HEALTH PLAN APPLICATION

NEW CONTRACTORS

DECEMBER 2006

HEALTH PLAN APPLICANT (the "Applicant")
CONTACT INFORMATION

Name of Applicant:	______________________
Mailing Address:	______________________
	______________________
	______________________
Individual Executing Application:	______________________
Title:	______________________
Telephone/Extension (Business):	( ) ______________________
Telephone (Cellular):	( ) ______________________
Fax Number:	( ) ______________________
Email address:	______________________

Type of Health Plan:	(___) PSN - Fee-for-service	
(Submit separate Applications	(___) PSN – Prepaid – Comprehensive	
for each type of Health Plan	(___) PSN – Prepaid – Comprehensive and Catastrophic	
requested)	(___) HMO – Prepaid – Comprehensive	
	(___) HMO – Prepaid – Comprehensive and Catastrophic	
	(___) Other Authorized Health Plan – Prepaid – Comprehensive	
	(___) Other Authorized Health Plan – Prepaid – Comprehensive and Catastrophic	
Target Population(s)	(___) Temporary Assistance for Needy Families (TANF)	
(Check each population	(___) Supplemental Security Income (SSI)	
to be served)	(___) Children with Chronic Conditions (CCC)	
	(___) HIV/AIDS	
Proposed Area of Operation	(___) Baker	(____) Broward
(Check each County	(___) Clay	(____) Duval
to be served)	(___) Nassau	

I certify that all information and statements made in this Health Plan Contract Application (the "Application') are true, complete, and current, to the best of my knowledge and belief, and are made in good faith. I further certify that I am a duly authorized representative of this organization with full signatory authority.

Signature: ____

Date: ____

Name of CEO or Executive Director (If different from above individual): ______________________________

Title: ______________________________

Mailing Address: ______________________________

Telephone/Extension: (   ) ______________________________

Fax Number: (   ) ______________________________

Email address: ______________________________

Name of Board Chairman: ______________________________

Mailing Address: ______________________________

Telephone/Extension (Business): (   ) ______________________________

Fax Number: (   ) ______________________________

Email address: ______________________________

NOTE: If the organization is a joint venture or limited partnership, provide the above information for each entity in the organization. Of those entities, designate a single point of contact for the organization (if different from the individual with authority to execute the Application).

Applicant Designated Contact Person: ______________________________

Title: ______________________________

Mailing Address: ______________________________

Telephone/Extension (Business): (   ) ______________________________

Telephone (Cellular): (   ) ______________________________

Fax Number: (   ) ______________________________

Email address: ______________________________

NOTE: The Agency will correspond ONLY with the person designated as the Applicant contact.

I. INTRODUCTION/GENERAL INFORMATION

A. The Agency for Health Care Administration (the "Agency") is accepting applications from qualified organizations capable of providing health care services to eligible Medicaid recipients consistent with the requirements of the applicable contract terms and conditions.

B. This multi-purpose Health Plan Application (the "Application") is designed to capture detailed information that will facilitate a contract between the Agency and any Provider Service Network (PSN) or other authorized Health Plan that meets the requirements of a Medicaid Reform Health Plan. The requirements in this Application are to be described by both types of organizations, unless otherwise specified. This Health Plan Application is specifically designed for plans that do not currently have a Reform contract with Florida Medicaid.

C. Upon receipt of an Application, the Agency will begin the Application process on the date the Agency mails its Acknowledgement Letter to the Applicant. The Acknowledgment Letter notifies the Applicant whether the Application includes all of the Mandatory Items and whether it will proceed to the Application process. Incomplete Applications and Applications that do not conform to the requirements of these Application instructions will result in a notification of the opportunity to provide the additional information (Request for Additional Information) within ten (10) days. Upon submission of the additional data, the Agency will make a determination as to the completeness of the additional information. The Agency may discontinue the review and issue a Notice of Deficiency if the Agency determines that the Application is incomplete. The Checklist of Mandatory Items is provided below in Section II.C.

D. Because the Application process is intended to be an opportunity for the Applicant to prove to the Agency that the Applicant is a suitable contracting partner, the Agency reserves the right to discontinue any Application for insufficient response to any of the requirements set forth in these Application instructions, for any misrepresentation, or, if the Agency determines that it is in the best interest of the Agency to discontinue the Application process. All information submitted to the State is considered a public record unless it meets the definition of "trade secret" under Section 812.081, F.S. Information specifically identified as a trade secret under Section 812.081, F.S., 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 Applicant as a trade secret under Section 812.081, F.S., the Agency will notify the responder of such request 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.

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

F. At a minimum, the Applicant's responses to the information requested in this Application must comport with all current Medicaid Handbooks, the current Contract and all applicable amendments. It is the Applicant's responsibility to review this information and be knowledgeable of all Medicaid requirements. The Applicant can access this information at the following website: http://ahca.myflorida.com/Medicaid/index.shtml

G. The contact person assigned by the Agency to assist the Applicant through the Application process may provide or direct the Applicant to a source for forms.

H. For existing Reform Health Plans that wish to expand into other counties please refer to the Reform expansion application located on the Medicaid Reform Website.

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II. APPLICATION PROCESS

A. Phases of the Application

The Applicant’s responses must be complete with regard to all four (4) phases upon the Applicant's initial submission. Incomplete responses will result in a Request for Additional Information. If the Agency determines that the additional information submitted is incomplete, the Agency may discontinue the Application process and send a Notice of Deficiency to the Applicant. The timeframes for Agency activities and the process set forth herein are guidelines and do not confer any rights on the Applicant.

1. Phase I: Organizational Review

Phase I of the Application process includes, but is not limited to, the Applicant’s business plan, background checks, licenses, organizational structure, background and experience. The Agency may schedule a conference call within thirty (30) days of the date of the Acknowledgement Letter to discuss questions and possible deficiencies within the Application. The Agency may discontinue the review and issue a Notice of Deficiency if, in the Agency’s sole discretion, the Agency determines that the Application is incomplete or if the Applicant fails to submit information within ten (10) business days of receipt of a Request for Additional Information.

2. Phase II: Fiscal Review/Comprehensive Desk Review

Phase II of the Application process includes, but is not limited to, the Applicant’s networks, policies and procedures, model subcontracts and participating provider agreements, financial statements, Enrollee materials and handbook and all marketing materials. The Applicant must work with the Agency in order to test its electronic reporting compliance. The Agency may discontinue the review and issue a Notice of Deficiency if, in the Agency’s sole discretion, the Applicant fails to submit information within ten (10) business days of receipt of a Request for Additional Information. (For quick reference, Phase II requirement headings correspond with the headings of the Fee-For-Service PSN and Prepaid Health Plan Contracts, unless otherwise specified.)

3. Phase III: Site Visit

Phase III of the Application process includes an on-site review of the Applicant’s facilities and desk review of the Agency’s findings. The Agency may discontinue the review and issue a Notice of Deficiency if, in the Agency’s sole discretion, the Applicant fails to submit information within ten (10) business days of receipt of a Request for Additional Information.

4. Phase IV: Contract Execution

Phase IV of the Application process involves preparing the Agency’s contract documents. Once the appropriate documents are approved throughout the Agency and the Centers for Medicare and Medicaid Services (“CMS”) approves the terms of the contract between the Agency and the Applicant, the Agency will send a contract to the Applicant for signature. As the final contract routes for signatures, the Agency will update the network files to initiate the mandatory assignment process.

B. Submission Requirements

1. The Applicant must submit five (5) hard copies and two (2) individual electronic copies of the Application (i.e., on separate diskettes or CD-ROMs) to the Agency. Text must be in black ink and Arial 11 font. Any graphics may be in color. Applications must be in high-quality, three-ring binders that are no larger than three (3) inches in width. If there is more than one (1) binder, the Applicant must consecutively paginate the Application throughout the series of binders. Each original version must contain an original signature, in contrasting ink other than black, of an official authorized to bind the Applicant.

2. The Applicant must submit electronic versions of the Application at the same time it submits hard copies of the Application to the Agency. The electronic files must be in Microsoft Word or Excel and not be in a locked format. These electronic files must be logically named in accordance with the application subjects and topics, and easily mapped to the hard copy Application. The electronic media must be clearly labeled in the same manner as the hard copies and submitted with the corresponding hard copies. The duplicate copies of the Application must be identical to the original, including all required documentation.

