

MEDICAID REFORM HEALTH PLAN APPLICATION FREQUENTLY ASKED QUESTIONS

Application Process Questions

Question 1: When is the Medicaid Reform Health Plan Application due?

Answer 1: The Agency is using an open application process in Duval County and Broward County; therefore, there is no official due date for submission. However, in order for the Agency to process applications and review all necessary documentation for a July 1, 2006, contract start date, the Agency must receive a completed Medicaid Reform Health Plan Application by April 14, 2006. Medicaid Reform Health Plan Applications submitted after April 14, 2006, will be effective after July. Please note that submittal of a complete Medicaid Reform Health Plan Application by April 14, 2006 does not guarantee an applicant a July 1, 2006 start date; completed applications must meet the Medicaid Reform Health Plan Application and contract requirements as determined by the Agency for a contract start date to be assigned. Responding quickly and completely to Agency application information requests will help ensure a speedy Agency review. Please also see the Agency's response to Question 15.

Question 2: Some of the information requested in the Medicaid Reform Health Plan Application is proprietary. Will the documents submitted by the applicant to the Agency be released by the Agency under a public records request?

Answer 2: All information submitted to the state is considered a public record unless it meets the definition of "trade secret" under section 812.081, Florida Statutes. Information specifically identified as a trade secret under section 812.081, Florida Statutes, will be kept confidential to the extent for which it is provided by law. If the Agency receives a public records request for information that has been identified by the responder as a trade secret under section 812.081, Florida Statutes, the Agency will notify the responder of such request so that the responder may take legal action to protect the confidentiality of the information. Please be sure that any documents considered proprietary are clearly labeled as such in the application submitted to the Agency.

Question 3: In the Medicaid Reform Health Plan Application, Section II, Application Process, B.1., Submission Requirements, does the request for consecutive pagination include attachments?

Answer 3: Attachments as referenced in the prospective Health Plan's application do not have to be consecutively paginated within the document, but must be paginated and easily identifiable as specific (titled) individual attachments.

Phase I General and Specific Questions

Question 4: In the Medicaid Reform Health Plan Application, Phase I, Section III, Legal Background and Experience, item 5, do you want us to list our contract with AHCA here along with other contracts?

Answer 4: Yes.

Question 5: In the Medicaid Reform Health Plan Application, Phase I, Section III, Legal Background and Experience, item 9, "Have there been, or are there any legal actions, taken or pending, against the Applicant or any predecessor of the Applicant in the last five (5) years? If yes, give a brief explanation and the status of each action." Could you define legal actions?

Answer 5: A legal action would be any action taken by a government agency (such as the Centers for Medicaid and Medicare Services, the Office of Insurance Regulation or AHCA) 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. In addition, see the Medicaid Reform Fee-for-Service Provider Service Network Contract, Section XVI, K., Legal Action Notification. In addition, the Agency retains the right to request information regarding any other legal action, suit or claim made against the applicant.

Question 6: Regarding the Medicaid Reform Health Plan Application, Phase I, Section V, Criminal Background Screening, item 12, if an organization is actively enrolled as a Florida Medicaid provider and the same organization intends to submit a Health Plan Application for Medicaid Reform, is that organization required to submit fingerprint cards for the purpose of criminal history background screenings?

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Answer 6: Pursuant to section 409.907(8)(a), Florida Statutes, the Health Plan Application requires fingerprinting and criminal history background screenings be conducted on all partners of your business AND all individual officers, directors, managers, the financial records custodian, and all individuals who hold signing privileges on the Health Plan's depository account. This screening is also known as a level 2 screening under section 435.04, Florida Statutes. Exemptions to this requirement are outlined in the instructions in the [Guide for Completing a Medicaid Provider Enrollment Application](#) on the ACS website,

<http://floridamedicaid.acs-inc.com/index.jsp?display=enrollment>

A Health Plan Applicant whose organization is an actively enrolled Florida Medicaid provider may have submitted some or all required individual's fingerprint cards to the State's fiscal agent for screenings. For the individual's already screened through this process, or within the past twelve months by another Florida agency or department, fingerprint cards are not required. For any individuals listed under the requirements of section 409.907(8)(a), Florida Statutes for whom the criminal history background screenings cannot be documented, the Health Plan Applicant must provide fingerprint cards. See related responses to Questions 7 through 11.

Question 7: In the Medicaid Reform Health Plan Application, Phase I, Section V, Criminal Background Screening, item 12, which provider agreement are the Health Plans, i.e., HMOs and PSNs, supposed to file with ACS?

