REFORM HEALTH PLAN APPLICATION

EXPANSION

JANUARY 2007

FOR USE ONLY BY EXISTING HEALTH PLANS SEEKING TO EXPAND TO ADDITIONAL COUNTY(IES)

AGENCY FOR HEALTH CARE ADMINISTRATION
TALLAHASSEE, FL 32308

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:
(Submit separate Applications for each type of Health Plan requested)

(___) PSN - Fee-for-service
(___) PSN – Prepaid – Comprehensive
(___) PSN – Prepaid – Comprehensive and Catastrophic
(___) 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)
(Check each population to be served)

(___) Temporary Assistance for Needy Families (TANF)
(___) Supplemental Security Income (SSI)
(___) Children with Chronic Conditions (CCC)
(___) HIV/AIDS

Proposed Area of Operation

(___) Broward (____) Duval
(___) Baker, Clay and Nassau (must serve all three)

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

Name: _____

Signature: _____

Date: _____

CONTACT INFORMATION (continued)

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. This Reform Health Plan Expansion Application (the "application") is designed to capture detailed information that will facilitate an amendment between the Agency and any currently contracted Provider Service Network (PSN) or other authorized health plan that meets the requirements of a Medicaid Health Plan. All types of organizations must meet the requirements in this application unless specifically exempted. Please see the Frequently Asked Questions at the following web site for additional helpful information: http://ahca.myflorida.com/Medicaid/medicaid_reform/provider/index.shtml#yearone

B. Upon receipt of an application, the Agency will begin the application process on the date it mails an acknowledgement letter to the applicant. The acknowledgment letter specifies whether the application includes all of the mandatory items and whether it will continue in the application process. If an application is incomplete or does not conform to the requirements of these application instructions, the Agency will ask the applicant to provide additional information (Request for Additional Information) within ten (10) days. When the Agency receives the additional data, it will determine whether the application is complete. The Agency may stop the review and issue a Notice of Deficiency if it determines the application is incomplete. The Checklist of Mandatory Items is provided below.

C. The application process is intended to prove to the Agency that the applicant is suitable for expansion to additional county(ies). The Agency reserves the right to discontinue review of 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. 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 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 applicant that it may take legal action to protect the confidentiality of the information. The applicant is responsible for clearly labeling any documents considered proprietary.

D. 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. 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.

E. At a minimum, the applicant's responses to the information requested 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

F. 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.

II. APPLICATION PROCESS

A. Phases of the Application

The applicant must complete all of the application in its initial submission. Incomplete responses will result in a Request for Additional Information. Timeframes for Agency action and the process set forth herein are guidelines and do not confer any rights on the applicant. During any phase 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.

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, and 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.

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 to test its electronic reporting compliance.

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.

4. Phase IV: Contract Amendment Execution

Phase IV of the application process involves preparing contract amendment documents. Once the Agency approves the application 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 amendment to the applicant for signature. As the final contract amendment routes for signatures, the Agency will update the network files to initiate the mandatory assignment process.

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B. Submission Requirements

1. The applicant must submit five (5) hard copies and two (2) individual electronic copies of the application (on separate diskettes or CD-ROM). 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 with spines no larger than three (3) inches. 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. 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. The Agency will not review an application that is not clearly labeled or does not include the required copies.

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 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 submission of a new application under the new ownership. The application is assigned a new start date at time of receipt.

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 package.

9. Any release of information about the application or the contract by the applicant to the media, the public or other entities requires prior written approval from the Agency.

10. Refer to the online 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 - 8)	
Ownership and Control Interest (9)	
Criminal Background Screening (10)	
Organizational Structure (11, 12)	
Terms and Conditions (13 -17)	
PHASE II: FISCAL REVIEW AND COMPREHENSIVE DESK REVIEW	
Fiscal Requirements (18 -25)	
Eligibility and Enrollment (26 - 34)	
Enrollee Services and Marketing (35 - 49)	
Covered Services (50 - 71)	
Behavioral Health Services (72 - 81)	
Provider Network (82 – 100)	
Quality Management (101 – 116)	
Grievance System (117– 133)	
Information Systems (134 – 149)	
Administration and Management (150 – 178)	
Reporting (179 – 181)	
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 applicant must reference the appropriate Reform Model Contract and ensure that the responses submitted comport with contract requirements. Plans that have had no changes to the information required below may attest to the accuracy of existing documents on file and need not submit duplicate material. If changes have occurred since execution of the original Reform Health Plan Contract, the plan must submit new information. Indicate in the column on the right of each criterion whether the applicant is attesting to the accuracy of existing information or submitting new information. Except where noted MUST SUBMIT, there is an option to check "A" or "S" for each item in the application. For those optional items, it is the applicant's responsibility to determine whether new material needs to be submitted to meet the requirements of expansion.

