Florida Healthy Kids Corporation

Invitation to Negotiate 2015-01: Health Benefits Coverage Underwriting and Services

For

THE FLORIDA HEALTHY KIDS CORPORATION

Florida Healthy Kids Corporation
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INVITATION TO NEGOTIATE 2015-01:
Health Benefits Coverage Underwriting and Services
TABLE OF CONTENTS

INVITATION TO NEGOTIATE 2015-01: 2

HEALTH BENEFITS COVERAGE UNDERWRITING AND SERVICES 2

TABLE OF CONTENTS 2

I. INTRODUCTION 3

II. SCOPE OF INVITATION TO PARTICIPATE (ITN) 3

III. PROCUREMENT PROCESS 4

A. EVALUATION OF PROPOSALS 4
B. CALENDAR OF EVENTS 7
C. SINGLE POINT OF CONTACT 8
D. QUESTIONS REGARDING THE ITN 8
E. BIDDER'S CONFERENCE 8
F. REQUESTS FOR SUPPLEMENTAL INFORMATION 9
G. AMENDMENT OF THE ITN 9
H. SPECIAL NOTE – DISCLOSURE STATEMENT 9

IV. OTHER TERMS AND CONDITIONS 10

A. MOST FAVORABLE TERMS 10

B. WITHDRAWAL OF PROPOSALS 10
C. CONDITIONS 10
D. COMPETITIVE NEGOTIATION PROCESS 10
E. LIMITATIONS 10
F. ANNOUNCEMENTS AND PRESS RELEASES 11

V. SUBMISSION REQUIREMENTS 11

A. SUBMISSION ADDRESS AND DEADLINES 11
B. SPECIFIC CONTENTS 11

APPENDIX DOCUMENTS 35

I. Introduction

The Florida Healthy Kids Corporation ("FHKC") is a Florida non-profit corporation. It was established by the State of Florida in 1990 to demonstrate the concept of using school systems as a grouping mechanism for the purpose of providing comprehensive health insurance coverage for children. The Florida Healthy Kids Corporation Act can be found in section 624.91, Florida Statutes.

Eligibility and benefits for the program are determined by FHKC in accordance with federal and state law. Families enrolled in the Healthy Kids program contribute towards the cost of their coverage based on their family size, income and other factors. FHKC contracts with a third party administrator ("TPA") to determine eligibility, collect premium payments and provide certain customer service functions.

The Healthy Kids program is one component of Florida's KidCare program which provides health insurance coverage to children through four separate programs: Healthy Kids, Medikids, Children's Medical Services Network ("CMSN") and Medicaid for children. Florida KidCare is Florida's Title XXI or state Children's Health Insurance Program ("CHIP") which was created federally in 1997, re-authorized in 2009, and authorized in state law in sections 409.810 through 409.821, Florida Statutes.

Terms used in this Invitation to Negotiate ("ITN") are defined in the same manner as in the standard Contract included in this ITN and incorporated by reference. References to "Respondents" and "Insurers" refer to those Parties that will respond or intend to respond to this ITN.

II. Scope of Invitation to Negotiate (ITN)

FHKC is soliciting proposals under this ITN from Insurers or any provider of health care services meeting standards established by FHKC to assume the underwriting risk of the health benefits coverage provided by FHKC (the "Program"). FHKC encourages all interested parties to respond to this ITN. However, FHKC is not an insurer and cannot assume risk.

This procurement document is issued for the re-bid of existing managed care plan contracts for the Healthy Kids component of the Florida KidCare program. The proposed effective date for implementation of awards under this ITN is October 1, 2015. All existing health plan contracts will be terminated effective September 30, 2015. Separate dental plan contracts are not affected by this ITN. Existing contractors are eligible to participate in this ITN and all other qualified plans are encouraged to submit proposals.

The Insurer should understand that current and future enrollment is contingent upon the continued availability of funding from multiple sources. Therefore future enrollment levels cannot be assured. Insurers are not guaranteed any minimum level of enrollment in any Region. Additional information regarding the assignment and choice process is provided in later sections of this ITN.

The award of any Contracts under this ITN or any future renewals is contingent upon the availability of funds for the Program.

Whether or not an incumbent Insurer remains in a Region will be dependent upon contract negotiations between FHKC and the Insurer. However, FHKC has a strong interest in the promotion of continuity of care for its enrollees.

III. Procurement Process

A. Evaluation of Proposals

Proposals will be evaluated in a two (2) step process. First, proposals that do not offer an insured product, fail to meet the minimum benefit package specifications, increase the cost sharing specifications or change the program's objectives will be disqualified in FHKC's sole discretion.

Proposals meeting these minimum qualifications will then be evaluated consistent with state law which requires FHKC to competitively bid for health services and to purchase services in a cost effective manner consistent with the delivery of quality health care.

Factors that are taken into consideration during this process include, but may not be limited to:

- Respondent's compliance status with requirements of other regulatory agencies in Florida (for example: Agency for Health Care Administration ("AHCA"), Office of Insurance Regulation ("OIR") and ("DFS") Department of Financial Services);
- Sufficiency of proposed provider network within the Region;
- Respondent's status as an incumbent Insurer with FHKC;
- Ability to offer a statewide network;
- Respondent's compliance and performance status with FHKC if a current contractor or if a previous contractor;
- Existing or previous litigation or regulatory action by or against the State of Florida, United States Government or FHKC;
- Respondent and its subsidiaries, subcontractors or agents that would be engaged under this Contract are not de-barred or otherwise prohibited from contracting with FHKC, the State of Florida or from receiving federal or state funds;
- Reference checks conducted on Respondent's performance as a vendor for comparable Contracts;
- Respondent's current and recent financial status;

- Sufficiency of the proposed provider network within the Region;
- Geographic representation of provider network within the Region;
- Member Services functions;
- Quality Assurance and medical case management services;
- Ability to meet access and appointment standards within the Region;
- Compliance with all Reporting Requirements (Incumbents are evaluated based on current compliance status; non-incumbents will be evaluated based on testing results and reference check results);
- Competitiveness of premium rate; and
- Past performance under HEDIS standards.

Proposals are evaluated under the supervision of the Purchasing and Contracting Committee, which may establish a special evaluation committee to review the ITN responses. The Purchasing and Contracting Committee is established by the FHKC Board of Directors. Personal interviews may be requested with any, all or none of the Respondents, in FHKC's sole discretion. Any interviews will be conducted in or from Tallahassee, Florida by the Purchasing and Contracting Committee or its special evaluation workgroup, and are scheduled by FHKC.

The scope and length of any such Personal Interviews will be set by FHKC. Any materials presented by Respondents at the Personal Interviews will be considered public records. Respondents should also be aware that submissions received during this ITN process, selection criteria, scoring system and results from this ITN will be available for inspection upon request after the ITN process has been concluded in accordance with Florida law.

Respondents are responsible for ensuring that all elements of the proposals are provided in an organized and concise fashion. FHKC is not obligated to interpret any elements not clearly labeled or described. All elements of Respondent's proposals are subject to public inspection following the conclusion of the ITN process. FHKC reserves the right to review and evaluate proposals as submitted without further input or clarification from the Respondent.

Respondents may request that certain documents or elements of their submissions be deemed as "trade secrets" during this process. Such documents, as noted above, may be deemed to be public records at the conclusion of the procurement process. In order to properly assert that a

document provided to FHKC constitutes a "trade secret," Respondent must meet the following requirements:

1. Each page of such document or specific portion of the document claimed to be a trade secret must be clearly marked as "trade secret";
2. All material marked as "trade secret" must be separated from all non-trade secret material, such as being submitted in a separate envelope clearly marked as "trade secret" and provided at the end of the section where the material was required to be submitted; and,
3. When submitting "trade secret" material to FHKC under this ITN, Respondent must include the affidavit included with this ITN as Appendix VIII, certifying under oath concerning the documents claimed to be "trade secrets."

If FHKC receives a request from a third party for a document or information that is marked and certified as a "trade secret", FHKC will promptly notify the requesting entity or person that the document is identified as a "trade secret." The entity which has filed and designated the documents as trade secrets will also be notified and informed that such entity has thirty (30) days following receipt of such notice to file an action in Circuit Court in Leon County seeking a determination whether the document or information in question contains trade secrets, as well as an order barring FHKC from disclosing the document. If such action is commenced within the (30) thirty day period, FHKC will not release the documents pending the outcome of the legal action(s). The failure to file such action within the (30) thirty days constitutes a waiver of any claim of trade secrets regarding the documents in question.

FHKC may disclose a trade secret, together with the claim that it is a trade secret, to an officer or employee of any governmental agency, state or federal, whose use of the trade secret is within the scope of his or her employment.

Respondents may not mark the entirety of its response as a "trade secret" and FHKC will not attempt to discern which elements a Respondent was attempting to mark as "trade secrets" in any such wide-ranging efforts.

B. Calendar of Events

A proposed Calendar of Events has been established for this ITN process. This Calendar is subject to change by FHKC. Any changes to the timeline will be posted to the FHKC website at www.healthykids.org.

Event	Date (All Times are Eastern)
Draft ITN Release Date	December 23, 2014
Questions and Comments on Draft ITN Due	January 6, 2015
Answers to Questions on Draft ITN Posted on FHKC Website	January 9, 2015
Final ITN Release Date	January 30, 2015
Bidders' Conference – Tallahassee, FL	February 9, 2015
Letters of Intent Due to Issuing Officer *Mandatory*	February 13, 2015
Proposal Deadline	Noon, March 2, 2015
Personal Interviews	Need will be assessed by FHKC on a case by case basis, at the discretion of FHKC
Anticipated Award Date	April 15, 2015
Implementation Date	October 1, 2015

A recommendation on the selection of an Insurer or Insurers will be made to the FHKC Board of Directors following the conclusion of the evaluation process. The FHKC Board of Directors shall determine the final award of any Contract or Contracts. Award announcements are anticipated to made by the Board at a special meeting called for that purpose on or about April 15, 2015.

Any of the deadlines or dates in this ITN may be modified in FHKC's sole discretion.

C. Single Point of Contact

Respondents to this ITN and their agents may only contact the Issuing Officer, Steven Malono, Corporate Counsel, at malonos@healthykids.org during this procurement process. If Respondents or their agents contact any other employee of FHKC, an FHKC Board Member, Ad Hoc Board Member, or member of any Committee regarding this ITN or this procurement process before the final Contract awards has been made by the FHKC Board of Directors, Respondent's proposal may be disqualified in the sole discretion of FHKC.

D. Questions Regarding the ITN

Any explanation desired by Respondents regarding the meaning or interpretation of the ITN must be submitted in writing electronically to the Issuing Officer at malonos@healthykids.org. No phone calls will be accepted. Only those questions received in writing will receive a response. All questions will be posted to the website for all Respondents to view.

Questions will be accepted through January 6, 2015. All questions received by the deadline will be answered by January 9, 2015 and posted to the website. Questions received after the deadline will be considered on a case-by-case basis by FHKC for a determination as to whether or not all potential bidders would benefit from a response. Any responses will be posted to the FHKC website.

E. Bidder's Conference

A bidders' conference for all interested parties will be held in Tallahassee, Florida on February 9, 2015 at 9:00 A.M. The location will be announced on the FHKC website.

The final ITN document will be reviewed at the bidders' conference and attendees will have an opportunity to ask questions and receive preliminary verbal responses to those questions. Final written answers for questions not previously asked and answered will be posted to FHKC's website following the bidders' conference.

