

MEDICAID REFORM HEALTH PLAN APPLICATION FREQUENTLY ASKED QUESTIONS

Application Process Questions

Question 1: We plan to provide our electronic copy of the application in CD form. Is this acceptable? Also, does the plan have the option of submitting a scanned PDF or a series of individual Excel, Word and PDFs?

Answer 1: For the electronic submission, a CD is acceptable. 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 (with hard copy submission as well).

Question 2: Must all attachments to the Health Plan applications be in 11 point Arial font? If we have documents, such as member handbooks, that have been printed in other fonts, must we revise to the 11 point Arial format?

Answer 2: Attachments do not have to be in 11 point Arial font. We do ask that the narrative responses to the application be in 11 point Arial font. In addition, we ask that the narrative response be consecutively paginated. The attachments should be identified (tabbed) and paginated, but not consecutively with the rest of the narrative response.

Question 3: Is it acceptable to submit the Reform Health Plan Application on double-sided pages?

Answer 3: Yes, provided you check to make sure all copies are appropriately double-sided, and that you do not include more than one policy/item response on a page.

Question 4: When will the Medicaid Reform Prepaid Health Plan Model Contract draft be available?

Answer 4: The Medicaid Reform Prepaid Health Plan Model Contract draft application has been posted on the Medicaid Reform website at:

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

Question 5: Do we need submit one Reform Health Plan Application for each county in which we plan to operate?

Answer 5: No. Submit one application for all counties in which you plan to operate.

General Operational Questions

Question 6: Under reform, if a MediPass primary care provider (PCP) joins a reform Health Plan, how will recipients be notified? A PSN's PCP's patients do not automatically stay with the PCP if the PCP does not remain with the PSN network – if the PSN's PCP leaves the PSN's network, will his/her patients stay with the plan?

Answer 6: When a MediPass PCP joins a reform Health Plan, the Agency will notify the Agency's Choice Counselor/Enrollment Broker of the new PCP enrollment into the Health Plan. If the reform Health Plan is a PSN, the Choice Counselor/Enrollment Broker will then send a letter to the PCP's MediPass members and advise them that their PCP has joined the PSN and they may choose to follow their PCP into the reform PSN or choose a different reform Health Plan.

If the reform Health Plan is an HMO, then the MediPass PCP will be added to the HMO's PCP panel. The MediPass recipients will remain assigned to their MediPass PCP until the recipients' re-determination dates when they would be asked to choose a reform plan.

Question 7: Under reform, may a provider participate with more than one Medicaid Reform Health Plan?

Answer 7: Yes.

Question 8: If a MediPass primary care physician (PCP) joins two reform PSNs, will the state transfer members to both PSNs. How will this work?

Answer 8: If a MediPass PCP joins two reform PSNs, the Agency will notify the PCP's patients of their ability to select a new plan. If the patient does not select a plan, then the Agency will "rollover" such patients to the first operational PSN on record. The second PSN will not receive any members through this new process. Also see the Agency's responses to questions 6 through 9 of this FAQ document.

Question 9: Under reform, how will mandatory assignments occur with Health Plan expansions since it is possible that one Health Plan may operate two or more Health Plans in the same county?

Answer 9: If a Health Plan requests an expansion in the same county where it is currently operating a plan, and the new plan will serve the same population(s), then the Agency will treat the Health Plans as a single entity for mandatory-assignment purposes. However, please note that in reform counties, mandatory assignments will only be made to reform entities. For counties where both companies currently operate, we will continue with the current mandatory assignment process; but for new expansions, the Agency will treat the companies as one organization for mandatory assignment.

Question 10: In the draft reform Prepaid Health Plan Contract, Section II, D.13., it states “Health Maintenance Organizations and other licensed managed care organizations shall enroll all network providers with the Agency’s Fiscal Agent, no later than November 30, 2006, using the Agency’s streamlined Provider Enrollment process.” What is this streamlined Provider Enrollment process?

Answer 10: Attached to this FAQ is the two page form titled “Managed Care Treating Provider Application” that must be completed and submitted. Prepaid Health Plans must be sure to list their provider number in the “Approval Section” on the bottom of the second page of this document. In addition to this document the Prepaid Health Plan must submit a Non-Institutional Provider Agreement that is found on the Medicaid fiscal agent’s website: <http://floridamedicaid.acs-inc.com/index.jsp>.