A=Attest

S=Submitting new information

I. Authority to Operate		
1. Submit a statement that the applicant is an 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. The applicant must have all required licensures and certifications pursuant to applicable Florida law.		A _____ S _____
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 either a fee-for-service Provider Service Network (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.		**MUST SUBMIT**

II. Entities Eligible to Submit Applications		
3. To be eligible to submit an application, the applicant must document that it (including its subsidiaries and affiliates) has not unilaterally and willfully terminated any previous contract with a state or federal government prior to the end of the contract period and has not had a contract terminated by a state or federal government (for cause), before the end of the contract term, within the past five (5) years.		A _____ S _____

III. Legal Background and Experience 4. In chronological order, describe the applicant's legal history, 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, shall include, but not be limited to, the following information: a. Dates established; b. The applicant's Federal Employer 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.		A _____ S _____

5. In the past 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, brief description of scope of work, name of the project officer (contact person for the contract), address, telephone number, and beginning and ending dates of the contract.		A _____ S _____

6. 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.		A _____ S _____

7. Have there been or are there any legal actions, taken or pending, against the applicant or any predecessor in the past 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 Medicare and Medicaid Services, the Office of Insurance Regulation or the Agency for Health Care Administration) which would have resulted in a legal order resulting in a monetary or non-monetary penalty. In addition, see the appropriate Medicaid Reform Model Contract, Section XVI, Legal Action Notification.		A _____ S _____

8. Provide the names and contact information of any agents or managing employees of the applicant, who have been convicted of a felony or criminal offense related to the involvement in any federally funded health care program or convicted of fraud, income tax evasion, or obstruction of justice.		A _____ S _____

IV. Ownership and Control Interest 9. Prepare an unduplicated list of (1) all individuals listed on the CMS Disclosure of Ownership and Control Interest Statement, (2) 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 (3) all trustees of the Applicant. Disclosure of Ownership and Control Interest Statement, CMS 1513, is available at the following web site: http://www.cms.hhs.gov/forms/cms1513.pdf 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, 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.		A ____ S ____

V.	**Criminal Background Screening**		
	10. A plan must submit a background check for a new employee or individual for whom a background check has not been previously submitted. A list of individuals required to submit fingerprint cards is in the attached document labeled IV. Background Screen Managers List. The Florida Medicaid Provider Enrollment Application and the Guide for Completing a Florida Medicaid Provider Enrollment application are available at the following web site: http://floridamedicaid.acs-inc.com/index.jsp		A ____ S ____

VI.	**Organizational Structure**		
	11. 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 applicant's administrative and health service delivery components. Explain how the organizational structure depicted is appropriate for the provision of services under the contract.		A ____ S ____
	12. 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 contract execution. Include Form I., Model Format for Enrollment Projection, with the business plan. Use existing rates for projections.		**MUST SUBMIT**

VII.	**Terms and Conditions**		
	13. 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.		A ____ S ____

	14. Provide certified copies of the Articles of Incorporation 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.		A ____ S ____

15.	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.		A ____ S ____

16.	Describe in detail the applicant's policies and procedures for its annual background screening for all management employees.		A ____ S ____

17.	Describe how the current disaster plan will incorporate the expansion area. If the applicant has a delegated TPA, the applicant must also provide a copy of the TPA's detailed disaster plan.		**MUST SUBMIT**