F. Requests for Supplemental Information

Written requests for any information not included with this ITN will be considered by FHKC. All attempts to satisfy reasonable requests for information will be made by FHKC. If FHKC determines that such information would be beneficial to all Respondents, the information will be posted on FHKC's website.

Once an ITN has been issued, individual public records requests for information relating to prior procurement processes and bid responses will be honored through the scheduling of a public viewing of such records. Grading tools and procurement files from prior processes are no indication of future processes.

Any information or responses received by interested parties verbally or through other representatives before this ITN process are not binding on FHKC, and Respondents should not rely on such information.

In accordance with state law, proposals received under this ITN, the grading tools and other materials developed as part of this process are not available to the public until the process has concluded. Information about marking items submitted by Respondents as "trade secret" has been addressed under Section II.

G. Amendment of the ITN

FHKC reserves the right to amend any portion of the ITN at any time prior to the announcement of Contract award. In any such event, all Respondents will be afforded an opportunity to revise their proposals to address ONLY the amendment, if in FHKC's sole discretion, it determines such an amendment is necessary.

H. Special Note – Disclosure Statement

FHKC is a private, Florida non-profit corporation and not subject to the strict procurement requirements applicable to agencies of the State of Florida. FHKC may elect to consider or reject any or all responses. Information contained in any proposals received under this ITN is not available to any other respondents until the ITN process has been concluded. FHKC intends to award Contracts to more than one Respondent in a Region or a program site. A Respondent's response to this ITN and the submission of any subsequent formal proposal or bid indicates its agreement to this statement.

IV. Other Terms and Conditions

A. Most Favorable Terms

FHKC reserves the right to award a Contract without any further discussion with the Respondents regarding the proposals received. FHKC reserves the right to contact individual Respondents to clarify any point regarding their proposals or to correct minor discrepancies. FHKC is not obligated to accept any proposal modification or revision after the bid submission date.

B. Withdrawal of Proposals

Respondents may withdraw any or all proposals at any time prior to execution of a Contract by submitting a written statement to the Issuing Officer.

C. Conditions

Any conditions, caveats or contingencies included in a proposal for acceptance will not be considered and may be disqualified without further consideration or opportunity for modification or clarification by the Respondent.

D. Competitive Negotiation Process

In the final phase of the ITN, FHKC may elect to enter into negotiations with selected Respondents in order to purchase comprehensive insurance coverage consistent with the delivery of quality medical care. State law requires FHKC to select its health plans through a competitive bid process.

FHKC also may elect to execute a Contract or Contracts with a selected Respondent or Respondents without any further negotiation. Therefore, proposals should be submitted in complete form, and pursuant to all terms and conditions as required in this ITN.

FHKC is the sole judge of which proposals provide the best solutions in terms of technical merit and price.

E. Limitations

Respondents may not submit proposals for the same Region under multiple plans that are affiliated and linked by shared ownership or controlling interests. FHKC shall make the final determination of such affiliation, will notify Respondents of any such situations and request that Respondent withdraw all but one of the affiliated proposals. Otherwise all

of the Respondents' proposals from all affiliated entities may risk disqualification from the ITN process.

F. Announcements and Press Releases

Any announcements or press releases regarding Contracts awarded under this ITN must be approved by FHKC prior to release.

V. Submission Requirements

A. Submission Address and Deadlines

In order to be considered, all proposals must be submitted to the Issuing Officer at the address listed below in the manner prescribed under this ITN:

Steven Malono
Corporate Counsel
Florida Healthy Kids Corporation
661 East Jefferson Street
Florida Bar Annex Building, 2nd Floor
Tallahassee, Florida 32301

Respondents should thoroughly address all of the stated components for each designated lettered Tab. The Respondent should consult the ITN and associated documents, the designated statutes and the proposed Contract for additional information or guidance on each of the proposal components. Proposals must follow the exact format and order described in this ITN or risk disqualification.

Proposals must be received by 12:00 noon (Eastern) on March 2, 2015. Proposals received after this date and time will NOT be considered.

B. Specific Contents

Each proposal must be separated into three (3) distinct volumes and presented in electronic format only, in searchable CD or flash drive format, in the following manner:

Volume One (1) (Administrative):
5 CDs or flash drives

Volume Two (2) (Networks):
5 CDs or flash drives

Volume Three (3) (Rate Proposals):
5 CDs or flash drives

Each CD or flash drive must be clearly marked with the Respondent's official and legal name, address and contact information on each CD cover. Individual flash drives should be sealed in an envelope with the outside envelope clearly labeled with the required information.

Information contained on the CD or flash drive must be in WORD, EXCEL or PDF format (only scanned documents may be in PDF format) as specified in each Tab and easily searchable.

Within each volume, the contents should be organized by lettered and numbered tabs as designated below.

Special Notes:

CDs and flash drives that have been encrypted or password protected will be rejected.

All information received under this ITN is considered a public record and should not be password protected. Any such submissions may result in the rejection of the overall proposal at FHKC's sole discretion and may not receive further consideration.

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VOLUME ONE: ADMINISTRATIVE RESPONSE

PROPOSAL COVER PAGE

Respondent should insert Appendix IX as the Proposal Cover page fully executed by an Executive Officer of the Respondent's Organization. An Executive Officer is defined as an officer that can legally bind the Respondent's organization.

Tab A: Profile of Respondent

Tab 1:
Background information and corporate profile of Respondent, including any experience Respondent may have with providing comprehensive health insurance coverage to children through Medicaid, Title XXI (state Children's Health Insurance Programs ("CHIP")) or similar initiatives.

Tab 2:
Respondent must provide documentation of the financial solvency of the organization, including audited financial statements for the organization's two (2) most recent fiscal years. If the organization's two (2) most recent fiscal years ended within 120 days prior to the proposal due date (in accordance with the ITN Calendar) and the last audited financial statement is not yet available, FHKC will consider the two (2) immediately prior fiscal years as the most recent.

Tab 3:
Respondent must provide information about any pending litigation with which Respondent is involved and in which Respondent's potential liability would exceed $500,000 or 10% of the Respondent's reserves, whichever is greater.

Tab 4:
Information regarding the location of where services will be provided if Respondent is awarded a Contract, and what percentage of the total Contract such services represents.

Except as noted below, Respondent must provide an affirmative statement that no services under this Contract would be provided outside of the United States.

If any services would be provided outside of the United States, Respondent must specifically identify those services and the rationale for that activity being conducted outside of the United States.

Tab 5:
Respondent's Corporate Organizational Chart with identification of key staff members who would have responsibilities if awarded this Contract.

Tab 6:
Conflict of Interest Statement and Disclosure

FHKC has a Code of Ethics which is included in the ITN. The Respondent must review that Code of Ethics and disclose any relationships with any members of FHKC's Board of Directors or its employees.

Tab 7:
Affirmation attesting agreement to all terms and conditions as proposed under this ITN and proposed Contract or Amendment, as applicable. This attestation also must affirm that the Respondent is not de-barred or otherwise prohibited from or being eligible to receive federal or state funds.

This attestation must be signed and dated by an Executive Officer of the Respondent.

Tab 8:
References
Respondent must provide at least three (3) references from current or recent (within the past two (2) years) contracts of comparable population, size or annual premium volume utilizing the form included in the Appendix to this ITN. FHKC shall not be listed as one of the references.

Tab B: Copy of Letter of Intent

A copy of Respondent's Letter of Intent (the "LOI") must be included under Tab B.

Only those Respondents who have filed a written LOI with the Issuing Officer by 5:00 p.m. (Eastern) on February 13, 2015 will have their proposals considered.

The LOI should clearly identify the responding organization, a contact name and contact information including mailing address, email address, telephone number and fax number, alternate contact name and corresponding information and list the counties of interest. The LOI must be signed by an Executive Officer of the Respondent's organization.

A single LOI may cover all Regions of interest.

The LOI and identification of Regions is non-binding and may be withdrawn or modified at any time by the Respondent.

Tab C: Evidence of Regulatory Authority

Respondent must submit evidence of its regulatory authority to operate as proposed in Florida. Appropriate regulatory evidence will be determined based on the insurance model being proposed by the Respondent. FHKC will determine whether or not the evidence provided by the Respondent is sufficient.

Examples of adequate evidence include, but are not limited to, the following:

- A copy of Insurer's Certificate of Authority in the State of Florida from the OIR; or
- A copy of an Insurer's Health Care Provider Certificate authorizing Insurer to operate as a managed care entity in all counties in any Region for which a Contract is sought.

If licensure has not yet been obtained, the Respondent should provide evidence of its submission status, the type of licensure or authority being sought and Respondent's arguments and assurances that such licensure or authority meets this mandatory component of the ITN and a timeline for successful completion of this requirement.

Preference will be given to those Respondents who are fully authorized to conduct business in the manner proposed in its response as of the submission date of its proposal to FHKC.

If not yet licensed or authorized to conduct business in all or some of the counties in a proposed Region, the Respondent will be evaluated and graded during the review period based on its current status and the likelihood that licensure status will be attained by the contract award date.

If not fully licensed by the date of the FHKC Board Meeting when contracts are awarded, the Respondent will be disqualified from further consideration in that Region.

Tab D: Evidence of Accreditation

If Respondent is accredited, a copy of both the award certificate and awarding letter should be included behind this Tab. Such documentation should clearly indicate the accrediting body, the type of accreditation achieved and the length of accreditation.

Example: NCQA, 2 Year Accreditation
AAAHC, 1 Year Accreditation

If the accreditation award letter or certification lists any deficiencies, Respondent must address how and when those deficiencies were cured as part of its submission.

While accreditation may not be required, FHKC reserves the right to award points based on Respondent's type and level of accreditation in FHKC's sole discretion. Preference may be given based on the type of accreditation achieved and the level of years of accreditation that has been attained by the Respondent.

Tab E: Eligibility and Enrollment Process

For background information on the eligibility and enrollment process, please review the Appendix. For Respondent's proposal, however, FHKC is seeking Respondent's affirmation of the following:

- FHKC shall determine eligibility for its Applicants and Enrollees.
- Respondent may request that eligibility be reviewed for any Enrollee in accordance with the Contract but may not deny coverage or benefits to any Enrollee once FHKC has determined that a child is eligible for the Program.
- Respondent understands that other state agencies also may play a role in the determination of eligibility under the Florida KidCare program, and FHKC cannot require another state agency or program to enroll an Applicant or Enrollee in a particular Program.
- Respondent shall accept at least two (2) eligibility files (834 file) from FHKC on a monthly basis. FHKC also may request that Respondent accept manual adjustments to the enrollment file after the first of the month which are effective back to the first (1st) of the coverage month. Payment for manual adjustments will be made in the following month's coverage payment.
- Respondent shall accept an 820 capitation file to reconcile all monthly payments.
- Respondent must agree to accept payments through electronic mechanisms.
- Any non-incumbent Respondent must be able to successfully test both 834 files and 820 files with FHKC's Third Party Administrator by April 1, 2015.

Under this Tab, Respondent should affirm its understanding of this process and detail how it will ensure that these enrollments will be handled on a timely basis. Under this process, all such enrollments are effective on the first (1st) of the month.

