinical information required by the health plan, including CHCUP reporting (if applicable).	Y ☐ N ☐	*CC-XVI.O.2.c*	
15	Provide for the participation in any internal and external quality improvement, utilization review, peer review, and grievance procedures established by the health plan.	Y ☐ N ☐	*CC-XVI.O.2.c*	
16	Require safeguarding of information about enrollees.	Y ☐ N ☐	*CC-XVI.O.2.d.1-3* *CC-XVI.O.2.d* *42 CFR 438.224*	
17	Require compliance with HIPAA privacy and security provisions.	Y ☐ N ☐	*CC-XVI.O.2.d.1-3* *CC-XVI.O.2.d*	
18	Require an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that Medicaid recipients or the Agency will not be held liable for any debts of the subcontractor.	Y ☐ N ☐	*CC-XVI.O.2.d.1-3* *CC-XVI.O.2.d*	
19	If there is a health plan physician incentive plan, the health plan agrees to include a statement that the health plan makes no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care.	Y ☐ N ☐	*CC-VII.D.2.C* *CC-XVI.O.2.d.4*	

	Subcontract Review Tool			
Item Number	Standard	Standard Met	Reference	Comments
20	Require full cooperation in any investigation by the Agency, MPI, MFCU or other state or federal entity or any subsequent legal action that may result from such an investigation.	Y ☐ N ☐	*CC-XVI.O.2.d.5*	
21	Contain a clause indemnifying, defending and holding the Agency and the health plan's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency.	Y ☐ N ☐	*CC-XVI.O.2.d.6*	
22	The Agency may waive the required clause in #19 for itself, but not health plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency.	Y ☐ N ☐	*CC-XVI.O.2.d.6*	
23	Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this Contract unless such employees are covered by the protection afforded by the health plan. Such insurance complies with Florida's Workers' Compensation Law.	Y ☐ N ☐	*CC-XVI.O.2.d.7*	
24	Specify that if the subcontractor delegates or subcontracts any functions of the health plan, that the subcontract or delegation includes all the requirements of this Contract.	Y ☐ N ☐	*CC-XVI.O.2.d.8*	
25	Make provisions for a waiver of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of this Contract.	Y ☐ N ☐	*CC-XVI.O.2.d.9*	
26	Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate.	Y ☐ N ☐	*CC-XVI.O.2.d.10*	

	Subcontract Review Tool			
Item Number	Standard	Standard Met	Reference	Comments
27	Provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	Y ☐ N ☐	*CC-XVI.O.2.d.11*	
28	Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005: a. The False Claims Act b. The penalties for submitted false claims and statements. c. Whistleblower protections. d. The law's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.	a. Y ☐ N ☐ b. Y ☐ N ☐ c. Y ☐ N ☐ d. Y ☐ N ☐	*CC-XVI.O.2.d.12*	

Total # Applicable Elements	
Total # Compliant Elements	
Total Percent Compliant	

Agency For Health Care Administration
Managed Care Organizations
Transportation Audit Tool

Vendor Name:	
Review Period:	
Date of Review:	
Reviewer:	
Participating Vendor Staff Member:	

Transportation Review Tool				
Item Number	**Standard**	**Found in Handbook**	**Reference**	**Comments**
NON-REFORM COVERING TRANSPORTATION AND REFORM PLANS				
1	The health plan provides transportation services, including emergency transportation, for its enrollees who have no other means of transportation available to any Medicaid-compensable, medically necessary service, including Medicaid services not covered by this Contract such as prescribed pediatric extender care (this example does not apply to the specialty plan for children with chronic conditions).	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
2	The health plan complies with provisions of the Medicaid Transportation Services Coverage and Limitations Handbooks. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the health plan be more stringent than those in the Medicaid Transportation Services Coverage and Limitations Handbooks.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
3	The health plan is not obligated to follow the requirements of the Commission for the Transportation Disadvantaged (CTD) or the Transportation Coordinating Boards as set forth in Chapter 427, F. S., unless the health plan has chosen to coordinate services with the CTD.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
4	The health plan may provide transportation services directly through its own network of transportation providers or through a provider contract relationship, which may include the Commission for the Transportation Disadvantaged. In either case, the health plan is responsible for monitoring provisions of services to its enrollees.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
5	The health plan ensures that all transportation providers comply with standards set forth in Chapter 427, F. S., and Rules 41-2 and 14-90, FAC. These standards include drug and alcohol testing, safety standards, driver accountability, and driver conduct.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	