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HEALTH PLAN APPLICATION

PHASE II
REQUIREMENTS

FISCAL REVIEW AND COMPREHENSIVE DESK REVIEW

I. FISCAL REQUIREMENTS

Prepaid and Fee-For-Service Health Plans

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

A.	**Financial Statements** 18. Attach copies of the applicant's financial statements for the past two (2) years. 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.		**MUST SUBMIT**
	19. 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.		**MUST SUBMIT**
	20. Provide copies of bank statements for the following required accounts: start-up, reserves and insolvency protection.		**MUST SUBMIT**
	21. Ensure that enrollment and revenue projections, as set forth in #20 above, correspond with the information provided in response to enrollment projections in Phase I, and the Marketing plan in Phase II.		**MUST SUBMIT**
	22. Provide a statement, signed by the applicant's President or Chief Executive Officer, attesting that no assets of the applicant have been pledged to secure personal loans.		**MUST SUBMIT**

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) Reference the Reform Model Contract for the specific sections identified. 23. Provide copies of each applicable insurance binder along with a list, in table format, labeled "Insurance Coverage" on the applicant's company letterhead. Information 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.		A ____ S ____

<u>Prepaid Health Plans</u> **C. Insolvency Protection** 24. Provide documentation of a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida. Describe how the applicant will manage the insolvency protection account. The Agency may waive this requirement if it has evidence on file of adequate insolvency insurance.		**MUST SUBMIT**

25. Applicants that are HMOs 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.		**MUST SUBMIT**

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II. ELIGIBILITY AND ENROLLMENT

Prepaid and Fee-For-Service Health Plans

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

A. Eligibility 26. Describe how the applicant will assist the Agency in identifying enrollees excluded from participation in Medicaid Reform.		A ____ S ____

B. Enrollment 27. Submit the applicant's policies and procedures for primary care provider (PCP) assignment, including how the applicant will provide enrollees with a choice in the selection of a particular PCP. 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.		A ____ S ____

28. Describe the applicant's methods to ensure that enrollees receive written notification of enrollment by the first day of enrollment into the Health Plan.		A ____ S ____

29. Describe how the applicant will identify pregnant enrollees and comply with all requirements regarding unborn activation.		A ____ S ____

30. Submit policies and procedures regarding newborn assignment to pediatricians or other appropriate PCPs.		A ____ S ____

C. Disenrollment 31. 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.		A ____ S ____

32. Describe how the applicant will document: 1) attempts to contact the enrollee within the first three months of enrollment; and 2) enrollee lack of services within the first three months of enrollment.		A ____ S ____

33. 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 verbal and one 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.		A ____ S ____

34. 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.		A ____ S ____

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III. ENROLLEE SERVICES AND MARKETING

Prepaid and Fee-For-Service Health Plans

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

A. Enrollee Services 35. 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 submit a grievance, file an appeal or request a Medicaid Fair Hearing; f. How to report suspected fraud and abuse; and g. Procedures for obtaining required behavioral health services.		A ____ S ____
36. Describe how the applicant will answer enrollee inquiries through written materials, telephone, electronic transmission, and face-to-face communication.		A ____ S ____
37. Describe and submit the 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.		A ____ S ____
38. 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.		A ____ S ____
39. 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 correspondence with the application		A ____ S ____

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40. 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, how to access those formats, how the applicant will notify enrollees at least annually of their right to request and obtain information, and how the applicant will ensure that enrollees receive a thirty (30) day notice of any change in benefits.		A ____ S ____

41. Describe how the applicant will ensure that all written materials are at or near the fourth (4^{th}) grade comprehension level. Please specify which software the applicant will use to meet this requirement.		A ____ S ____

42. Describe in detail the applicant's enrollee services system and the type of access that will be available to enrollees.		A ____ S ____

43. 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 requirements are continuously met, how the applicant will route calls among 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. Include the number of help line staff that are fluent in one of the state-identified prevalent non-English languages.		A ____ S ____

44. Provide a copy of the applicant's written Cultural Competency Plan.		A ____ S ____

B. Marketing 45. Provide a statement specifying whether the applicant intends to engage in marketing activities.		A ____ S ____

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46.	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.		A ____ S ____

47.	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 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 its marketing staff and providers to ensure full compliance with all requirements set forth in the contract.		A ____ S ____

48.	Describe how the applicant's marketing materials are developed for the Medicaid population, including materials available in alternative formats and foreign languages.		A ____ S ____

49.	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 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 only elements specified in Section IV, of the appropriate model contract.		A ____ S ____