Phase I General and Specific Questions

Question 11: In the Medicaid Reform Health Plan Application, Phase I, Section I, Authority to Operate, item 1, when the Agency is asking for corporate charter numbers, what does the Agency want?

Answer 11: The Agency needs the corporate Document Number.

Question 12: In the Medicaid Reform Health Plan Application, Phase I, Section IV, Ownership and Control Interest, item 11.g., list Subcontractors, participating providers or suppliers with whom the Applicant has had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the Application. For clarification purposes, is the Agency seeking to verify

subcontractors, and participating providers or suppliers, with whom the health plan has executed non-clinical contracts for Medicaid Reform counties?

Answer 12: Yes. This requirement applies to both administrative and managerial subcontracts.

Question 13: In the last Medicaid Reform Health Plan Application Frequently Asked Questions Document, FAQ-1-040406, Answer 6, regarding the Medicaid Reform Health Plan Application, Phase I, Section V, Criminal Background Screening, item 12, the Agency's Answer 6 stated that completed fingerprint cards must be submitted for the proposed managers of the reform Health Plan (in addition to other defined individuals). In this instance, to whom does the term "managers" refer?

Answer 13: The Agency considers managers to be, at a minimum, the particular staff positions listed in the Reform Fee-for-Service Provider Service Network Model Contract draft and the Prepaid Health Plan Model Contract draft in Section X., B.1., Minimum Staffing Requirements, and B.2., Behavioral Health Staff Requirements. In addition, we have found that there is a lot of confusion regarding who should be submitted for background screening, fingerprints, and the screening submittal process. We recommend that all Health Plan applicants review the attached fact sheet titled "Frequent Errors in Criminal Background Screen and Simplified Enrollment Protocol Submissions" for further information. See also the Agency's response to Question 14 of this FAQ.

Question 14: Do Health Plan applicants have to submit fingerprint cards for currently-licensed health care practitioners?

Answer 14: It depends. You may submit licensure screen prints from the Department of Health website for all licensed individuals for whom a level 2 background screening is required. In other words, for individuals who are licensed by the Department of Health (such as, medical, osteopathic, podiatric and chiropractic physicians, as well as advanced registered nurse practitioners, registered nurses and licensed practical nurses), the screening completed by the Department of Health for licensure purposes meets the Medicaid background-screening requirement. The Applicant should submit an Internet screen print showing the current, active status of the license from the Department of Health website

<http://ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP>

However, you must submit fingerprint cards for physician assistants, dentists, and pharmacists unless they are already on file with the Agency. See also the Agency's response to Question 13 of this FAQ.

Question 15: What is the website address for the Florida Medicaid Provider Enrollment Application? The address in item 12 on the Medicaid Reform Health Plan Application is incorrect.

Answer 15: The correct website address is:

<http://floridamedicaid.acs-inc.com/index.jsp>

Then go to the navigation table on the left and click on provider support, then click on enrollment.

Phase II General and Specific Questions

Question 16: When will the benefit sufficiency tool be made available?

Answer 16: The online benefit sufficiency tool, or Plan Evaluation Tool (PET), is available now on the Internet through the Medicaid Reform website or at:

<https://secure.mercerhq.com/reform/index.aspx>

Question 17: What is the status of the data book? Will we receive an updated version?

Answer 17: A new version of the Florida Medicaid Reform Data Book version 1.4 (release date April 10, 2006) has been released. Prospective plans will find this information essential in the development of their proposed benefit package(s). The April 10th Medicaid Reform Data Book is available in CD format upon request. You may submit your request to Jason Campbell at campbejt@ahca.myflorida.com. Please include your name, organization name, address, phone number and the number of CD[s] you are requesting. There is a limit of 2 CDs per organization. You should 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 18: In the Medicaid Reform Health Plan Application, Phase II, Section I, Fiscal Requirements, item 22, the agency requests the preparation of pro forma financial statements by month for the first three years. Shall the pro forma financial statements include a balance sheet for each month or may the applicant submit a balance sheet for each year?

Answer 18: The Agency prefers that the pro forma financial statements include a balance sheet for each month quarter, but a quarterly or an annual balance sheet is acceptable.