3. Failure to clearly label and submit duplicates of the Application will result in the discontinuation of the review of the Application.

4. The Applicant must submit the original and all copies to the following address:

   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

5. For technical assistance please contact the Bureau of Health Systems Development at (850) 487-2355.

6. The Applicant must submit any changes to the information in the Application to the Agency, in writing, to the address listed above, within ten (10) business days of the effective date of the change. This includes, but is not limited to, any change in directors, officers, address, etc. Any change in ownership requires termination of the Application and resubmission of a new Application under the new ownership. The official date and time of receipt of above application will be the date and time of receipt of the new application.

7. If the Agency does not receive complete responses to Requests for Additional Information within ten (10) days of the request, the Agency shall issue a Notice of Deficiency.

8. The signature pages must be completed, signed and submitted with the Application packages.

9. Any release of information relative to the Application or the contract by the Applicant to the media, the public or other entities requires the prior written approval of the Agency.

10. Refer to the attached contracts for definitions and detailed requirements.

C. Checklist of Mandatory Items

Please indicate the location of each mandatory item in the Application binders and include a copy of the following checklist behind the Cover Page of each copy.

Mandatory Items for New Applicants (Requirement Number(s))	Location in Application (Binder, Tab & Page #)
Application and copies pursuant to Submission Requirements above	
PHASE I: ORGANIZATIONAL REVIEW	
Authority to Operate (1, 2)	
Entities Eligible to Submit Applications (3)	
Legal Background and Experience (4 - 10)	
Ownership and Control Interest (11)	
Criminal Background Screening (12, 13)	
Organizational Structure (14, 15)	
Terms and Conditions (16 – 20)	
Required State and Federal Disclosures (21)	
PHASE II: FISCAL REVIEW AND COMPREHENSIVE DESK REVIEW	
Fiscal Requirements (22 – 29)	
Eligibility and Enrollment (30 – 38)	
Enrollee Services and Marketing (39 – 53)	
Covered Services (54 – 75)	
Behavioral Health Services (76 – 87)	
Provider Network (88 – 106)	
Quality Management (107 – 122)	
Grievance System (1203– 139)	
Information Systems (140 – 155)	
Administration and Management (156 – 184)	
Reporting (185 – 187)	
PHASE III: SITE REVIEW (No Application submission requirements)	
PHASE IV: CONTRACT EXECUTION (No Application submission requirements	

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HEALTH PLAN APPLICATION

PHASE I REQUIREMENTS

ORGANIZATIONAL REVIEW

ORGANIZATION

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

I. Authority to Operate

1. The Applicant shall submit a statement indicating that it is a corporation or other legal entity authorized to do business in Florida. If the Applicant uses Subcontractors, the Applicant shall also submit a statement indicating that all Subcontractors are registered with the State in accordance with Florida law. The Applicant shall also provide the Subcontractors' corporate Document Numbers. In addition, the Applicant must be licensed pursuant to applicable Florida law.

2. Describe and provide evidence of the Applicant's authority to operate as a Health Maintenance Organization (HMO), i.e., a Certificate of Authority from the Florida Department of Financial Services, Office of Insurance Regulation and a Health Care Provider Certificate from the Agency; or as either a Fee-For-Service PSN or a Prepaid PSN, i.e., a license as a Third Party Administrator (TPA) from the Florida Department of Financial Services, Office of Insurance Regulation.

II. Entities Eligible to Submit Applications

3. To be eligible to submit an Application, the Applicant must provide documentation, such as a signed affidavit, declaring:

   a. The Applicant (including its subsidiaries and affiliates) has not unilaterally and willfully terminated any previous contract prior to the end of the contract period with a state or federal government and has not had a contract terminated by a state or federal government (for cause), prior to the end of the contract term, within the past five (5) years; and

   b. The Applicant has demonstrated, or can demonstrate, the ability to maintain confidentiality of Enrollee data.

III. Legal Background and Experience

4. In chronological order, describe the legal history of the Applicant, including all predecessor business entities, parent corporations, holding companies, subsidiaries, mergers, reorganizations and changes of ownership. Be specific as to dates and parties involved. The details of the background of the Applicant, all predecessor business entities, parent companies, subsidiaries, holding companies and its size, and resources, shall include, but not be limited to, the following information:

   a. Dates established;

   b. The Applicant's Federal Employer's Identification Number (FEIN). Corporations must include their Florida Corporate Charter Number;

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

d. Applicant's primary business;

e. Total number of employees;

f. Number of FTEs engaged in activities relevant to this Application; and

g. Any applicable licensures.

5. In the last five (5) years, has the Applicant executed a contract with a government entity, including current contracts with a government entity (i.e. federal, state or local)? 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.

6. If the Applicant has ever defaulted on or voluntarily withdrawn from a contract or had a contract terminated for cause, 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.

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

8. Provide a minimum of three (3) separate and verifiable references. The references listed must be for work similar in nature to that specified in the Application. Confidential references shall not be included. Do not list the Agency as a client reference. The same client may not be listed for more than one reference. In the event that the Applicant changed names since performing work for a listed reference, the Applicant shall provide the name under which the Applicant operated at the time that the Applicant performed the work. References should be available to be contacted during normal working hours. The Agency will attempt to contact each selected reference by telephone up to four (4) times. In the event that the contact person cannot be reached after four (4) attempts, the Agency will request an alternate reference.

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. A legal action is defined as an action taken by a government agency (such as the Centers for 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. In addition, see the Medicaid Reform FFS Provider Network contract, Section XVI,K, Legal Action Notification.

10. Provide the names and contact information of all individuals who are agents or managing employees of the Applicant, who have been convicted of a felony or criminal offense related to the individual's/individuals' involvement in any federally funded health care program, or has been convicted of fraud, income tax evasion, or obstruction of justice.

IV. Ownership and Control Interest

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

    a. List the names, addresses, and official capacities of these individuals.
    b. If the Board of Directors has delegated its responsibilities as governing board related to this Contract, provide evidence of the delegation (i.e., minutes and by-laws).

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

    d. List the name and address of each person or corporation with an ownership or controlling interest in any Subcontractor or supplier in which the Applicant has direct or indirect ownership of five percent (5%) or more.

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

    f. List any Subcontractors, participating providers or suppliers owned by the Applicant, its management, its owners or any members of its Board of Directors including the percent of financial interest.

    g. List Subcontractors, participating providers or suppliers, with whom the Applicant has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the Application.

    h. List the name of each officer, director, agent or owner of the Applicant or its affiliates, who is an employee of the State of Florida or any of its agencies. Denote the percent of financial interest in the contracting Applicant held by the individual.

V. Criminal Background Screening

12. Submit a completed Florida Medicaid Provider Enrollment Application using the Non-Institutional Medicaid Provider Agreement, including fingerprint cards and the required screening fee to the Agency contact person listed in Section II.B., Submission Requirements, of the Enrollment Application. The Florida Medicaid Provider Enrollment Application and the Guide for Completing a Florida Medicaid Provider Enrollment Application may be accessed at the website of the Agency's fiscal Agent or at the following link:

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

For plans currently contracted as a Reform Plan, the plan is required to submit a background check for a new employee or individual which a background check has not been previously submitted.

13. Fingerprint cards are required to be submitted for all individuals indicated 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. For further reference, the Applicant may find a list of individuals required to submit fingerprint cards in the attached document labeled IV. Background Screen Managers List...

VI. Organizational Structure

14. Provide detailed exhibits (i.e., flow charts) showing the Applicant's organizational structure, including relationships and detailed lines of authority with the Board of Directors, parent companies, affiliated companies, subsidiaries, holding companies, Subcontractors, etc. Illustrate how the relationships support the 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 Contract.

15. Provide the Applicant's business plan, including but not limited to prospective county expansion, product expansion, and strategy for growth and development. At a minimum, the business plan should provide an overview of operations for twenty-four (24) months after the anticipated date of the Contract execution. The Applicant should include Form I., Model Format for Enrollment Projection, with its business plan. For new Health Plans, this information is required for the entire state.

VII. Terms and Conditions

16. Indicate the categories of administrative and management services obtained through subcontracts and the status of any subcontract(s), claims resolution and assistance process, data processing, management services, administrative services, and any other services. Be sure to include the Subcontractor's name, status of Subcontract, and anticipated signing date.