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IV. COVERED SERVICES

Prepaid and Fee-For-Service Health Plans

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

A.	**Covered Services** 50. Submit 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.		A ____ S ____
	51. Capitated plans and fee-for-service plans that do not use the Medicaid pharmacy benefits manager must submit their preferred drug lists (PDL) and all policies and procedures relating to prior authorization.		**MUST SUBMIT**
	52. Capitated plans must submit the output from the online plan evaluation tool.		**MUST SUBMIT**
B.	**Expanded Services** 53. Describe any expanded services (as detailed in the contract) the applicant will provide in the expansion counties. 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		A ____ S ____
	54. Capitated plans must submit the per member per month (PMPM) actuarial value of the service and supporting documentation used to derive the PMPM.		**MUST SUBMIT**
C.	**Moral or Religious Objections** 55. Describe any required service the applicant does not intend to provide on the basis of a moral or religious objection.		A ____ S ____
D.	**Special Coverage Provisions** 56. Describe the applicant's policies and procedures on 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 the advance directive.		A ____ S ____

57. Submit specific policies and procedures related to providing Child Health Check-Up (CHCUP) services. Such policies and procedures must include how the applicant will identify children/adolescents who have not received all required screenings, and how the applicant will ensure they 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. Describe how the applicant will ensure that appointments are scheduled for enrollees to obtain screenings.		A ____ S ____
58. Submit policies and procedures related to dental services and include any outreach and education provided to enrollees to encourage access to dental screenings and services for children/adolescents.		A ____ S ____
59. Submit policies and procedures and all documentation used to explain the process by which enrollees can obtain emergency services. Describe how the applicant will educate all enrollees and network providers on emergency medical and behavioral health services.		A ____ S ____
60. Submit policies and procedures for family planning and how the applicant will ensure confidentiality for all enrollees unless the applicant does not intend to provide these services on the basis of moral or religious objections.		A ____ S ____
61. Describe how the applicant will maintain a log of all hysterectomy, sterilization and abortion procedures performed for all enrollees unless the applicant does not intend to provide these services on the basis of moral or religious objections.		A ____ S ____
62. Describe how the applicant will ensure that providers are enrolled in the Vaccines for Children (VFC) program, and how it will ensure that providers identify Title XXI MediKids in order to bill for their immunizations separately.		A ____ S ____
63. Provide policies and procedures, documentation, and checklists relating to the applicant's outreach program, and other strategies it intends to implement to identify every pregnant enrollee.		A ____ S ____
64. Describe how the applicant will address all screening and coordination requirements for pregnant women, including Healthy Start screening and referral, Women, Infants and Children (WIC) referral, HIV and Hepatitis B counseling and testing, and comprehensive prenatal care, delivery, newborn and postpartum care requirements.		A ____ S ____

65.	Describe how the applicant will comply with the settlement agreement relating to *Hernandez et. al. v. Medows,* case number 02-20964 Civ-Gold/Simonton.		A ____ S ____
66.	Submit the policies and procedures used to ensure that all enrollees under age twenty-one (21), who are taken into protective custody or foster care are physically screened within seventy-two (72) hours, or immediately if required.		A ____ S ____
67.	Submit policies and procedures related to Quality Enhancements as outlined in Section V Covered Services, and provide a list of such services.		A ____ S ____
68.	Indicate whether the applicant intends to coordinate transport with the CTD or 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.		**MUST SUBMIT**
69.	Describe any incentive programs and/or provisions the applicant intends to offer to enrollees and/or providers.		A ____ S ____
Prepaid Health Plans **A. Covered Services** 70.	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, it must provide all medically necessary services to pregnant women and children. The health plan must provide services 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.s		**MUST SUBMIT**

html#two The policies and procedures submitted in this section must correspond to the covered services to be provided by the applicant.		