Tab F: Benefits and Cost Sharing

The benefit package for the Healthy Kids program is prescribed by state law and is subject to change during the Contract term. The co-payment structure is established pursuant to federal and state laws and regulations. Such statutory and regulatory legal requirements are set forth in the standard Contract included in this ITN.

If Respondent proposes any changes to the benefit package, including modifying the benefits or the co-payment schedule, to include enhancements to the benefits or reductions to the co-payments, the Respondent also must provide actuarial evidence that such modifications would not affect the overall premium assistance payment by the State or the Respondent's expected 85% medical loss ratio. State law prohibits enhancements to the benefits package which result in such an increase or achieves a lower than statutorily prescribed medical loss ratio.

FHKC also offers a "Full Pay" program for Enrollees with a Modified Adjusted Gross Income above 200% of the Federal Poverty Level. The Full Pay program is not a Title XXI CHIP program, and benefits must therefore comply with the relevant portions of the Patient Protection and Affordable Care Act ("ACA"). Specifically, the proposal must indicate that the Respondent will provide each Full Pay Enrollee with all "Minimum Essential Benefits" required by the ACA, without limitation, including elimination of any lifetime limitation on benefits. If a Respondent submits a proposal under this ITN, they will be deemed to understand and accept this requirement. On a monthly basis, FHKC will notify all successful Respondents as to the identity of any Full Pay Enrollees they cover. Respondents shall submit separate rates under Volume III of this ITN for both the subsidized and full pay populations. The 85% medical loss ratio also applies to the full pay program.

Under this Tab, the Respondent must:

- Affirm its understanding of the benefits package by re-stating the benefits package and co-payment schedule;
- If any enhancements to the benefits package are offered, provide actuarial evidence that those enhancements do not impact the proposed cost of the program;
- Any limitations or conditions relating to benefits not prescribed in state law or in the Contract must be included in the response under this Tab and Insurer must affirm that these conditions do not conflict or otherwise unlawfully restrict the benefits required by federal or state law;
- Respondent must affirm its understanding that certain Enrollees may be prohibited from participation in cost sharing (if costs exceed 5% of family income or if an American Indian or Alaskan Native Enrollee) and explain how Respondent would

implement measures to ensure that Enrollees would be protected from cost sharing requirements;

- Describe how Respondent's network providers will be made aware that certain Enrollees may have different cost sharing requirements under the Program;
- Respondent must address how benefits will be coordinated with an Enrollee's dental providers, specifically situations involving injuries to the mouth and jaw; dental procedures requiring inpatient hospitalization (for sedation/behavior management); and addressing how Respondent will ensure coverage of any prescriptions written by the Enrollee's dental provider;
- Coordination of benefits with other insurers that may be responsible for benefits for Enrollees such as auto insurance coverage should be detailed.
- Respondent must affirm its acceptance of the requirements described above relating to FHKC's Full Pay program.

Areas of Special Emphasis for ITN 2015-01 under Tab F:

Tab F-1 – Third Party Payor Coordination of Benefits

Respondent should specifically address how its organization addresses the coordination of benefits with other insurers that may be responsible for benefits for Enrollees such as auto insurance coverage.

This response should also re-assure the Corporation that Respondent does not deny coverage of services to enrollees who may have access to third party coverage such as auto insurance coverage that may offer coverage only for certain benefits in limited situations.

Tab F-2 – Coordination of Benefits with Dental Plan

Respondent must address how the limited dental benefits provided under the health plan contract for injuries to the mouth and jaw will be coordinated with an Enrollee's Healthy Kids dental providers. Of specific interest to the Corporation are those situations involving injuries to the mouth and jaw where coordination of benefits with the Enrollee's Healthy Kids' dental plan is essential and assistance to the families is of utmost concern. The focus should be on addressing the needs of the Enrollee.

The Respondent should address how the plan will ensure that the Enrollee receives the benefits covered by law and that the family is not required to coordinate the benefits and services between the two plans and its providers.

Respondent should describe how its plan will provide the least burdensome process to its Enrollees while ensuring access to all of the covered health and dental benefits and services in a timely manner.

And finally, under Tab F-2, the Respondent should address how the Healthy Kids health plan will ensure coverage of any prescriptions written by the Enrollee's dental provider in such situations.

Tab F-3 – Prescription Formularies

Under Tab F-3, the Respondent should describe in more detail its prescription benefit. If a formulary or preferred drug list is to be used, the Respondent must affirm its understanding that all formularies or preferred drug lists must be approved by the Corporation prior to its implementation and that any changes to that formulary must also be approved by the Corporation.

Additionally, the Respondent must affirm its understanding that any such formulary must be no more restrictive than any drug list used by Florida Medicaid.

Under this Tab, the Respondent must also include its policies for exceptions to the formulary, the process for physicians, the timeline involved, if changes are made to the formulary, how impacted enrollees are informed and the timeline for changes, if any, to their prescriptions, etc. Emergency refill policies, step-therapy requirements, exceptions to step-therapies and any other policies on prescriptions or pharmaceutical management that would impact the Healthy Kids population should be included under this sub-Tab.

The formulary or preferred drug list recommended under this proposal should be included under this sub-Tab.

Tab F-4 – Provision of Immunizations

One key benefit is the provision of immunization to Enrollees. While immunizations may be further addressed under Member Services, Provider Networks and as a cost factor under premium rates, the Respondent should address here how the plan will ensure that Enrollees will continue to receive this important benefit under their plan. Respondents should also explain how the plan will ensure that all primary care providers are registered with the SHOTS program and continue to keep the Enrollee's immunization record updated in the SHOTS data base. Immunizations must be administered at each provider's office.

The Respondent should affirm its understanding that the provision of immunizations is a key benefit under the Healthy Kids program and the Respondent must have a robust provider network capable of delivering this benefit and creating a medical home.

Tab G: Program Management

Respondent's Tab should fully address each of the components detailed below as it specifically relates to the Healthy Kids program. If there are any differences in how the program would be managed in one Region as compared to another, these differences should be highlighted and a rationale provided for each of those differences.

Additional information about each of these components may be found in the Appendix.

Tab 1:

Member Services

Proposal should address, at a minimum:

- Member education and sample member materials;
- New member orientations or welcome strategies;
- How members will access services;
- Referral process and any prior authorization processes;
- Identification of medical home for each Enrollee;
- Grievance and Resolutions Processes, including requests for expedited or emergency reviews;
- Handling requests for Second Opinions;
- Member Services Hours of Operations;
- Availability of Bilingual Customer Service Representatives;
- Availability of Materials in languages other than English;
- Availability of Materials in Braille and other alternate formats;
- Provision for Out-of-Network Services when necessary;
- Urgent Care and Emergency Services;
- Out-of-the Area Services (Child injured or sick when out of the service area); and
- Retention Efforts for Renewing Enrollees.

Tab 2:
Provider Network Management

Proposal should address and include, at a minimum:

- Respondent's Provider contracting policies;
- Copies of the Respondent's standard provider contracts and any addendums that would be executed specific to the Healthy Kids program, including primary care, specialty care, hospital, tertiary and any other contracts for specific services or levels of care;
- Proposed compensation schedule for each type of provider must be included and provide sufficient description to allow FHKC to

understand the Respondent's reimbursement methodologies and structure by provider type including any variances; the specific schedule must be made available for review by the Corporation if requested during the review process;
- Description of any Provider education programs, including the structure, content and frequency of provider visits;
- Description of how Provider network changes and primary care provider transitions are handled; and
- Status of Respondent's provider contracting efforts for providers included in submission.

Tab 3:
Quality Assurance

Respondent should describe its quality assurance programs with a particular emphasis on any pediatric and adolescent programs, and describe any process or initiatives for performance improvement projects.

Respondents must affirm their understanding that FHKC will conduct its own quality audits and research efforts during the Contract term, either directly or through contracted third parties, and Respondent will cooperate fully with any and all such efforts.

Tab 4:
Medical Case Management

Respondent will be responsible for the management of medical situations of its Enrollees on an ongoing basis. The Respondent should highlight in its submission any specialized pediatric or adolescent programs that would be available to Healthy Kids Enrollees, and how these programs would be beneficial to its Enrollees and to the program overall.

A method for identifying children with special health care needs who may be eligible for the Children's Medical Services Network is highly desirable. Respondent should address any programs or systems it has in place or would propose that enhance opportunities for identifying, managing and assisting such children and their families.

Tab 5:
Mental Health Care and Substance Abuse Services

Respondent should address specifically its approach to the delivery of mental health care and substance abuse services to children and adolescents.

While the response under this particular section should not include the specific provider network, the Respondent should address how Enrollees and the provider community will be educated about the availability of the mental health and substance abuse benefits and how services will be delivered, including the referral and prior authorization process, if any for services.

For these services, Respondent is strongly encouraged to contract with providers who are accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) or Commission of Accreditation of Rehabilitation Facilities (CARF).

Respondent should also address the following specific questions:

- Whether the Respondent and its individual Providers are accredited by JCAHO or CARF;
- Whether the Respondent and its individual providers are licensed Mental Health or Substance Abuse Treatment Providers by the State of Florida;
- Whether a specific evidence based standard clinical assessment instrument is mandated for use by the Respondent or its subcontractors;
- If so, which tool is utilized and if not, the rationale for why a tool is not mandated;
- Whether a Co-Occurring Assessment Tool mandated for use among providers; and
- If so, please identify the tool.
- The Corporation does not currently mandate the use of a specific tool but preference may be given for those plans that require the use of a specific system or evaluation tool.

Tab 6:
Confidentiality and Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA") Compliance

Describe Respondent's activities to ensure confidentiality and compliance with HIPAA.

Describe Respondent's compliance activities related to the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Tab 7:
Disaster Recovery and Business Continuity and Recovery Plans

Describe Respondent's approach to Disaster Recovery and its Business Continuity and Contingency plan including alternative locations for services should natural disasters occur where primary services are conducted.

Tab H: Implementation Period and Transition Process

Respondents must include a detailed time-line that would ensure the successful implementation of the Contract by October 1, 2015.

Specific emphasis should be placed on how the Respondent would ensure a smooth transition or delivery of the following:

- Implementation of necessary infrastructure and systems, if not a current Insurer with FHKC, or expansion of existing system if an incumbent Insurer;
- Development of member materials and education of member services and plan staff on the Program, if a new Insurer;
- Identification and maintenance of existing medical homes of Enrollees transferring to Insurer;
- Transition of coverage with specialists for Enrollees with prior relationships with such providers;
- Identification of any pre-existing authorizations and hospitalizations;
- Transition of members being followed by case management teams or other providers; and,
- Compliance with all contractual requirements (reporting, access, appointment, credentialing, etc.).

The time-line should include specific dates and events beginning with the Contract award date shown in the ITN and continue through the end of the first contract year, September 30, 2016.

Those awarded Contracts under this ITN will be required to submit a more detailed transition plan for FHKC approval within ten (10) days of Contract execution. Respondents must affirm their understanding of this requirement in their response.

Tab I: Reporting Requirements

Respondent must meet all of the reporting requirements described in the proposed Contract and shall bear the financial responsibility for all costs incurred in order to comply with these reporting requirements.

Existing Contractors with FHKC will be evaluated based on their current compliance status with all reporting requirements, including the quarterly submission of claims data with FHKC's Contractor, the Institute for Child Health Policy (the "ICHP") and to FHKC. FHKC solely will determine each Contractor's compliance status and provide notice of each Contractor's status prior to the ITN submission deadline. FHKC may also, from time to time, request specific claims data directly from Respondent, which shall be provided within a reasonable time as provided in the Contract.