Transportation Review Tool				
Item Number	Standard	Found in Handbook	Reference	Comments
6	The health plan ensures that all transportation providers maintain vehicles and equipment in accordance with state and federal safety standards and the manufacturers' mechanical operating and maintenance standards for any and all vehicles used for transportation of Medicaid recipients.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
7	The health plan ensures that all transportation providers comply with applicable state and federal laws, including, but not limited to, the Americans with Disabilities Act (ADA) and the Federal Transit Administration (FTA) regulations.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
8	The health plan ensures that transportation providers immediately remove from service any vehicle that does not meet the FL Department of Highway Safety and Motor Vehicles licensing requirements, safety standards, ADA regulations, or Contract requirements and re-inspect the vehicle before it is eligible to provide transportation services for Medicaid recipients under this Contract. Vehicles will not carry more passengers than the vehicle was designed to carry. All lift-equipped vehicles must comply with ADA regulations.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
9	The health plan ensures transportation services meet the needs of its enrollees including use of multi-load vehicles, public transportation, wheelchair vehicles, stretcher vehicles, private volunteer transport, over-the-road bus service, or, where applicable, commercial air carrier transport.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
10	The health plan collects and submits encounter data, as required elsewhere in this Contract.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
11	The health plan ensures a transportation network of sufficient size so that failure of any one component will not impede the ability to provide the services required in this Contract.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
12	The health plan ensures that any subcontracts for transportation services meet the subcontracting requirements.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
13	The health plan maintains policies and procedures, consistent with 42 CFR 438.12 to ensure there is no discrimination in serving high-risk populations or people with conditions that require costly transportation.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	

Transportation Review Tool				
Item Number	Standard	Found in Handbook	Reference	Comments
14	The health plan ensures that all transportation providers maintain sufficient liability insurance to meet requirements of FL law.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
15	The health plan is responsible for the cost of transporting an enrollee from a nonparticipating facility or hospital to a participating facility or hospital if the reason for transport is solely for the health plan's convenience.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
16	The health plan approves and processes claims for transportation services in accordance with the requirements set fort in this Contract.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
17	If the health plan subcontracts for transportation services, it provides a copy of the model subcontract to BMHC for approval before use.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
18	Before providing transportation services, the health plan provides BMHC a copy of its policies and procedures for approval relating to the following: a. How the health plan determines eligibility for each enrollee and what type of transportation to provide that enrollee. b. The health plan's procedure for providing prior authorization to enrollees requesting transportation services. c. How the health plan reviews transportation providers to prevent and/or identify those who falsify encounter or service reports, overstate reports, or upcode service levels, or commit any form of fraud or abuse as defined in s. 409.913, F. S. d. How the health plan deals with providers who alter, falsify, or destroy records before the end of the retention period; make false statements about credentials; misrepresent medical information to justify referrals; fail to provide scheduled transportation; or charge enrollees for covered services. e. How the health plan provides transportation services outside of its service area.	a. Y ☐ N ☐ N/A ☐ b. Y ☐ N ☐ N/A ☐ c. Y ☐ N ☐ N/A ☐ d. Y ☐ N ☐ N/A ☐ e. Y ☐ N ☐ N/A ☐	*Exhibit 5*	
19	The health plan reports immediately, in writing to BMHC, any transportation-related adverse or untoward incident (see s. 641). The health plan also reports, immediately upon identification, in writing to MPI, all instances of suspected enrollee or transportation services provider fraud or abuse.	Y ☐ N ☐ N/A ☐	*s. 641.55, F. S.* *s. 409.913, F. S.* *Exhibit 5*	

