

State of Florida
Medicaid Area One
Prepaid Mental Health Plan
Request for Proposals
AHCA-0108
June 1, 2001



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1.0 DEFINITIONS, INTRODUCTION, AND STATEMENT OF NEED

This section provides definitions that are used in the prepaid mental health plan Request for Proposals (RFP), and also provides an introduction and overview to the prepaid mental health plan.

1.1 Definitions

- A. ADM– The Alcohol, Drug Abuse, and Mental Health Program Office of the Florida Department of Children and Families (DCF).
- B. AHCA – The State of Florida’s Agency for Health Care Administration.
- C. Area One – Area One, for the purposes of this RFP, is the Medicaid Area One service area, which is comprised of Escambia, Okaloosa, Santa Rosa, and Walton Counties.
- D. Baker Act – The Florida Mental Health Act, Chapter 394, Florida Statutes.
- E. Behavioral Health Care – Includes the prevention, diagnosis, and treatment of disabling mental health and substance abuse and substance dependence problems.
- F. Benefits – A schedule of care services available to enrollees by the prepaid mental health plan.
- G. C&F – The Florida Department of Children and Families (DCF).
- H. CFR – Code of Federal Regulations.
- I. Capitation Payment – The monthly fee that is paid in advance by the agency to a contractor or provider for each Medicaid recipient enrolled under a contract for the provision of Medicaid services, whether or not the enrollee receives the services during the payment period.
- J. Capitation Rate – The amount to be advanced monthly to the prepaid mental health plan for each Medicaid recipient, by age group and eligibility category, enrolled in the plan.
- K. Care Coordination – The manner of practice of planning, directing, and coordinating the provision and utilization of mental health care services of enrolled recipients.
- L. Certification – The process of determining that a facility, equipment, or an individual meets the requirements of federal or state law, or whether Medicaid payments are appropriate or will be made in certain situations.
- M. Children/Adolescents – Persons under the age of twenty-one (excluding 21st birthday).
- N. Child Welfare Targeted Case Management – Covers targeted case management activities and services for all Medicaid eligible children, ages 0-21, in Florida who have been placed under protective supervision or have been court ordered into shelter or foster care and who are not receiving case management under another target group.

- O. Clinical Record – A single complete record kept at the site of the member’s mental health care provider, which documents all of the service implementation plans developed for, and mental health services received by the enrollee.
- P. Community Based Care Lead Agency Provider – A not-for-profit community based agency with which the Department of Children and Families contracts for the provision of child protective services in the community.
- Q. Complaint – In accordance with Section 641.47(5), F.S., a complaint is any expression of dissatisfaction by a member, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the plan’s contract and which is submitted to the plan or to a state agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a grievance as defined in this section.
- R. Contracting Officer – The Secretary for the Agency for Health Care Administration or his/her delegate.
- S. Contractor – The contractor who contracts directly with the state for performance of the work specified herein.
- T. Covered Services – See Benefits.
- U. Crisis Support – Services for persons initially perceived to need emergency mental health services but upon assessment do not meet the criteria for such emergency care. These are acute care services that are available 24 hours a day, seven days a week for intervention. Examples include: crisis/emergency screening, crisis telephone and emergency walk-in.
- V. Cultural Competency – The concept of cultural competency is one based on the definitions and principles developed by the national Child and Adolescent Service System Program (CASSP). Cultural Competence is a set of congruent practice skills, behaviors, attitudes, and policies that comes together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.
- W. Culture – As defined by the CASSP, culture is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs.
- X. DCF – Department - The State of Florida’s Department of Children and Families.
- Y. DD – Developmental Disability Services Office of the Florida Department of Children and Families.
- Z. Deputy Secretary – The Deputy Secretary for Medicaid for the Agency for Health Care Administration.

- AA. Direct Ownership Interest – Direct ownership interest is defined as the ownership of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicaid provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid, or health related services under the social services program.
- BB. Direct Service Mental Health Care Professional – An individual qualified by training or experience to provide direct mental health services under the supervision of the plan’s medical director.
- CC. Disenrollment – The agency-approved discontinuance of an enrollee’s eligibility to receive covered services through the prepaid mental health plan, and the deletion from the approved list of members furnished by the agency to the contractor.
- DD. District Case Review Committee – An advisory body appointed by the DCF district administrator to provide uniform case review of children with emotional disturbances who are referred for consideration of placement into a residential treatment program.
- EE. DJJ – The State of Florida’s Department of Juvenile Justice.
- FF. Downward Substitution of Care – The use of less restrictive, lower cost, and medically appropriate services provided as an alternative to higher cost State Plan services. Downward substitution of care may include private practice psychologists and social workers, inpatient care in institutions for mental disease, and other services the plan considers are more cost effective than hospital inpatient care.
- GG. Eligible Recipient – Any person certified by the department as eligible to receive services and benefits under the Florida Medicaid Program (Title XIX).
- HH. Emergency Mental Health Services – Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is at a level of severity that would meet the requirements for involuntary examination pursuant to Section 394.463, Florida Statutes and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.
- II. Enrollee – An eligible Medicaid recipient who is enrolled in the contractor’s prepaid mental health plan in accordance with the provisions of this contract. Also referred to as “member.”
- JJ. Enrollment – The process by which an eligible Medicaid recipient becomes a member of the contractor’s prepaid mental health plan.
- KK. Facility – Any premise (a) owned, leased, used or operated directly or indirectly by or for the contractor or its affiliates for purposes related to this contract; or (b) maintained by a sub-contractor to provide services on behalf of the contractor.
- LL. Family Services Planning Team – A multi-agency team comprised of core members and child-specific members, including the child’s parents and/or foster parents, who convene to assist parents in developing a holistic service plan and in securing the least restrictive, most relevant and appropriate services necessary to keep their child living in the home and community.

- MM. Federal Financial Participation (FFP) – A percent of state expenditures to be reimbursed by the federal government.
- NN. Fee-For-Service – A method of making payment for health services based on fees set by the agency for defined services.
- OO. Fiscal Agent – A private corporation under contract with AHCA to process Medicaid claims. Consultec is the current Florida Medicaid Fiscal Agent.
- PP. Fiscal Year – The State of Florida’s fiscal year covers July 1st through June 30th.
- QQ. Florida Mental Health Act – Chapter 394, Florida Statutes, which includes the Baker Act, which covers involuntary admissions for persons who are considered in an emergency mental health condition (a threat to themselves or others).
- RR. FMMIS – Florida Medicaid Management Information System. The computer system used to process Florida Medicaid claims and to produce management information relating to the Florida Medicaid program.
- SS. FTE – Full-time equivalent position.
- TT. Grievance – In accordance with Section 641.47(10), F.S., a grievance is a written complaint submitted by or on behalf of a member or a provider to the plan or the agency regarding the availability of service coverage, or quality of the service, including a complaint regarding an adverse determination made pursuant to utilization review, claims payment, handling, or reimbursement for services, or matters pertaining to the contractual relationship between a member and provider, or the plan and agency.
- UU. Grievance Procedure – An organized process by which prepaid mental health plan members may express dissatisfaction with services and benefits received under the program in which they are enrolled and the resolution of these dissatisfactions.
- VV. Health Care Financing Administration (HCFA) – The unit of the United States Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII and Medicaid under Title XIX of the Social Security Act.
- WW. HMO – Health Maintenance Organization: an entity certified by the Florida Department of Insurance under applicable provisions of Part I of Chapter 641, Florida Statutes, or as defined in the Florida Medicaid State Plan.
- XX. Hospital – A facility licensed in accordance with the provisions of Chapter 395, Florida Statutes.
- YY. Indirect Ownership Interest – Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of five percent or more in the disclosing entity. Example: If “A” owns ten percent of the stock in a corporation that owns eighty percent of the stock of the disclosing entity, “A’s” interest equates to an eight percent indirect ownership and must be reported.

- ZZ.** Insolvency – A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceeds its assets.
- AAA.** Licensed – A facility, equipment, or an individual that has formally met state, county, and local requirements, and has been granted a license by a local, state or federal governmental entity.
- BBB.** Marchman Alcohol and Other Drug Services Act of 1993 – An act also known as Chapter 397, Florida Statutes, which was created to provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and treatment services in the least restrictive environment of optimum care that protects and respects the rights of clients, especially for involuntary admissions, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.
- CCC.** Marketing – Any activity conducted by or on behalf of the contractor that is intended to encourage Medicaid recipients to enroll in the contractor’s prepaid mental health plan.
- DDD.** Medicaid – The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C.s. 1396 et seq., and regulations there under, as administered in this state by the agency under s. 409.900 et seq., Florida Statutes.
- EEE.** Medicaid Area One – The Agency’s Medicaid Area One service area, which is comprised of Escambia, Okaloosa, Santa Rosa, and Walton counties. Medicaid Area One encompasses the ADM District One. Also referred to as “Area” or “Area 1.”
- FFF.** Medical Director – A board-certified psychiatrist licensed to practice medicine in Florida who is responsible for supervising, coordinating, assessing and securing the provision of mental health care to patients, for initiating referral to specialized mental health care, and for maintaining the continuity of patients’ mental health care.
- GGG.** Medically Necessary – In accordance with 59G-1.010 (166) Florida Administrative Code, means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