If the Respondent is **not** a current Contractor, the Respondent must initiate a testing phase with FHKC's Contractor, ICHP, with regard to the quarterly submission of claims data prior to Respondent's Personal Interview. The testing phase must be initiated through at least one successful (1) exchange of files with the ICHP by **March 15, 2015.** The definition of a successful exchange of files will be determined by ICHP.

Successful completion of this testing phase is a required component of this ITN and is a graded component. An incumbent Insurer who is delinquent or non-compliant with **any** existing reporting requirements will have points deducted and may be disqualified from further consideration at FHKC's sole discretion.

Non-incumbent Respondents should successfully complete the testing process with the ICHP no later than **April 1, 2015.** Points will be deducted if the testing process has not been successful during the evaluation process and Respondent may be disqualified from further consideration at FHKC's sole discretion, if by the date of the Purchasing and Contracting Committee Meeting at which final grades are presented, the testing requirements have not been completed to FHKC's satisfaction. It is Respondent's sole responsibility to ensure that the necessary steps have been taken to complete these requirements.

A copy of the required data layout for such transmissions will be posted to the FHKC website with the final ITN document.

All Respondents must affirm their understanding of those requirements under this Tab and agree to meet those requirements.

All successful Respondents must register, and remain registered during the term of the contract, with the "Hospitalization Alert" program maintained by the Florida Health Information Exchange.

Tab J: Contract

A contract for services will be executed between FHKC and the successful Respondent or Respondents. The proposed Contract will be provided no later than the Bidder's Conference. The Respondent's submission to this ITN will be incorporated by reference to the final Contract.

Conflicts

Any conflicts between the proposed Contract, this ITN and the Respondent's proposal will be resolved by FHKC and included in the final Contract that is executed between the Parties.

Revisions

Revisions to FHKC's standard Contract are not generally accepted; however, the Respondent may include in its response any requested changes. Requested changes are reviewed and evaluated and points may be deducted for substantive changes.

Excessive or unreasonable changes, substantive or otherwise, or changes that modify the program's objectives or impair FHKC's fiduciary or other contractual responsibilities may result in points being deducted or the proposal being removed from further consideration. FHKC reserves the right to reject any or all requested changes in its sole discretion.

If the Respondent anticipates requesting revisions, the specific revisions must be requested in writing in a strikethrough and underline format of the original document and submitted with the proposal.

If no changes are requested, the Respondent must state explicitly its acceptance of the Contract or Amendment, as applicable.

FHKC may make awards without proposed revisions being accepted.

VOLUME TWO: PROVIDER NETWORKS, BY REGION

FHKC is adopting the Agency for Health Care Administration's Medicaid Managed Care regional approach ("Region") to contracting, and eliminating its previous "county" approach. See, APPENDIX X to this ITN. Provider Networks should be provided under the following Tabs in alphabetical order, by Region, as detailed below, based on where the provider is located. Providers can be included from any Region so long as those providers can meet the access, appointment and credentialing standards established under this ITN for the area of expertise.

Providers from outside of Florida are not generally accepted; however, the Respondent may include out of state providers if a rationale for their inclusion is also incorporated into

Respondent's submission. The narrative should be included under the specific Tab where such providers are utilized.

FHKC will make a case by case determination as to whether or not to include the provider or facility in the network adequacy review process of this ITN. If selected as an Insurer, FHKC will have a prior approval process for the use of out of state facilities and approval of out of state primary care or specialty providers will continue to be reviewed by FHKC's Quality Committee under the existing process.

Providers that have multiple offices may be listed more than once; however, the office hours cannot overlap. For example, a provider cannot be shown to be present in both offices from 8 a.m. to 5 p.m., Monday through Friday in both locations. If Respondent is not able to discern the provider's specific hours in each location then the Respondent must list the provider only once or FHKC will disqualify the provider in its review of the Respondent's network.

The Geo-Access information is required only for the enrollees that reside in those Regions for which the Respondent has provided a LOI and should be included behind the appropriate Region as required.

Additional information regarding FHKC's standards, review guidelines and board certification requirements can be found in the Appendix.

In front of designated Tabs for this Volume, a summary sheet which provides a count of unique providers under each Tab is required. The summary sheets are provided in the Appendix. The summary sheet should be the first page behind each Tab followed by an EXCEL listing of providers as detailed for each Tab and then Geo-Access Maps, as appropriate.

Except for Tab A, Geo-Access Maps are not required, but Respondents are strongly encouraged to include such maps for each Tab.

SPECIAL NOTES:

Respondent should list those providers and facilities that the Respondent already has under contract and that have already agreed to specifically participate with Respondent for Healthy Kids through executed contracts, amendments to existing contracts, or executed letters of agreement on the EXCEL lists under each of the Tabs being described below.

If the Respondent has a contract with the provider but it is not specific to Healthy Kids, the contracting has not been completed or the provider, physician or facility has not yet agreed to extend their contracting to include Healthy Kids through one of these identified mechanisms, the provider listing must be shaded to indicate that the contracting status had not been completed.

To be an un-shaded provider or facility, the contracting process must be fully completed. Fully completed is defined as the provider, physician or facility has

executed a contract specifically for the Healthy Kids product line and is ready to see a Healthy Kids Enrollee.

Respondents may not imply to any provider, physician or facility during the ITN process that the Insurer is already a Healthy Kids provider, has a contract or is about to receive a Healthy Kids contract unless they are an incumbent in that specific county. Respondents may not also imply that Healthy Kids requires a specific reimbursement schedule.

While not required for Respondent's submission, FHKC may request evidence of such contracts, amendments and letter of agreements during the ITN process.

Additional information about the contracting process can be found in the Appendix and should be covered by the Respondent under Volume I, Tab 2 – Provider Network Management and not covered under this Tab.

Tab A: Primary Care Providers

In alphabetical order BY REGION with each Region presented as a separate sub-Tab and its own EXCEL list and then listed within each Region by physician type alphabetically and then alphabetical by last name within each physician type, Respondent should provide the following minimum information about each primary care provider (pediatricians and family physicians only) in the EXCEL Spreadsheet format provided below. Information not provided in the format prescribed below may be rejected.

Physician extenders should not be included in the chart below. Respondents may include them as separate, supplemental material under this Tab but they will not be considered when determining the adequacy of the Respondent's network.

EXAMPLE:
REGION 1

Region	Type FP PED	LNAME	FNAME	Suffix (MD, DO)	Address	Board Certification Status	Office Hours	Age Restrictions	Panel Capacity	Panel Status
	FP	Brown	John	MD		Family Practice	9-5 M,T,R,F 9-12 W	3-99	250	OPEN
	FP	Jones	Melissa	MD		Family Practice	9-12 M-F	5-99	50	CLOSED
	PED	Smith	Susie	MD		PEDIATRICS	9-5 M-F	0-18	100	Existing Only

A Geo-Access Map indicating the location of each primary care provider for each Region is required.

If primary care physicians from surrounding Regions that meet the geographic access standards of this ITN, including the rural exceptions, are also available to Enrollees in this Region they may also be included in this chart. These physicians should be listed AFTER

the Region-based physicians. In the example above, physicians for Region __ should be listed first and then any surrounding Regions may follow in numerical order.

<u>If including primary care providers from surrounding Regions:</u>

1	Type FP PED	LNAME	FNAME	Suffix (MD, DO)	Address	Board Certification Status	Office Hours	Age Restrictions	Panel Capacity	Panel Status
	FP	Brown	John	MD		Family Practice	9-5 M,T,R,F 9-12 W	3-99	250	OPEN
	FP	Jones	Melissa	MD		Family Practice	9-12 M-F	5-99	50	CLOSED
	PED	Smith	Susie	MD		PEDIATRICS	9-5 M-F	0-18	100	Existing Only
Surrounding Region Providers:										
	PED	Lloyd	Sara	DO			8-5 M-F	5-99	100	OPEN
	FP	Floyd	Lyle	MD		Family Practice	9-5 M-F	12-99	250	Existing Only

Tab B: Specialists

In alphabetical order by Region with each Region proposal presented as a separate sub-Tab under Tab B and its own separate EXCEL list and then alphabetical by specialty in that Region, then by alphabetical by provider last name within each specialty alphabetically, Respondent should provide the following information about each specialist in EXCEL Spreadsheet format:

PROPOSAL FOR REGION 1

Region	Specialty	LNAME	FNAME	Suffix	Address	Office Hours	Age Restrictions	Pediatric Specialist?
	Allergy	Smith	John	MD		9-12 M-F 8-5 W	10-99	No
	Dermatology	Jones	Mary	MD		9-12 M-F 8-5 W	10-99	No
	OB/GYN	Moore	Harry	MD		M-Th 8-5	15-99	No
	OB/GYN	Moore	Harry	MD		8-12 F	15-99	No
	Pulmonary	Montana	Hannah	MD		8-5 M, W	12-99	No

Respondents only need to include the provider networks for the Regions in which they have indicated intent to provide services. Providers from surrounding areas may be included if those providers are available to Enrollees and can meet the access, appointment and credentialing standards established in this ITN. Surrounding Region

providers should be presented in the same manner and format as shown under Tab A: Primary Care Providers.

NOTES:

Specialists should be listed based on the location of their practice office. Credit is provided only for specialists that meet the access standards of this ITN unless the Respondent can provide a rationale for why a certain specialist should be included outside of those standards. The narrative supporting that request should be included under this Tab behind the EXCEL spreadsheets.

Tab C: Behavioral Health Care and Substance Abuse

In numerical Region order with each Region proposal presented as a separate EXCEL list and its own sub-Tab and then alphabetical by specialty, then by provider last name within each specialty, Respondent should provide the following information about each Behavioral Health Care or Substance Abuse Treatment Provider in EXCEL Spreadsheet format as shown in the tabs above:

PROPOSAL FOR REGION 1:

For Individual Providers:

County	Specialty	LNAME	FNAME	Suffix	Address	Office Hours	Age Restrictions	Pediatric or Adolescent?	Accreditation or Licensure Status

For Facilities:

County	Facility Name	Types of Services Provided	Address	Hours of Operation	Age Restrictions	Accreditation or Licensure Status

Respondents only need to provide information for the Regions in which they have indicated intent to provide services.

As noted above, providers and facilities from surrounding areas may be included if those providers are available to Enrollees and those providers or facilities can meet the access, appointment and credentialing standards established in this ITN.

Providers under this Tab are considered specialists and must meet the standards applicable to specialists and credit will be given based on the access standards of this ITN.

Providers should be listed under the Region Tab where their office is physically located.

Tab D: Participating Hospitals and Tertiary Facilities

In alphabetical Region order by location of the facility, provide the facility name, street address, county in which the facility is located and the services available in each facility. The hospital and tertiary facility network must include sufficient services to be able to cover all of the mandatory benefits for a pediatric and adolescent population. The number of pediatric and adolescent beds available in each facility also must be indicated.

Hospitals and facilities must be within the access and facility standards provided for in the Contract. Respondent may include out of state facilities for consideration; however, all such facilities will be subject to a review and approval process prior to implementation should the Respondent be awarded a contract under this ITN.

If a Region has a hospital facility within its borders and that hospital has pediatric or adolescent beds or the majority of primary care providers have privileges at that facility, Respondents should have a contract with that facility.