Transportation Review Tool				
Item Number	Standard	Found in Handbook	Reference	Comments
20	The health plan ensures compliance with the minimum liability insurance requirement of $100,000 per person and $200,000 per incident for all transportation services purchased or provided for the transportation disadvantaged through the health plan. (see S. 768.28[5], F.S.) The health plan indemnifies and holds harmless the local, state, and federal governments and their entities and the Agency from any liabilities arising out of or due to an accident or negligence on the part of the health plan and/or all transportation providers under contract to the health plan.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
21	The health plan ensures adequate seating for paratransit services for each enrollee and escort, child, or personal care attendant, and ensures that the vehicle meets the following requirements and does not transport more passengers than the registered passenger seating capacity in a vehicle at any time: Enrollee property that can be carried by the passenger and/or driver, and can be stowed safely on the vehicle, is transported with the passenger at no additional charge. The driver provides transportation of the following items, as applicable, within the capabilities of the vehicle: wheelchairs, child seats, stretchers, secured oxygen, personal assistive devices, and/or intravenous devices.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
22	Each vehicle posts inside the health plan's toll-free telephone number for enrollee complaints.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
23	The interior of all vehicles is free from dirt, grime, oil, trash, torn upholstery, damaged or broken seats, protruding metal or other objects or materials which could soil items place in the vehicle or cause discomfort to enrollees.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	

Transportation Review Tool				
Item Number	Standard	Found in Handbook	Reference	Comments
24	The transportation provider provides the enrollee with boarding assistance, if necessary or requested, to the seating portion of the vehicle. Such assistance includes, but is not limited to, opening the vehicle door, fastening the seat belt or wheelchair securing devices, storage of mobility assistive devices and closing the vehicle door. In the door-through-door paratransit service category, the driver opens and closes doors to buildings, except in situations in which assistance in opening and/or closing building doors would not be safe for passengers remaining in the vehicle. The driver provides assisted access in a dignified manner.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
25	Smoking, eating, and drinking are prohibited in any vehicle, except in cases in which, as a medical necessity, the enrollee requires fluids or sustenance during transport.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
26	All vehicles are equipped with two-way communications, in good working order and audible to the driver at all times, by which to communicate with the transportation services hub or base of operations.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
27	All vehicles have working air conditioners and heaters.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
28	Vehicle transfer points provide shelter, security, and safety of enrollees.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
29	The transportation provider maintains a passenger/trip database for each enrollee it transports.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
30	The health plan establishes a minimum 24-hour advance notification policy to obtain transportation services, and the health plan communicates the policy to its enrollees and the transportation providers.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
31	The health plan establishes enrollee pick-up windows and communicates those timeframes to enrollees and the transportation providers.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	

Transportation Review Tool				
Item Number	Standard	Found in Handbook	Reference	Comments
32	The health plan establishes performance measures to evaluate the safety, quality, timeliness, and adequacy of its transportation services. The transportation performance measures are submitted to the Medicaid Bureau of Quality Management for approval by the end of the first month of the Contract term and report on those measures to the Agency as specified in Attachment II, Section VIII, Quality Management, Item A., Quality Improvement, sub-item 3.c.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
33	The health plan provides an annual attestation to BMHC by January 1 of each Contract year that it is in full compliance with the policies and procedures relating to transportation services, and that all vehicles used for transportation services have received annual safety inspections.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	
34	The health plan provides an annual attestation to BMHC by January 1 of each Contract Year that all drivers providing transportation services have passed background checks and meet all qualifications specified in law and in rule.	Y ☐ N ☐ N/A ☐	*Exhibit 5*	

Attachment IV
Special Term and Condition #14c

- Draft MLR Instructions and Templates
- Draft MLR Reporting Schedule
- Draft Chapter 40 of the Report Guide

Medical Loss Ratio

The following draft amendment language was provided to the managed care provider industry on February 17, 2012, and a conference call was held with the industry on February 27, 2012, to discuss the changes to be included in each health plan's Contract Attachment II, Core Contract Provisions, Section II, General Overview, Item D., General Responsibilities of the Health Plan:

In accordance with the Florida's Section 1115 Demonstration Special Terms and Conditions, capitated health plans shall maintain an annual (July 1 through June 30) medical loss ratio (MLR) of eighty-five percent (85%) for operations in the demonstration counties beginning July 1, 2012. The health plan shall submit data to the Agency for Health Care Administration quarterly to show ongoing compliance. The Centers for Medicare & Medicaid Services will determine the corrective action for non-compliance with this requirement.