- HHH. MediPass – A Medicaid primary care case management program operated by the agency.
- III. Member – Any eligible Medicaid recipient enrolled in the contractor’s prepaid mental health plan. Also referred to as “enrollee.”
- JJJ. Mental Health Care Professional – A licensed mental health professional, as defined in Section 394.455(2), Florida Statutes, or a registered nurse, licensed under Chapter 464, Florida Statutes, and qualified due to training or competency in mental health care, who is responsible for the provision of mental health care to patients.
- KKK. Mental Health Targeted Case Manager – An individual who provides mental health case management services directly to or on behalf of an enrollee on an individual basis, in accordance with the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.
- LLL. Prepaid Mental Health Plan – A comprehensive mental health provider under contract with the agency on a capitated basis to provide certain mental health services to a particular population. Also referred to as “the plan” or “PMHP.”
- MMM. Prior Authorization – The approval given by the Medicaid prepaid mental health plan in advance of the delivery of services or goods, for an affiliated provider to deliver plan covered services or goods.
- NNN. Proposer – An entity submitting a proposal to become the Medicaid Area One prepaid mental health plan contractor, as specified in this Request for Proposals.
- OOO. Provider – A person or entity that has a Medicaid provider agreement in effect with the agency, or a subcontractual agreement with a contractor, and is in good standing with the agency.
- PPP. Psychiatric Community Hospital Bed – A psychiatric bed in a community hospital that provides medical and surgical care as well as psychiatric care.
- QQQ. Quality Improvement – The process of monitoring and assuring that services are available and provided in sufficient quantity, of acceptable quality, within established standards of excellence, and appropriate for meeting the needs of the enrolled population.
- RRR. Risk – The potential for loss that is assumed by the contractor and that may arise because the cost of providing services may exceed the capitation fees paid by the agency to the contractor under terms of the contract.
- SSS. RFP – Request for Proposals.
- TTT. Service Area – The designated geographical area within which the contractor is authorized by contract to provide covered services to enrollees and within which the enrollees reside.
- UUU. Service Location – Any location at which an enrollee obtains mental health care services provided by the contractor.

- WW. Service Site – The locations designated by the contractor at which prepaid mental health plan members receive services covered under the terms of the contract.
- WWW. Shall – Indicates a mandatory requirement or a condition to be met.
- XXX. State – State of Florida.
- YYY. Subcontractor – An entity or contracted provider network that agrees to furnish covered services to enrollees or agrees to perform any administrative function or service for the contractor specifically related to fulfilling the contractor's obligations to the agency.
- ZZZ. Targeted Case Management Services – Services that will assist Medicaid eligible individuals in gaining access to needed medical, social, educational, or other services.
- AAAA. Third Party – An individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.
- BBBB. Third Party Benefit – Any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the agency, for any Medicaid-covered injury, illness, goods, or services, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral as defined in Section 409.901, Florida Statutes, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance, or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.
- CCCC. Upper Payment Limit – UPL – The maximum amount Medicaid will pay on a capitated basis for any group of services, based upon fee-for-service Medicaid expenditures for those same services.
- DDDD. Urgent Grievance – In accordance with Section 641.47(17), F.S., an urgent grievance means an adverse determination when the standard timeframe of the grievance procedure would seriously jeopardize the life or health of an enrollee or would jeopardize the enrollee's ability to regain maximum function.

1.2 Introduction

The 1991 Florida Legislature created Section 34 of Chapter 409.905, Florida Statutes, which directed the state of Florida to apply for a waiver from the Health Care Financing Administration (HCFA) to provide mental health services to Area Six Medicaid recipients in the most cost effective setting possible. It stipulated that the waiver incorporate competitive bidding for services, prepaid capitated arrangements, and that it propose no additional aggregate cost to the state. A 1915(b) federal waiver request to HCFA was approved for two years effective July 1, 1993. The waiver has since been renewed in January 1996 and again in July 1999.

The Medicaid Area Six Prepaid Mental Health Program (PMHP) has been operating as a demonstration project in Hillsborough, Hardee, Highlands, Manatee, and Polk counties since March 1, 1996. Recipients in AFDC, Foster Care, SOBRA, and SSI with no Medicare categories are enrolled in the program. When Medicaid recipients in Area Six choose or are assigned to MediPass for their physical health care, they are automatically assigned to the PMHP for their mental health services. MediPass provides primary care case management and authorizes physical health services and the PMHP manages and provides mental health services. Medicaid HMOs also provide health care and mental health care in Area Six.

Medicaid pays the PMHP a per member per month (PMPM) rate based on eligibility category and age groups. This payment is currently 92 percent of Medicaid's anticipated cost of providing mandatory covered mental health services to eligible persons residing in the project area. The mandatory services covered by the PMHP include mental health related inpatient, outpatient, and physician services, community mental health and mental health targeted case management services. The PMHP also provides, to qualifying members as a downward substitution, several additional services not reimbursable by Medicaid.

Medicaid Program Development staff currently manage and monitor the contract. Quality of care and compliance monitoring is completed by Medicaid Program Development staff with each PMHP provider at least twice a year. These monitoring visits are coordinated with the local Alcohol, Drug Abuse, and Mental Health Program Offices. Results are shared with the local Managed Care Advisory Group to obtain input and direction for quality improvement activities.

The Agency for Health Care Administration contracted with the Florida Mental Health Institute (FMHI) at the University of South Florida to complete an independent evaluation of the PMHP (carve-out) as part of the HCFA requirement for a 1915(b) waiver.

In 2000, the Florida Legislature amended Chapter 409.912, F.S. to authorize expansion of Medicaid managed mental health care services into Medicaid Areas One, Five, Eight, and Alachua County by December 31, 2001. It additionally required that the Agency add substance abuse services to the Area Six contract by January 1, 2001.

1.3 Statement of Intent

The agency intends to selectively contract with a single, comprehensive mental health care provider on a prepaid, capitated basis, to manage and provide mental health services to Medicaid recipients who reside in Medicaid Area One. The contractor will be referred to as the prepaid mental health plan (PMHP). The state intends to choose a single provider, if at least one proposer meets the minimum standards for the RFP. The goals of this contract are that quality services will be provided to enrolled members; that services will be provided in a timely

manner; that services will be provided in sufficient quantity and duration to each member; that services provided will be a part of a comprehensive community-based system of care; that services will be creative; that the best possible outcomes will be achieved; and that services will be provided in a cost effective manner.

Most of the current Area One Medicaid recipients who are enrolled in MediPass will be required to receive their mental health services through the PMHP. Area One Medicaid recipients enrolled in Medicaid HMOs will not be members of the PMHP.

2.0 PROGRAMMATIC AND ADMINISTRATIVE REQUIREMENTS

2.1 Overview

The prepaid mental health care delivery system envisioned by the agency must adhere to the following principles:

- A. Services shall be individualized, as a result of a comprehensive understanding of an individual's multiple needs and strengths.
- B. Services shall be delivered within a strengths-based culturally competent service design, focusing on the comprehensive discovery of cultural strengths of the individual, family, and community.
- C. Services shall be delivered in a timely fashion in the least restrictive, most appropriate environment.
- D. Services shall be based upon an individual plan of care with goals, measurable objectives and specific treatment strategies.
- E. Services related to medication management shall be delivered in a manner consistent with current evidence-based protocol and integrated with other necessary mental health services.
- F. Services shall be coordinated in such a manner as to address the full range of human needs and provide continuity of care. Continuity of care shall effectively address the coordination of services for recipients who experience co-occurring illnesses (specifically, mental illness, substance abuse, developmental disorders, or physical illnesses).
- G. Services shall be administered with recognition and sensitivity to every individual regardless of geographic location, age, level of functioning, cultural heritage, or degree of illness.
- H. Service planning and implementation will include the participation of family, significant others, state agencies/entities involved in the recipients' life, community, and care givers, in assessment, intervention and treatment.
- I. Services shall be provided in an integrated manner with the schools, other state agencies, and other community organizations providing services to enrollees.
- J. The provision of services shall be communicated in a language spoken by the enrollee.
- K. The contractor shall not interpret general Medicaid policy, but shall refer policy issues to the Medicaid Area Office or Medicaid Program Development.

2.2 General Service Requirements

- A. The prepaid mental health plan contractor will provide a full range of mental health service categories authorized under the state Medicaid plan as follows:

Note: Diagnostic codes listed in the Medicaid Community Mental Health Services Coverage and Limitations Handbook must be covered by the contractor. Medicaid handbooks may be accessed at one of the following web sites:
<http://floridamedicaid.consultec-inc.com> or <http://www.fdhc.state.fl.us>

1. Inpatient hospital care for psychiatric conditions (ICD-9-CM codes 290 through 290.43, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
2. Outpatient hospital care for psychiatric conditions (ICD-9-CM codes 290 through 290.43, 293 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
3. Psychiatric physician services (for psychiatric specialty codes 42, 43, 44 and ICD-9-CM codes 290 through 290.43, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
4. Community mental health services (ICD-9-CM codes 290 through 290.43, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
5. Mental Health Targeted Case Management (Children: W9891; Adults: W9892); and
6. Mental Health Intensive Targeted Case Management (Adults: W9899).

Services available:

Services available under the plan must represent a comprehensive range of appropriate services for both children and adults who experience impairments ranging from mild to severe and persistent. The agency's expectations and requirements related to each of the categories of service are included in Sections 2.3 and 2.4 below. Section 2.3 includes all Medicaid services required by federal and state law or rule. Section 2.4 describes additional service requirements under the prepaid mental health plan and outlines possible optional services under the plan.

Optional services may be available and provided with the savings achieved, and are defined as additional services that will enhance the services mandated in the contract. A list of possible optional services is included in Section 2.4 as an example of services that may be beneficial for plan enrollees. Optional services may be provided under the prepaid mental health plan contract as a downward substitution of care (see definition in Section 1.1). When a service is intended to be provided as a downward substitution, the provider must use clinical rationale for determining the benefit of the service for the enrollee.

Covered services must be provided to Medicaid recipients enrolled in the contractor's prepaid mental health plan as required by each enrolled recipient without regard to the frequency or cost of services relative to the amount paid pursuant to the RFP.

Payment for services will be on a monthly, prepaid capitated basis.