Answer 7: The Non-Institutional Medicaid Provider Agreement.

Question 8: The Non-Institutional Medicaid Provider Agreement is renewed annually, correct?

Answer 8: No. The Non-Institutional Medicaid Provider Agreements must be renewed every ten (10) years.

Question 9: How are the Health Plans reminded or noticed to renew their Non-Institutional Medicaid Provider Agreements?

Answer 9: They will receive a re-enrollment packet when it is time.

Question 10: Who is authorized to sign the Non-Institutional Medicaid Provider Agreement?

Answer 10: The CEO or President usually signs in lieu of all management/owners. An authorized signer may sign if the application includes a resolution from the full board naming a specific individual as an authorized signer.

Question 11: When will the Agency begin the Health Plan provider enrollment process?

Answer 11: The Agency is currently accepting fingerprint cards from potential Medicaid Reform Health Plan applicants to initiate the provider enrollment process. Each screening costs \$47 per individual and must be paid by check or money order payable to ACS State Healthcare. You will find detailed instructions, including identifying individuals exempted from the fingerprinting and criminal history background screenings, the required Non-Institutional Medicaid Provider Agreement, and the required EFT, ECS, and ERV forms in the [Guide for Completing a Medicaid Provider Enrollment Application](#) on the ACS website,

<http://floridamedicaid.acs-inc.com/index.jsp?display=enrollment>

You **must** use the fingerprint cards supplied by the Medicaid fiscal agent. These cards may be obtained by calling toll-free 1-800-377-8216 or by calling your local Area Medicaid Office. The FBI will not accept any other fingerprint cards. The correct fingerprint cards must match the sample shown in the [Guide for Completing a Medicaid Provider Enrollment Application](#).

Unless exempted, all shareholders (five percent or more ownership), all partners of your business AND all individual officers, directors, managers, the financial records custodian, and all individuals who hold signing privileges on your depository account must undergo fingerprinting and criminal history background screenings. Please refer to the aforementioned guide for a full explanation of the screening process and the use of information obtained from the screenings. In addition, the Medicaid Reform Health Plan Application includes questions pertaining to Ownership and Control Interest and Organizational Structure. When submitting the Non-Institutional

Medicaid Provider Agreement, be sure to provide fingerprint cards for all individuals required to be included in the screening process, attach the applicable payment for processing, and send to:

Agency for Health Care Administration
Medicaid, Bureau of Health Systems Development
Fort Knox Building 3, Room 2219-A
2727 Mahan Drive, MS 50
Tallahassee, FL 32308

Question 12: In the Medicaid Reform Health Plan Application, Phase I, Section VI, Organizational Structure, item 14, requires the provision of 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 shall provide an overview of operations for 24-months after the anticipated date of contract execution. Please clarify the requirement. Do you want this for the entire state or just for the reform counties?

Answer 12: For new Health Plans, the Agency will need all of the requested information for the entire state. The Business Plan is required to be submitted with the Medicaid Reform Health Plan Application.

For current contractors, the Agency will need product expansion as it relates to Medicaid Reform and the populations the plan intends to serve. We will also need to review the Health Plan's strategy for growth and development in an area with respect to projected increases in enrollment. This information is necessary to evaluate and ensure network adequacy. The Business Plan is required to be submitted with the Medicaid Reform Health Plan Application. See also our response to Question 13.

Question 13: Is the business plan limited only to this program and the counties covered by Medicaid reform or should we include all Medicaid products (such as Health and Home and Florida Senior Care) and counties?

Answer 13: The business plan should include products for Reform applicants only in Reform counties. Also see our response to Question 12.

Phase II General and Specific Questions

Question 14: When will the Benefit Sufficiency Tool be made available?

Answer 14: Prospective Health Plans will have an opportunity to enter their Customized Benefit Package information into an online evaluation tool that will evaluate the Customized Benefit Package “entered” for actuarial equivalence and sufficiency. Once the Customized Benefit Package is evaluated by the tool, the tool will furnish an output report that provides the results of the actuarial equivalence test and sufficiency test as well as a detail of the Customized Benefit Package services that failed, if applicable. The user can download an Excel file that contains their completed Customized Benefit Package grid form for electronic submission with their entity’s completed Medicaid Reform Health Plan Application. The online evaluation tool will be available soon on the Internet at:

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

Question 15: We need our risk score in order to finalize our pro forma and complete the Customized Benefit Package (benefit grid). Can we submit these two components to the Agency after we submit the Medicaid Reform Health Plan Application, as long as they are submitted prior to contract execution?