The draft update to the Report Guide is in the following template and draft chapter. These updated modifications will be posted April 1, 2012, and will be effective 90 days later on July 1, 2012. Health plans will be expected to submit quarterly and annual MLR reports using a new Agency supplied template (see enclosed draft Chapter 40 of the Report Guide). Quarterly reports will be due to the Agency no later than 45 days following the close of the quarter. The first Annual MLR report, for the waiver demonstration year July 1, 2012 - June 30, 2013, is due to the Agency September 15, 2013.

Draft MLR Instructions and Templates

March 2012

Agency for Health Care Administration

DRAFT QUARTERLY AND ANNUAL MEDICAL LOSS RATIO (85%) REFORM COUNITES ONLY

As a managed care plan providing health care covered services to Medicaid beneficiaries in Reform counties (Baker, Broward, Clay, Duval, Nassau), your organization is subject to the requirements of Section II, Medicaid Health Plan Medicaid Contract, CFR 45 Part 158, and Chapter 409, Florida Statutes. This reads, in part, as follows:

> "To ensure unimpaired access to health care covered services by Medicaid beneficiaries in Reform counties, all contracts issued pursuant to this paragraph shall require 85 percent of the capitation paid to the managed care plan to be expended for the provision of health care covered services. In the event the managed care plan expends less than 85 percent of the capitation paid pursuant to this paragraph for the provision of health care covered services, the Federal Centers for Medicare and Medicaid Services (CMS) will determine corrective action for non-compliance under this contract."

The Agency has determined that for this purpose, "health care covered services" are defined as services provided by the health plan to Medicaid beneficiaries in Reform counties in accordance with the Health Plan Medicaid Contract and as outlined in Section V, Covered Services, and Section VI, Behavioral Health Care, and Attachment I.

Report the total capitation paid to your health plan for these specific services in Reform counties (Baker, Broward, Clay, Duval, Nassau) only. Use this financial worksheet for calculating the medical loss ratio (MLR). The calculation shall utilize uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method for calculating the medical loss ratio shall meet the following criteria:

(a) Except as provided in paragraphs (b) and (c), expenditures shall be classified in a manner consistent with 45 C.F.R. part 158.

(b) Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the position for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients.

(c) Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period.

2727 Mahan Drive, MS#26
Tallahassee, Florida 32308

Visit AHCA online at
http://ahca.myflorida.com

Complete the form by obtaining the required signature attesting to the accuracy of the information as reported by the health plan. Report the 85/15 Medical Loss Ratio Template using the instructions supplied under the 20 ___ 20 ___ Report Guide, Chapter and Exhibit of the 20 ___ 20 ___ Medicaid Health Plan Contract.

The quarterly worksheet must be received by the Agency no later than 45 calendar days after the end of the reporting quarter. The annual worksheet must be received by the Agency on or before, but no later than close of business on **September 15, 2013**. Email the worksheet to MMCFIN@ahca.myflorida.com or mail to the following address to be received by the Agency on or before the due date:

Agency for Health Care Administration
Bureau of Managed Health Care
Attention: Hazel Greenberg, Program Administrator
2727 Mahan Drive, MSC #26
Tallahassee, Florida 32308

For questions regarding the filing of the MLR, please contact Ms. Greenberg at (850)412-4292 or via email at Hazel.Greenberg@ahca.myflorida.com.