2.3 Medicaid Service Requirements

The Florida Medicaid Program provides a wide range of services/programs for Medicaid eligible recipients, as prescribed by the Medicaid provider handbooks. The services described below include those required by federal or state rules governing the Medicaid program. Services specifically required under the RFP are identified in this section by the word "mandatory".

In no instance may the plan's service limitations be more restrictive than those that exist in the Florida Medicaid fee-for-service program, as described below for each service. The plan is encouraged to exceed these service limits.

The contractor shall establish "medical necessity" criteria, including admission criteria, continuing stay criteria, exclusion criteria, and discharge criteria for all mandatory and optional services. Criteria must be specific to recipient ages and diagnoses.

A. Inpatient Hospital Services – MANDATORY

Inpatient hospital psychiatric services are medically necessary mental health care services provided in a hospital setting. Services may be provided in a general hospital psychiatric unit or in a specialty hospital. The inpatient care and treatment services that an individual receives must be under the direction of a licensed physician with the appropriate Medicaid specialty requirements. A hospital's per diem (daily rate) for inpatient mental health hospital care and treatment covers all services and items furnished during a 24-hour period. The facilities, supplies, appliances, and equipment furnished by the hospital during the inpatient stay are included in the per diem as well as the related nursing, social, and other services furnished by the hospital during the inpatient stay.

Inpatient hospital service Medicaid policy requirements are as follows:

1. The contractor is at risk for the provision of up to 45 days of hospital inpatient mental health treatment for each state fiscal year for all adult enrollees (enrollees 21 years of age or older). The 45-day limit on coverage is the sum of mental health inpatient days used by an enrollee within a state fiscal year. After an enrollee reaches their 45-day limit, the contractor remains responsible for mental health physician management while the enrollee is in the hospital setting.
2. For all child/adolescent enrollees (enrollees under 21 years of age), the contractor shall be responsible for the provision of up to 365 days of mental health-related hospital inpatient care for each year.
3. For all enrollees, the contractor shall pay for inpatient mental health-related hospital days determined medically necessary by the plan's medical director or designee, up to the maximum number of days required under the contract.
4. If an enrollee is admitted to a hospital for a non-psychiatric diagnosis and during the same hospitalization transfers to a psychiatric unit or the treatment of a psychiatric diagnosis, the contractor is at risk for the medically necessary mental health treatment inpatient days up to the maximum number of days required under the contract.

5. The contractor will be responsible to cover the cost of all enrollees' medically necessary stays resulting from a mental health emergency, until such time as enrollees can be safely transported to a designated facility.
6. Crisis Stabilization Units may be used as a downward substitution for inpatient psychiatric hospital care when determined medically appropriate. These bed days are included toward the 45-day coverage count discussed above in A.1. They are calculated on a two for one basis. Two CSU days count toward one inpatient day. Beds funded by the Department of Children and Families, Alcohol Drug Abuse and Mental Health cannot be used for Medicaid covered recipients if there are non-funded clients in need of the beds. If CSU beds are at capacity, and some of the beds are occupied by Medicaid covered recipients, and a non-funded client presents in need of services, the Medicaid enrolled recipient must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the contractor must demonstrate adequate capacity for inpatient hospital care in anticipation of such transfers.

Performance measures for this section include:

- ❖ The number of prepaid mental health plan recipients utilizing CSU beds each quarter.
- ❖ Any events where a non-funded client is unable to access care at an ADM funded facility.

B. Outpatient Hospital Services - MANDATORY

Outpatient hospital services are medically necessary mental health care services provided in a hospital setting. The outpatient care and treatment services that an individual receives must be under the direction of a licensed physician. Outpatient hospital services are paid at a line item rate for covered outpatient revenue center codes. Specifically, the contractor is at risk for outpatient revenue center codes:

- ❖ REV 450 - Emergency room
- ❖ REV 513 - Psychiatric clinic
- ❖ REV 901 - Psychiatric electroshock treatment
- ❖ REV 914 - Psychiatric visit/individual therapy
- ❖ REV 918 - Psychiatric/Testing

The contractor is NOT at risk for outpatient medical supplies such as dressings, splints, oxygen, drugs and services such as x-rays and laboratory. These outpatient medical supplies and services are covered under the Medicaid fee-for-service system.

The contractor is at risk for outpatient emergency hospital services related to a mental health condition that falls within the definition of emergency mental health services. Emergency mental health services are those services required to meet the needs of an individual who is experiencing an acute crisis which is at a level of severity that would

meet the requirements for involuntary examination pursuant to Section 394.463, Florida Statutes, and who, in the absence of a suitable alternative or mental health medication, would require hospitalization.

Outpatient hospital service Medicaid policy requirements are as follows:

1. The contractor provides outpatient hospital and emergency mental health services as medically necessary and appropriate, and without any specified dollar limitation.
2. The contractor designates a facility to provide emergency mental health and evaluation services to all enrollees on a 24 hours a day, 7 days per week basis.
3. The contractor covers the cost of emergency mental health and evaluation services provided to all enrollees at any non-designated facility when medically necessary and appropriate until such time as they can be safely transported to a plan facility.
4. The contractor does not require prior authorization of emergency mental health services by any enrollee but may require post authorization to expedite plan payment.

Performance measures for this section include:

- ❖ Utilization rates and access times for emergency room mental health care/evaluation services during evenings and weekends.
- ❖ Payment of claims for emergency room mental health care or evaluation services.

C. Physician Services – MANDATORY

Physician services are those services rendered by a licensed physician who possesses the appropriate Medicaid specialty requirements when applicable. A psychiatrist must be certified as a psychiatrist by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or have completed a psychiatry residency accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada. The contractor is at risk for the provision of physician services related to a mental health condition.

Physician services include specialty consultations, or consultations for evaluations. A physician consultation must include an examination and evaluation of the recipient with information from family member(s) or significant others as appropriate. The consultation must include written documentation on an exchange of information with the attending physician and/or MediPass primary care physician. The components of the evaluation and management procedure code and diagnosis code must be documented in the recipient's medical record. A hospital visit to a recipient in an acute care hospital for a mental health diagnosis must be documented with a mental health procedure code and mental health diagnosis code. All procedures with a minimum time requirement must be documented in the medical record to show the time spent providing the service to the

recipient. The provider must be responsive for requests for consultations made by the primary care physician who may be out of network or in the MediPass network.

Physicians are required to coordinate medically necessary mental health care with the primary care physician and other physicians involved with the care of the recipient. The contractor must have a set of protocols that indicate when such coordination will be required.

Performance measures for physician services include:

- ❖ The number of cases in which there is documentation of appropriate coordination of care.
- ❖ Payment of mental health care claims for physician services specialty consultations, or consultations for evaluations.

D. Community Mental Health Services – MANDATORY

Community mental health services include mental health services that are provided for the maximum reduction of the recipient's mental health disability and restoration to the best possible functional level. Community mental health services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. The contractor must provide services that are medically necessary and are rendered or recommended by a physician or psychiatrist and included in a treatment plan. Medically necessary community mental health services must be provided to persons of all ages from very young children through the geriatric population. The contractor is encouraged to expand the criteria for some services and base those upon social necessity rather than strict medical necessity requirements. Provision of those services very early may reduce the provision of expensive services later. Services should be age appropriate and sensitive to the developmental level of the recipient. The term "community mental health services" is not intended to suggest that the following services must be provided by state funded "community mental health centers" or to preclude state funded "community mental health centers" from providing these services.

The services must meet the intent of the services covered in the Florida Medicaid Community Mental Health Services Coverage and Limitations Handbook. Although the provider can provide flexible services, the service limits and medical necessity criteria cannot be more restrictive than those in Medicaid policy as stated in Medicaid handbooks and the PMHP contract. Additionally, the contractor may have available additional services, but must have the core services available as outlined and discussed below.

There are seven basic categories of mental health care services provided under community mental health. The frequency, duration, and content of the services should be consistent with the age, developmental level and level of functioning of the recipient. The contractor shall develop clinical care criteria appropriate for each service to be provided. The following seven categories of mental health services are required:

1. Treatment planning and review:

Treatment planning includes working with the recipient, the natural support system, and all involved treating providers to develop an individualized plan for addressing identified clinical needs. A face-to-face interview with the recipient by a licensed practitioner must be completed during the development of the plan. The individualized treatment plan should accurately reflect the presenting problems of the recipient, identified strengths of the recipient, family, and other natural support systems, and outcome-oriented objectives for the recipient. The treatment plan shall also include an outcome-oriented schedule of services that will be provided to meet the recipient's needs. Services and service frequency shall be individualized and reflect the needs, goals, and abilities of each recipient.

Treatment plan reviews shall be conducted at appropriate time intervals to assure that the services being provided are effective and remain appropriate for addressing individual needs. A review is expected whenever clinically significant events occur. The provider is expected to use the treatment plan review process in the utilization management of medically necessary services.

2. Evaluation and testing services:

- a. These services include psychological testing (standardized tests) and evaluations that assess the recipient's functioning in all areas. Evaluations completed prior to provision of treatment must include a holistic view of factors that underlie or may have contributed to the recipient's need for services. Evaluations that are completed for diagnostic purposes are included in this category also. Diagnostic evaluations must be comprehensive and when completed must be used in the development of an individualized treatment plan. All evaluations must be appropriate to the age, developmental level and functioning of the recipient. All evaluations must include a clinical summary that integrates all the information gathered and identifies recipient's needs. The evaluation should prioritize the clinical needs, evaluate the effectiveness of any prior treatment, and include recommendations for interventions and services to be provided. All new recipients should receive an evaluation unless there is sufficient collateral information that a new evaluation would not be necessary.
- b. Evaluation services, when determined medically necessary must include psychological testing, bio-psychological evaluations, and in-depth assessments. Also included in this category is the administration of functional assessments that are required by the Agency for Health Care Administration or the Department of Children and Families or the Florida Mental Health Institute Independent Evaluation.