Respondents are strongly encouraged to have a contract with at least one hospital in each county within each Region in which a contract is being sought and with hospitals that the majority of its primary care physicians have admitting privileges. If Respondent does not have a contract for an existing hospital, the Respondent should provide an explanation for the lack of such relationship and identify its contracts with the next closest hospital and provide a rationale for why it lacks such contracts.

PROPOSAL FOR REGION____:

County	Facility Name	Street Address	Services Provided	Number of Pediatric or Adolescent Beds	Accreditation or Licensure Status

Tab E: Proposed Pharmacy Network

In alphabetical Region order with each Region proposal presented as its own EXCEL list and then alphabetical by pharmacy name, provide a listing of all pharmacies, each pharmacy's county, street address and each pharmacy's hours of operation.

County	Pharmacy Name	Street Address	Hours of Operation	24 Hour Access (Y/N)

Tab F: Other Services (Non-Physician)

Under Tab F, Respondents shall provide in alphabetical order with a separate listing for each Region proposal presented in its own Region tabs an EXCEL list of any other non-physician providers that have not otherwise be included in this Volume, using the order provided on the summary sheet provided in the Appendix.

For each non-physician provider above, the EXCEL listing must include the following information:

- Region and county where located;
- Company Name;
- Street Address;
- Hours of Operation; and
- Pediatric or Adolescent Experience, if Any (Yes or No).

Tab G: Public Providers

For each Region tab, presented as its own EXCEL list and then alphabetical by name of the facility, provide a list of any contracted relationships with any public providers, such as County Health Departments, federally qualified health centers, and rural health clinics by Region, using the following format shown below.

Respondents are not required to contract with these public providers; however, there are minimum reimbursement requirements under federal and state law should Insurers contract with these entities and Enrollees receive services from these organizations or individual providers.

Proposal for Region _____:

For Facilities:

County	Facility Name	Types of Services Provided	Address	Hours of Operation	Reimbursement Equivalent to Medicaid PPS?	Type of Facility (CHD, FQHC, RHC)

For Individual Providers (Not Included under other Tabs):

County	Specialty	LNAME	FNAME	Suffix	Address	Office Hours	Age Restrictions	Pediatric or Adolescent?	Board Certification Status

Respondents should describe through narrative following the EXCEL listing under each Region Tab the Respondent's relationships with Public Providers, including how contracted, the reimbursement mechanism and how Enrollees are seen in such facilities

(appointment process, reimbursement, co-payments, etc.). Federal law requires that if an Enrollee utilizes services from a contracted Federally Qualified Health Centers ("FQHC") or Rural Health Centers ("RHC") that these entities receive reimbursement that is no less than an amount equivalent to the Medicaid Prospective Payment System ("PPS") amount.

Under this Tab, all Respondents should provide an affirmative statement that they understand this federal requirement whether or not they currently contract with these providers now or plan to under this ITN proposal.

Tab H: Any Other Sub-Contracted Services

Please describe any other services not listed already, provided directly by Respondent or through contracts or other vendors. A separate tab for each Region is not necessary so long as the information is provided on a Region-specific basis, as appropriate.

Any contracts utilized for these sub-contracted services must be included in the response. Respondent must affirmatively state its understanding that FHKC must provide prior approval of any subcontracted relationships and receive notification of any changes to these relationships during the Contract term in accordance with the Contract provisions.

Tab I: Affiliated Entities

Under this Tab, Respondent must identify and disclose any providers or facilities included in any of the Tabs A through H which is affiliated, owned or operated by the Respondent or the Respondent's parent company.

If this section does not apply to Respondent, an affirmative statement attesting that no such relationships exist between the Respondent and any providers or facilities included in this response must be provided.

VOLUME THREE: PREMIUM RATE PROPOSALS

Respondents may submit as many premium rate proposal combinations as may be desired under the following conditions for each rate proposal:

1. Any proposed premium rate that includes conditions for acceptance or contingencies will be disqualified.
2. Each rate proposal must include a breakdown of the rate using the forms provided in Appendix VIA and VIB with the designated categories. Rates submitted not using these forms and the designated categories will be disqualified from further consideration. Respondent may be given one (1) opportunity, in FHKC's sole discretion, to correct the discrepancy before disqualification. If a particular service category is $0.00, Respondent's proposal should indicate $0.00.
3. The statutorily required minimum medical loss ratio is 85% (eighty-five percent), and applies to both the subsidized and full pay programs.
4. The statutorily required maximum administrative component is 15% (fifteen percent).

5. Respondents must agree to meet the minimum medical loss ratio, maximum administrative component and to provide an experience adjustment to FHKC, in accordance with the provisions of the proposed Contract.
6. Each proposed rate should be mutually exclusive of all other rates proposed and cannot be contingent upon any other rate proposals.
7. Bonus points may be awarded for a single statewide rate.
8. Every rate proposal must be supported by an actuarial memorandum.
9. In subsequent Contract years, the Respondent will be required to submit any annual rate adjustment requests in the same Region groupings as any accepted premium rate proposals.

Rate Presentation Options

Premium rate proposals should be presented as independent rate proposals on a CD or flash drive labeled as Volume Three (3): Premium Rate Proposals.

Tab 1: Affirmation Statement

Respondent should include in its submission an affirmation attesting its understanding of the nine conditions listed above as well as the requirements in the proposed Contract regarding Premium Rates.

Following Tab 1, Respondent should begin numbering its individual rate proposals beginning with Tab 2 and following in sequential order (Tab 2, Tab 3, etc.), with each rate proposal keeping Regions in alphabetical order to the greatest extent possible. Respondent may elect to provide a summary of all rate proposals behind Tab 2, and then begin the presentations of rate proposals with Tab 3.

Rates may be presented using the following options:

Option One: Individual Region Rates

Under this option, Respondent may submit individual Region-by-Region rate proposals. Respondent may propose rates for any or all Regions on an individual basis for consideration. An actuarial memorandum must be included for each proposed rate.

Option Two: Single Statewide Rate

Under this option, Respondent offers a single rate that covers all eleven (11) Regions.

Respondent may submit proposals using either or both of the above options.

Respondents shall submit two (2) separate rates for each Region applied for. The first shall be the rate applicable to the FHKC Title XXI subsidized population only. The second rate shall be applicable only to FHKC's non-subsidized "full pay" population. Respondents must utilize the same geographic option (described above) as it utilized for the subsidized rate in that Region. Successful Respondents will be notified monthly of the identity of each full pay enrollee covered, and reimbursed accordingly. If otherwise appropriate, Respondents may include the rate analysis and justification for each rate in a single actuarial memorandum.

The trade secret provisions of this ITN do not apply to Respondent's Volume III submissions.

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APPENDIX DOCUMENTS

APPENDIX I: BACKGROUND INFORMATION

I. Program Eligibility

Generally, to be eligible for the Healthy Kids program, an applicant must be uninsured at the time of application and be between the ages of 5 (five) and 19 (nineteen) years. Age eligibility is based on the child's age on the first day of the month. For example, if a child reaches the age of nineteen on the first day of the month, the coverage would cancel that month; however, if the child turns nineteen on the tenth of the month, the coverage would end on the last day of the month in which the child turned age nineteen.

Other eligibility criteria may be utilized to determine whether a child is eligible for subsidized coverage in accordance with federal and state laws and regulations. Program eligibility and premium assistance calculations are not the responsibility of the Insurer. Except for "full pay" Enrollees, FHKC will not identify subsidy levels of its Enrollees to Insurers.

Most families with household incomes at or below 200% of the federal poverty level ("FPL") pay a monthly premium of $15 or $20 per family per month to participate in the Program. While there is no income limit for the Healthy Kids program, a family's household size and income, or any voluntary cancellation of employer sponsored coverage for the Enrollee during the prior sixty (60) day period will determine whether subsidized coverage is available. FHKC shall make these determinations in accordance with federal and state laws and regulations. There are state statutory exceptions to these requirements.

Another factor that may impact a child's ability to qualify for subsidized coverage is citizenship status.

To be eligible for Title XXI federally subsidized coverage, a child must be a United States citizen or meet the definition of a qualified alien. Enrollment of non-qualified non-citizen children was closed several years ago; however, some children were grandfathered-in and remain enrolled in the program.

New enrollees who are not eligible for subsidy are offered the opportunity to participate in the program at a non-subsidized rate.

Once a child has been determined eligible, the child is eligible for coverage for twelve (12) months, without re-determination or re-verification of eligibility. Enrollees are required to renew their coverage once every twelve (12) months based on the month of their initial enrollment in the Program or the last renewal completion date. Each Enrollee's renewal date also will be provided to the Insurer in the enrollment files. Insurers are encouraged to implement their own initiatives to encourage families to complete the renewal process. All such efforts must be approved in writing by FHKC prior to implementation.

Eligibility for the program is determined by FHKC. The Insurer must accept all Enrollees deemed eligible by FHKC. The eligibility criteria for the Healthy Kids program are subject to change during the Contract term.

Additionally, the Insurer should be aware and acknowledge that eligibility for the Medicaid Program is determined by the Department of Children and Families ("DCF") and not Healthy Kids. Applicants and Enrollees eligible for the CMSN program must be both financially eligible through either Title XXI (CHIP) or Title XIX ("Medicaid") of the Social Security Act and meet clinical eligibility requirements that are established by the Florida Department of Health ("DOH"). Applicants and Enrollees who meet the eligibility criteria described above for Medicaid or the CMSN, as determined by the responsible state agency, are not eligible for the Healthy Kids program.

Effective July 1, 2009, revisions to the Florida KidCare Act were implemented which permitted Enrollees who were both financially and clinically eligible for the CMSN program to elect to opt out of the CMSN program and enroll in the Healthy Kids program. Insurers should be aware that some Enrollees in the Healthy Kids program may meet the financial and clinical requirements for the CMSN program but have elected to enroll in the Healthy Kids program instead.

II. Enrollment

The current enrollment process is handled by FHKC and its Third Party Administrator ("TPA"). FHKC's current TPA is PSI Services Holdings, Inc. ("PSI").

Families may complete a Family Medical Assistance application. Documentation of income is first attempted electronically, and if not able to be determined electronically, the family is asked to submit evidence of family income. Whether or not a child is currently insured is also part of the eligibility process; however, good cause exceptions do exist in state law.

Choice is provided to Healthy Kids enrollees in all Regions. New Enrollees are auto-assigned among the plans available in the Region keeping family members together in the same plan. A copy of FHKC's policy on *Enrollee Protections Relating to Managed Care Assignments* is provided later in this Appendix for reference. After the initial year of the Contract, a plan's performance under relevant HEDIS performance measures will be taken into consideration by FHKC for future auto assignment purposes, as well as other factors relevant to such decision, in FHKC's sole discretion. New Enrollees are provided a ninety (90) day "free look" period to change plans before a lock-in period begins. Plan changes may occur after this free look period under one of the good cause exceptions as provided in the policy.

Once approved for enrollment by FHKC, the Insurer will be responsible for the distribution of member materials, including identification cards, member handbooks and provider information to Enrollees. Enrollee information is transmitted to the Insurer in the monthly eligibility files.

An on-line portal permitting Insurers to look-up the eligibility status of its Enrollees is also available.