AGENCY FOR HEALTH CARE ADMINISTRATION
BUREAU OF MANAGED HEALTH CARE

DRAFT FINANCIAL WORKSHEET FOR THE
CALCULATION OF THE QUARTERLY AND ANNUAL
MEDICAL LOSS RATIO
DEMONSTRATION YEAR 201_

Plan Name: _____

Seven Digit Medicaid Provider ID#: _____

QUARTERLY ☐ ANNUAL ☐

QUARTER ENDING: _____ YEAR: _____

Section _____, Health Plan Medicaid Contract and CFR 45 Part 158, managed care entities that provide health care covered services must expend at least eighty-five (85) percent of the capitation paid by the Agency on those services, defined as medical and hospital services only. If less than eighty-five (85) percent of the capitation is expended on these services, the Federal Centers for Medicare and Medicaid Services will determine corrective action for non-compliance under this contract.

The following simple calculation will determine the medical loss ratio:

Reform Capitation Paid to the Health Plan by the Agency for Covered Health Care Services:
Health Care Expenses:
(Only authorized Codes) -- Fee-for-Service:
*(Paid to providers/subcontractors) -- Capitation:
Total Expenses:
Funds to graduate medical education institutions:
Contributions to designated state trust fund for the purpose of supporting Medicaid and indigent care:
Reform Capitation minus Total Expenses:
(Total Expenses/Total Capitation) Medical Loss Ratio:

Note: The calculation shall utilize uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method for calculating the medical loss ratio shall meet the following criteria:

(a) Except as provided in paragraphs (b) and (c), expenditures shall be classified in a manner consistent with 45 C.F.R. part 158.

(b) Funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions shall be classified as medical expenditures, provided the funding is sufficient to sustain the position for the number of years necessary to complete the

residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients. **

(c) Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period.

* Please provide a copy of the first and last page of any capitated provider/subcontractor contract if reporting capitation paid to providers/subcontractors.

** Please provide an attestation from the graduate medical education institutions that the funding amount is sufficient to sustain the position(s) for the number of years necessary to complete the residency requirements and the residency positions funded are active providers of care to Medicaid and uninsured patients (included Medicaid provider identification numbers).

DRAFT ATTESTATION OF 201_
QUARTER ENDING _____
HEALTH CARE COVERED
SERVICES QUARTERLY
MEDICAL LOSS RATIO

(USE THE FOLLOWING HEADING FOR THE ANNUAL ATTESTATION)

DRAFT ATTESTATION OF 201_ - 20__
HEALTH CARE COVERED
SERVICES ANNUAL MEDICAL
LOSS RATIO

I, _____, CEO/President of

(Health Plan), do hereby swear or affirm that the expenditure information reported for the provision of health care covered services is true and correct to the best of my knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 20__.

Signature Date

(Print Name)

Affix Corporate Stamp:

Draft MLR Reporting Schedule

March 2012

Agency for Health Care Administration

Draft MLR Reporting Schedule

Health plans will be required to submit their Quarterly Medical Loss Ratio (MLR) reports to the Agency for Health Care Administration (the Agency) no later than 45 days following the close of the quarter. The Agency submits the report to the Centers for Medicare and Medicaid Services (Federal CMS) within 15 days of receiving the report from the health plan. The Annual MLR report will be due to the Agency by September 15th of each year.

Provided below is the schedule health plans are required to meet for quarterly and annual MLR reporting for submission to the Agency, and the schedule the Agency is required to meet for submission to Federal CMS for demonstration years (DY) 7 and DY 8 of Florida's Section 1115 Research and Demonstration Waiver.

Draft MLR Reporting Schedule			
Demonstration Year	**Quarter**	**Due to Agency**	**Due to CMS**
Demonstration Year 7 (07/01/12 – 6/30/13)	**Q1:** 07/01/12 – 09/30/12	11/14/12	11/29/12
	Q2: 10/01/12 – 12/31/12	02/14/13	03/01/13
	Q3: 01/01/13 – 03/31/13	05/15/13	05/30/13
	Q4: 04/01/13 – 06/30/13	08/14/13	08/29/13
	DY 7 Annual Report	09/15/13	09/30/13
Demonstration Year 8 (07/01/13 – 06/30/14)	**Q1:** 07/01/13 – 09/30/13	11/14/13	11/29/13
	Q2: 10/01/13 – 12/31/13	02/14/14	03/01/14
	Q3: 01/01/14 – 03/31/14	05/15/14	05/30/14
	Q4: 04/01/14 – 06/30/14	08/14/14	08/29/14
	DY 8 Annual Report	09/15/14	09/30/14