Question 19: Also regarding application item 22, should the pro forma financial statements include financial information for the reform part of the HMO only, the total Medicaid part of the HMO, or the total HMO?

Answer 19: The Agency prefers that the pro forma break the financial information down by line of business. However, at a minimum, the Medicaid line of business must be included. The Agency prefers that you further separate out the Medicaid line of business into reform and non-reform so we can review the Health Plan's reform and non-reform networks in those areas for adequacy.

Question 20: In the Medicaid Reform Health Plan Application, Phase II, Section I, Fiscal Requirements, item 23, for Fee-for-Service (FFS) Provider Service Networks (PSNs), does a FFS PSN applicant need to establish the insolvency protection account prior to submitting the application. How much is the insolvency requirement for FFS PSNs?

Answer 20: FFS PSNs are not required to establish an insolvency account prior to submitting the application. However, the draft contract does require a FFS PSN start planning for an insolvency account because one is required for the FFS PSN to become capitated (capitation required after three Contract Years). See the specifications in the Medicaid Reform Fee-for-Service Provider Service Network Contract, Section XV, Financial Requirements, A., restated in italics below.

The PSN shall submit to the Agency for approval a comprehensive plan for transitioning from a fee-for-service PSN to a prepaid capitated PSN. Such transition plan shall be in accordance with Agency guidelines, per Section II.C.18, General Overview, Responsibilities of the State of Florida and the Agency for Health Care Administration (the Agency), and shall be designed to ensure that the PSN is capable of meeting all solvency, reserves and working capital requirements of chapter 641 F.S. Although the PSN shall not be required to be licensed in

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accordance with Chapter 641, F.S., the PSN shall be required to comply with all solvency requirements of Medicaid HMOs, at such time as the PSN transitions from a fee-for-services PSN to a pre-paid capitated PSN. Such transition plan shall be submitted to the Agency no later than the first (1st) quarter of the second year of the Contract.

Once a PSN accepts capitation for the comprehensive benefit package it will be required to meet the following financial reserve requirements:

1. The entity shall maintain a minimum surplus in an amount that is the greater of \$1 million or 1.5 percent of projected annual premiums.
2. In lieu of the requirements in subparagraph 1., the Agency may consider the following:
 - a. If the organization is a public entity, the Agency may take under advisement a statement from the public entity that a county supports the managed care plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer, or oversee the managed care plan, either partly or wholly, through a county department or agency;
 - b. The state guarantees the solvency of the organization;
 - c. The organization is a federally qualified health center or is controlled by one or more federally qualified health centers and meets the solvency standards established by the state for such organization pursuant to s. 409.912(4)(c), Florida Statutes; or
 - d. The entity meets the financial standards for federally approved provider-sponsored organizations as defined in *42 C.F.R. ss. 422.380-422.390.*

Question 21: In the Medicaid Reform Health Plan Application, Phase II, Section I, Financial Statements, item 26, requests the prospective Health Plan to submit insurance binders with their application. Can we bind the insurance coverages within thirty days of contract award rather than binding prior to submitting the application?

Answer 21: The inclusion of insurance binders is required to complete the application. Delay in providing this information could compromise the applicant's chances of a contract being effective with a July 1, 2006 start date.

Question 22: In the Medicaid Reform Health Plan Application, Phase II, Section VI, Provider Network, item 91, requests copies of the signature and cover pages of all executed provider contracts for each reform county. Can we submit just one copy of these rather than seven copies?

Answer 22: Yes; however, be sure that the signature page copies you send have been executed and that the electronic versions are also executed signature pages and are in pdf format. In addition, we will need a complete template contract (model) for each type of provider contract to be used. We will need this in electronic format as well as hard copy.

Question 23: Regarding participating pharmacies, does a FFS PSN Health Plan applicant have to provide copies of the signature and cover pages of all executed provider pharmacy contracts for each reform county or include geo-mapping? What if we do not have any pharmacies under contract because our pharmacy network is any willing provider?