Program eligibility is determined by FHKC. Should the Insurer believe that a child is no longer eligible for the Program or has other comprehensive health insurance coverage, the Insurer may contact FHKC for review of the child's eligibility in accordance with the Contract. Only FHKC may dis-enroll or cancel a child's coverage. If FHKC determines that coverage should be cancelled, the cancellation would take effect only at the end of the current month and would not be done retroactively.

The Insurer will receive two (2) enrollment files (834 file) and one capitation file (820 file) each month from FHKC's TPA. The first enrollment file will be sent to the Insurer approximately seven (7) business days before the end of the month. A second (2nd) supplemental eligibility file will be sent to the Insurer after the third (3rd) business day of each month and will contain a listing of eligible participants who are eligible back to the first (1st) of the month. The second (2nd) eligibility file includes primarily Enrollees whose prior coverage has been reinstated, but also may include a small number of Enrollees who are eligible for the first time and/or some cancellations back to the first of the month. A single monthly premium payment is forwarded to the Insurer for the total new enrollment from both enrollment files. All payments to the Insurers are currently performed electronically.

Manual additions after the supplemental file must also be acceptable to the Insurer. Additional information about the enrollment file transmissions are contained in the standard Contract.

On occasion, FHKC may request that Insurer also accept second (2nd) supplemental files of Enrollees retroactive to the first (1st) of the coverage month. Such requests shall be limited to those circumstances where an error by FHKC or its TPA resulted in cancellation of coverage for eligible Enrollees.

The Insurer also must be willing to accept other authorizations from FHKC indicating that an Enrollee will be on a supplemental eligibility file prior to the Insurer's receipt of that file. It is the Insurer's responsibility to load and implement the enrollment files in a timely manner to ensure that Enrollees have access to coverage the first (1st) of each month.

EXAMPLE:

Coverage Month:	November 2015	
Effective Date:	November 1, 2015	
File	Due to Insurers	Payment To Insurer
Regular Enrollment	October 21, 2015	By November 10, 2015
Supplemental Enrollment	November 3, 2015	By November 10, 2015
Manual Adds/Deletes	Throughout November	By December 10, 2015

III. Benefits

The Healthy Kids program provides a comprehensive health services package. In addition to these benefits, the "full pay" program also provides "minimum essential benefits" required under the Affordable Care Act. The minimum benefit level is specified by state law, section 409.815, Florida Statutes, and cannot be modified. Respondent must meet this minimum benefit package, as well as the required benefits under the "full pay" program, and must be able to conform to any changes in federal or state laws or regulations during the Contract term. Any proposals which do not meet these requirements will be disqualified. Comprehensive dental benefits pursuant to section 409.815(2(q), Florida Statutes, are currently being provided to Enrollees under separate contracts. Any Respondent selected under this ITN must agree to work with Healthy Kids' contracted dental plans to coordinate dental benefits including coverage for prescriptions written by an Enrollee's dental provider and coverage for oral surgeries or other dental related procedures on the mouth or jaw due to accident or injury and dental procedures requiring inpatient hospitalization (for sedation/behavior management).

The proposed Contract provides more detailed description of the required benefit plan and the maximum co-payments allowable for each benefit. The Insurer must have a system for tracking each Enrollee's out-of-pocket costs so as to ensure that no Enrollee exceeds the federal cost sharing maximums. Healthy Kids will make the final determination as to whether a family has reached its maximum, and therefore, no additional co-payments can be collected from the Enrollee for the remainder of the designated year. American Indian and Alaskan Native Enrollees who qualify for subsidy are also prohibited from paying any out of pocket costs towards their care.

FHKC shall identify each month those Enrollees for whom no cost sharing may be collected on the monthly enrollment files. Insurer must have a mechanism for ensuring that any designated Enrollee incurs no further cost sharing for the time period designated after such notification by FHKC and that its provider network is also made aware of such policies.

IV. Delivery of Services

Insurers must provide benefits through a network of designated plan providers. Provisions must also be made for out-of-area (including out-of-state and out-of-the-country services) emergency services and tertiary care. Providers should include pediatric specialists and facilities that specialize in pediatric services. Networks will be reviewed closely to determine whether sufficient access to primary care providers and specialists is available and that access and appointment standards can be met both at Contract inception and throughout the Contract term.

FHKC does not contract directly for provider services and does not intervene in contract disputes between its contracted Insurers and individual providers. FHKC expects its contracted providers to settle its disputes with its providers in accordance with any contract between the entities and any controlling federal and state laws or regulations. FHKC is not required to intervene in any such disputes.

It is the Insurers' responsibility to ensure an adequate service network is established and maintained that meets or exceeds contractual requirements, and ensures that Enrollees' access to care is not compromised. If the Insurer does not meet the service network contractual requirements, FHKC will direct its Enrollees to seek care from any willing provider and the Insurer will be responsible for the cost of any such covered services under the Contract.

A. Provider Network Standards

The proposed network must be sufficient to provide adequate appointment access and geographic distribution in accordance with contractual standards. Additionally, the proposal must provide evidence of a network of specialists, hospitals, tertiary facilities and other providers that will adequately address the needs of a pediatric and adolescent population and support the benefit package.

Respondent's primary care network shall include only board certified pediatricians and family practice physicians or physician extenders working under the direct supervision of a board certified practitioner. All primary care physicians must provide immunizations to Enrollees in the provider office, and are not authorized to use Vaccines for Children supplies. Primary care physicians that do not provide immunizations will not be counted as a FTE. Insurer must be able to identify and assign a primary care physician which shall be the Enrollee's primary source of medical care and referrals for each such Enrollee.

The adequacy of primary care providers is measured in accordance with the following:

1 Board Certified Pediatrician	= 1.00 FTE
1 Board Certified Family Practice Physician	= 00.25 FTE

No credit is given during the evaluation process for Internal Medicine Physicians or General Practice physicians. Additionally, only those Internal Medicine or General Practice physicians that have received a specific exemption from FHKC may be authorized to participate in Insurer's network for the Program.

Healthy Kids Enrollees may not be assigned directly to a physician extender and physician extenders are not counted as a primary care provider for purposes of determining the adequacy of an Insurer's network during the ITN review process.

An exception process for non-board certified providers has been established by FHKC. Providers previously granted exemptions by FHKC may be included in a submission if the specific date of the exemption is

noted. Exemptions are valid only for the plans that received the original exemption. Except for these exemptions, non-board certified providers will not be counted in determining the adequacy of a Respondent's provider network.

Contracted health plans may request that exemptions be granted for non-board certified primary care providers by making a written request to FHKC for consideration through the FHKC Quality Committee, a Committee of the FHKC Board of Directors. The Committee meets at least quarterly.

The Committee reviews requests at any regularly scheduled meeting. These requests are considered on a case by case, plan by plan basis, taking into account the provider's education and background, medical specialty, other medical training and expertise, any exemption that has been or previously granted through the Department of Health's Children's Medical Services Network program, the need for providers in the area, special needs or populations served by the provider and other factors unique to that provider or the county. Exemptions are generally valid for three (3) years but can be granted for shorter periods of time depending on the situation and can also be granted with conditions.

B. Facility Standards

Facilities used for Enrollees shall meet applicable accreditation and licensure requirements and meet facility regulations specified by the Agency for Health Care Administration (AHCA).

C. Mental Health Care and Substance Abuse Providers

Respondent must have established standards of care for contracting with providers for mental health care and substance abuse services. Those standards of care should be described in the proposal.

D. Geographic Access

1. Primary Care Providers

a. Medical

Geographical access to board certified family practice physicians, pediatric physicians, primary care provider experienced in child health care must be within twenty (20) minutes driving time from residence of each Enrollee to provider.

This driving time limitation may be reasonably extended in those areas where such limitation with respect to rural residence is

unreasonable. In such instances, Respondent is required to provide access for urgent care through contracts with the closest available providers. Respondent should indicate in their proposal what is considered to be reasonable for a rural area.

b. Dental

Geographical access to primary care dental providers experienced in child dental health are to be available within twenty (20) minutes driving time from Enrollee's residence to Provider. The driving time limitation may be reasonably extended in those areas where such limitation with respect to rural residences is unreasonable. In such instances, Respondent shall provide access for urgent care through contracts with the closest available Providers.

NOTE: These dental standards are provided for informational purposes only and represent the standards adopted by the FHKC Board of Directors. This ITN covers comprehensive health care services for contracts that will expire on September 30, 2015.

2. Specialty Care Providers

Specialty medical services, ancillary services and hospital services are to be available within sixty (60) minutes driving time from Enrollee's residence to provider. The driving time may be reasonably extended or waived in those areas where such limitation with respect to rural residences is unreasonable.

E. Appointment Standards

1. Emergency care must be provided immediately.
2. Urgently needed care shall be provided within twenty-four (24) hours of Enrollee request.
3. Routine care of Enrollees who do not require emergency or urgent care as noted above shall be provided within seven (7) calendar days of the Enrollee's request for services.
4. Routine physical examinations shall be provided within four (4) weeks of Enrollee's request.
5. Follow-Up care shall be provided as medically appropriate.
6. "Routine Dental Examinations" means the semi-annual preventive office visit including a dental cleaning and examination of an Enrollee where no specific condition has been identified.

F. Provider Contracting

Respondent must provide evidence of the status of its proposed network. The response must clearly indicate whether these providers have already committed to provide services to Healthy Kids' Enrollees, or if these providers must complete a contracting process once the Respondent is awarded this Contract. If a contracting process must still occur, the response should identify those physicians and include a description of the contracting process and a time frame for completion. The contracting status of the entire provider network will be considered in determining the adequacy of the Respondent's proposed network. The Respondent's recruitment process must articulate clearly that the Respondent has not been awarded a contract.

The provider contract for the proposed provider network or any addendum to an existing provider contract for the Healthy Kids line of business must be approved in writing by Healthy Kids. Approval of contracts includes the re-approval of any contracts previously reviewed and approved by FHKC of incumbent Insurers. Any such agreements will be reviewed after the award of any contracts under this ITN and subject to change by the request of FHKC.

In addition to the standards provided above, the Insurer must also meet the standards developed in compliance with the requirements of section 409.820, Florida Statutes, (see below). The Respondent should review Proposed Administrative Rule 64C-10 – Florida KidCare Quality Assurance and Access Standards - and acknowledge that these standards as proposed and as they may be amended over the contract term are the minimum requirements. The Corporation may enhance these requirements and to the extent that the requirements stated above exceed those in the proposed rule, the higher standards would be applicable to the Program.

409.820 Quality assurance and access standards.— Except for Medicaid, the Department of Health, in consultation with the agency and the Florida Healthy Kids Corporation, shall develop a minimum set of quality assurance and access standards for all program components. The standards must include a process for granting exceptions to specific requirements for quality assurance and access. Compliance with the standards shall be a condition of program participation by health benefits coverage providers. These standards shall comply with the provisions of this chapter and chapter 641 and Title XXI of the Social Security Act.

V. Member Services

Respondent's proposal should detail any activities the Respondent would undertake to educate Enrollees about their benefits, how to access services and the importance of preventive care. The proposal also should address the Respondent's referral or pre-authorization process, if any, for Enrollees.

A sample member handbook, either currently approved by FHKC or proposed, should be included with the Respondent's response. The Respondent must agree to distribute new member materials, including a member handbook and identification card within five (5) business days of the receipt of an enrollment file or notice of enrollment in the case of manual additions. These member materials and member correspondence must be pre-approved in writing by FHKC prior to distribution, be available in languages other than English and must comply with federal Title XXI regulations.