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

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

19. Describe in detail the Applicant's policies and procedures for its annual background screening for all management employees.

20. The Applicant shall provide a detailed disaster plan. If the Applicant has a delegated TPA, the Applicant must also provide a copy of the TPA's detailed disaster plan.

VIII. Required State and Federal Disclosure

21. The Applicant must complete and return the following disclosure forms to the Agency:

    a. HIPAA Certification form;

    b. Certification Regarding Lobbying;

    c. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts;

    d. Disclosure of Ownership and Control Interest Statement, CMS 1513, available at the following web site: http://www.cms.hhs.gov/forms/cms1513.pdf; and,

    e. Letter disclosing information on the Applicant's significant business transactions with a party with any interest in the profits of the Applicant.

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HEALTH PLAN APPLICATION

PHASE II
REQUIREMENTS

FISCAL REVIEW AND COMPREHENSIVE DESK REVIEW

I. FISCAL REQUIREMENTS

<u>Prepaid and Fee-For-Service Health Plans</u>

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. Financial Statements

22. Attach copies of the Applicant's financial statements for the past two (2) years. If the Applicant is a new entity, without a previous or parent entity, the Applicant must submit financial statements for those individuals listed in Phase I, Section IV. The financial statements must undergo an independent certified audit. The Applicant is responsible for ensuring that this audit is performed. All audits shall include:

    a. The opinion of a certified public accountant;
    b. A statement of revenue and expenses;
    c. A balance sheet;
    d. A statement of changes in financial position; and
    e. A copy of all management letters.

23. Provide the following pro forma financial statements for the health plan's Florida operation; these must be prepared on an accrual basis by month for the first three (3) years beginning with the first month of the proposed execution date of the Contract:

    a. A statement of monthly revenue and expenses;
    b. A monthly cash flow analysis; and
    c. A balance sheet.

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

25. Ensure that Enrollment and revenue projections, as set forth in #22 above, correspond with the information provided in response to Enrollment projections in Phase I, #14 and the Marketing plan in Phase II, #49.

26. The Applicant must provide a statement, signed by the Applicant's President or Chief Executive Officer, attesting that no assets of the Applicant's have been pledged to secure personal loans.

B. General Insurance Requirements

(Note: The General Insurance Requirements in the Contract are found in Section XVI.AA and XVI.BB, Terms and Conditions. The Fidelity Bond requirements are found in Section XV.G, Financial Requirements)

27. The Applicant must provide copies of each applicable insurance binder and include them with a list, in table format, labeled "Insurance Coverage" on the Applicant's company letterhead. Information contained in the Applicant's

submittal must include, but is not limited to, the carrier; the entity covered; a description of coverage, including deductibles, co-insurance, minimum and maximum benefits, premium in effect, additional policies to cover these risks and other arrangements, for the following types of insurance:

a. Medical malpractice insurance;
b. General liability insurance;
c. Professional liability insurance;
d. Fire and property insurance;
e. Fidelity Bond;
f. Workers' compensation insurance; and
g. Directors' errors and omission insurance.

Prepaid Health Plans

C. Insolvency Protection

28. The Applicant must provide documentation of a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida. The Applicant must describe how it will manage the insolvency protection account. The Agency may waive this requirement if there is evidence on file with the Agency for adequate insolvency insurance.

29. Applicants that are HMO's in counties with no managed care or Prepaid PSNs must indicate whether they intend to accept the comprehensive premium or the comprehensive and catastrophic premium, and thus accept financial risk for catastrophic medical expenses of Enrollees.

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II. ELIGIBILITY AND ENROLLMENT

<u>Prepaid and Fee-For-Service Health Plans</u>

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. Eligibility

30. Describe how the Applicant will assist the Agency in identifying Enrollees excluded from participation in Medicaid Reform.

B. Enrollment

31. Submit the Applicant's policies and procedures for PCP assignment, including how the Applicant will provide Enrollees with a choice in the selection of a particular PCP. The Applicant must also describe how it will ensure that each Enrollee has an ongoing source of primary care, and the timeframe for changing PCPs at the Enrollee’s request.

32. Describe the Applicant’s methods to ensure that Enrollees receive written notification of Enrollment by the first day of Enrollment into the Health Plan.

33. Describe how the Applicant will identify pregnant Enrollees and comply with all requirements regarding unborn activation.

34. The Applicant must submit policies and procedures regarding newborn assignment to pediatricians or other appropriate PCPs.

C. Disenrollment

35. Describe how the Applicant will process Disenrollment requests, how the Disenrollment request log will be maintained, and how the Applicant will provide Disenrollment summary reports.

36. Describe how the Applicant will document: 1) attempts to contact the Enrollee within the first three (3) months of Enrollment; and 2) Enrollee lack of services within the first three (3) months of Enrollment.

37. Describe the policies and procedures for involuntary Disenrollment requests, including the process for identification and verification of instances when involuntary Disenrollment is appropriate. Describe how the Applicant will: 1) document that attempts were made to educate the Enrollee regarding his/her rights and responsibilities, including one (1) verbal and one (1) written warning when appropriate; 2) provide assistance to enable the Enrollee to comply, including through case management; and 3) how the Applicant will determine that the Enrollee’s behavior is not related to the Enrollee’s medical or behavioral condition. Describe how the Applicant will ensure an Enrollee's right to appeal in cases of involuntary Disenrollment.

38. Describe how the Applicant will inform Enrollees about Open Enrollment and of the Enrollees' right to disenroll or change Health Plans without cause during the ninety (90) day change window, and to disenroll with cause thereafter. Submit all relevant policies and procedures with the Application.

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III. ENROLLEE SERVICES AND MARKETING

Prepaid and Fee-For-Service Health Plans

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. Enrollee Services

39. Provide the Applicant's policies and procedures for Enrollee Services, including how the Applicant will ensure that Enrollees are aware of:

    a. Their rights and responsibilities;
    b. The role of PCPs;
    c. How to obtain care;
    d. What to do in an emergency or urgent medical situation;
    e. How to request a Grievance, Appeal or Medicaid Fair Hearing;
    f. How to report suspected Fraud and Abuse; and
    g. Procedures for obtaining required Behavioral Health Services.

40. Describe how the Applicant will have the capability to answer Enrollee inquiries via written materials, telephone, electronic transmission, and face-to-face communication.

41. Describe and submit the New Enrollee materials the Applicant will send to new Enrollees. Such materials should include at a minimum: the Enrollee Handbook, the Provider Directory, the Enrollee Identification Card, and other notices outlined in the Contract. All new Enrollee materials must include all items specified in the Contract.

42. Describe the distribution system and methods employed to ensure the Applicant will deliver all materials promptly. Submit all relevant policies and procedures with the Application.

43. Provide policies and procedures for follow-up with Enrollees whose new Enrollee materials are returned to the Applicant for any reason, include policies for documentation. Submit copies of all relevant model correspondences with the Application.

44. Provide the Applicant's policies and procedures for making all written materials available in alternative formats and in all appropriate foreign languages. Such policies and procedures should include how the Applicant will notify all Enrollees and Potential Enrollees that information is available in alternative formats and foreign languages, and how to access those formats, how the Applicant will notify Enrollees on at least an annual basis of their right to request and obtain information; and how the Applicant will ensure that Enrollees receive a thirty (30) day notice in any change in benefits.

45. Describe how the Applicant will make all written materials at or near the fourth (4th) grade comprehension level. Please specify which software the Applicant will use to meet this requirement.

46. Describe in detail the Applicant's Enrollee services system and the type of access that will be available to Enrollees.

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

48. Provide a copy of the Applicant's written Cultural Competency Plan.

B. Marketing

49. Provide a statement specifying whether or not the Applicant intends to engage in Marketing activities.

50. If the Applicant intends to market to potential Enrollees, the Applicant must submit a Marketing plan. The Marketing 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. At a minimum, the Marketing plan shall include, but not be limited to, the following:

    a. A listing of the groups to which the Applicant plans to market;

    b. Specific strategies that the Applicant will use in Marketing to Medicaid Recipients; and

    c. An explanation, including policies and procedures, showing how the Applicant will provide Medicaid Recipients with the State's Choice Counselor/Enrollment Broker's toll-free telephone number for inquiries regarding Enrollment options, Health Plan benefits and the opportunity to raise questions and discuss potential Enrollment.