Answer 23: The Agency will allow a FFS PSN to use the Medicaid Pharmacy Network *as long as it is unrestricted*. Under that circumstance, you do not need to provide model or signed pharmacy subcontracts nor do you need to provide geo-mapping; however, this must be clearly stated in your application response. If the FFS PSN Health Plan is limiting pharmacy to certain Medicaid providers, then all documentation (including copies of executed provider contracts and geo-mapping) must be provided as per the application, and the Health Plan would have to contract with a Pharmacy Benefits Manager (PBM), and that PBM would have to be or become a Medicaid pharmacy provider. See also the Agency's response to Question 24.

Question 24: Regarding other providers, could a FFS PSN Health Plan applicant use any-willing-Medicaid provider for other parts of its provider network (like ancillary, durable medical equipment (DME), etc.)?

Answer 24: The FFS PSN must create its own provider network for all providers other than pharmacy providers, and provide all documentation as required by the application. See also the Agency's response to Question 23.

Question 25: In the Medicaid Reform Health Plan Application, Phase II, Section VIII, Grievance System, item 130 under Appeal Process requests the prospective Health Plan to submit policies and procedures which cover the PSN activities once an appeal is resolved. Does this submission requirement apply to PSNs only?

Answer 25: No. *Both* PSNs and Prepaid Health Plans must submit their policies and procedures regarding appeals.

Question 26: In the Medicaid Reform Health Plan Application, Phase II, Section IX, Information Systems, item #137, references a "continuously available email link." Is AHCA looking for something other than an email system (like the one that we are using to communicate), or is something else required (i.e. Instant Messenger system)?

Answer 26: Instant messaging is not a requirement. By "continuously available" we mean that we expect to be able to communicate with the Health Plan via e-mail at any time.

Question 27: In the Medicaid Reform Health Plan Application, Phase II, Section X, Administration and Management, items 165 and 166, and in regard to the same titled section in the Medicaid Reform Fee-for-Service Provider Service Network Contract, Section X, Administration and Management, G. Claims Payment, page 150, are FFS PSNs required to adjudicate provider claims? If not, may we elect to adjudicate provider claims? Are there claim submittal data requirements that we can begin to review?

Answer 27: The FFS PSN will review claims for appropriate authorizations and potentially deny unauthorized claims, and then transmit the approved claims to the Agency. In order to submit claims to the Medicaid fiscal agent, the FFS PSN must either be a third party administrator (TPA) or subcontract with one. The FFS PSN may submit claims directly to the Medicaid fiscal agent (if the FFS PSN is a TPA) or subcontract with a TPA to perform the submission. All claims must comport with Florida Medicaid claims requirements. The Medicaid fiscal agent will make payment directly to the provider under contract with the FFS PSN.

If you subcontract with a TPA to submit claims to the Medicaid fiscal agent, that TPA must be an actively-enrolled Florida Medicaid provider. If the Health Plan uses a TPA to submit claims on the Health Plan's behalf to the Medicaid fiscal agent, then the TPA must enroll as a Medicaid provider (Provider Type 99) and submit a provider application

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to the Medicaid fiscal agent in order to submit claims to the Medicaid fiscal agent. In addition the TPA must also complete and submit the Electronic Claims Submission Agreements.

There is a wealth of information on the Medicaid fiscal agent website. This includes information on EDI specifics and provider coverage and limitations, and reimbursement handbooks. Here is a link to that website:

http://floridamedicaid.consultec-inc.com/index.jsp?parm2=sub&parm4=Handbooks&parm3=Provider_Support&parm1=Florida_Medicaid

Click on the EDI link on the left. Then you will see the following choices on the left.

- Florida Medicaid
- EDI Services
- * [MEVS Vendor List](#)
- * [Submission Information](#)
- * [Manuals and Specifications](#)
- * [Registration Forms and Agreements](#)
- * [Field Representatives](#)

Question 28: 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 28: There are two subcontract checklists: one check list for the Reform FFS PSN Health Plans and one check list for the Prepaid (or capitated) Health Plans. We have attached both checklists and these are available on the Agency's Reform website.

The checklist for the Reform FFS PSN Health Plans is the PDF attachment titled "Provider Service Network (PSN) Subcontract and Provider Contract Checklist."

The checklist for the Reform Prepaid (or capitated) Health Plans is the PDF attachment titled "2006-2008 Reform Sub-Contract and Contract Review Checklist."