
# FLORIDA MEDICAID APPLICATION FOR AN EXISTING NON-REFORM HEALTH PLAN EXPANSION INTO REFORM COUNTY

**JULY 2011**

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# INSTRUCTIONS AND GENERAL INFORMATION

## FLORIDA MEDICAID APPLICATION FOR AN EXISTING NON-REFORM HEALTH PLAN EXPANSION INTO REFORM

### APPLICABILITY

This Application is designed to capture detailed information that will facilitate a contract amendment between the Agency and a non-Reform Provider Service Network (PSN) or Health Maintenance Organization (HMO) to expand into one or more Reform counties. The requirements in this Application are to be described by all types of organizations, unless otherwise specified. The applicant must prove it is capable of providing health care services to eligible Medicaid recipients consistent with the requirements of the applicable Contract terms and conditions.

The Agency may request additional information if the need arises.

### ONLINE TOOL KIT

Model documents and other materials to help with preparing the application are in the application tool kit on the Web site at Become a Medicaid Health Plan (http://ahca.myflorida.com/Medicaid/managed_care/index.shtml). A partial list follows:

- Model Contract Documents
  - Model Attachment I & Exhibits
  - Model Attachment II & Exhibits
  - Report Guide

### THE APPLICATION

A. Applications must be complete and accurate when submitted.

B. The health plan application is designed to capture detailed information for review by the Agency to determine whether the applicant is prepared to meet the requirements of the Medicaid managed care Contract.

C. All information requested in the application is based on Contract requirements.

D. Fill out only those portions of the application that apply to a single health plan. For example, if the health plan is capitated, do not fill out any fee-for-service information. If the health plan will serve only non-Reform counties, do not fill out Reform information.

E. Unless otherwise specified in the Contract, the health plan will be responsible for complying with the provisions of all applicable federal and state Medicaid laws and regulations and with the current Medicaid handbooks. Links to those resources are on the Web site listed above.

F. Contact the Agency's Bureau of Health Systems Development at (850) 412-4004 for assistance with the application process.

# SUBMISSION REQUIREMENTS

A. Number of Copies – The health plan must submit one hard copy with original signatures and two electronic data CDs containing all items included with the hard copy.

B. Format – Please ensure all electronic files are legible and able to be photocopied easily. The electronic files must not be in a locked format. The narrative responses should be in Word format, but the attachments (supporting documents) can be scanned as PDFs, in Excel, or any format that can be viewed electronically. Files must be logically named in accordance with application subjects and topics and easily mapped to the hard copy. Documents should be uniquely identifiable by title. Policies and procedures must be appropriately branded with the applicant's health plan name.

The narrative response shall be consecutively paginated. The attachments should be easily identifiable (tabbed and titled) and paginated within the attachment, but do not have to be consecutively paginated within the document.

The hard copy may be double-sided as long as the applicant does not include more than one policy/item response on a page.

C. Organization – The application narrative responses must be organized in the same order as the application items/questions. For example, narrative response labeled #1 should answer application item 1, which requests a description of the applicant's legal history.

D. Where to Submit – Submit the hard copy and electronic data CDs to:

Agency for Health Care Administration
Medicaid Bureau of Health Systems Development
2727 Mahan Drive, MS 50
Tallahassee, FL 32308

E. Changes in Applicant Information – If any information in the application changes after the application is submitted, the health plan must submit the new information, in writing, to the Bureau of Health Systems Development within 10 days of the effective date of the change. This includes, but is not limited to, any change in directors, officers, or address. Failure to do so may result in the rejection of the application.

F. Changes in Ownership – Any change in ownership that would necessitate a revision to the CMS-1513 while the Agency is reviewing the application requires termination of the application and resubmission under the new ownership. The official time and date of receipt will be the time and date of receipt of the new application.

G. Release of Information – 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.

H. Agency's Right to Discontinue – Because the application process is intended to be an opportunity for the applicant to prove to the Agency that the applicant is a suitable contracting partner, the Agency reserves the right to discontinue any application for insufficient response to any of the requirements set forth in these instructions, for any misrepresentation, or, if the Agency determines that it is in its best interest to discontinue the application process.

I. Public Record – All information submitted to the state is considered a public record unless it meets the definition of "trade secret" under s. 812.081, F.S. Information specifically identified as a trade secret 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, the Agency will notify the applicant, who may take legal action to protect the confidentiality of the information. Please be sure that any documents considered proprietary are clearly labeled as a trade secret in the application submitted to the Agency.