FHKC also requires the Respondent to identify, for each Enrollee, a primary care physician which shall be the Enrollee's primary source of medical care and referrals. To accomplish the requirement, the Respondent must have a system in place to assign each Enrollee a Board Certified primary care physician to direct and manage the Enrollee's care as defined by the American Academy of Pediatrics. The Respondent's response must address how members are assigned to primary care physicians in compliance with this requirement.

The Respondent's proposal should briefly detail the member services offered by the Respondent, including the number of member services representatives that will be available to Healthy Kids Enrollees, the hours of operation of the member services call center, whether or not a toll-free number is utilized, the availability of representatives who speak languages other than English or provide services for hearing impaired Applicants or Enrollees, how assistance during after-hours or holidays is provided, and whether written materials are available in languages other than English. Member services days and hours of operation should be conducive to the needs of the Enrollees.

The Respondent's response must include a copy of the Respondent's current grievance process. The grievance process must conform to all applicable state and federal laws and regulations. Any subsequent changes to the process must be reviewed and approved by FHKC prior to implementation. Insurers must be able to generate quarterly reports of grievances received from Healthy Kids' Enrollees.

Coverage offered under this Agreement is considered creditable coverage for the purposes of part 7 of subtitle B of Title II of ERISA, Title XXVII of the Public Health Services Act and subtitle K of the Internal Revenue Code of 1986. The Respondent is responsible for issuing a certificate of creditable coverage to those eligible Enrollees.

The Respondent should also address under Member Services how the Insurer will address new Enrollees transitioning to their plan from another Insurer. An outreach plan to ensure that Enrollees maintain any existing provider relationships that the Enrollee wants to continue as well as to ensure continuity of care with specialty providers, prior authorizations or other medical needs should also be addressed.

APPENDIX II:	UTILIZATION DATA

Utilization information is posted as separate links on the Healthy Kids website with the ITN materials.

APPENDIX III: ENROLLEE DEMOGRAPHIC INFORMATION

Table I: Current Enrollment by County – February 2015

This information is posted as a separate link to the ITN as an EXCEL spreadsheet.

Table II: Enrollment by Zip Code, by County – February 2015

This information is posted as a separate link to the ITN as an EXCEL spreadsheet.

Table III: Enrollment by Age and Gender, by County – February 2015

This information is posted as a separate link to the ITN as an EXCEL spreadsheet.

APPENDIX IV: REFERENCE FORM

Provide at least three (3) contract references where Respondent has provided comprehensive health care services to a similar population, comparable demographic or equivalent premium volume. Contracts should either be current or have concluded within the last two (2) years.

FHKC should not be utilized as a reference.

	1	2	3
Contract Name:			
State:			
Medicaid or CHIP?			
Contract Begin Date:			
Contract End Date:			
Area of Contract: (Statewide, County, Regional)			
Benefits Provided:			
How Compensated Under Contract: (Pre-Paid, Capitated, Fee-For Service, Other, Explain)			
Average Annual Member Months			
Co-Payments Charged?			
Met Performance Standards?			
Any Penalties or Liquidated Damages or Withheld Levied During Contract Term?			
If Yes, Explain.			
Claims or Encounter Data Level Reporting Requirements?			
Annual Premium Volume			
Contract Manager:			
Contact Information:			

APPENDIX V: VOLUME TWO SUMMARY SHEETS

A summary sheet must accompany each Tab in Volume II as set forward under this Appendix V unless otherwise indicated. Failure to provide the designated summary tab may result in points being deducted from Respondent's proposal or the disqualification of the proposal from further consideration.

Summary Sheets for each required Tab follow in sequential order.

Volume Two
Tab A: Primary Care Providers (PCP) Summary Sheet

Instructions: Each Region that has a provider should have its own summary sheet. Providers whose age restrictions are severely limited (example: see children age 15 and up only) or are outside of this age range will be excluded.

Region: _____

*Only those PCPs physically located in the Region

Total PCP Network
(PCPs Fully Contracted with Open Panels):

Total Unique PCPs in Network:	
Of those PCPs, # of Pediatricians:	
Of those PCPs, # of Family Practice:	
Total Unique PCP Locations:	
Of those locations, # with Pediatricians:	
Of those locations, # with Family Practice:	

Total PCP Network
(All PCPs, Pending Contracts, Any Panel status):

Total Unique PCPs in Network:	
Of those PCPs, # of Pediatricians:	
Of those PCPs, # of Family Practice:	
Total Unique PCP Locations:	
Of those locations, # with Pediatricians:	
Of those locations, # with Family Practice:	

Definitions:
Contracted means the provider is already under contract with the Respondent and is ready to see Healthy Kids enrollees.
Unique means the primary care provider is counted once. The PCP may have multiple practice locations but can be counted as only one PCP.
PCP can only be a board certified pediatrician or family practice physician who provides immunizations. For the purposes of this summary sheet, no other provider may be counted.
Contract Pending means that the provider is under contract with Insurer for another product line but not for Healthy Kids and additional contracting must still be completed.

Volume Two
Tab B: Specialty Care Providers Summary Sheet

Instructions: Each Region that has a provider should have its own summary sheet.

**Only those specialists that see Enrollees within the Healthy Kids age range (anywhere within the ages of 5 through 18) should be listed on the summary sheet and on the EXCEL worksheet that follows the summary sheet.*

Providers whose age restrictions are severely limited (example: see children age 15 and up only) or are outside of this age range will be excluded.

Region: _____

*Must be physically located in the Region

Specialty Physician	TOTAL UNIQUE NUMBER WHO SEE CHILDREN	THOSE IDENTIFIED AS PEDIATRIC SPECIALISTS	Locations List County of Each Provider's Office represented in the count
Allergy\Immunology			
Anesthesiology			
Cardiology			
Certified Nurse Midwife			
Chiropractic			
Dermatology			
Endocrinology			
ENT\Otolaryngology			
Gastroenterology			
Gynecology Only			
Hematology\Oncology			
Infectious Diseases			
Internal Medicine			
Neonatology			
Nephrology			
Neurology			
Obstetrics\Gynecology			
Oncology			
Ophthalmology			
Optometrist			
Orthopedics			
Pulmonary			
Radiation Oncology			
Rheumatology			
Rehabilitative Services – Physical Therapy			
Rehabilitative Services -Respiratory Therapy			
Rehabilitative Services –			

Specialty Physician	TOTAL UNIQUE NUMBER WHO SEE CHILDREN	THOSE IDENTIFIED AS PEDIATRIC SPECIALISTS	Locations List County of Each Provider's Office represented in the count
Speech Therapy			
Rehabilitative Services – Occupational Therapy			
Surgery - Cardiovascular			
Surgery – Colo-rectal			
Surgery - General			
Surgery - Hand			
Surgery - Neurological			
Surgery - Orthopedic			
Surgery - Oral			
Surgery – Plastic/Reconstructive			
Surgery – Thoracic			
Surgery - Urology			
Other Specialties Not Included Above – Be Specific:			

Respondents may add other specialists not included on this summary sheet to the bottom of this sheet. Please add any names in alphabetical order.

Volume Two
Tab C: Mental Health and Substance Abuse Services Providers Summary Sheet

Instructions: Each Region that has a provider should have its own summary sheet.

**Only those specialists that see Enrollees within the Healthy Kids age range (anywhere within the ages of 5 through 18) should be listed on the summary sheet and on the EXCEL worksheet that follows the summary sheet.*

Providers whose age restrictions are severely limited (example: see children age 15 and up only) or are outside of this age range will be excluded.

Region: _____

*Must be physically located in the Region

Specialty Physician\Provider	TOTAL UNIQUE NUMBER WHO SEE CHILDREN	THOSE IDENTIFIED AS PEDIATRIC SPECIALISTS	Locations List City of Each Provider's Office that has a count
Licensed Mental Health Counselor			
Licensed Clinical Social Worker			
Licensed Marriage & Family Therapist			
ARNP			
Behavior Analysts			
Psychology			
Psychiatry			
Other Mental Health Providers: List Specific Types:			

Volume Two
Tab E: Pharmacy

Instructions:
Each Region must have its own summary sheet.

For chain pharmacies, list the chain name, the number of locations and the number of 24 hour locations.

For independent pharmacies, list the individual pharmacies, the total locations for that independent pharmacy and if any 24-hour locations.

Region: _____

Pharmacy Name (Chain Name or Independent Pharmacy)	TOTAL LOCATIONS IN REGION	24 HOUR LOCATIONS IN REGION

Volume Two
Tab F: Non-Physician Services Summary Sheet

Instructions:
Each Region must have its own summary sheet.

**Only those specialists and facilities that see Enrollees within the Healthy Kids age range (anywhere within the ages of 5 through 18) should be listed on the summary sheet and on the EXCEL worksheet that follows the summary sheet.*

Providers whose age restrictions are severely limited (example: see children age 15 and up only) or are outside of this age range will be excluded.

Region: _____

*Must be physically located in the Region

Facility\Service\Providers	TOTAL UNIQUE NUMBER (Locations in Region)	THOSE WITH PEDIATRIC OR ADOLSECENT EXPERIENCE (USE X)
Birth Centers		
Diagnostic Radiology		
Dialysis		
DME\Supplies (including orthotics\prosthetics)		
Hearing		
Home Health Care		
Hospice Services		
Laboratory		
Outpatient Surgery Centers		
Skilled Nursing Facilities		
Urgent Care Centers		
Vision		
Other Providers Not Included Above (Be Specific):		

APPENDIX VI:	Volume Three– Required Cover Sheet Premium Rate Proposal Form

APPENDIX VI A: Subsidized Rate

All rate proposals in Volume Three must be presented utilizing this form.

Rates not presented using this form may be disqualified from further consideration.

Rate Component	Per Member Per Month Cost
Primary Care	$
Immunizations	$
Specialty Care	$
Hospital Inpatient	$
Hospital Outpatient	$
Behavioral and Mental Health Care	$
Substance Abuse Services	$
Pharmacy	$
Durable Medical Equipment	$
Lab and Radiology	$
Rehabilitation Services *(Physical Therapy, Speech Therapy, Occupational Therapy, Respiratory Therapy)*	$
Chiropractic Services	$
Home Health Care Services, including Hospice Services	$
Other Services Not Listed Above *(Be Specific)*	$
Reinsurance Costs:	
Subtotal of Costs Above:	$
Administration:	$
Grand Total:	$
Expected Medical Loss Ratio:	

APPENDIX VI B: Full Pay Rate

All rate proposals in Volume Three must be presented utilizing this form.

Rates not presented using this form may be disqualified from further consideration.

Rate Component	Per Member Per Month Cost
Primary Care	$
Immunizations	$
Specialty Care	$
Hospital Inpatient	$
Hospital Outpatient	$
Behavioral and Mental Health Care	$
Substance Abuse Services	$
Pharmacy	$
Durable Medical Equipment	$
Lab and Radiology	$
Rehabilitation Services *(Physical Therapy, Speech Therapy, Occupational Therapy, Respiratory Therapy)*	$
Chiropractic Services	$
Home Health Care Services, including Hospice Services	$
Other Services Not Listed Above *(Be Specific)*	$
Reinsurance Costs:	
Subtotal of Costs Above:	$
Administration:	$
Grand Total:	$
Expected Medical Loss Ratio:	

APPENDIX VII:	Enrollee Protections Relating to Managed Care Assignments

Florida Healthy Kids Corporation
Public Input Policy Process

Date Proposed: October 21, 2010 Board of Directors Meeting
Policy Name: Enrollee Protections Relating to Managed Care Assignments
Revisions to original policy shown as ~~strikethroughs~~ (deletes) and underlines (adds)

Effective Date: January 1, 2011

Original Policy

Date Proposed: March 26, 2009 Board of Directors Meeting
Date Approved: June 18, 2009 Board of Directors Meeting
Effective Date: October 1, 2009

Policy

1. New applicants to the Healthy Kids program who reside in a county with multiple health and dental plan choices will be assigned to one of the available plans. Siblings will be assigned to the same health plan. Assignment ratios among the plans may vary by county based on factors determined by the Board.