Draft Chapter 40 of the Report Guide

March 2012

Agency for Health Care Administration

Draft Chapter 40

Quarterly and Annual Medical Loss Ratio Report

PLAN TYPES:

Health plans that must submit this report:

- ✓ Reform HMOs
- ✓ Reform Capitated PSNs
- ✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To supply the Agency with quarterly and annual (July 1 through June 30) unaudited financial data showing Reform Medicaid medical loss ratio (MLR) information in order to comply with the Special Terms and Conditions of Florida's Section 1115 Research and Demonstration Waiver (Project No. 11-W-002064) approved December 15, 2011.

FREQUENCY & DUE DATES:

Due quarterly

- ➢ No later than 45 days after the end of the reporting quarter.

Due annually by September 15:

- ➢ One unaudited report using the Agency's supplied template for the June 30 through July 1 year being reported.

SUBMISSION:

1. The health plan shall submit the following in an email to the Agency Bureau of Managed Health Care (BMHC) mailbox MMCFIN@ahca.myflorida.com:

   - ➢ For the quarterly and the annual submissions:

     a. The quarterly or annual MLR report using the Agency-supplied template

     b. A report attestation (see Chapter 2) which shall be named: MLR***YYQ#.pdf for the quarterly and MLR***YYYY-cert.pdf for the annual filing. The attestation must specifically address the accuracy and completeness of the submission.

INSTRUCTIONS:

1. The Quarterly and Annual MLR template supplied by the Agency must be used to report the quarterly and annual MLR.
2. The health plan shall report the MLR for the previous July 1 through June 30 annual period.

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VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency supplied quarterly and annual MLR template can be found on the Bureau of Managed Health Care's Medical Health Plan information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/ANNUAL_MLR_REPORT.xls

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Attachment V
Special Term and Condition #14d

- Health Plan Transition Process
- Provider Termination Policy

Health Plan Transition Process

March 2012

Agency for Health Care Administration

Mission to Ensure Quality Care:

The Agency's mission is to ensure quality care is provided to Florida's residents. On occasion, market fluctuations result in a Medicaid health plan leaving a county, terminating its contract, or being purchased by another entity. Our primary goal when a Medicaid beneficiary faces such change is to ensure continuity of care. The following is a summary of the processes and requirements established to enable us to reach this goal.

Overview of Health Plan Requirements:

When a health plan decides to withdraw from a county, terminate its contract, or sell their book of business to another entity, the health plan must provide written notice to the Agency at least 120 days prior to the anticipated effective date and must cease community outreach activities as specified in the contract. Our model contract also allows the Agency to extend the termination/transition effective date depending on the volume of health plan enrollees affected. In addition, 60 days prior to the withdrawal date, the Agency halts enrollment of new members into the health plan.

The health plan is required to work with the Agency to ensure a smooth transition for enrollees, particularly those in the hospital, under case management, or with complex medication needs. The health plans are contractually obligated to provide the Agency with any data needed to plan for the transition. Frequently requested data includes listings of high-risk pregnancies, members currently in the hospital, and members in active behavioral health care.

Enrollee Notifications:

Regardless of scenario, enrollees receive at least two written notifications of the upcoming change, with an explanation of how to select another health plan.

At least 60 days prior to the transition effective date, the health plan must send an Agency-approved letter to all its members. These member notices must include the date on which the health plan will no longer participate in the state's Medicaid program and instructions on contacting the Agency's choice counseling/enrollment broker toll-free help line to obtain information on enrollment options or to request a change in health plans.

The Agency sends a second letter to impacted beneficiaries at least 30 days prior to the transition date. If an affected enrollee contacts the choice counseling/enrollment broker to select a new health plan 30 days prior to transition date, the Agency's letter simply confirms the choice and the effective date of enrollment into the new health plan. If an affected enrollee does not select a new health plan 30 days prior to transition date, the Agency will assign a new plan and send a notification letter to the enrollee with information on the new plan enrollment and how to contact the Agency's toll-free help line to request a change in health plans prior to the enrollment effective date.