51. Provide copies of all proposed marketing policies and procedures. Marketing policies and procedures shall comply with all State, federal, and contract requirements. The policies and procedures should detail how the Applicant will monitor its Marketing Representatives to ensure that they do not engage in prohibited Marketing activities The Agency must review and approve in writing the Applicant's Marketing policies and procedures before implementation. In addition to the policies and procedures the Applicant must describe how it trains it Marketing staff and Providers to ensure full compliance with all requirements set forth in the Contract.

52. Describe how the Applicant's Marketing materials are developed for the Medicaid population, including materials available in alternative formats and foreign languages.

53. Describe how the Applicant will ensure that it directs Medicaid Recipients to the State's Choice Counselor/Enrollment Broker for information relating to Health Plan options. Such description must include the process the Applicant will follow in ensuring the a Potential Enrollee is referred to the Choice Counselor/Enrollment Broker after the Applicant has visited a Potential Enrollee in response to a Request for Benefit Information. Submit a copy of the Applicant's Request for Benefit Information form, which must include all elements specified in Section IV.B.7.c., of the Contract.

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IV. COVERED SERVICES

<u>Prepaid and Fee-For-Service Health Plans</u>

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. Covered Services

54. The Applicant must submit their policies and procedures for all services to be covered under the Contract. Such policies and procedures must detail how the Contract requirements will be met.

55. The Applicant must submit their Preferred Drug List (PDL), and all policies and procedures relating to prior authorization.

56. The Applicant must submit the output from the online plan evaluation tool.

B. Expanded Services

57. The Applicant must describe any expanded services (as detailed in the Contract) it will provide. The description must fully describe the service, including eligible populations, service setting, and the type of health professional expected to provide the service. The description should include the expected health related benefit to the Enrollee of obtaining the service.

58. In addition, the Applicant must submit the per member per month (PMPM) actuarial value of the service and supporting documentation used to derive the PMPM.

C. Moral or Religious Objections

59. The Applicant must describe any required service that it does not intend to provide on the basis of a moral or religious objection.

D. Special Coverage Provisions

60. The Applicant's policies and procedures must address Advance Directives, including how the Applicant will train and educate its staff about Advance Directives and how it will educate Enrollees about their ability to direct their care using this Advance Directives.

61. The Applicant must submit specific policies and procedures related to the provision of Child Health Check-Up (CHCUP) Services. Such policies and procedures must include how the Applicant will identify Children/Adolescents that have not received all required screenings, and how the Applicant will ensure that Children/Adolescents receive all required screenings and treatment for conditions found at CHCUP screenings, including blood lead screenings and follow up and case management in cases where an Enrollee has elevated blood

lead levels. The Applicant must describe how it will ensure that appointments are scheduled for Enrollees to obtain screenings.

62. The submitted policies and procedures related to Dental services should include any outreach and education provided to Enrollees to encourage access to Dental screenings and services for Children/Adolescents.

63. The Applicant must submit policies and procedures and all documentation used to explain the process by which Enrollees can obtain emergency services. The Applicant must describe how it will educate all Enrollees and network Providers of the provisions related to Emergency Medical and Behavioral Health Services.

64. In its policies and procedures for Family Planning the Applicant must address how it will ensure confidentiality for all Enrollees.

65. The Applicant must describe how it will maintain a log of all hysterectomy, sterilization and abortion procedures performed for all Enrollees.

66. The submitted policies and procedures must address how it will ensure that Providers are enrolled in the VFC program, and how it will ensure that Provider differentiate Title XXI MediKids in order to bill for their immunizations separately.

67. The Applicant must provide policies and procedures, documentation, and checklists relating to the Applicant's outreach program, and other strategies the Applicant intends to implement in order to identify every pregnant Enrollee.

68. The Applicant's policies and procedures must address all screening and coordination requirements for pregnant women, including Healthy Start screening and referral and WIC referral, and HIV and Hepatitis B counseling and testing. It must also address the comprehensive prenatal care, delivery, newborn and postpartum care requirements.

69. The Applicant must describe how it will comply with the settlement agreement relating to *Hernandez et. al. v. Medows,* case number 02-20964 Civ-Gold/Simonton.

70. The Applicant must submit policies and procedures used to ensure that all Enrollees under the age of twenty-one (21) who are taken into protective custody or foster care are physically screened within seventy-two (72) hours, or immediately if required.

71. The Applicant must submit its policies and procedures related to its Quality Enhancements as outlined in Section V Covered Services, F. coverage Provisions, 15. Quality Enhancements and must provide a list of such services.

72. The Applicant must indicate whether it intends to coordinate with the CTD for Transportation services, or whether it will provide such services directly through its Provider Network. The Applicant's policies and procedures must address how it will monitor the provision of all Transportation services to ensure compliance with all requirements in the Contract.

73. The Applicant must describe any incentive programs and/or provisions it intends to offer to Enrollees and/or Providers.

Prepaid Health Plans

A. Covered Services

74. Prepaid Health Plans have the flexibility to provide all Medicaid-covered services (as outlined in the Medicaid Coverage and Limitations Handbook) or to design a customized benefit package in accordance with State-established standards for a target population. Regardless of which option the Health Plan chooses, all Medically Necessary services must be provided to pregnant women and children. Services must be provided to other Enrollees in accordance with the State-established standards. The Applicant must identify the target population(s), if applicable, and must indicate whether it intends to provide all Medicaid-covered services or a customized benefit package tailored to the target population(s) it will serve as indicated in "Contact Information" of this application. The Applicant must fully complete a Form III., Model Format for The Benefit Grid, for each targeted population. If the same benefit package will be provided to each target population, submit only one Benefit Grid; however, the benefits must meet the sufficiency requirements for each target population to be served and be approved by the Agency. Information regarding submission and approval may be accessed at the Reform website, Florida Medicaid Reform Evaluation Tool: http://ahca.myflorida.com/Medicaid/medicaid_reform/provider/index.shtml#two

The policies and procedures submitted pursuant to #54 of this Section must correspond to the Covered Services to be provided by the Applicant.

Fee for Service PSNs

A. Covered Services

75. The FFS PSN must cover all Medicaid-covered services listed in the Section V.A through V.D., Covered Services, of the Contract. All services must be provided in the same amount, duration and scope as services provided to Medicaid Recipients in non-Medicaid Reform FFS and as outlined in the Medicaid Coverage and Limitations Handbook. The policies and procedures submitted pursuant to #54 of this Section must correspond to these services.

NOTE: See the following Agency website for information regarding the Form III, Model Format for The Benefit Grid. http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

V. BEHAVIORAL HEALTH SERVICES

Prepaid and Fee for Service Health Plans

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

All documents and materials addressing Behavioral Health Services are to be in a separate binder labeled Behavioral Health Services. A contact person for this section of the application must be identified along with contact information.

A. General Provisions

76. All Applicants must cover the services specified in Section VI.A through VI.B, Behavioral Health Services, of the Contract. Prior to the submission of the application contact Carol Barr Platt at (850) 410-1069 or plattc@fdhc.state.fl.us, to receive a copy of the Behavioral Health Policy and Procedure Review Tool, the Policy and Procedure Template, and instructions.
All Applicants must submit their policies and procedures for Behavioral Health Services and Targeted Case Management to be covered under the Contract. These Policies and Procedures must be submitted as instructed above and in the provided Template. Such policies and procedures must detail the Applicant's approach to providing Behavioral Health Care and must document the Applicant's ability to provide the full range of Behavioral Health Services.

77. The Applicant must fully describe how Behavioral Health Services and Targeted Case Management will be provided. The Applicant must indicate if it intends to contract with another behavioral health care entity to provide any services, and if so, must indicate specifically which services and how they will monitor for compliance. In the case of a Provider contract arrangement, the Applicant must fully explain how it will monitor the Provider to ensure full compliance with all Contract requirements.

78. The Applicant must submit an Enrollee Handbook which has a separate Behavioral Health section that includes the following information:

    (1)Description of Behavioral Health services provided, including limitations and general restrictions on Provider access, exclusions and out-of-network use;
    (2)Procedures for obtaining required services, including second opinions, and authorization requirements, including those services available without Prior Authorization;

    (3)Description of Behavioral Health Emergency Services and procedures for obtaining services both in and out of the PSN's Service Area, including explanation that Prior Authorization is not required for Emergency Services, the locations of any emergency settings and other locations at which Providers and Hospitals furnish Emergency Services and Post-Stabilization Care Services

(4)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;

(5)A notice that clearly states that the Enrollee may select an alternative behavioral health case manager or direct service provider within the PSN, if one is available;

(6)Information to assist the Enrollee in assessing a potential behavioral health problem;

79. The Applicant must submit a Behavioral Health Provider Network that demonstrates that the applicant has sufficient facilities, service locations, service sites and personnel to provide the Covered Services described in Section VI Behavioral Health Care.