Fee for Service PSNs **A. Covered Services** 71. The FFS PSN must cover all Medicaid-covered services in the Section V.A through V.D., Covered Services, of the Reform Model Contract. All services must be provided in the same amount, duration and scope as services provided to Medicaid recipients as outlined in the Medicaid Coverage and Limitations Handbook. The policies and procedures submitted pursuant to this section must correspond to these services.		A ____ S ____

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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**		
72.	All applicants must cover the services specified in Section VI.A through VI.B, Behavioral Health Services, of the Reform model contract. Before submitting 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. The applicant must detail its approach to providing behavioral health care and must document its ability to provide the full range of behavioral health services.		A ____ S ____
73.	Fully describe how the applicant will provide behavioral health services and targeted case management. Indicate if the applicant intends to contract with another behavioral health care entity to provide any services, and if so, specifically which services and how the applicant will monitor for contract compliance.		A ____ S ____
74.	The applicant must submit an enrollee handbook with a separate behavioral health section that includes the following information: a. Description of behavioral health services provided, including limitations and general restrictions on provider access, exclusions and out-of-network use; b. Procedures for obtaining required services, including second opinions, and authorization requirements, including those services available without prior authorization; c. Description of behavioral health emergency services and procedures for obtaining services both in and out of the PSN 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		A ____ S ____

	d. The extent to which, and how, after-hours and emergency coverage is provided, and that the enrollee has a right to use any hospital or other setting for emergency care; e. A notice that clearly states that the enrollee may select an alternative behavioral health case manager or direct service provider within the PSN, if one is available; f. Information to assist the enrollee in assessing a potential behavioral health problem		

75.	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 of the Reform model contract.		**MUST SUBMIT**

76.	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.		A ____ S ____

77.	Submit a behavioral health specific utilization management program description that addresses: a. Procedures for identifying patterns of enrollee over-utilization and under-utilization and for addressing potential problems identified as a result of these analyses. b. How the health plan shall report fraud and abuse information identified through the utilization management program to the Agency's contract manager, Medicaid Program Integrity (MPI) and the Attorney General's Medicaid Fraud Control Unit (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 how the health plan will handle 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 concurrent authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting provider when appropriate, hospital discharge planning, and a retrospective review of both inpatient and ambulatory claims, meeting the predefined criteria as stated in Section VIII.B. of the Reform model contract. The Health Plan is responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate.		A ____ S ____

78.	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 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. Notice that the amount paid to providers by the Agency shall be the Medicaid fee schedule amount less any applicable co-payments; m. Notice that provider complaints regarding claims payment should be sent to the health plan; n. The health plan's cultural competency plan; o. Enrollee rights and responsibilities; and p. Health Plan bulletins should have examples to incorporate any needed changes to the provider handbook.		A ____ S ____

79.	Describe or be prepared to submit a training plan, training manual and training schedule specific to behavioral health.		A ____ S ____

80.	Submit an organization chart that represents the oversight and structure of the behavioral health services component of the health plan.		A ____ S ____

B.	**Service Requirements**		
	81. Describe the applicant's 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.		A ____ S ____

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VI. PROVIDER NETWORK

Prepaid and Fee-For-Service Health Plans

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

A.	**General Provisions** **The Agency will accept letters of agreement with application submission; however, prior to expansion approval all letters must be replaced with signed provider contracts.** 82. Demonstrate that the applicant 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 of the appropriate Reform model contract.		**MUST SUBMIT**

	83. 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 mapping software format. **NOTE: The Agency shall require the applicant to provide services in an Agency predetermined service area.**		**MUST SUBMIT**

	84. Provide 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; b. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients.		**MUST SUBMIT**

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85.	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. Indicate whether the provider's panel is open or closed to new Medicaid enrollees (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 the Agency's Bureau of Managed Health Care (BMHC).		**MUST SUBMIT**

86.	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 (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 the Agency's Bureau of Managed Health Care (BMHC).		**MUST SUBMIT**

87.	The applicant must provide to the Agency on approved 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 mapping report for each dentist, pedodontist, and primary care provider by specialty. The mapping report must also provide the locations for pediatricians, County Health Departments (CHD), Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) to demonstrate that the access requirement of thirty (30) minutes' travel time has been met, as well as one board-certified child psychiatrist. The applicant must also submit a mapping report that documents that the applicant's network meets all access standards for pharmacies, hospitals, and direct service behavioral health providers.		**MUST SUBMIT**