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All impacted beneficiaries are given 90 days after enrollment into the new health plan to select another health plan without cause.

Health Plan Detailed Transition Processes:

Regardless of whether the scenario is a withdrawal from a county, a contract termination, or a health plan acquisition, the Agency carefully plans the transition of the affected enrollees. To ensure continuity of care to affected enrollees, to minimize any disruption to the enrollees, and to assist them through the choice process, the Agency follows a multi-layered approach:

- Evaluating the volume and geographic impact of the transition to determine if there is a need to stagger transitions with the choice counseling/enrollment broker.
- Conducting weekly calls with the impacted Florida Medicaid Area Offices, Medicaid Contract Management, and the Agency to plan all aspects of the transition and provide a forum to ensure all issues are resolved quickly.
- Assessing the provider network capacity of the remaining/purchasing plan(s) to ensure all impacted enrollees have access to quality care.
- In cases of health plan acquisition, comparing the outgoing provider PCP and behavioral health network to that of the new plan to ensure at least a 90% match in order to preserve continuity of care.
- In cases of withdrawal or termination, requiring the health plan to provide a listing of members' primary care providers (PCPs). Agency then reviews provider networks of other plans to determine where the same PCPs are available.
- Assisting PCPs unique to the withdrawing/terminating plan through the Medicaid provider enrollment process to facilitate their enrollment in other health plan networks.
- Confirming the health plan notifies all network providers of the transition effective date at least 60 days in advance. Notice must include instructions on claims submission after the transition date.
- In cases of health plan acquisition, reviewing the benefit package of the acquiring entity to ensure it offers at least the same benefits as the existing health plan.
- Working with the plans, the Agency's choice counseling/enrollment broker, local area staff, and advocacy groups to coordinate outreach efforts, such as:
    - Appropriate and timely notice to enrollees, including developing and releasing flyers to locations and providers frequented by impacted enrollees to help ensure beneficiaries understand the changes that are occurring.
    - Hiring additional choice counselors if needed.
    - Posting choice counselors in the impacted Medicaid Area Offices and highly utilized provider locations to offer face-to-face counseling sessions specifically geared to transition enrollees.
    - Arranging outbound choice counseling call to enrollees with special needs.
    - Sharing final enrollee notice templates (60-day and 30-day) with impacted area offices, current health plan, incoming health plan, and others identified throughout transition planning.

- Obtaining data from the health plan about its most vulnerable enrollees, such as high-risk pregnancies, those in active behavioral health care, those in case management, and those complex medication needs.

After the Transition:

All impacted beneficiaries are given 90 days after enrollment into the new health plan to select another health plan without cause.

The Agency works with the new health plan(s) to provide information about high-risk OB enrollees, special needs enrollees, enrollees in active behavioral health, enrollees currently on psychotropic prescriptions, and enrollees in the hospital the day before the transition effective date.

To further ensure continuity of care, health plans are contractually required to honor prior authorization of ongoing covered services for a period of thirty (30) calendar days after the effective date of enrollment in the new plan, or until the enrollee's PCP reviews the enrollee's treatment plan, whichever comes first. Prearranged covered services could include provider appointments, surgeries, and prescriptions. For covered behavioral health services, this policy is extended for up to three months.

Provider Termination Policy

March 2012

Agency for Health Care Administration

Mission to Ensure Quality Care:

The Agency's mission is to ensure quality care is provided to Florida's residents. On occasion, a provider leaves a health plan's network. Our primary goal when a Medicaid beneficiary faces such change is to ensure continuity of care. The following is a summary of the requirements established to enable us to reach this goal.

Pertinent Model Contract Cites:

Attachment II, Section VII, Item C., Network Changes
Attachment II, Section VII, Item D., Provider Contract Requirements
Attachment II, Section VII, Item E., Provider Termination
Attachment II, Section VII, Item G., Continuity of Care

Overview of Health Plan Requirements:

Health plans are required to notify the Agency of terminated providers, regardless of whether the plan or the provider initiates the termination. Health plans must also submit monthly reports listing terminated providers and providing documentation that enrollee notices were distributed in accordance with contract requirements.