J. 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 its 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, procedures, computer systems, enrollee records, accounting records, and internal quality control and staff interviews. The applicant shall work with any reviewing entity selected by the state.

K. Disclaimer – The Agency may provide information and guidance, illustrative direction, and technical assistance to assist the applicant in the managed care application process. This information is not meant to be exhaustive and neither constitutes legal or medical advice, nor does it replace any laws, rules, policies, or executed contracts. The technical assistance and guidance contained herein is for informational purposes only and the applicant's reliance upon this information does not guarantee a contract with the Agency. By providing this information, the Agency does not waive any legal right or remedy to which it may be entitled including the right to pursue corrective actions, fines or other sanctions including termination of provider contracts.

# BASIC INFORMATION

**Name of Health Plan Applicant:** _____

**Mailing Address:** _____

**Contact Person for Application:** _____
*(If this is a joint venture or limited partnership, this person must be the single point of contact for all entities. This application page must be officially updated if the applicant's primary contact changes during the course of application review.)*

**Title:** _____

**Office Telephone/Extension:** _____

**Cellular Telephone:** _____

**Fax Number:** _____

**E-mail Address:** _____

**Type of Health Plan:**
☐Provider Service Network – Fee-for-service
☐Provider Service Network – Capitated
☐Health Maintenance Organization

**Target Population(s):**
*(Check each population requested)*
☐Temporary Assistance for Needy Families (TANF)
☐Supplemental Security Income (SSI)

**Service Level(s):**
*(Check all that apply)*
☐Reform Comprehensive and Catastrophic
☐Reform Comprehensive Only

**Reform Counties to Be Served upon Initial Contract Execution:**
*(Check all that apply. Note that counties grouped in a block must be implemented at the same time. Also note that all provider network requirements must be complete at the time of application for all counties checked.)*

| | COUNTY NAME | MEDICAID AREA |
|---|---|---|
| | Baker<br>Clay<br>Nassau | 4 |
| | Broward | 10 |
| | Duval | 4 |

## ORGANIZATIONAL INFORMATION

### A. Required Certificates

Submit a copy of the following applicable documents:

1. AHCA Health Care Provider Certificate.

2. OIR Certificate of Authority.

### B. EFT and EDI Forms

Submit a completed EFT form and EDI form for each requested expansion county.

### C. Revised Business Plan

Provide the applicant's revised business plan that incorporates expansion into each requested Reform county, including a maximum enrollment level requested for each. At a minimum, the business plan should provide an overview of operations for the entire state for 24 months after the anticipated date of the Contract amendment execution. Include Form title "Enrollment Projection" with the business plan.

## FISCAL REQUIREMENTS

### D. Financial Statements

Provide the following pro forma financial statements for the applicant's Florida operation for the Reform line of business. The pro forma financial statements must be prepared on an accrual basis by month for the first three years beginning with the first month of the proposed execution date of the Contract:

1. A statement of monthly revenue and expenses;

2. A monthly cash flow analysis; and

3. A balance sheet for each month.

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## ENROLLEE SERVICES

### E. Enhanced Benefit Program

Submit policies and procedures that describe how the applicant will ensure that it will assist the enrollee of the enhanced benefit program specified in Attachment II, Exhibit 4, of the model Contract.

## COVERED SERVICES

*Note: See Model Contract Attachment I and Attachment II, Sections II and V and Exhibit 5*

### F. Customized Benefit Package

Capitated health plans in Medicaid Reform counties have the flexibility to provide all Medicaid-covered services, as outlined in the Medicaid Coverage and Limitations Handbooks, or to design a customized benefit package (CBP) in accordance with state-established standards for a target population. Fee-for-service plans must provide all Medicaid-covered services, as outlined in the Medicaid Coverage and Limitations Handbooks, but have the option to waive copayments or provide expanded services. Regardless of which option the applicant chooses, it must provide all medically necessary services to children and pregnant women. Reform applicants must complete a benefit grid for each targeted population, following the benefit grid specifications in model Contract Attachment I (an electronic version for submission may be found in the application tool kit at Become a Medicaid Health Plan. To be approved, the benefit grid must meet actuarial equivalency and sufficiency standards for the population(s) to be covered. Policies and procedures must correspond to the covered services the applicant will provide.

The grid template is part of the application tool kit at Become a Medicaid Health Plan. It displays the services to be covered and the areas the applicant may customize, whether that is co-pays, or the amount, duration or scope of the services. The shaded areas indicate that no changes can be made to the services in that part of the grid.