80. The Applicant must submit a Behavioral Health specific Quality Improvement Program Description that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered.

81. The Applicant must submit a Behavioral Health specific Utilization Management Program Description that addresses:

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

b. The Health Plan shall report Fraud and Abuse information identified through the Utilization Management program to the Agency's contract manager, MPI and MFCU as described in Section X, and referenced in 42 C.F.R. 455.1(a)(1).

c. A procedure for Enrollees to obtain a second medical opinion and that the Health Plan shall be responsible for authorizing claims for such services in accordance with section 641.51, F.S.

d. Service Authorization protocols for Prior Authorization and denial of services; the process used to evaluate prior and con-current authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting
Provider when appropriate, Hospital discharge planning, and a retrospective review of both inpatient and ambulatory claims, meeting the predefined criteria as stated in Section VIII.B. The Health Plan shall be responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting Provider when appropriate.

82. The Applicant must submit a Provider Handbook that is specific to Behavioral Health and includes the following information:

a. Description of the program;
b. Covered Services;
c. Emergency Service responsibilities;
d. Policies and procedures that cover the Provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Health Plan's Provider services to file a Provider complaint and which individual(s) has the authority to review a Provider complaint;
e. Information about the Grievance System, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the Enrollee's right to request continuation of Benefits while utilizing the Grievance System;
f. Medical Necessity standards and clinical practice guidelines;
g. Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
h. PCP responsibilities;
i. Other Provider or Subcontractor responsibilities;
j. Prior Authorization and referral procedures;
k. Medical Records standards;
l. Claims submission protocols and standards, including instructions and all information necessary for a clean or complete claim; m. Notice that the amount paid to Providers by the Agency shall be the Medicaid fee schedule amount less any applicable co-payments;
n. Notice that Provider complaints regarding claims payment should be sent to the Health Plan;
o. The Health Plan's cultural competency plan;
p. Enrollee rights and responsibilities; and
q. The Health Plan shall disseminate bulletins as needed to incorporate any needed changes to the Provider handbook

83. The Applicant must describe or be prepared to submit a training plan, training manual and training schedule which is specific to Behavioral Health.

84. The Applicant must submit an Organization Chart which represents the oversight and structure of the Behavioral Health services component of the Health Plan.

B. Service Requirements

85. **T**he Applicant must describe its clinical practice guidelines for each service to be provided and how it will ensure that the frequency, duration, and content of services is consistent with the age, developmental level and level of functioning of the Enrollee.

Prepaid Health Plans

A. General Service Provisions

86. Prepaid Health Plans have the flexibility to provide all Medicaid-covered services (as outlined in the Medicaid Coverage and Limitations Handbook) or to design a customized benefit package for a target population. Regardless of which option the Health Plan chooses, all Medically Necessary services must be provided to pregnant women and children, and certain mandatory services must be provided to other Enrollees in accordance with the state-established sufficiency standards. The Applicant must provide the target population and must indicate whether it intends to provide all Medicaid-covered services or a customized benefit package tailored to the target population.

FFS Health Plans

87. In addition to providing the full range of services described in Section VI.A through VI.B, the FFS PSNs may not alter the amount, duration and scope of such services from that specified in the Handbooks. The PSN may not establish service limitations that are lower than, or inconsistent with the Handbooks.

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VI. PROVIDER NETWORK

<u>Prepaid and Fee-For-Service Health Plans</u>

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. General Provisions

88. The Applicant must demonstrate that it has sufficient facilities, service locations, service sites and personnel to provide the Covered Services described in Section V and Behavioral Health Care described in Section VI.

89. The Applicant must indicate in which Medicaid Reform counties the Applicant intends to operate during the Contract period, and if the Applicant anticipates a phase-in period different from that of Medicaid Reform. The Applicant must describe how it will increase and adapt its network as it expands to additional counties. The Applicant must provide network information in a geo-access format.
NOTE: The Agency may require the applicant to provide services in an Agency predetermined service area.

90. The Applicant must provide the Agency with adequate assurances that the Applicant has the capacity to provide Covered Services to all Enrollees up to the maximum enrollment level in each county, including assurances that the Applicant:

    a. Offers an appropriate range of services and accessible preventive and primary care services such that the Applicant can meet the needs of the maximum enrollment level in each county; and

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

91. List, by county, the name, address, specialty, license number, hours of operation, and staffing of locations where the Applicant plans to provide primary care services and whether the Provider's panel is open or closed to new Medicaid Enrollees enrolled with the Applicant (in Excel spreadsheet format, as shown in Form II., Model Format for Provider Network Checklist). Applicants may submit a separate list of Primary care providers (PCPs) located in adjacent Non-Reform Counties who may provide services to Reform Enrollees. For enrollees in a Reform Plan who select a PCP or access providers in an adjacent county, the Plan is responsible for all service in the contract including transportation. The Plans must ensure that the provider's contract specifies that the provider will be serving individuals in the respective counties and the respective contract provisions for each Plan. This may require approval by Bureau of Managed Health Care (BMHC).

92. List, by county, the name, address, medical degree, hours of operation, and staffing of locations where the Applicant plans to provide specialty services and whether the Provider's panel is open or closed to new Medicaid Enrollees enrolled with the Applicant (in Excel spreadsheet format as shown in Form II., Model Format for Provider Network Checklist). Applicants may submit a separate list of specialist providers located in adjacent Non-Reform Counties who may provide services to Reform Enrollees. For

enrollees in a Reform Plan who access providers in an adjacent county, the Plan is responsible for all service in the contract including transportation. The Plans must ensure that the provider's contract specifies that the provider will be serving individuals in the respective counties and the respective contract provisions for each Plan. This may require approval by Bureau of Managed Health Care (BMHC).

93. The Applicant must provide GeoAccess or prior approved Agency mapping software reporting for each proposed county, including the location of all contracted Providers, within each proposed county and the travel times. The Applicant must submit a separate GeoAccess report for each dentist, pedodontist, and primary care provider by specialty. The GeoAccess report must also provide the locations for pediatricians, CHD, FQHC or RHC to demonstrate that the access requirement of thirty (30) minutes travel time has been met., as well as one (1) board certified child psychiatrist (or one (1) child psychiatrist. The Applicant must also submit a GeoAccess report that documents that the Applicant's network meets all access standards for pharmacies, hospitals, and Direct Service Behavioral Health Providers.

94. The Applicant must provide an Excel spreadsheet listing of all participating Providers, as well as the cover page and signature page from the executed contracts of all participating Providers in each county. The spreadsheet must also indicate those Providers currently accepting new Medicaid patients.

95. List the name, address, service locations, hours of operation and staffing of locations where the Applicant plans to provide twenty-four (24) hours a day, seven (7) days a week emergency services (in Excel spreadsheet format). Please provide a separate list for behavioral health emergency services locations.

96. Submit the policies and procedures that the Applicant will use to ensure that its Providers offer emergency services, urgent care, routine sick patient care, and well care visits within the time frames specified in the Contract.

97. Submit the policies and procedures, documents and checklists that the Applicant intends to use for the purposes of conducting an annual review of each primary care physician's active patient load and ensure that additional Enrollees are not assigned to physicians with appointment waiting times and geographic access standards are out of compliance with Section VII, Provider Network.

98. Submit policies and procedures, documents and checklists detailing how the Applicant will ensure that Providers' facilities:

    a. Are accessible to persons with disabilities;
    b. Maintain adequate space for a waiting room and patient rooms;
    c. Keep sufficient supplies on hand;
    d. Have adequate fire and safety procedures;
    e. Have adequate patient medical record procedures and have sufficient space set aside to store medical records;
    f. Are kept in a sanitary condition; and
    g. Maintain a smoke free environment.

99. The Applicant must submit describe its policies and procedures for notifying the Agency any time there has been a significant change in the Applicant's operations that would affect adequate capacity and services, including, as outlined in Section VII.A.7 of the Contract.