Answer 15: The Technical Advisory Committee recently brought this to the Agency’s attention. Based on their concerns, the Agency will accept Health Plan Applications without a completed benefit grids and the pro forma financial statements. Health Plans will need to submit their benefit grids and the pro forma financial statements no later than April 28, 2006. Please be advised that implementation by July 1, 2006, will be substantially more feasible with the *earliest* possible submission of a fully completed Health Plan Application. Therefore, we encourage prospective Health Plans to submit their benefit grids and pro forma financial statements in their final formats *as early as possible and no later than April 28, 2006*. Benefit plans submitted after this date may not be included in the choice counseling materials and may result in a delay of approval of the Health Plan’s enrollee and marketing materials. See also the Agency’s response to Question #1 (When is the Medicaid Reform Health Plan Application due?) for additional submission information.

Question 16: What is the status of the data book? Will we receive an updated version?

Answer 16: On March 22, 2006, the Agency began distributing copies of the Florida Medicaid Reform Data Book to prospective Health Plans. Since the distribution date, the Data Book has been revised (version 1.4) based upon initial user feedback to correct the trend application. The correction affects the projected values in the summary tables. The base data and distribution table data remain unchanged. Also included along with the trend adjustment revision, was additional documentation to better highlight the difference between the documentation period and the expected evaluation period.

A new version of the Florida Medicaid Reform Data Book version 1.4 (release date March 30, 2006) will be provided soon. We are sorry for any inconvenience this may have caused. Once it is available, please use the new version of the Data Book in developing your Customized Benefit Package as the old version may yield results that do not meet the state-established sufficiency levels.

Question 17: When will the risk adjustment model be made available to the Health Plans?

Answer 17: Florida's version of the Medicaid Rx program (the interim risk adjustment model for Medicaid Reform) has been updated for current NDC codes and to reflect the requirements for Medicaid Reform. The model will be available for public release by April 21, 2006, and a technical training session will subsequently be conducted for Prospective Health Plan applicants.

Question 18: When will validation and risk scores be made available to Health Plans?

Answer 18: We anticipate that several reports pertaining to risk adjustment analyses and simulations on the FFS and HMO populations will be presented to the Technical Advisory Panel on April 21, 2006. These will include distribution analyses, risk score analyses, and scoring criteria analyses.

Question 19: In the Medicaid Reform Health Plan Application, Phase II, Section I, Fiscal Requirements, item 23, requires the Applicant to provide copies of its bank statements for the following required accounts: start-up, reserves, and insolvency protection. Does this have to be

submitted with the Medicaid Reform Health Plan Application or will the Agency review the information during the on-site visit?

Answer 19: This component can be reviewed as part of the on-site visit and is not required to be submitted with the Medicaid Reform Health Plan Application.

Question 20: Regarding the Medicaid Reform Health Plan Application, Phase II, Section I, Fiscal Requirements, item 26, please confirm that the pro forma financial statements will be for the bidder's entire business, not just for the Medicaid reform counties.

Answer 20: This should apply to the Health Plan applicant's Florida operations only. We would require, however, the Health Plan's expected enrollment levels in the reform areas to be identified separately.

Question 21: In the Medicaid Reform Health Plan Application, Phase II, Section II, Eligibility and Enrollment, item 29, asks that we address identification of Enrollees "excluded from participation" in Medicaid Reform. Would you clarify whether these Enrollees are the same as are currently named "ineligible enrollees" in the current contract, and/or Enrollees considered ineligible for other reasons?

Answer 21: These are the Medicaid beneficiaries ineligible to enroll in a Medicaid Reform Health Plan.

Question 22: In the Medicaid Reform Health Plan Application, Phase II, Section III, Enrollee Services and Marketing, item 45, what do you mean by enrollee services system and the type of access that will be available to enrollees?

Answer 22: This describes any customer service centers, call center services, mail outs to members, etc. We are asking you to describe the process and overall systems for each.

Question 23: In the Medicaid Reform Health Plan Application, Phase II, Section III, Enrollee Services and Marketing, item 49, requires the Applicant to submit a Marketing plan. The plan must contain logically developed strategies for reaching Medicaid Recipients and it must

comply with the measures set forth in Section IV.B., Marketing, of the Contract. Do we have to submit this?