3. Treatment services provided by a psychiatrist, psychiatric ARNP, or physician:

- a. These services include medically necessary interventions that require the skills and expertise of a psychiatrist, psychiatric ARNP, or physician.

- b. Medical psychiatric interventions include the prescribing and management of medications, monitoring side effects associated with prescribed medications, individual or group medical psychotherapy, psychiatric evaluation (for diagnostic purposes and for initiating treatment), psychiatric review of treatment records for diagnostic purposes, and psychiatric consultation with a recipient's family or significant others, primary care providers, and other treatment providers. Clinic visits are also a required service. They include specimen collections, taking vital signs and administering injections.
 - c. These services are distinguished from the physician services outlined above in that they are provided through a community mental health provider. Psychiatric or physician services must be available at sites where substantial amounts of community mental health services are provided.
4. Therapy Services:
- a. These services include individual or group therapy, which may include psychotherapy or supportive counseling focused on assisting recipients with the problems or symptoms identified in an assessment. The focus should be on identifying and utilizing the strengths of the recipient, family, and other natural support systems. Therapy services should be geared to the individual needs of the recipient and should be sensitive to the age, developmental level, and functional level of the recipient.
 - b. Family or marital therapy is also included in this category. Examples of interventions include those that focus on resolution of a life crisis or an adjustment reaction to an external stressor or developmental challenge. The contractor shall offer recipients a choice of direct service providers, as well as location, to the extent feasible and appropriate.
5. Rehabilitative services:
- a. Rehabilitative services are those services that assist recipients in functioning within the limits of a disability or disabilities resulting from a mental illness. Services focus on restoration of a previous level of functioning or improving the level of functioning. Services must be individualized and directly related to goals for improving functioning within a major life domain.
 - b. The coverage must include social rehabilitation and counseling, and basic living skills training. Social rehabilitation and counseling includes the redevelopment of communication or socialization skills. These services are directed toward improving the recipient's level of functioning. Rehabilitative services also include training that will promote redevelopment or restoration of skills needed to live independently in the community.

6. Day Treatment Services:
- a. Adult day treatment services include therapy, rehabilitation, social interactions, and other therapeutic services that are designed to redevelop, maintain, or restore skills that are necessary for individuals to function in the community. The contractor must have an array of available services designed to meet the individualized needs of the recipient, and which address the following primary functions:
- ❖ Stabilize symptoms related to a mental health disorder to reduce or eliminate the need for more intensive levels of care;
 - ❖ Provide a level of therapeutic intensity between traditional outpatient and an inpatient or partial hospital setting;
 - ❖ Provide a level of treatment that will assist recipients in transitioning from an acute care or institutional settings;
 - ❖ Assist individuals in redeveloping the skills required to maintain a living environment, use community resources, and conduct activities of daily living;
 - ❖ Assist individuals in redeveloping or restoring skills that are needed to increase an individual's ability to live independently in the community.
- b. Children's day treatment services include therapy, rehabilitation and social interactions, and other therapeutic services that are designed to redevelop, maintain, or restore skills that are necessary for children to function in their community. For children, the approach must take into consideration their developmental levels and delays in development due to emotional disorders. If the child is school age, the services must be coordinated with the school system. All therapeutic day treatment interventions for children must have a component that addresses caregiver participation and involvement. Services for all children should be coordinated with home care to the greatest extent possible. The coverage of day treatment must include an array of programs with the following functions:
- ❖ Stabilize the symptoms related to a mental health disorder to reduce or eliminate the need for more intensive levels of care;
 - ❖ Provide transitional treatment after an acute episode, admission to an inpatient program, or discharge from a residential treatment setting;
 - ❖ Provide a therapeutic intensity not possible in a traditional outpatient setting;

- ❖ Assist the child in redeveloping the skills required to conduct activities of everyday living in the community that are age appropriate.
 - c. Staff providing adult or children's day treatment services must have appropriate training and experience as indicated in Attachment 24 – Staff Training and Experience Requirements. Licensed professionals must be available to provide clinical services when necessary.
7. Additional Community Mental Health Services for Children:
- a. All of the community mental health services discussed above must be made available to children when medically necessary. The services described in this section are two additional core services that must be available to children when medically necessary. This coverage is mandatory for children with a serious emotional disturbance. These services may be optional for adults at the contractor's discretion. These services are intended to maintain the child in the home and to prevent reliance upon a more intensive, restrictive, and costly mental health placement. They are also focused on helping the child possess the physical, emotional, and intellectual skills to live, learn and work in their own communities. Coverage must include the provision of these services outside of the traditional office setting. The services must be provided where they are needed, in the home school or other community sites.
 - (1) Intensive Therapeutic On-Site Services include the provision of a professional level therapeutic service that may include the teaching of problem solving skills, behavioral strategies, normalization activities and other treatment modalities that are determined to be medically necessary. These services should be designed to maximize strengths, reduce behavior problems or functional deficits stemming from the existence of a mental health disorder.
 - (2) Home and Community Based Rehabilitative Services should be designed for the restoration, modification, and maintenance of social, personal adjustment and basic living skills. These services are usually provided by a paraprofessional and are used to support the therapeutic approach rendered through the intensive therapeutic on-site service. The services should only be provided when they are directly related to a mental health disorder.
 - b. The Comprehensive Assessment is NOT a covered service at this time. It will be available through Medicaid fee-for-service and may be considered as a covered service in the future (refer to Section 2.6 for further information). The contractor is required to review the results of a completed comprehensive assessment and is responsible for medically necessary covered services recommended. It is expected that the contractor will use the findings as a basis for the child's treatment plan. For children in foster care, the review of the comprehensive assessment must be coordinated with the Department of Children and Families Office

of Family Safety or the Department's contracted Community Based Care provider.

- c. Specialized Therapeutic Foster Care (STFC) is NOT a covered service. The plan will not be responsible for the provision of room and board or any psychotherapeutic service covered by Medicaid under the Specialized Therapeutic Foster Care Program. The plan is responsible for inpatient psychiatric services, outpatient psychiatric hospital services, emergency mental health services, and psychiatric physician services.

The contractor is also responsible for Medicaid services, if necessary, that would be reimbursable, except for the daily per diem for each level of care, under the Medicaid fee-for-service system. These services include the following:

- ❖ Intensive Therapeutic On-Site Services
 - ❖ Home and Community-Based Rehabilitative Services
 - ❖ Day Treatment Services
 - ❖ Psychiatric services by a psychiatrist when these services are required more than once per month.
 - ❖ Treatment planning
- d. Children receiving Behavioral Health Care Overlay Services (BHOS) are NOT covered in the prepaid mental health program. Any Medicaid allowable mental health services for these children may be reimbursed on a fee-for-service basis. Youths in residential treatment centers will also not be covered by the prepaid mental health program. Placement will be coordinated with the appropriate District Case Review Committee. Any allowable Medicaid services will be provided on a fee-for-service basis. Children admitted to a facility that provides Medicaid Behavioral Health Care Overlay Services will be disenrolled from the plan and then covered under Medicaid fee-for-service for mental health services. The Medicaid contract manager or designee will be responsible for the disenrollment process. The Department of Children and Families, Department of Juvenile Justice, residential providers, and/or the assigned Mental Health Targeted Case Management providers will be responsible for notifying Medicaid of all admissions and discharges. A specific agreement regarding the disenrollment and re-enrollment process will be developed between the agency, residential providers, and the departments.

The contractor shall establish "Medical Necessity" criteria, including admission criteria, continuing stay criteria, and discharge criteria for all mandatory and optional services. Criteria must be specific to recipient ages and diagnoses.

Performance measures for community mental health services are:

- ❖ The number of days spent in the community (not in inpatient hospitals, detention, or correctional facilities).
 - ❖ Improvement in individual functioning.
- E. Assertive Community Treatment (ACT) is NOT a covered service. If a recipient enrolled in the prepaid mental health plan is designated eligible by the Department of Children and Families, Alcohol, Drug Abuse, and Mental Health Program Office to be served within an Assertive Community Treatment Team, the department will be responsible for notifying the PMHP Contract Manager or designee to disenroll the recipient from the plan. A specific agreement regarding the disenrollment and re-enrollment process will be developed between the agency, the contractor, and the department.
- F. Mental Health Targeted Case Management – MANDATORY

The contractor must provide targeted case management services to children with serious emotional disturbances and adults with a severe mental illness as defined below. The contractor shall meet the intent of the services as outlined below and in the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.

1. Target Population

The contractor shall set criteria and clinical guidelines for case management services. Service limits and criteria developed cannot be more restrictive than those in Medicaid policy and as stated below.

- a. The contractor must have case management services available to children who have a serious emotional disturbance as defined as: a child with a defined mental disorder; a level of functioning which requires two or more coordinated mental health services to be able to live in the community; and be at imminent risk of out of home mental health treatment placement.
- b. The contractor must also have case management services available for adults who:
 - (1) Are awaiting admission to a long-term mental health institution or residential treatment facility; or
 - (2) Have been discharged from a long-term mental health institution or residential treatment facility.

Case management services shall be available to all recipients within the principles and guidelines described as follows:

- ❖ Recipients who require numerous services from different providers and also require advocacy and coordination to implement or access services are appropriate for case management services;

- ❖ Recipients who would be unable to access or maintain consistent care within the service delivery system without case management services are appropriate for the service;
- ❖ Recipients who do not possess the strengths, skills, or support system to allow them to access or coordinate services are appropriate for case management services;
- ❖ Recipients without the skills or knowledge necessary to access services may benefit from case management. Case management provides support in gaining skills and knowledge needed to access services and enhances the recipient's level of independence.