100. The Applicant must submit its policies and procedures for informing Potential Enrollees and Enrollees of any changes to service delivery and/or the Provider network as outlined in Section VII.I, 1-3, of the Contract. Such policies and procedure must also address changes in the Applicant's network that negatively affect the ability of Enrollees to access services, including access to a culturally diverse Provider network.

101. The Applicant must submit policies and procedures for the provision of continued care from terminated providers. Such policies and procedures must address how, in the even a PCP ceases participation in the Applicant's network, the Applicant will send written notice to Enrollees who have chosen the Provider as their PCP no less than ninety (90) Calendar Days prior to the effective date of the termination and no more than ten (10) Calendar Days after receipt or issuance of the termination notice

102. The Applicant must submit policies and procedures documenting how the Applicant will notify the Agency within seven (7) Business Days of any significant changes to the Applicant's network.

103. The Applicant must describe how it will make a good faith effort to enter into a memorandum of agreement with the local CHD and FQHCs.

104. The Applicant must describe how it will make a good faith effort to enter into a memorandum of agreement with local school districts participating in the certified match program.

105. The Applicant (Capitated Health Plans only) shall require each Provider to have unique Florida Medicaid Provider number. The Applicant shall enroll all network providers who are not verified as Medicaid-enrolled providers with the Agency's Fiscal Agent per Section II.D.13 of the Contract. For Applicant network providers who do not have a Florida Medicaid Provider number and who do not intend to become a Medicaid Provider, the provider shall complete the two page form "Florida Medicaid Provider Enrollment Application For A Treating Provider Contracted To A Medicaid Managed Care Entity" which may be accessed at the website of the Agency's fiscal Agent or at the following link:

http://floridamedicaid.acs-inc.com

106. The Applicant shall require each provider to have National Provider Identifier (NPI) in accordance with Section X, C.2. ii, of the Contract. The Applicant must submit the provider's NPI as part of the Provider Network Report.

VII. QUALITY MANAGEMENT

Prepaid and Fee-For-Service Health Plans

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. Quality Improvement

107. Describe the staffing plan for the QIP, including an organizational chart and job descriptions. Include staff resumes, if available, which describe pertinent experience and certification/licensure. Provide the policies and procedures used to ensure that all persons acting for or on behalf of the Applicant are properly licensed under applicable federal and State laws and/or regulations.

108. Describe the committee structure of the Applicant and its relationship to the QIP. This should include, but not be limited to the governing body, a QIP Committee, peer review committee and a credentialing/recredentialing committee. The description should include the membership (and whether members are Applicant staff or external to the Applicant), the members' qualifications and certifications/licensure, and the responsibilities, reporting relationships and communication requirements for the committees. The communication process should be depicted in a flow chart.

109. Describe how the Applicant ensures that its committees' memberships and chairs are not the same across multiple committees.

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

B. Utilization Management

111. Describe the staffing plan for the UM Department, including an organizational chart and job descriptions. Include staff resumes, if available, which describe pertinent experience and certification/licensure.

112. Submit Service Authorization protocols, including those which cover new Enrollees

113. Describe procedures for identifying patterns of over-utilization and under-utilization.

114. Describe procedure for reporting potential fraud and abuse information gained from UM activities.

115. Describe the process by which Enrollees can obtain a second medical opinion.

116 Describe the procedure for authorizing claims from CHDs, migrant health centers and FQHCs.

117. Submit policies and procedures describing notices of Action. Include a model notice of Action.

118. Submit policies and procedures describing the Applicants care management activities and new enrollee activities.

119. Describe the Applicant's planned process for the development and implementation of disease management programs.

120. Submit policies and procedures which describe the requirements for treatment plans for those with chronic diseases and for those receiving Behavioral Health Services.

121. Submit a description of the Applicant's incentive program, if any.

122. Describe the Applicant's process for adopting practice guidelines.

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VIII. GRIEVANCE SYSTEM

<u>Prepaid and Fee-For-Service Health Plans</u>

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. General Requirements

123. Describe the staffing plan for the Grievance System, including an organizational chart and job descriptions. Include staff resumes, if available, which describe pertinent experience and certification/licensure.

124. Describe the orientation and education that will be given to the Applicant's staff, who interact with Enrollees and providers, regarding the recognition and handling of Enrollee Grievances and Appeals.

125. Describe the process for ensuring decision makers about Grievances and Appeals have not been involved in previous levels of review of decision making.

126. Describe the process for identifying appropriate Health Care Professionals, when deciding a Grievance or Appeal involving clinical issues, an Appeal of a denial based on lack of Medical Necessity or a Grievance regarding the denial of an expedited resolution of an Appeal.

127. If there are materials in addition to the Enrollee handbook, describe the information regarding the Grievance System, including the Beneficiary Assistance Panel, to be provided to Enrollees.

128. Submit the policy and procedure which describes the assistance which will be provided to Enrollees in completing the procedural steps of the Grievance System.

129. Describe how the Health Plan will ensure that no punitive action will be taken against a provider who supports the submission of an Appeal, a request for a Medicaid fair hearing or a request for the continuation of Benefits by an Enrollee or a provider who submits an Appeal, a request for a Medicaid fair hearing or a request for a continuation of Benefits on an Enrollee's behalf.

130. Describe how the analysis of Grievance System information will be used for Quality Improvement.

131. Submit the policy and procedure for Grievance System documentation.

B. Grievance Process

132. Submit policies and procedures which cover the filing and resolution of Enrollee Grievances.

133. Submit policies and procedures which cover the expedited review process.

C. Appeal Process

134. Submit policies and procedures which cover the filing and resolution of appeals, as well as the continuation of Benefits during an Appeal.

135. Submit policies and procedures which cover the PSN activities once an appeal is resolved.

136. Submit policies and procedures which cover the expedited review process.

D. Medicaid Fair Hearings

137. Submit policies and procedures for filing a request for a Medicaid fair hearing.

138. Submit policies and procedures for the continuation of Benefits during a Medicaid fair hearing.

139. Submit policies and procedures which cover the Health Plan responsibilities once a Medicaid fair hearing decision is delivered.

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IX. INFORMATION SYSTEMS

<u>Prepaid and Fee-For-Service Health Plans</u>

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. System Capacity, Availability and Performance

140. Describe in detail how the Applicant will ensure that the capacity, availability and performance of its systems will meet the requirements set forth in the contract. The description should, at a minimum, encompass:

  a. Information and telecommunications systems architecture (for information and telecommunications systems within your span of control),
  b. Data and voice communications network architecture,
  c. Business continuity and disaster recovery strategies
  d. Monitoring tools and resources.

  The description should address technologies, including those that support system scalability and flexibility, as well as policies and procedures.

141. Please identify the timing of implementation of the mix of technology and management (policies and procedures) strategies outlined in the response to question 134, above.

142. Please state the projected recovery times and data loss for each mission-critical system identified in your business continuity-disaster recovery (BC-DR) plan (these projections are pertinent only in the event of a declared disaster).

B. E-Mail System

143. Describe the Applicant's proposed solution for a continuously available electronic mail communication link (E-mail system) with the Agency. In the description please address:

  a. Availability from the workstations of the designated PSN staff
  b. Capabilities to attach and send documents created using software products other than the vendor's systems, including the Agency's currently installed version of Microsoft Office and any subsequent upgrades as adopted.
  c. Capabilities to, as needed, encrypt and/or otherwise secure the content of electronic messages.

144. Identify the timing of implementation of the e-mail solution outlined in the response to question 137, above.

C. Data and Report Validity and Completeness

145. Describe the processes the Applicant shall institute to ensure the validity and completeness of the data, including reports, you will submit to the Agency. At a minimum the response should address data validity and completeness audits and the use of relevant statistical techniques.

D. Data Exchange

146. Cite at least two currently-live instances where the Applicant is successfully:

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

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

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

E. Reporting – System Capabilities

148. 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.

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F. Companion Documents

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

SYSTEMS PROFILE

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

REFER TO ATTACHMENT

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

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

Additionally, as part of the Systems profile indicate:

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

150. Identify whether any of the applications identified in the Systems Profile will be replaced (and by what application, if known), or undergo a major upgrade or release/version update, in the next eighteen months.