Answer 23: This information is currently required and received by the Agency. The Agency is required to prior approve all marketing activities. As such, this information must be submitted to the Agency for review. If the Applicant does not intend to market to potential enrollees, it can stipulate such to the Agency in its application (and, therefore, no marketing plan would be required).

Question 24: Regarding the Medicaid Reform Health Plan Application, Phase II, Section IV, Covered Services, item 53, the current practice is not to have a separate Policy and Procedure on every covered service. They are listed in the Member and Provider Handbooks and our general Policies and Procedures cover how these services are met. Is this sufficient?

Answer 24: The Agency will review Policies and Procedures for general categories of services; such as, medical, behavioral health, transportation, and dental. In addition, the Health Plan should provide details on services within a general category of service if there are different procedures or requirements governing coverage.

Question 25: Regarding the Medicaid Reform Health Plan Application, Phase II, Section IV, Covered Services, item 67, what is meant by quality enhancements?

Answer 25: This is defined in the draft Model Fee-for-Service Provider Service Network Contract that is posted on the web; the same language is in the Model Prepaid Health Plan contract as well. In the Model Fee-for-Service Provider Service Network contract, the language is in Section V, D. Special Coverage Provisions, 15. Quality Enhancements.

Question 26: Regarding the Medicaid Reform Health Plan Application, Phase II, Section VI, Provider Network, item 88, what do you mean by staffing of locations?

Answer 26: This pertains to network adequacy. Please describe your Health Plan's Provider staffing; for example, in Primary Care Providers offices (i.e., use of Nurse Practitioners or Physician Assistants as extenders).

Question 27: Regarding the Medicaid Reform Health Plan Application, Phase II, Section VI, Provider Network, items 88, 89 and 90, we may not have finalized discussions with some providers by the time the Medicaid Reform Health Plan Application is submitted. If we have signed letters of intent, would that suffice?

Answer 27: Initially, a letter of intent will be sufficient to start the Medicaid Reform Health Plan Application review process. The Health Plan must provide to the Agency some form of written assurance documenting access to care. A contract would be preferable, a letter of agreement may be sufficient if it contains terms which are material to a contract, including but not limited to: term of agreement; consideration to be paid; notice requirements to the parties and the Agency; time frames for claims payments; dispute resolution; and prohibitions against balance billing.

Question 28: In the Medicaid Reform Health Plan Application, Phase II, Section VI, Provider Network, item 90, requires a GeoAccess report. For production of the Geo Access reports, generally we need a membership file to use in mapping our providers to determine whether the Health Plan's provider network meets the accessibility standards set by the state. Will you be sending a file with potential MediPass members on it?

Answer 28: We have provided as an attachment to this document an Excel chart with the number of MediPass individuals by county, and then by zip code. The attachment is titled "**Current MediPass Beneficiaries by Zip Code - Broward and Duval Counties.**"

Question 29: In the Medicaid Reform Health Plan Application, Phase II, Section IX, Information Systems, item 142, describe how the Applicant will provide systems-based capabilities such that authorized Agency staff, on a secure and read-only basis, can retrieve and/or utilize data in the Applicant's systems for ad hoc reporting purposes.

Answer 29: The Agency does not need to have access to the live section of the plan's information systems environment. The purpose of this requirement was to allow the Agency to have access to a data mart/data warehouse/repository which would be frequently refreshed. Authorized Agency staff would then be able to create custom queries/reports or run canned queries/reports. However, the Agency is currently reviewing this requirement and any changes will be provided through an FAQ document if they occur.

Question 30: In the Medicaid Reform Health Plan Application, Phase II, Section IX, Information Systems, item 143, is there an Excel table that you can provide?

Answer 30: Yes. The Systems Profile document is provided as an Attachment to this document. The attachment is titled “**Systems Profile.**”

Question 31: In the Medicaid Reform Health Plan Application, Phase II, Section X, Administration and Management, item 150, what does the term “minimum staffing positions” mean in that paragraph?

Answer 31: The minimum Staffing requirements are in Section X, Administration and Management, B. of the draft model contract for the FFS PSN and Section 20.4 of the current HMO contract. Both of these documents are on our Medicaid Reform website:

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

Question 32: Regarding the Medicaid Reform Health Plan Application, Phase II, Section X, Administration and Management, item 171, can we get a copy of Agency Check List for subcontracts?

Answer 32: The check list is currently being revised. We anticipate releasing the check list in the next few weeks.