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88.	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.		**MUST SUBMIT**
89.	List the name, address, service locations, hours of operation and staffing of locations where the applicant plans to provide twenty-four (24) hour, seven (7) day a week emergency services (in Excel spreadsheet format). Provide a separate list for behavioral health emergency services locations.		**MUST SUBMIT**
90.	Submit the policies and procedures 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.		A ____ S ____
91.	Submit the policies and procedures, documents and checklists the applicant intends to use to conduct 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 out of compliance with Section VII, Provider Network of the appropriate model contract.		A ____ S ____
92.	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 maintain a smoke-free environment.		A ____ S ____
93.	Describe the applicant 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. of the Reform model contract.		A ____ S ____

94.	Submit the applicant policies and procedures for informing enrollees and potential enrollees of any changes to service delivery and/or the provider network as outlined in Section VII.I, of the appropriate Reform contract. Such policies and procedures must also address changes in the applicant's network that negatively affect the ability of enrollees to access services, including access to a culturally diverse provider network.		A ____ S ____
95.	Submit policies and procedures for the provision of continued care from terminated providers. Such policies and procedures must address how, in the event a PCP leaves 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.		A ____ S _____
96.	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.		A ____ S ____
97.	Describe how the applicant will make a good faith effort to enter into a memorandum of agreement with the local County Health Department (CHD) and Federally Qualified Health Centers (FQHCs).		**MUST SUBMIT**
98.	Describe how the applicant will make a good faith effort to enter into a memorandum of agreement with local school districts participating in the certified match program.		**MUST SUBMIT**
99.	Capitated health plans shall require each provider to have a 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. of the Reform model 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**		**MUST SUBMIT**
100.	The applicant shall require each provider to have a National Provider Identifier (NPI) in accordance with Section X, of the Reform model contract. The applicant must submit the provider's NPI as part of the provider network report.		**MUST SUBMIT**

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

101.	Describe the staffing plan for the Quality Improvement Program (QIP), including an organization chart and job descriptions. Include staff resumes, if available; 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.		A ____ S ____
102.	Describe the applicant committee structure 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.		A ____ S ____
103.	Describe how the applicant ensures that its committees' memberships and chairs are not the same across multiple committees.		A ____ S ____
104.	Provide the policies and procedures that 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.		A ____ S ____

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B.	**Utilization Management (UM)**		A ____
105.	Describe the staffing plan for the UM Department, including an organization chart and job descriptions. Include staff resumes, if available, which describe pertinent experience and certification/licensure.		S ____
106.	Submit service authorization protocols, including those that cover new enrollees		A ____ S ____
107.	Describe procedures for identifying patterns of over-utilization and under-utilization.		A ____ S ____
108.	Describe procedures for reporting potential fraud and abuse information gained from UM activities.		A ____ S ____
109.	Describe the process by which enrollees can obtain a second medical opinion		A ____ S ____
110.	Describe the procedure for authorizing claims from CHDs, migrant health centers and FQHCs.		A ____ S ____
111.	Submit policies and procedures describing notices of action. Include a model notice of action.		A ____ S ____
112.	Submit policies and procedures describing the applicant's care management activities and new enrollee activities		A ____ S ____
113.	Describe the applicant's planned process for the development and implementation of disease management programs.		A ____ S ____
114.	Submit policies and procedures that describe the requirements for treatment plans for those with chronic diseases and for those receiving behavioral health services.		A ____ S ____

115. Submit a description of the applicant's incentive program, if any.		A ____ S ____

116. Describe the applicant's process for adopting practice guidelines.		A ____ S ____

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VIII. GRIEVANCE SYSTEM

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.	**General Requirements**		A ____
117.	Describe the staffing plan for the grievance system, including an organization chart and job descriptions. Include staff resumes, if available, which describe pertinent experience and certification/licensure.		S ____
118.	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.		A ____ S ____
119.	Describe the process for ensuring that grievances and appeals staff have not been involved in previous levels of the review.		A ____ S ____
120.	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.		A ____ S ____
121.	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.		A ____ S ____
122.	Submit the policy and procedure that describes the assistance that will be provided to enrollees in completing the procedural steps of the Grievance System.		A ____ S ____
123.	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, or a request for a continuation of benefits on an enrollee's behalf.		A ____ S ____
124.	Describe how the analysis of grievance system information will be used for quality improvement.		A ____ S ____