The contractor will not be required to seek approval from the Department of Children and Families, District Alcohol, Drug Abuse and Mental Health Program Office for client eligibility or mental health targeted case management agency or individual provider certification. The staffing requirements for case management services are listed in Section 2.5.

2. Required Services

- a. Mental Health Targeted Case Management services include working with the recipient and the recipient's natural support system to develop and promote a needs assessment-based service plan. The service plan reflects the services or supports needed to meet the needs identified in an individualized assessment of the following areas: education or employment, physical health, mental health, substance abuse, social skills, independent living skills, and support system status. The approach used should identify and utilize the strengths, abilities, cultural characteristics, and informal supports of the recipient, family, and other natural support systems. Targeted case managers focus on overcoming barriers by collaborating and coordinating with other service providers and the recipient to assist in the attainment of service plan goals. The targeted case manager takes the lead in both coordinating services/treatment and assessing the effectiveness of services provided.
- b. When targeted case management recipients enrolled in the prepaid mental health plan are hospitalized in an acute care setting, state mental hospital, or are incarcerated in a forensic or corrections facility, the contractor shall maintain contact with the individual and shall participate actively in the discharge planning processes and assist recipients in corrections facilities with immediate access to care upon return to the community.
- c. Case managers are responsible for coordination and collaboration with the Department of Children and Families, or the community based care provider contracted with the department, for services provided to children who are in the care or custody of the state. The contractor shall make reasonable efforts to assure that prepaid mental health plan recipients who are in the care or custody of the state and who receive mental health targeted case management services have all services covered by the

plan integrated with the case plans developed by the department. This integration shall reflect active collaboration with the department.

- d. Case managers are also responsible for coordination and collaboration with the parents or guardians of children who receive mental health targeted case management services. The contractor shall make reasonable efforts to assure that case managers include the parents or guardians of prepaid mental health plan children in the process of providing targeted case management services. Integration of the parent's input and involvement with the case manager and other providers shall be reflected in clinical record documentation and monitored through the agency's quality of care monitoring activities.

3. Contractor Requirements for Case Management

The contractor must have a case management program, including clinical guidelines and protocol, that addresses the issues below:

- a. Caseloads must be set to achieve the desired results. Size limitations must clearly state the ratio of recipients to each individual case manager. The limits shall be specified for children and adults, with a description of the clinical rationale for determining each limitation. If the contractor permits "mixed" caseloads, i.e., children and adults, a separate limitation is expected along with the rationale for the determination.
- b. A system must be in place to manage caseloads when positions become vacant.
- c. The modality of service provision, and the location that services will be provided must be described.
- d. Case management protocol and clinical practice guidelines, which outline the expected frequency, duration and intensity of the service, must be available.
- e. Clinical guidelines must address issues related to recovery and self-care, including services that will assist recipients in gaining independence from the mental health and case management system.

The case management program shall have services available based on the individual needs of the recipients receiving the service. The service should reflect a flexible system that allows movement within a continuum of care that addresses the changing needs and abilities of recipients.

Performance measures for this service are:

- ❖ Evidence of access to needed services.
- ❖ Evidence that services were appropriate to the needs of the individual.
- ❖ Days that the individual remained in the community.

G. Intensive Case Management – MANDATORY

This service is intended to provide intensive team case management to highly recidivistic adults who have a severe and persistent mental illness. The service is intended to help recipients remain in the community and avoid institutional care. Clinical care criteria for this level of case management shall address the same elements required above, as well as expanded elements related to access and 24-hour coverage as described below. Additionally, the intensive case management team composition shall be expanded to include members of the team especially selected to assist with the special needs of this population. The contractor shall include this in the description of how this service will be provided.

The contractor shall provide this service for all prepaid mental health plan enrollees for whom the service is determined to be medically necessary.

Intensive case management provides services through the use of a team of case managers. The team can be expanded to include other specialists that are qualified to address identified needs of the recipients receiving the service. This level of care for case management is the most intensive and serves individuals with the most severe and disabling mental conditions. Services are frequent and intense with a focus on assisting the individual with attaining the skills and supports needed to gain independent living skills. Intensive case management services are provided primarily in the recipient's residence and include community-based interventions.

The contractor shall provide this service in the least restrictive setting with the goal of improving the client's level of functioning, and providing ample opportunities for rehabilitation, recovery, and self-sufficiency. Intensive targeted case management services shall be accessible 24 hours per day, 7 days per week. The contractor shall demonstrate adequate capacity to provide this service for the targeted population within the guidelines outlined.

Intensive case management teams shall provide the same coordination and case management services for recipients admitted to inpatient facilities, state mental hospitals, and forensic or corrections facilities as those listed above for mental health targeted case management services.

The following performance measures shall be addressed in the provision of intensive case management:

- ❖ Average number of days spent in the community by all prepaid mental health plan recipients receiving intensive case management services.
- ❖ Number of prepaid mental health plan recipients admitted to the state mental hospital.

2.4 Additional Service Requirements

In addition to the above requirements, the contractor shall also adhere to the requirements specified below.

A. Community Treatment of Patients Discharged from State Mental Hospitals -
MANDATORY

The contractor shall provide medically necessary mental health services to enrollees who have been discharged from any Florida state mental hospital. The plan of care should be directed at encouraging the enrollees to achieve a high quality of life while living in the community in the least restrictive environment and reducing the likelihood that these enrollees will be readmitted to a state mental hospital. Recipients who were enrolled in the plan prior to admission to the state mental hospital must be followed by the plan during their stay, and a mental health targeted case manager must attend and participate in discharge planning activities at the facility. Targeted case managers are responsible for working with the enrollee prior to discharge from the state facility to assure that benefits are reinstated as soon as possible once the enrollee returns to the community. The contractor must develop a cooperative agreement with the hospital to enable the contractor to anticipate recipients who were plan enrollees prior to admission who will be soon discharged from the institution. The cooperative agreement must address arrangements for persons who are to be discharged but for whom re-enrollment may not take effect immediately. All enrollees who have previously received services at the state mental hospital, must receive close follow-up and care. All recipients who were prepaid mental health plan enrollees prior to admission and Medicaid eligible recipients who are likely to enroll in the plan upon return to the community must receive a community mental health service within 24 hours of discharge from the state facility.

Performance measures for this section include:

- ❖ The amount of time between discharge from the state mental hospital and first date of service received from the provider.

B. Community Services for Recipients involved with the Corrections System -
MANDATORY

The contractor shall provide medically necessary community-based services for plan enrollees who have corrections involvement as follows:

1. Establish a linkage to pre-booking sites for assessment, screening or diversion related to mental health services;
2. Provide immediate access (within 24 hours of release) for psychiatric services upon release from a jail, prison, juvenile detention facility, or other corrections facility to assure that prescribed medications are available for all prepaid mental health plan enrollees.
3. Establish a linkage to post-booking sites for discharge planning and assuring that prior plan enrollees receive necessary services upon release from the facility. Plan enrollees must be linked to services and receive routine care within seven days from the date they are released.
4. Provide outreach to homeless and other populations of plan enrollees at risk of corrections involvement, as well as those plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity should be oriented toward preventative measures to assess mental

health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or corrections system.

5. The contractor must develop a cooperative agreement with corrections facilities to enable the contractor to anticipate recipients who were plan enrollees prior to incarceration who will be released from these institutions. The cooperative agreement must address arrangements for persons who are to be released, but for whom re-enrollment may not take effect immediately. All recipients who were prepaid mental health plan enrollees prior to incarceration and Medicaid eligible recipients who are likely to enroll in the plan upon return to the community must receive a community mental health service within 24 hours of discharge from the corrections facility.

Performance measures for this section include:

- ❖ Access time for plan enrollees released from a corrections facility.
- ❖ The number of mental health assessments completed for plan enrollees at the pre-booking site.
- ❖ The number of enrollees who have discharge planning services provided at the post-booking site prior to release from a corrections facility.

C. Treatment and Coordination of Care for Recipients with Medically Complex Conditions – MANDATORY

The contractor shall ensure that there are appropriate treatment resources available to address the treatment of complex conditions that reflect both mental health and physical health involvement. The following conditions must be addressed:

- ❖ Mental health disorders due to or involving a general medical condition, specifically ICD-9-CM Diagnoses 293.0 through 294.1, 294.9, 307.89, and 310.1.
- ❖ Eating disorders – ICD-9-CM Diagnoses 307.1, 307.50, 307.51, and 307.52.

The contractor shall provide medically necessary mental health services to enrollees who exhibit the above diagnoses and shall develop a plan of care that includes all appropriate collateral providers necessary to address the complex medical issues involved. Clinical care criteria shall address modalities of treatment that are effective for each diagnosis. The contractor's provider network must include appropriate treatment resources necessary for effective treatment of each diagnosis within the required access time periods.

Performance measures for this section include:

- ❖ Evidence of access to needed services.
- ❖ Evidence that services are appropriate to the needs of the individual and that the diagnosis was effectively addressed.