Provider agreements between the health plan and its providers contain protections for enrollees, as well. By signing a provider agreement, a provider agrees to give the health plan ninety days' notice prior to terminating his/her agreement. This allows the health plan to notify enrollees and transition their care to other providers as appropriate.

Enrollee Notifications:

Regardless of scenario, enrollees receive notice when one of their providers terminates from the health plan. When a primary care provider (PCP) ceases participation with a health plan, the enrollee notice must be issued by the health plan within fifteen calendar days after receipt of the termination notice. When the health plan initiates the termination, it must notify enrollees in active care at least sixty days before the effective date of the termination.

Provider Termination Policy Details:

Enrollees whose PCP is terminating may change PCPs immediately. They do not have to wait until the termination takes effect.

To minimize any disruption to the enrollees, health plan provider agreements must require providers of transitioning enrollees to cooperate in all respects with providers of other health plans to assure maximum health outcomes for enrollees.

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In addition, the health plan is required to allow enrollees in active treatment to continue care with a terminated treating provider when such care is medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, for a period not to exceed six months after the termination of the provider's contract. For pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, the health plan must allow the enrollee to continue care with a terminated treating provider until completion of postpartum care.

Attachment VI
Special Term and Condition #14e

- Adequate Choices of Managed Care Options

Adequate Choices of Managed Care Options

March 2012

Agency for Health Care Administration

Adequate Choice of Managed Care Options

Agency Mission to Ensure Quality Care:

The Agency's mission is to ensure quality care is provided to Florida's residents. On occasion, market fluctuations result in a Medicaid health plan reaching its enrollment cap, leaving a county, terminating its contract, or being purchased by another entity. To ensure recipients in the demonstration area are provided adequate choice of health plan or provider, recipients are advised of their choices of health plan/provider. The following is a summary of the processes and requirements established to enable us to reach this goal.

Policy:

Recipients enrolled in the demonstration are provided 30 days to select a choice of health plans. If there are fewer than two plans in a demonstration county from which a recipient can choose, the Agency will allow the recipient to enroll in Florida's primary care case management program (MediPass).

Overview of MediPass (PCCM):

MediPass is currently operational in all areas of the state (including the demonstration counties) and is available to recipients who may voluntarily enroll in the demonstration or where there are less than two plans in an area. The Agency ensures that MediPass has a sufficient network of providers through its ongoing credentialing and monitoring. Recipients have access to providers in accordance with 42 CFR 438.52.

Overview of Choice Counseling Requirements:

The Agency's enrollment broker works in conjunction with Agency staff to ensure Medicaid recipients are informed of health plan choices. The Agency notifies the enrollment broker of changes in plan availability. The enrollment broker processes enrollments, changes and disenrollments, notifies recipients of required (mandatory) or voluntary participation in a health plan or MediPass, mails confirmations of enrollment, disenrollment and change requests and notification of open enrollment and annual change opportunity. The enrollment broker operates a toll-free helpline to provide choice counseling and enrollment assistance as well as a website with choice information and online enrollment,
enrollment by mail and in person through face-to-face choice counseling.

Choice Counseling Responsibilities when Choices Change or are Limited:

Several functions are modified or updated when a health plan leaves a county or reaches enrollment capacity.

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The enrollment broker takes the following actions:

- Discontinues accepting voluntary enrollments to the affected plan.
- Notifies choice counselors of the change in available plans, including MediPass, for the affected area.
- Updates written materials available to recipients and used by the choice counselors to accurately show the available plan options, including MediPass.
- Updates online enrollment processes and website information to accurately show the available plan options, including MediPass.
- Updates auto-assignment processes to prevent future auto-assignments to the affected plan.
- Update provider network file databases to accurately reflect the change in available plans and network providers.
- Work with the Agency staff to transition existing enrollees in the plan leaving the area or when a plan reaches enrollment capacity. (See STC 14d Health Plan Transition Process Policies.)