125. Submit the policy and procedure for grievance system documentation.		A ____ S ____

B. Grievance Process 126. Submit policies and procedures that cover the filing and resolution of enrollee grievances.		A ____ S ____

127. Submit policies and procedures that cover the expedited review process		A ____ S ____

C. Appeal Process 128. Submit policies and procedures that cover the filing and resolution of appeals, as well as the continuation of benefits during an appeal.		A ____ S ____

129. Submit policies and procedures that cover the plan's actions once an appeal is resolved.		A ____ S ____

130. Submit policies and procedures that cover the expedited review process.		A ____ S ____

D. Medicaid Fair Hearings 131. Submit policies and procedures for filing a request for a Medicaid fair hearing.		A ____ S ____

132. Submit policies and procedures for the continuation of benefits during the Medicaid fair hearing process.		A ____ S ____

133. Submit policies and procedures that cover the health plan responsibilities once a Medicaid fair hearing decision is delivered.		A ____ S ____

IX. INFORMATION SYSTEMS

Prepaid and Fee-For-Service Health Plans

The Health Plan applicant must reference the appropriate Reform model contract and ensure that the responses submitted comport with contract requirements.

A.	**System Capacity, Availability and Performance**		
134.	Describe in detail how the applicant will ensure that the capacity, availability and performance of its systems in the expansion county(ies), 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.		A ____ S ____
135.	Identify the timing of implementation of the mix of technology and management (policies and procedures) strategies outlined in the response to question 135, above.		A ____ S ____
136.	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).		A ____ S ____
B.	**E-Mail System**		
137.	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, as needed, to encrypt and/or otherwise secure the content of electronic messages.		A ____ S ____

138.	Identify the timing of implementation of the e-mail solution outlined in the response to question 138, above.		A ____ S ____

C.	**Data and Report Validity and Completeness**		
139.	Describe the processes the applicant shall institute to ensure the validity and completeness of the data, including reports, it will submit to the Agency. At a minimum the response should address data validity and completeness audits and the use of relevant statistical techniques.		A ____ S ____

D.	**Data Exchange**		
141.	Cite at least two currently-live instances where the applicant is successfully: a. Providing <u>claims</u> 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.		A ____ S ____

141.	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.		A ____ S ____

E.	**Reporting – System Capabilities**		
142.	Describe how the applicant will provide systems-based capabilities such that authorized Agency staff, on a secure and read-only basis, can retrieve and/or utilize data in the applicant's systems for ad hoc reporting purposes.		A ____ S ____

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F. Companion Documents

143.	Provide a detailed profile of the information systems (refer to the Reference Table; below): 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.		A ____ S ____

SYSTEMS PROFILE

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

REFER TO ATTACHMENT

144.	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.		A ____ S ____

145.	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.		A ____ S ____

146.	Provide a sample system availability and performance report from a current customer.		A ____ S ____

147.	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:		A ____ S ____

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** 148. 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.		A ____ S ____

149. 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.		A ____ S ____

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X. ADMINISTRATION AND 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.	**Staffing**		
150.	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.		A ____ S ____

B.	**Provider Contracts**		
151.	Submit the applicant's model provider contracts. The applicant must 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.		A ____ S ____

152.	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.		A ____ S ____

C.	**Provider Terminations**		
153.	Submit the policies and procedures that cover provider rights regarding termination of a provider's participation with the applicant's network.		A ____ S ____

154.	Submit policies and procedures regarding notification when a provider is terminated.		A ____ S ____

D.	**Provider Services**		
155.	Submit policies and procedures that cover the applicant's responsibilities to ensure its providers are compliant with the contract and federal and State regulations.		A ____ S ____

156.	Describe the informational materials to be provided to providers and how they will be distributed including, but not limited to the provider handbook will submit the provider handbook.		**MUST SUBMIT**
157.	Describe the orientation the applicant will present to new providers, as well as the schedule and content of any continuing training for current providers.		A ____ S ____
158.	Describe the staffing plan for provider relations, the provider complaint system and the provider telephone help line, including an organization chart and job descriptions. Include staff resumes, if available, that describe pertinent experience and certification/licensure.		**MUST SUBMIT**
159.	Submit the policies and procedures covering the functions of the provider relations unit.		A ____ S ____
160.	Describe the provider telephone help line system.		A ____ S ____
161.	Submit the policies and procedures that cover the provider complaint system		A ____ S ____
E.	**Medical Records**		
162.	Submit the policies and procedures covering enrollee medical records requirements.		A ____ S ____
163.	Describe how the applicant will ensure that providers are compliant with the enrollee medical record requirements.		A ____ S ____
164.	Describe how the applicant will ensure the confidentiality of enrollee medical records.		A ____ S ____