- ❖ The number of treatment plans that indicate involvement of all appropriate collateral providers addressing complex medical issues.
- D. Monitoring of Enrollees admitted to Children's Residential Treatment (Levels I - IV) Programs – MANDATORY
1. The contractor shall maintain contact with children who are disenrolled from the plan due to placement in a residential treatment facility. The contractor shall participate in discharge planning, assist the recipient and their caregiver to locate community-based services, and notify Medicaid when the recipient is discharged from the facility. The prepaid mental health plan contract manager or designee shall re-enroll the recipient in the plan upon notification of discharge into the community.
 2. Children placed in the above residential facilities will be disenrolled from the plan and then covered under Medicaid fee-for-service for mental health services. The Medicaid contract manager or designee will be responsible for the disenrollment process. The Department of Children and Families, community based care provider (when applicable), Department of Juvenile Justice, residential providers, and/or the assigned Mental Health Targeted Case Management providers will be responsible for notifying Medicaid of all admissions and discharges. A specific agreement regarding the disenrollment and re-enrollment process will be developed between the agency, residential providers, and the departments.
- E. Coordination of Children's Services – MANDATORY
1. General Principles
 - a. The delivery and coordination of children's mental health services shall be provided for all children who are within a high-risk population and experiencing serious emotional disturbances. These children include those involved in the SED classes through the school system and those who exhibit the symptoms and behaviors of an emotional disturbance but are not receiving SED services through the school.
 - b. Services for all children shall be delivered within a strengths-based, culturally competent service design. The service design shall recognize and ensure the participation of family, significant others, informal support systems, school personnel, and any state entities or other service providers involved in the child's life.
 - c. The contractor shall assure provision of medically necessary services to all children enrolled in the plan within seven calendar days of receipt of the request for services. A log shall be maintained which records all calls or written requests received and the action taken related to each request. The date of the first service provided, along with the type of service and provider shall be part of the log. The services shall be of sufficient intensity and continuity to provide a realistic opportunity for progress. Services must be provided within the least restrictive and most normal environment that is clinically appropriate for the needs of the child and family.

- d. For all children receiving services under the plan, the contractor shall work with the parents, guardians, or other responsible parties to monitor the results of services and determine whether progress is occurring. Active monitoring of the child's status shall occur to detect potential risk situations and emerging needs or problems.
 - e. When the court mandates a parental mental health assessment, and the parent is a plan enrollee, the contractor must complete an assessment of the parent's mental health status and the effects on the child. Time frames for completion of this service shall be determined by the mandates issued by the courts.
2. Department of Children and Families
- a. Children's mental health services should be developed and coordinated to augment any local system of care for high-risk populations served by the Department of Children and Families, community based care providers, or by the Department of Juvenile Justice. (e.g. Medicaid eligible children in delinquency programs, shelters, and other in-reach initiatives in schools and housing projects). The contractor must develop a cooperative agreement with the Department of Children and Families or the community based care lead agency contracted to provide child protection services, and the Department of Juvenile Justice for coordination of care for enrolled children served within these systems or care.
 - b. The contractor must develop a service approach for children's mental health services that is designed to support the state's goals to achieve safety and permanency for children in the child protection system. All children enrolled in the plan who are in the state's care or custody and who have mental health needs shall have mental health services provided that are supportive of the department's case plan for the child.
 - c. The contractor will be available to participate in the development of the department's case plan for the child. Mental health treatment plans shall be consistent with the child and family's permanency goals, promote safety and address enhanced functioning for the child and family (if family members are also enrollees). The contractor shall invite the Family Services Counselor or the foster parents to participate in the treatment planning and service delivery process. If reunification is the goal, and with the department's concurrence, the contractor must involve the parents in the treatment planning and implementation.
 - d. The contractor shall provide mental health-related court-ordered evaluation and expert witness testimony required for children who are prepaid mental health plan enrollees. The contractor must provide these services in a way that is responsive to the needs and requirements of the department and judicial system.
 - e. The contractor shall collaborate with Family Services Counselors when providing services for children in care and custody of the department and

participate in the protocol established for compliance with Senate Bill 682 and Chapter 39, Florida Statutes. The contractor will coordinate care with family service counselors related to children being admitted to residential treatment facilities.

- f. The contractor must be available, if requested, to participate in all department case review staff meetings, school staff meetings, or other related meetings that pertain to the anticipated needs of the child or the provision of services for which the plan is responsible.
- g. Services provided to persons served by the Department of Children and Families, Family Safety Program related to child protective services, foster care, adoptions and special education services should be designed in an interactive familial manner. Such services should be provided in a conjoint manner with outcome goals oriented to family safety and protection of persons at risk of neglect or abuse.

3. Targeted Case Management

Children in the care or custody of the state who need mental health targeted case management services, as defined in the contractor's approved clinical protocols, shall receive mental health case management from the contractor. These children will not be transferred to the new Medicaid Child Welfare Targeted Case Management program. The contractor must develop a cooperative agreement with the Department of Children and Families or their provider of community based services, to address how to minimize duplication of case management services and to promote the establishment of one case manager for the child and family whenever possible.

4. Community Based Care Programs

If the community in which the contractor will operate has a community based care program contracted by the Department of Children and Families for the provision of children's protective services, the contractor must determine how the prepaid mental health services will be rendered to recipients served by the community based care program. The contractor must develop, during the implementation phase of the contract, or upon notification that the department has contracted with a provider, a cooperative agreement between the contractor and the community based care program. Medicaid and the Department of Children and Families must approve the agreement. The contractor must be prepared to provide services in a collaborative manner in each county covered by the plan.

Performance measures for this section will include:

- ❖ The number of court ordered evaluations completed within court mandated time frames for prepaid mental health plan enrolled recipients in the care or custody of the state.

- ❖ The extent to which mental health treatment plans are supportive of the department's case plans for prepaid mental health plan children who are in the state child protection system.
- ❖ Stakeholder satisfaction survey results related to services provided. Surveys shall be distributed as designated in Section 2.27 in each county covered by the plan.

F. Psychiatric Evaluations for Enrollees Applying for Nursing Home Admission - MANDATORY

The contractor shall, upon request from the Alcohol, Drug Abuse and Mental Health District Offices, promptly arrange for and authorize psychiatric evaluations for enrollees applying for admission to a nursing facility pursuant to OBRA 1987, and who, on the basis of a screening conducted by Comprehensive Assessment and Review for Long Term Care (CARES) workers, are thought to need mental health treatment. The examination shall be adequate to determine the need for "specialized treatment" under the Act. Evaluations must be completed within five working days from the time the request from the DCF ADM Program Office is received. State regulations have been interpreted by the state to permit any "mental health professional" defined under Section 394.4552 (a), Florida Statutes, to make the observations preparatory to the evaluation, although a psychiatrist must sign such evaluations. The contractor will not be responsible for annual resident reviews or for providing services as a result of a Pre-admission Screening Assessment Annual Resident Review (PASSAR) evaluation.

Performance measures for this section include:

- ❖ The number of enrollees who receive a psychiatric evaluation within required time frames prior to admission to a nursing facility.

G. Opportunities for Recovery and Reintegration - MANDATORY

The contractor shall offer a supportive element within the network for adults experiencing a serious mental illness. This element shall focus on aspects of recovery and reintegration into the community upon completion of active treatment. The support provided shall encourage and empower individuals to provide ongoing support and assistance for other individuals with similar mental health disorders.

Within this component, the contractor shall develop protocol for supporting consumer-driven activities and providing assistance as determined appropriate by recipients. This protocol may include professional involvement in an advisory or assistance capacity or it may limit the contractor's involvement to strictly administrative functions. Administrative functions for this purpose may include, but are not limited to: providing facility space for meetings; providing supplies or materials for activities; and providing professional staff for educational presentations.

It is expected that the contractor will include consumer advocates and recipients who are most likely to benefit from consumer-driven activities in the development of protocol. Periodic focus groups should be held to access information related to consumer satisfaction and to identify services that are perceived as inadequate or missing.

The provider must be knowledgeable about the local WAGES initiative and is responsible for medically necessary mental health services, which will assist the individual in finding and maintaining employment.

H. Assessment and Treatment of Mental Health Residents Who Reside in Assisted Living Facilities (ALF) that hold a Limited Mental Health License

The contractor must develop and implement a plan to ensure compliance with Section 394.4574, Florida Statutes, related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. The contractor must ensure that appropriate assessment services are provided to plan enrollees and that medically necessary mental health care services are available to all members who reside in this type of setting.

I. Optional Services

The contractor is encouraged to provide additional services that will enhance the plan's covered services for recipients. To the degree possible, the contractor should use existing community resources. Below is a list of possible optional services that could be provided with the savings achieved or as downward substitutions. This list is not intended to be all-inclusive and the contractor is encouraged to use creativity in developing new and innovative services to expand the array of services and meet the needs of recipients.

1. Respite Care Services
2. Prevention Services in the Community
3. Supportive Living Services
4. Supported Employment Services
5. Foster Homes for Adults
6. Parental Education Programs
7. Drop In Centers and other consumer operated programs (beyond the elements provided under the Opportunities for Recovery and Reintegration component)
8. Intensive Therapeutic On-Site Services for Adults
9. Home and Community Based Rehabilitation Services for Adults
10. Any other new and innovative interventions or services designed to benefit Prepaid Mental Health Plan enrollees

J. Community Coordination and Collaboration

The contractor must be or become a vital part of the community services and support system. They must actively participate with and support community programs and coalitions that promote school readiness, that assist persons to return to work and provide for prevention programs. The provider must have linkages with numerous

community programs that will assist enrollees in obtaining housing, economic assistance and other supports.

2.5 Minimum Access and Staffing Standards

The contractor shall also adhere to the following minimum standards:

A. Access standards

1. The contractor shall make available and accessible facilities, service sites, and personnel sufficient to provide the covered services (specifically non-hospital outpatient, emergency, and assessment services) throughout the geographic area, within thirty minutes typical travel time by public or private transportation of all enrolled recipients. (The typical travel time standard does not apply to waiting time for public transportation – it applies only to actual time in transit.)
2. The maximum amount of time between an enrollee's request for mental health services and the first point of service shall be as follows (except when otherwise noted in specific sections of this document):
 - a. For EMERGENCY mental health services as defined in Section 1.1, service shall be immediate.
 - b. For persons initially perceived to need emergency mental health services, but upon assessment do not meet the criteria for emergency care, they are deemed to require URGENT crisis support, and services must be provided within twenty-three hours.
 - c. For ROUTINE outpatient intake, an assessment shall be offered within seven calendar days. Follow-up services shall be offered within fourteen calendar days after the assessment.