2. Upon receipt of an application and identification of a potential Healthy Kids enrollee under that application, applicants will receive written correspondence that informs them of their choice options, the free look period and the disenrollment process described under this policy.

3. The enrollee shall have a 90 calendar day "free look" period beginning on the first day of the first month of coverage. During this free look period, the enrollee may change to another available plan without having to provide a reason for such a change. The change will become effective the first of the following month, if enrollment for that month has not already been processed. If enrollment has already been processed for the following month, the change will be effective the first of the second month.

   Examples: *Request received on March 10th for a plan change.*
   The change will be effective with April 1st coverage month.

   Request received on March 30th for a plan change.
   The change will be effective with May 1st coverage.

4. The Corporation may make available on its website the option for parents to request a plan change during the free look period.

5. After the "free look" period, the enrollee will be locked into that health or dental plan until the enrollee's renewal period, unless the enrollee meets one of the exceptions provided in this policy.

6. The Corporation will recognize and extend the time allotted for making plan-related choices if the Corporation's Third Party Administrator is under corrective action that includes access to the call center or delays in the review and processing of documents submitted by applicants or enrollees.

7. A request for disenrollment from a health or dental plan outside of the free look period will be granted if one of the following conditions is met:

    A. The enrollee moves out of the area.
    B. The plan does not, because of moral or religious objections, provide the service the enrollee seeks.
    C. The enrollee needs related services to be performed at same time; not all related services are available within the network; and the enrollee's primary care medical or dental provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
    D. Other reasons, including but not limited to: poor quality of care, lack of access to services or lack of access to providers experienced in providing care needed by enrollee.
    E. The enrollee has an active relationship with a health or dental care provider who is not on the health or dental plan's network but is in the network of another participating health plan that is open to new enrollees.
    F. The health or dental plan no longer participates in the county in which the participant resides.
    G. The enrollee's health or dental plan is under a quality improvement plan or corrective action plan relating to quality of care with the Corporation.

8. A request for disenrollment must be received by a parent or guardian listed on the account or in the case of an enrollee who is no longer a minor, from the enrollee. Requests may be received via telephone, fax or mail. Requests received via unsecured email will be reviewed and a confirmation phone call will be made to the parent or guardian to affirm the request.

9. Requests will be reviewed and processed within three (3) business days of receipt of the request.

10. Staff may request additional information from the requesting parent or guardian should the information provided not meet the conditions for one of the exceptions. If additional information is necessary, the review period clock will re-start for an additional three (3) day period upon receipt of the requested information.

11. If a request is denied as not meeting one of the exceptions, the parent or guardian may request that their request be reviewed through the Corporation's Dispute Resolution Process.

12. The Corporation may also refer the enrollee to the plan's grievance process should the reason provided for disenrollment include dissatisfaction with access to care or access to providers before considering the enrollee's plan change request. In such cases, the parent or guardian must complete the grievance process for the ~~health~~ plan before submitting a second request to the Corporation.

13. Any action taken, approval, denial or referral to the plan's grievance process, will be communicated in writing to the family within five (5) calendar days of the date of the Corporation's decision.

14. Renewal correspondence will be sent out at least sixty (60) days in advance of the renewal period and will inform the family of the following items:

    1) Their ability to change health and dental plans, if available;
    2) The good cause exceptions that are available under this policy for changes outside of their renewal period; and,
    3) How to initiate the disenrollment process outside of the renewal period opportunity.

15. All such correspondence shall be written in a manner and format that is easily understood by applicants and potential applicants and enrollees.

16. The effective date of this revised policy is January 1, 2011.

APPENDIX VIII:	Trade Secrets Affidavit

AFFIDAVIT OF _____

STATE OF _____
COUNTY OF _____

Affiant, (*Name of Officer*), after having been duly sworn, deposes and states as follows:

1. I am at least 18 years of age, a United States citizen and resident of the State of _____. The matters stated herein are based upon my personal knowledge.

2. I am the (*Office held*) of (*Name of Company*), ("Company"), located in located in _____.

3. The Florida Healthy Kids Corporation ("FHKC") has requested a copy of the Company's (*description of document or documents considered a trade secret*).

4. The Company considers this information a trade secret that has value and provides an advantage or an opportunity to obtain an advantage over those who do not know or use it.

5. The Company has taken measures to prevent the disclosure of the information to anyone other than those who have been selected to have access for limited purposes, and the Company intends to continue to take such measures.

6. The information is not, and has not been, reasonably obtainable without our consent by other persons by use of legitimate means, and the information is not publically available elsewhere.

FURTHER AFFIANT SAYETH NOT.

_____
(*Officer/Affiant*)

STATE OF _____
COUNTY OF _____

Sworn to and subscribed before me this _____ day of _____, 20__, by (*Officer/Affiant*), who is personally known to me or who has produced _____ as identification.

_____

_____

NOTARY PUBLIC
My Commission Expires:

APPENDIX IX

PROPOSAL COVER SHEET

THE FLORIDA HEALTHY KIDS CORPORATION

Invitation to Negotiate 2015-01

Page _1_ of _____ pages	SUBMIT PROPOSAL TO:
RELEASE DATE: February _, 2015	Steven M. Malono Florida Healthy Kids Corporation 661 East Jefferson Street, 2nd Floor Tallahassee, Florida 32301 (850) 224-5437 www.healthykids.org

SOLICITATION TITLE:

Invitation to Negotiate 2015-01

PROPOSALS WILL BE OPENED: 12:00 p.m., _____, 2015

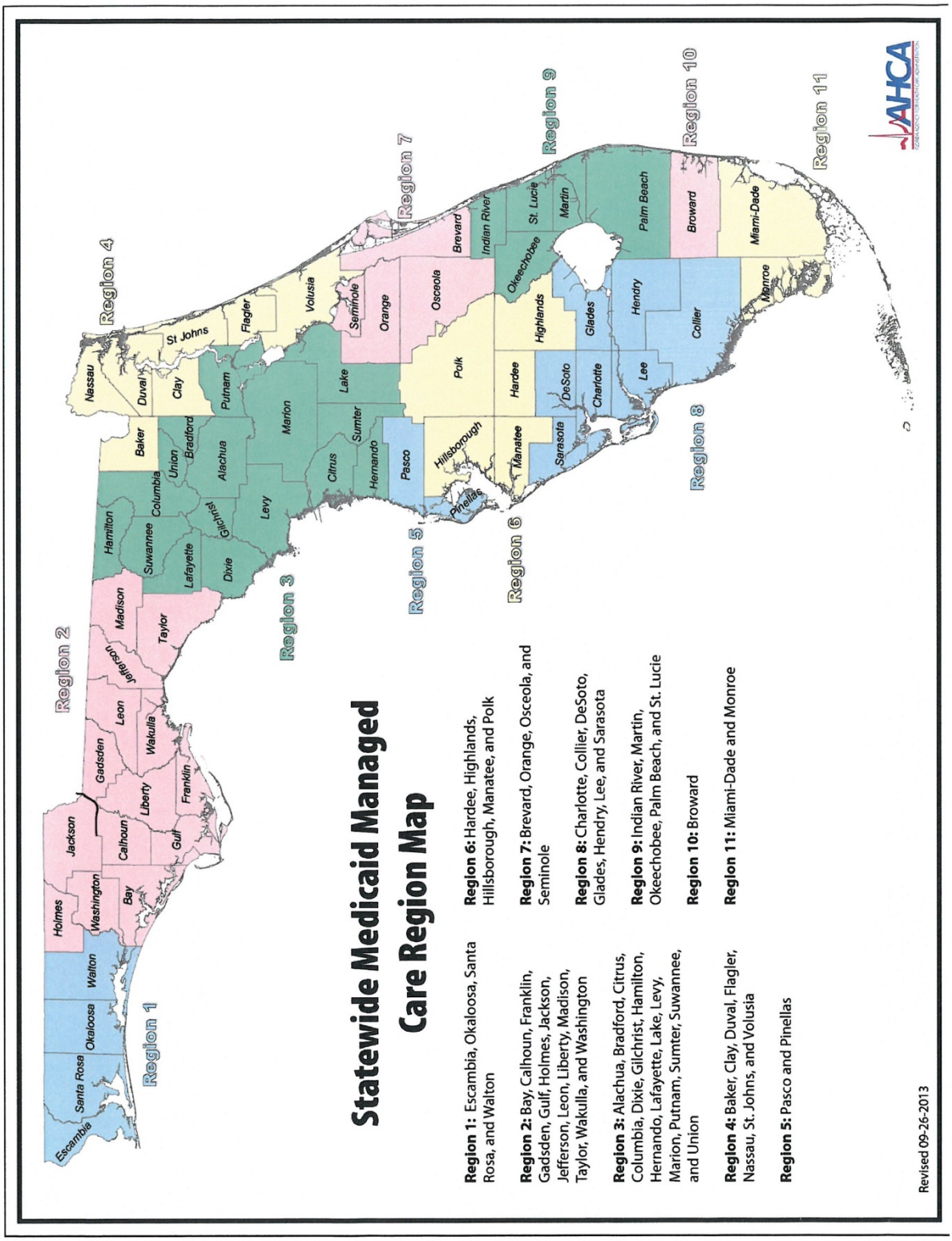
RESPONDENT NAME:		
RESPONDENT MAILING ADDRESS:		
CITY – STATE – ZIP:		*AUTHORIZED SIGNATURE (MANUAL)
PHONE NUMBER:		
TOLL FREE NUMBER:		
FAX NUMBER:		*AUTHORIZED SIGNATURE (TYPED), TITLE
EMAIL ADDRESS:		
FEID NO.:		*This individual must have the authority to bind the Respondent.

TYPE OF BUSINESS RESPONDENT (Corporation, LLC, partnership, etc.):	

I certify that this Proposal is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a proposal for the same materials, supplies or equipment, and is in all respects fair and without collusion or fraud. I agree to abide by all conditions of this proposal and certify that I am authorized to sign this proposal for the Respondent and that the Respondent is in compliance with all requirements of the Invitation to Negotiate, including but not limited to, certification requirements.

RESPONDENT CONTACTS: Please provide the name, title, address, telephone number and e-mail address of the official contact and an alternate, if available. These individuals shall be available to be contacted by telephone or attend meetings as may be appropriate regarding the solicitation schedule.			
PRIMARY CONTACT:		SECONDARY CONTACT:	
NAME, TITLE:		NAME, TITLE:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:		PHONE NUMBER:	
FAX NUMBER:		FAX NUMBER:	
EMAIL ADDRESS:		EMAIL ADDRESS:	

This proposal is for the following Regions:

APPENDIX X

AHCA MEDICAID MANAGED CARE REGIONS