F.	**Claims Payments**		
165.	Describe the staffing plan for the claims unit, including an organizational chart and job descriptions. Include staff resumes, if available, that describe pertinent experience and certification/licensure.		A ____ S ____
166.	Describe the applicant's provider claims complaint resolution process.		A ____ S ____
G.	**Fraud Prevention**		
167.	Describe the staffing plan for fraud prevention, including an organization chart and job descriptions if staff extends beyond the compliance officer. Include staff resumes, if available, that describe pertinent experience and certification/licensure.		A ____ S ____
168.	Submit the policies and procedures covering 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.		A ____ S ____
169.	Describe the orientation and ongoing education about program integrity that will be provided to the applicant's staff, providers and enrollees.		**MUST SUBMIT**
H.	**Subcontracts** **(Note: The subcontract requirements in the contract are found in Section XVI.Q, Terms and Conditions of the Reform model contract, not the Administration and Management section.)**		
170.	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 (PBM); c. Administrative service organizations; d. Management service organizations; and e. Third party administrators (TPA).		A ____ S ____

171.	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.		A ____ S ____
172.	Describe how the applicant will ensure that all subcontracts, including provider subcontracts, comply with all state and federal requirements		A ____ S ____
	<u>Prepaid Health Plans</u>		
	I. Claims Payment		
173.	Submit policies and procedures covering submission, processing and payment of provider claims.		A ____ S ____
174.	Describe the applicant's claims processing and payment performance metrics, including quality, accuracy and timeliness. Include a description of how they will be monitored.		A ____ S ____
	J. Encounter Reporting		
175.	Describe the staffing plan for the encounters unit, if different from claims, including an organizational chart and job descriptions. Include staff resumes, if available, that describe pertinent experience and certification/licensure.		A ____ S ____
176.	Submit the policies and procedures covering the generation and submission of encounters, including but not limited to how the applicant will ensure the completeness, accuracy and timeliness of its encounters.		A ____ S ____
	<u>Fee-for-Service Health Plan</u>		
	K. Claims Payments		
177.	Submit policies and procedures covering the submission, authorization and forwarding of provider claims to the Agency or its fiscal agent.		A ____ S ____
178.	Describe the applicant's role in coordination with the fiscal agent and when acting as an intermediary between a provider and the fiscal agent when there is a disagreement.		A ____ S ____

XI. REPORTING

Prepaid and Fee-for-Service Health Plans

A.	**General Requirements**		
179.	Submit a description of the responsible position (to be the Agency contact) for each report listed in Table 1 of the Reform Model Contract.		A ____ S ____
180.	Submit the policies and procedures that cover the assurance of the timeliness, accuracy and completeness of the reports.		A ____ S ____
181.	Describe the position that will certify the reports.		A ____ S ____

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HEALTH PLAN APPLICATION

PHASE III
REQUIREMENTS

SITE VISIT

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.

182.	Submit a listing of all marketing representatives for registration with the Agency as required in Section IV.B., of the contract.		**Available during site review**

II. INFORMATION SYSTEMS

Prepaid and Fee-For-Service Health Plans

A.	**Data Model and Accessibility**		
183.	Describe how the applicant's systems follow 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.		**Available during site review**

B.	**Data and Document Relationships**		
184.	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 Reform Model 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.		**Available during site review**

C.	**Testing and Change Management**		
185.	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.		**Available during site review**

FORMS AND REPORT FORMATS

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 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 Health Plan, whether that is co-pays, or the amount, duration or scope of the services. The shaded areas indicate the services in that part of the grid can not 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 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.

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 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. Below is 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/. **However, background screening for dentists, physician assistants, and pharmacists does require completion and submission of fingerprint cards.**