Requests for psychiatric medications and medication appointments shall be treated as a request for emergency services when a member is without necessary prescribed medications. Requests for appointments due to reports of non-emergent allergic reactions or serious side effects shall be treated as an urgent request for services. Routine medication appointments, such as for prescription renewals, shall be scheduled in a manner to avoid disruption in availability of necessary prescribed medications. Requests for medication appointments can be made by the member, the member's responsible party, other mental health treatment providers, or persons coordinating care for the purpose of jail diversion or aftercare.

3. The contractor shall operate, as part of its crisis support/emergency services, a 24-hour a day, 7 days a week, crisis emergency hot line to be available to all enrollees.
4. The contractor shall provide a designated emergency service facility per county to ensure unrestricted access to emergency care on a 24 hours a day, 7 days a week basis. Such designated emergency service facility shall have 24 hours a

day, 7 days a week, registered nurse coverage and on-call coverage by a mental health professional, as defined in, Chapter 394, Part I, F.S.

B. Minimum staffing standards:

The contractor must maintain credentialing files for all direct service staff members. The files must document the education, experience, prior training and ongoing in-service training for each staff member or individual contractor. If the services are provided through a subcontract with another member of the network, the contractor must ensure that the network provider properly maintains personnel and credentialing files. Minimum staffing standards shall be as follows, and failure to adhere to these staffing standards, or the staffing standards indicated in the winning proposal, whichever are greater, may result in termination of the contract (if the contractor's "staff" person does not fill one of the "key staff" positions, the staff person shall be a subcontractor). Minimum staffing standards shall be as follows:

1. The contractor's staff shall include at least one board certified adult psychiatrist, or one who meets all education and training criteria for board certification, to be available within thirty minutes typical travel time of all enrolled recipients.
2. The contractor's staff shall include at least one board certified child psychiatrist, or one who meets all education and training criteria for board certification, to be available within thirty minutes typical travel time of all enrolled recipients.
3. The contractor's outpatient staff shall include at least one FTE direct service mental health provider per 1,500 prepaid members. The agency expects the contractor's staffing pattern for direct service providers to reflect the ethnic and racial composition of the community.
 - a. The contractor's array of direct service mental health treatment providers for adults and children must include providers on staff or under contract that are licensed or eligible for licensure, and demonstrate two years of clinical experience in the following specialty areas or with the following populations:
 - (1) Adoption;
 - (2) Child protection or foster care;
 - (3) Dual diagnosis (mental illness and substance abuse);
 - (4) Dual diagnosis (mental illness and developmental disability);
 - (5) Developmental Disabilities;
 - (6) Behavior analysis;
 - (7) Behavior management and alternative therapies for children;
 - (8) Separation and loss;

- (9) Victims and perpetrators of sexual abuse (children and adults);
- (10) Victims and perpetrators of physical abuse (children and adults);
- (11) Victims of domestic violence and violent crimes (children and adults);
- (12) Court ordered mental health evaluations including assessment of parental mental health issues and parental competency as it relates to mental health; and
- (13) Expert witness testimony.

Additionally, all direct service providers and mental health targeted case managers serving the children's population must be certified by the department to administer the CFARS (or other rating scale required by the department or agency).

Mental health targeted case managers shall not be counted as direct service mental health treatment providers.

- b. The contractor shall provide staff with the education and training for each service provided as required and outlined in Attachment 24.
 - c. The contractor shall provide staff appropriately trained and experienced to provide psychological testing.
 - d. The contractor shall provide staff appropriately trained and experienced to provide rehabilitation and support services to persons with a severe and persistent mental illness.
4. For case management services, the contractor shall provide staff that meet the following minimum requirements:
- a. Have a baccalaureate degree from an accredited university, with major course work in the areas of psychology, social work, health education or a related human service field and if working with children, have a minimum of one-year full time experience or equivalent working with the target population. Prior experience is not required if working with the adult population; or
 - b. Have a baccalaureate degree from an accredited university and if working with children, have at least three years full time or equivalent experience working with the target population. If working with adults, the case manager must have two years of experience. (Note: case managers who were certified by the department prior to July 1, 1999, who do not meet the degree requirements, may provide case management services if they meet the other requirements; and
 - c. Have completed a training program within six (6) months of employment. The training program must be prior approved by AHCA. The training

must include a review of the local resources and a thorough presentation of the applicable state and federal statutes and promote the knowledge, skills, and competency of all case managers through the presentation of key core elements relevant to the target population. The case manager must also be able to demonstrate an understanding of the contractor's case management policy and procedures.

5. Case management supervision must be provided by a person who has a master's degree in a human services field and three years of professional full time experience serving this target population or a person with a bachelor's degree and five years of full time or equivalent case management experience. For supervising case managers who work only with adults, two years of full time experience is required. The supervisors must have had the approved contractor's training in case management or have documentation that they have prior equivalent training.
6. The contractor shall have access to no less than one fully accredited psychiatric community hospital bed per 2,000 prepaid members, as appropriate for both children and adults. Specialty psychiatric hospital beds may be used to count toward this requirement when psychiatric community hospital beds are not available within a particular community. Additionally, the contractor shall have access to sufficient numbers of accredited hospital beds on a medical/surgical unit to meet the need for medical detoxification treatment.
7. The contractor's facilities must be licensed, as required by law and rule, accessible to the handicapped, in compliance with federal Americans with Disabilities Act guidelines, and have adequate space, supplies, good sanitation, and fire, safety, and disaster preparedness and recovery procedures in operation.

Performance measures for this section include:

- ❖ Staffing requirements, accessibility requirements, and licensure requirements shall be monitored through contract compliance and quality of care monitoring protocol as noted in Section 2.42.
 - ❖ AHCA PMHP contract manager or designee(s) shall collaborate with the department in determining compliance with all licensure or certifications required through the department and the agency.
- C. The contractor shall be a receiving facility as defined in Chapter 394, Part I, F.S., in Escambia, Okaloosa, Santa Rosa, and Walton counties, or have access through contract to at least one receiving facility in Escambia, Okaloosa, Santa Rosa, and Walton counties.
1. If a public receiving facility is a provider under this plan, it shall insure that no state general revenue funds appropriated pursuant to the Florida Mental Health Act (Chapter 394, F.S.) or related matching funds, will be used to provide inpatient psychiatric care or crisis stabilization unit care to plan enrollees, within Medicaid inpatient service limitations.

The receiving facility available under the prepaid plan shall complete the involuntary examination within 72 hours of the client's original presentation at a receiving facility.

2.6 Services Not Covered

- A. The contractor is NOT obligated to pay for services available through Medicaid but not specified as required under the RFP. Plan enrollees who require services available through Medicaid but not covered by the proposal will receive those services through the existing Medicaid fee-for-service or MediPass reimbursement systems. The contractor shall NOT be responsible for specialized therapeutic foster care or children's residential treatment. The contractor shall NOT be responsible for transportation or medical/surgical interventions associated with a psychiatric problem. If the contractor determines the need for these or other services, the contractor shall refer the enrollee to the appropriate service provider. The contractor may request the assistance of the Area AHCA Medicaid Office or of the DCF District Alcohol, Drug Abuse and Mental Health Office for referral to the appropriate service setting. The contractor will continue to be responsible for the covered service categories listed in Sections 2.2, 2.3, and 2.4.
- B. **Florida Assertive Community Treatment Services:** The contractor shall NOT be responsible for the provision of mental health services to recipients assigned to a FACT team by the DCF Alcohol, Drug Abuse, and Mental Health Program Office.
- C. **Substance Abuse Treatment Services:** The prepaid mental health plan contractor will NOT be responsible for providing substance abuse services to plan enrollees. The contractor shall develop methods of coordinating and integrating mental health and substance abuse services for plan enrollees. The contractor is required to use the Florida Supplement to the American Society of Addictions Medicine Patient Placement Criteria for the coordination and treatment of substance-related disorders with substance abuse providers as a part of the integration effort (Second Edition ASAM PPC-2, July 1998).

Coordination of care with community-based substance abuse agencies shall be included in protocols developed for continuity of care practices for enrollees with dual diagnoses of mental illness and substance abuse or dependency, and shall incorporate the applicable ASAM PPC-2 discharge/transfer criteria. The protocol for integrating mental health services with substance abuse services shall be monitored through the Quality of Care monitoring activities detailed in Section 2.42 and the Quality Improvement requirements in Section 2.29.

- D. **Prescribed Drug Services:** Prescribed drug services are NOT covered under the plan. Such drugs will be reimbursable under the Medicaid fee-for-service program according to the policies and procedures specified in the Medicaid Pharmacy Provider Handbook. If the contractor operates a pharmacy for plan recipients, it must become a Medicaid pharmacy provider prior to commencement of services under the plan, and adhere to the policy requirements specified in the Medicaid Pharmacy Provider Handbook. However, pharmacy services may not be restricted to any one pharmacy or group of pharmacies.

The contractor will cooperate with the ADM Program Office and AHCA by coordinating care with the Pharmacy Algorithm Demonstration Project currently in operation within ADM District One.

The agency will provide the contractor with a monthly report indicating, for all classes of drugs, the prescribed drugs the plan's recipients have received. The report will list each recipient enrolled in the Prepaid Mental Health Plan who has had a pharmacy claim paid within the month. The report will at a minimum include the recipient's Medicaid identification number, national drug code (NDC), drug name, quantity of drug dispensed, days supply, refill indicator, prescription number, prescribing provider's name and pharmacy provider's name. The report will be sorted by recipient's name and NDC. The contractor shall use this report to assist in the management of recipients' mental health treatment, coordination with recipient's primary care physicians, integration of treatment with other providers, and for outreach purposes. Refer to Section 2.31 for reporting requirements.