If the CBP includes expanded services, the applicant must submit additional information with the grid including projected per member per month (PMPM) costs for the target population, as well as the actuarial rationale for developing the PMPM for that service. This rationale shall include utilization and unit cost expectations for services provided in the benefit.

### G. Behavioral Health Services

*Note: See Model Contract Attachment II, Section VI*

1. For an applicant that already provides behavioral health services in non-Reform

    a. 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 Attachment II, Section VI, Behavioral Health Care of the model Contract. Separate the network by counties, grouping together the community mental health centers, psychiatrists, licensed mental health professionals, and

hospitals/CSU's with inpatient psychiatric beds. Specify the number of child and adult beds.

b. As additional documentation of the behavioral health provider network, submit a completed and signed "Behavioral Health Service Gird," which is available in the application tool kit online at Become a Medicaid Health Plan.

c. Submit GeoAccess or other mapping software reporting approved by the Agency report/map that reflects the location of each full service community mental health center, CSU (capitated plans only) and inpatient psychiatric hospital by county.

2. For an applicant that does not currently provide behavioral health services in non-Reform

a. The applicant must cover the services specified in Attachment II, Section VI, Behavioral Health Services of the model Contract. Before submitting the application, visit the application tool kit online at Become a Medicaid Health Plan to download the Behavioral Health Policy and Procedure Review Tool, the Policy and Procedure Template, and instructions. The applicant must use the provided template to submit its policies and procedures for the provision of behavioral health services and targeted case management to be covered under the Contract and all administrative functions required by the Contract. The policies and procedures must document the applicant's ability to provide the full range of behavioral health services.

b. The applicant must indicate if it intends to subcontract with a managed behavioral health organization (MBHO) for the performance of work required under the Contract with the Agency. Identify the MBHO with which the applicant will subcontract and specify which services they will be subcontracted to provide. Include in the application a copy of the draft contract with the MBHO. Provide the MBHO's contact information for the staff to communicate with, including name, phone number, and e-mail address.

c. Submit copies of draft model contracts for behavioral health providers, groups, facilities, and community mental health centers as appropriate.

d. Submit an enrollee handbook that has a separate behavioral health section that includes the following information:

(1) Description of behavioral health services provided, including limitations and general restrictions on provider access (including for counseling and referral services the applicant will not cover because of moral and religious objections), exclusions and out-of-network use;

(2) Procedures for obtaining required services, including second opinions, and authorization requirements, including those services available without prior authorization;

(3) Description of behavioral health emergency services and procedures for obtaining services both in and out of the applicant's service area, including explanation that prior authorization is not required for emergency services, the locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization care services;

(4) The extent to which, and how, after-hours and emergency coverage is provided, and that the enrollee has a right to use any hospital or other setting for emergency care;

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

(6) Information to assist the enrollee in assessing a potential behavioral health problem.

*Note: Contact BMHC Behavioral Health Unit for a sample member handbook.*

e. Submit a behavioral health-specific quality improvement program description that details how the applicant will objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered.

f. Submit a behavioral health-specific utilization management program description that addresses:

(1) Procedures for identifying patterns of over- and under-utilization by enrollees and for addressing potential problems identified as a result of these analyses;

(2) Procedures for handling suspected and/or confirmed fraud and abuse information identified through the utilization management program;

(3) A procedure for enrollees to obtain a second medical/psychiatric opinion and how the applicant will handle claims for such services;

(4) 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; and

(5) Medical necessity criteria for determining behavioral health services that meets model Contract requirements.

g. Submit a provider handbook that is specific to behavioral health and includes the following information:

(1) Description of the program;

(2) Covered Services;

(3) Emergency Service responsibilities;

(4) Policies and procedures that cover the provider complaint system, including specific instructions on how to contact the applicant's provider services unit to file a provider complaint and a description of the staff position(s) with authority to address a provider complaint;

(5) Information about the Medicaid Fair Hearing process and the applicant's complaint, grievance, and appeal process, 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 system;

(6) Medical necessity standards and clinical practice guidelines;

(7) Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

(8) PCP responsibilities;

(9) Other provider or subcontractor responsibilities;

(10) Prior authorization protocols and referral procedures;

(11) Clinical records and targeted case management standards;

(12) Claims submission protocols and standards, including instructions and all information necessary for a clean or complete claim;

(13) The health plan's and the MBHO's cultural competency plan;