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

152. Provide a sample System availability and performance report from a current customer.

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

IS ORGANIZATIONAL PROFILE - PERSONNEL ROSTER TABLE EXAMPLE

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

Prepaid Health Plans

G. Data Exchange

154. Cite at least two (2) currently-live instances where the Applicant is successfully providing encounter data to a state's MMIS, DSS or other third party in accordance with HIPAA-compliant or Agency-specific coding, data exchange format and transmission standards and specifications, as required in the Contract.

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

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X. ADMINISTRATION AND MANAGEMENT

<u>Prepaid and Fee-For-Service Health Plans</u>

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

A. Staffing

156. Submit the job descriptions for each of the minimum staffing positions. Include the resumes showing pertinent experience and certification/licensure of the current staff, if available.

B. Provider Contracts

157. Submit the Applicant's model Provider contracts. The Applicant is required to have a Provider contract with all major service providers (including primary care sites), including but not limited to the following:

    a. Primary Care physicians;
    b. Specialty Physicians;
    c. Hospitals;
    d. Clinics; and
    e. Facilities.

158. The Applicant must submit a completed checklist of the required terms and conditions for each of the Applicant's proposed model Provider contracts. Such checklist may be obtained from the Agency Program Analyst.

C. Provider Terminations

159. Submit the policies and procedures which cover Provider rights regarding termination of a provider's participation with the Applicant's network.

160. Submit policies and procedures regarding notification when a provider is terminated.

D. Provider Services

161. Submit policies and procedures that cover the Applicant's responsibilities to ensure its Providers are compliant with the Contract, and federal and State regulations.

162. Describe the informational materials, which will be provided to Providers and how they will be distributed including, but not limited to the Provider Handbook. Submit the Provider Handbook.

163. Describe the orientation the Applicant will present to new Providers, as well as the schedule and content of any continuing training for current providers.

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

165. Submit the policies and procedures which cover the functions of the provider relations unit.

166. Describe the provider telephone help line system.

167. Submit the policies and procedures which cover the provider complaint system.

E. Medical Records

168. Submit the policies and procedures which cover Enrollee Medical Records requirements.

169. Describe the process by which the Applicant will ensure that Providers are compliant with the Enrollee Medical Record requirements.

170. Describe the process by which the Applicant will ensure the confidentiality of Enrollee Medical Records.

F. Claims Payments

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

172. Describe the Applicant's provider claims complaint resolution process.

G. Fraud Prevention

173. Describe the staffing plan for fraud prevention, including an organizational chart and job descriptions if staff extends beyond the compliance officer. Include staff resumes, if available, which describe pertinent experience and certification/licensure.

174. Submit the policies and procedures which cover program integrity, including, but not limited to compliance with the Contract, and federal and State regulations, and the identification, prevention and reporting of Fraud and Abuse.

175. Describe the orientation and ongoing education about program integrity that will be provided to the Applicant's staff, providers and Enrollees.

H. Subcontracts

(Note: the Subcontract requirements in the Contract are found in Section XVI.Q, Terms and Conditions, not the Administration and Management section.)

176. The Applicant must provide model Subcontracts with all major service providers (in addition to Provider Subcontracts referenced above in C.1) who are not salaried employees of the Applicant. Such entities include but are not limited to:

    a. Any Applicant-delegated administrative functions;
    b. Pharmacy benefits managers (“PBMs”);
    c. Administrative Service Organizations;
    d. Management Service Organizations; and
    e. Third Party Administrators (TPAs).

177. The Applicant must submit a completed checklist of the required terms and conditions for each of the Applicant’s proposed model Subcontracts. Such checklist may be obtained from the Agency Program Analyst.

178. The Applicant must describe how it will ensure that all Subcontracts, including Provider Subcontracts, comply with all State and federal requirements.

Prepaid Health Plans

I. Claims Payment

179. Submit policies and procedures which cover the submission, processing and payment of provider Claims.

180. Describe the Applicant’s Claims processing and payment performance metrics, including quality, accuracy and timeliness. Include a description of how they will be monitored.

J. Encounter Reporting

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

182. Submit the policies and procedures which cover the generation and submission of encounters, including but not limited to how the Applicant will ensure the completeness, accuracy and timeliness of its Encounters.

Fee-for-Service Health Plan

K. Claims Payments

183. Submit policies and procedures which cover the submission, authorization and forwarding of Provider claims to the Agency or its Fiscal Agent.

184. Describe the Applicant’s role in coordination with the Agent and when acting as an intermediary between a provider and the Agent when there is a disagreement.

XI. REPORTING

Prepaid and Fee-for-Service Health Plans

A. General Requirements

185. Submit a description of the responsible position (to be the Agency contact) for each report listed in Table 1 of the Contract.

186. Submit the policies and procedures which cover the assurance of the timeliness, accuracy and completeness of the reports.

187. Describe the position who will certify the reports.

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HEALTH PLAN APPLICATION

PHASE III
REQUIREMENTS

SITE VISIT

The following documentation shall be available during the Site Review.

I. ENROLLEE SERVICES AND MARKETING
Prepaid and Fee-For-Service Health Plans

The Health Plan Applicant must reference the Reform Model contract and ensure that the responses submitted comport with contract requirements.

188. A listing of all Marketing Representatives for registration with the Agency as required in Section IV.B.6.b., of the Contract.

II. INFORMATION SYSTEMS
Prepaid and Fee-For-Service Health Plans

A. Data Model and Accessibility

189. Describe how the Applicant's organization's systems have been architected following relational database conventions, as well as how they are Structured Query Language (SQL) and/or Open Database Connectivity (ODBC) compliant. If any of the Applicant's systems does not meet these standards, identify these systems and describe how you will ensure that data in these Systems are readily accessible by designated Agency staff.

B. Data and Document Relationships

190. Describe the Applicant's plan to store and codify documents used by members and Providers to interact and/or transact with the Applicant so as to maintain the logical relationships between certain documents and certain data as described in the Contract. Explain how the Applicant will enable data and documents related to the same entity (i.e. member, provider, claim) to be accessible via a singular process and/or System – if the Applicant's Systems possess this functionality at present, please elaborate.

C. Testing and Change Management

191. Describe the Applicant's policies and procedures for providing the Agency with sufficient system access during and subsequent to readiness review to perform necessary tests.

FORMS AND REPORT FORMATS

CERTIFICATION REGARDING HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 COMPLIANCE

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

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

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

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

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

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

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

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

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

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

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

CERTIFICATION

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

Vendor Name:

____________________________________ ____________________

Signature Date

____

Name and Title of Authorized Signer

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CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

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

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

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

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

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

_______________________________________ ___________________________

Signature Date

_______________________________________ ___________________________

Name of Authorized Individual Application or Contract Number

____

Name and Address of Organization

CERTIFICATION REGARDING
DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION
CONTRACTS/SUBCONTRACTS

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

INSTRUCTIONS

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

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

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

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

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

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

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

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

CERTIFICATION

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

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

____ _______________
Signature Date

____

I. Model Format for Enrollment Projection

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

Year	Quarter	Area	County	Estimated # Eligible	Projected Numbers	
					Members this Quarter	**Members Year-to-date**
		Example: One	*Example: Broward*			
Total						
Total						
Total						
Total						

.II. Model Format for Provider Network Checklist

HSD-1 COUNTY/DELIVERY SYSTEM SUMMARY OF PROVIDERS BY SPECIALTY							
Date Prepared:							
Applies to plan(s):							
	Provider Arrangements						
PRIMARY CARE PHYSICIANS	**Number of Participating Provider Agreements or Subcontracts**	**Names of Providers with Letter of Agreement (no contract)**	**Total # of Providers**	**May Providers Serve as PCPs?**	**Total # of PCPs Accepting New Patients**	**Total # of PCPs Accepting Only Established Patients**	**County**
Family Practice/General Practice – Must have at least one (1) FTE per County							
Internal Medicine – Must have at least one (1) FTE per County.							
Pediatrics – Must have at least one (1) FTE per County.							
Specialty Physicians							
(							
Allergist							
Anesthesiologist*							
Cardiologist							
Cardiovascular Surgeon							
Certified Nurse Midwife/Licensed Midwife							
Colo-rectal Surgeon							
Chiropractic Physician							
Dermatologist							
Endocrinologist							
Gastroenterologist							
General Surgeon							
Hand Surgery							
Hematology/Oncology							
Infectious Diseases/AIDS Specialist							
Internal Medicine							
Neonatology							