(14) Enrollee rights and responsibilities; and

(15) Behavioral health specific disaster plan that will include, but not be limited to, how the plan will address covering psychotropic medications, crisis services, and inpatient services.

h. Submit a training plan, training manual and training schedule specific to behavioral health that will address how the plan will train behavioral

health providers on its authorization protocols, medical necessity standards and clinical practice guidelines, contact information, etc.

i. Submit an organization chart that represents the applicant's oversight and structure of the behavioral health services component. If the plan is subcontracting the behavioral health services to an MBHO, the organization chart shall demonstrate who has the contractual oversight of the MBHO. Include who will be the designated behavioral health contact for the plan and/or the MBHO along with all relevant contact information.

j. Describe the applicant's clinical practice guidelines for each service (based on those behavioral health services/codes in the ~~c~~Contract) to be provided and how the applicant will ensure that the frequency, duration, and content of services is consistent with the age, developmental level and level of functioning of the enrollee.

**H. Dental Services**

Submit policies and procedures for providing dental services outlined in the model Contract.

**I. Preferred Drug List**

Capitated applicants must submit the preferred drug list (PDL) for Reform Choice Counseling to use with the Navigator program.

**J. Transportation Services**

Submit policies and procedures relative to coordinating and providing transportation services.

**PROVIDER NETWORK**

*Note: See Model Contract Attachment II, Section VII and Exhibit 7 as appropriate by plan type*

**K. General Provisions**

1. The applicant must demonstrate that it has sufficient facilities, service locations, service sites and personnel to provide the covered services described in Attachments I and II, Section V and Section VI of the model Contract.

2. Specify in which Medicaid counties the applicant intends to operate during the Contract period, and if the applicant anticipates a phase-in period. The applicant must describe how it will increase and adapt its network as it expands to additional counties. The applicant must provide network information in a geo-access format.

   *Note: The Agency may require the applicant to provide services in an Agency-predetermined service area.*

3. The applicant must demonstrate that it 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 to meet the needs of the maximum enrollment level in each county; and

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

4. List, by county, the name, address, specialty, license number, hours of operation, and staffing of locations where the applicant plans to provide all covered services, including ancillary and hospital services, and whether the provider's panel is open or closed to new Medicaid enrollees enrolled with the applicant. The Excel spreadsheet template for this information is available in the application tool kit online at Become a Medicaid Health Plan. See the link titled "Provider Network Spreadsheet."

5. Submit a separate list of primary care providers (PCPs) located in adjacent counties who may provide services to enrollees. For enrollees who select a PCP or access providers in an adjacent county, the health plan is responsible for all services in the Contract including transportation to the provider in an adjacent county.

6. Submit GeoAccess or other mapping software reporting approved by the Agency to show, by county, the location of all contracted providers listed below, including travel times within the county. Submit a GeoAccess report that documents that the applicant's network meets all access standards for pharmacies and hospitals. These maps/reports are required to demonstrate that the access requirement of thirty (30) minutes travel time to PCPs and hospitals and sixty (60) minutes travel time to specialists and ancillary providers have been met.

   a. Dentists;
   b. Pedodonists;
   c. Primary care physicians, by specialty;
   d. County Health Departments;
   e. Federally Qualified Health Centers;
   f. Rural Health Clinics;
   g. Pharmacies;
   h. Hospitals; and
   i. Specialists.

7. Provide the cover page and signature page from the executed contracts of all participating providers in each county.

## QUALITY MANAGEMENT

*Note: See Model Contract Attachment II, Section VIII and Exhibit 8*

### L. Disease Management

Submit policies and procedures that describe the process for the development and implementation of disease management programs.

## ADMINISTRATION AND MANAGEMENT

*Note: See Model Contract Attachment II, Section X and Exhibits 10 and 13*

### M. Kick Claims

Submit policies and procedures that cover the submission of claims for kick payments as specified in Attachment II, Exhibit 13, of the model Contract.

## REPORTING

*Note: See Model Contract Attachment II, Section XII*

### N. Reports Specific to Reform

For reports specific only to Reform, submit policies and procedures and the position(s) within the organization responsible for the compilation and submission of each report listed in Attachment II, Section XII, Table 1, of the model Contract in accordance with the specifications detailed in the Agency's Health Plan Report Guide. Also include the position, and contact information for the person holding this position, that will assure and certify the timeliness, accuracy and completeness of the reports.

# FORM

**Enrollment Projection**

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** | | | | | | |
| | | | | | | |
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