	Provider Arrangements						
SPECIALTY PHYSICIANS	Number of Participating Provider Agreements or Subcontracts	Names of Providers with Letter of Agreement (no contract)	Total # of Providers	May Providers Serve as PCPs?	Total # of PCPs Accepting New Patients	Total # of PCPs Accepting Only Established Patients	County
Nephrologist							
Neurosurgeon							
Neurologist							
Obstetrical/Gynecology							
Oncologist							
Ophthalmologist							
Optometrist							
Oral Surgeon							
Orthopedist							
Orthopedic Surgeon							
Otolaryngologist							
Pathologist*							
Pediatric Cardiologist							
Pediatric Endocrinologist							
Pediatric Nephrologist							
Pediatric Orthopedist							
Pediatric Therapist - Occupational							
Pediatric Therapist - Physical							
Pediatric Therapist – Respiratory							
Pediatric Therapist - Speech							
Plastic/Reconstructive Surgeon							
Podiatrist							
Psychiatrist							
Psychology							
Pulmonologist							
Radiologist*							
Radiation Oncology							
Regional Perinatal Care Center (RPICC) or a hospital licensed for Neonatal intensive Care Unit (NICU) Level III beds							
Rheumatology							
Therapist – Occupational							
Therapist – Physical							
Therapist – Respiratory							
Therapist – Speech							
Thoracic Surgeon							
Urologist							
TOTALS							
*These specialties may be hospital based.							

	Provider Arrangements						
ANCILLARY SERVICES	**Number of Participating Provider Agreements or Subcontracts**	**Names of Providers with Letter of Agreement (no contract)**	**Total # of Providers**	**May Providers Serve as PCPs?**	**Total # of PCPs Accepting New Patients**	**Total # of PCPs Accepting Only Established Patients**	**County**
Birth Center							
Dental							
Diagnostic Radiology							
Durable Medical Equipment (DME)/Supplies (Includes Orthotics/Prosthetics)							
Free-Standing Dialysis Centers							
Hearing							
Home Health Care							
Laboratory Services							
Mental Health							
Outpatient Surgery							
Portable X-ray Services							
Skilled Nursing Facility							
Vision Services							
School-Based Services (only in counties which school-based services exit)							
Contract or Good Faith Effort							
County Public Health Departments							
Contract or Good Faith Effort							
TOTALS							

	Provider Arrangements						
EXPANDED OR OPTIONAL NETWORK PROVIDERS	**Number of Participating Provider Agreements or Subcontracts**	**Names of Providers with Letter of Agreement (no contract)**	**Total # of Providers**	**May Providers Serve as PCPs?**	**Total # of PCPs Accepting New Patients**	**Total # of PCPs Accepting Only Established Patients**	**County**
Dental							
Transportation							
Vision							
Other:							
ADDITIONAL NETWORK PROVIDERS							
(Last Name of Provider and the Services/Products They Provide,							
TOTALS							

III. Model Format for the Benefit Grid

The Benefit Grid (Grid) below is to be used to describe the Prepaid Health Plan's Customized Benefit Package (CBP). As described in Section V, Covered Services, E. Customized Benefit Package, the CBP must meet actuarial equivalency and sufficiency standards for the population or populations which will be covered by the CBP.

The Grid displays the services to be covered and the areas that can be customized by the Prepaid Health Plan, whether that is co-pays, or the amount, duration or scope of the services. The shaded areas indicate that no changes to the services in that part of the Grid can be changed from the description above in this section or in Section VI, Behavioral Health Services.

If the CBP includes expanded services, beginning with #10 of the Grid, the Prepaid Health Plan must submit additional information with the Grid including projected PMPM costs for the target population, as well as the actuarial rationale for them. This rationale shall include utilization and unit cost expectations for services provided in the benefit.

III. Model Format for The Benefit Grid

Health Plan: ____________________

Target Population: ____________________

All Listed Services must be covered for Children & Pregnant Adults if medically necessary with no co-pay

	Covered Service Category	AHCA Standard for Adult Coverage	Day/Visit Limit	Limit Period (Annual/Monthly)	Dollar Limit	Limit Period (Annual/Monthly)	Copay Amount	Copay Application
1	**Hospital Inpatient**	45 days						
	Behavioral Health							day or admit
	Physical Health							day or admit
2	**Transplant Services**	all medically nec						
3	**Outpatient Services**							
	Emergency Room	all medically nec						
	Medical/Drug Therapies (Chemo, Dialysis)	all medically nec						
	Ambulatory Surgery - ASC	all mecially nec.						
	Hospital Outpatient Surgery	all medically nec						visit
	Independent Lab / Portable X-ray	all medically nec						day
	Hospital Outpatient Services NOS	sufficiency tested						visit
	Outpatient Therapy (PT/RT)	coverage						visit
	Outpatient Therapy (OT/ST)	not applicable						
4	**Maternity and Family Planning Services**	all medically nec						
	Inpatient Hospital	all medically nec						
	Birthing Centers	all medically nec						
	Physician Care	all medically nec						
	Family Planning	all medically nec						
	Pharmacy	all medically nec						
5	**Physician and Phys Extender Services (non maternity)**							
	EPSDT	not applicable						
	Primary Care Physician	all medically nec						visit
	Specialty Physician	all medically nec						visit
	ARNP / Physician Assistant	all medically nec						visit
	Clinic (FQHC, RHC)	all medically nec						visit
	Clinic (CHD)	all medically nec						
	Other	all medically nec						visit

6	**Other Outpatient Professional Services**							
	Home Health Services	sufficiency tested						visit
	Chiropractor	coverage						visit
	Podiatrist	coverage						visit
	Dental Services	coverage						visit
	Vision Services	coverage						visit
	Hearing Services	coverage						visit
7	**Outpatient Mental Health**	all medically nec						visit
8	**Outpatient Pharmacy**	sufficiency tested						
	Generic Pharmacy							
	Brand Pharmacy							
9	**Other Services**							
	Ambulance	all medically nec						
	Non-emergent Transportation	all medically nec						trip
	Durable Medical Equipment	sufficiency tested						

	Additional Services (if applicable)*	**Projected PMPM**
10		
11		
12		
13		
14		

* Attach benefit description and supporting documentation.

IV. Background Screening Manager List

List of individuals who must complete a background screen: Submit a detailed list of all individuals who must complete a background screen (regardless of whether they have already completed a screen for a different state agency/department, already been submitted to AHCA/ACS, are exempt, etc.). The list of positions for which a screening is required is provided in item 4. below. Your list must include the individual's full legal name (first name, middle initial, last name); title; position (relative to the applicant/health plan; such as, Plan employee, Owner, Subcontractor, etc.); date of birth; Social Security number; and indicate whether you are submitting a fingerprint card or a licensure screen print for the individual. See item 3. below for a listing of individuals for whom licensure screen prints may be submitted in lieu of the fingerprint cards.

Manager Type	Full Name	Health Plan Title (if different than manager type)	Position (Plan Employee, Subcontractor, etc.)	Date of Birth	SSN	Fingerprint (FP)/ Licensure Screen Print (LSP)/ Exempt (E)
Contract Manager					23423243333	
Full-Time Administrator						
Medical Director						
Medical Records Review Coordinator						
Data Processing and Data Reporting Coordinator						
Marketing Oversight Coordinator						
QI Manager						
UM Manager						
Grievance System Coordinator						
Compliance Officer						
Case Management Manager/Coordinator						
Behavioral Health Oversight Manager						
Board Certified or Board Eligible, Licensed Staff Psychiatrist						
Financial records custodian						
Individuals w/signing privileges on depository account						
Any other with direct decisions or have impact on services rendered to beneficiaries						

For licensed individuals holding management positions, include in your submittal copies of licensure screen prints from the Florida Department of Health website for licensed individuals holding management positions. For certain licensed individuals (medical, osteopathic, podiatric, and chiropractic physicians as well as advanced registered nurse practitioners, registered nurses and licensed practical nurses) who hold active licenses with the Florida Department of Health, the screening completed by the Department of Health for licensure meets the Florida Medicaid background-screening requirement. Please submit an Internet screen print showing the current, active status of the license from the Department of Health web site: http://www.doh.state.fl.us/IRMOOPRAES/PRASLIST.ASP. **However, background screening for dentists, physician assistants, and pharmacists does require completion and submission of fingerprint cards.**