- E. **Comprehensive Assessment Services:** The contractor shall NOT be responsible for the provision of comprehensive assessment services upon initial implementation of this contract. The service shall be reimbursed on a fee-for-service basis from state Medicaid funds until the agency has adequate paid claims data for calculating coverage of the service under a prepaid plan. At that time, the agency may add the service into the contract as a covered item in the prepaid mental health plan. The contractor is encouraged to plan for this coverage by including the appropriately credentialed direct service providers necessary for conducting comprehensive assessments.

The agency has implemented an expansion of this service in the Medicaid fee-for-service system effective January 1, 2000. Under this expansion, comprehensive assessments are available to all Medicaid eligible children being considered for Specialized Therapeutic Foster Care or being taken into out-of-home care or emergency shelter by the Department of Children and Families or a community based care provider contracted with the department.

As noted in Section 2.3, the contractor is responsible for medically necessary services that are recommended for plan enrollees in a comprehensive assessment completed within the Medicaid guidelines of the expanded service. It will be required that the contractor develop cooperative agreements with providers of this service and coordinate care with the providers and the department or community based care program.

- F. **Qualified Evaluator Services:** The contractor is not responsible for the provision of evaluations of children being admitted to residential treatment facilities as required in Section 39.407, Florida Statutes. These services will remain funded through Medicaid fee-for-service and the Department of Children and Families.
- G. **Specialized Therapeutic Foster Care** is NOT a covered service. Refer to Section 2.3.D.7.c. for details.
- H. **Behavioral Health Overlay Services (BHOS)** is NOT a covered service. Refer to Section 2.3.D.7.d. for details.
- I. **Services for children admitted to residential treatment centers** are NOT covered services. Refer to Section 2.3.D.7.d. for details.
- J. **Long-term care institutional services** in a nursing home, an institution for the developmentally disabled, or a state mental hospital are NOT covered by the PMHP. For enrollees requiring those services, the contractor will consult with the Area AHCA

Medicaid Office and/or the District DCF Alcohol, Drug Abuse and Mental Health Office to identify appropriate methods of assessment and referral. The contractor is responsible for referral and transition to and from appropriate service providers. Enrollees admitted to long-term care institutions will be disenrolled from the plan.

2.7 Cost Sharing for Services

The contractor shall not require any co-payment or cost sharing for the provision of services, nor may the contractor charge enrollees for missed appointments.

2.8 Care Coordination and Management

The contractor shall be responsible for the coordination and management of mental health treatment and continuity of care for all enrolled Medicaid recipients through the following minimum functions:

- A. Minimizing disruption to the enrollee as a result of any change in service provider or mental health targeted case manager occurring as a result of the awarding of this contract. All activities and efforts to assist enrollees during the transition from one provider to another shall be documented and available for review during contract monitoring as stated in Section 2.42.
- B. Providing appropriate referral to the enrollees' MediPass primary care case managers (or other physician, for non-MediPass enrollees) and scheduling of assistance for enrollees needing physical health care and mental health treatment services. The contractor shall document all activities related to referrals and assistance provided to plan enrollees related to accessing physical health care.
- C. Documenting in clinical records all enrollee emergency encounters and appropriate follow-up. Documentation of emergency encounters must be completed for all plan enrollees, even if the recipient is not receiving ongoing services with the service provider. In the event that a clinical record is not established, the contractor shall have in place a protocol for assuring that documentation is kept on all emergency encounters.
- D. Documenting all referral services in the enrollees' clinical records. Referral services include referrals to substance abuse providers when this is identified as appropriate. Outcomes of these referral efforts must be documented and available for review during monitoring activities. As stated in item 2.8 C. above, the contractor shall have a protocol for assuring documentation of referral services for enrollees who may not have clinical records established.
- E. Monitoring enrollees with ongoing mental health conditions. The contractor shall develop and implement a protocol that describes best practices for monitoring the status of enrollees with ongoing conditions. This protocol must use objective and specific language to convey the activities and services that will be used in the provision of monitoring services. Documentation in clinical records shall be required to include individualized and specific information, along with a rationale for monitoring services. Generic phrases and non-specific language are prohibited.
- F. Providing direct mental health service providers with copies of the Medicaid Prescribed Drug Report relating to their respective plan enrollees, and coordinating, on an as

- needed basis, with other staff, subcontractors, or non-plan providers the provision of mental health-related drugs to plan enrollees. The contractor shall assure that the Drug Report distributed to the service providers is in a format that can be practically used for clinical management of enrollees. Additionally, a protocol shall be developed and in place related to “best practices” and specific methods for effectively using the information to improve the quality and continuity of care received by plan enrollees.
- G. The contractor shall have in place protocols for coordinating care among multiple providers. This shall include mental health, substance abuse, primary care physicians, and other non-plan providers who are identified as prescribing drugs to plan enrollees. The protocol shall address outreach efforts, educational opportunities, treatment guidelines, and how the plan will bring multiple providers together in the management of care for enrollees.
- H. When the drug report indicates that an enrollee is receiving an anti-psychotic medication (including atypicals) from a MediPass physician or prescribing non-psychiatrist physician, the provider shall request a consultation with the MediPass physician or prescribing non-psychiatrist physician. When the drug report indicates that an enrollee is receiving medications for certain physical conditions (such as hypertension, diabetes, neurological disorders, cardiac problems, or any other serious medical condition) a consultation with the MediPass physician shall be attempted prior to prescribing additional medications, to discuss coordination of care and concerns related to drug interactions.
- I. Monitoring enrollees admitted to state mental health institutions. As stated in Section 2.4 A., the plan is responsible for following former plan enrollees who are admitted to a state mental institution within Florida. The performance measure detailed in Section 2.4 A. states specific requirements. Additionally, performance measures related to mental health targeted case management services in Section 2.3 F. and G. apply to this item.
- J. Monitoring enrollees admitted to Children’s Residential Treatment (Levels I – IV). As stated in Section 2.4 D., the plan is responsible for following children in the plan who are placed in residential treatment facilities. The outcomes applicable to this item are detailed at the end of Section 2.4 D. Section 2.3 E. includes outcomes related to targeted case management services for this population as well.
- K. The contractor shall provide a quarterly report related to the follow-up of children placed in residential treatment. The report shall include any activities that the contractor conducts and anticipated discharge date.
- L. The contractor shall coordinate care with the Department of Children and Families, Family Safety Office for children in care and custody of the department who are admitted to residential treatment facilities.
- M. Coordinating hospital and/or institutional discharge planning for psychiatric admissions including appropriate post-discharge care. Plan enrollees who are admitted to an inpatient hospital or crisis stabilization unit must receive appropriate services upon discharge from the acute care facility. The contractor shall provide a follow-up service to plan enrollees within 24 hours of discharge from an acute care facility. Clients discharged from state mental health facilities will be maintained on the medication that was prescribed for them by the facility at discharge for at least 90 days unless there is

some extenuating medical reason for changing the client's prescription or the client requests the change. This includes performing required lab tests and appropriate physician oversight.

- N. Providing referral of the enrollee for non-covered services to the appropriate service setting, and requesting referral assistance, as needed, from the Area Medicaid Office.
- O. Entering, prior to commencement of services, into agreements with agencies funded pursuant to Chapter 394, Part IV, F.S., that will not be a part of the plan's provider network, regarding coordination of care and treatment of enrollees jointly or sequentially served. These agreements shall be approved by the agency. The contractor may be released from this requirement by the agency if the contractor makes good faith efforts and no agreement is consummated.
- P. Providing court ordered mental health evaluations for its enrollees as required by and within the time limits specified by the courts. The contractor shall also provide expert mental health testimony for its enrolled recipients as ordered by the courts. Refer to Section 2.4 E.2.d. for specific requirements related to court ordered evaluations for children in the care and custody of the state. This does not include court orders for evaluations to determine competency to proceed under Chapters 916 and 985, Florida Statutes.
- Q. Providing appropriate screening, assessment, crisis intervention and support for enrollees who are in the care and custody of the state. Refer to Section 2.4 E. for specific requirements.
- R. Acknowledging and incorporating into the plan's operational procedures the following policy: that, in the event of a disagreement between the agency and the contractor regarding the appropriate treatment of an enrollee who has been referred to the contractor's provider, the decision of the agency shall prevail. The contractor or plan enrollee may appeal decisions through the fair hearing process established by the Department of Children and Families. (Please refer to Section 2.15 for grievance procedures.) This protocol shall be included in all subcontracts implemented to carry out the prepaid mental health plan contract.

2.9 Out-of-Plan Services

The contractor shall make provisions for and advise all enrollees of the provisions governing out-of-plan services. The contractor shall inform the member that other than emergency services and unless otherwise specified and authorized by the plan, the contractor shall not be liable for the cost of out-of-plan mental health services where a member uses out-of-plan services that are available under the plan. The contractor shall include on any plan identification card or outreach materials the telephone number that a member or non-contract provider may call for covered services and out-of-plan service information.

- A. Emergency Out-of-Plan Services
 - 1. The contractor must evaluate and authorize or deny payment for care for enrollees presenting at non-plan mental health receiving facilities within the contract service area for involuntary examination and assessment within three hours of being notified by phone by the receiving facility. The receiving facility at

which the enrollee presents must notify the contractor within four hours of the enrollee presenting, that the enrollee has come to the receiving facility for evaluation and treatment. If the receiving facility fails to provide the contractor with an accounting of the enrollee's presence and status within four hours, the contractor shall be obligated to pay only for the first four hours of the enrollee's treatment or evaluation services, in accordance with medical necessity.

However, if the receiving facility, as documented in the clinical record, is unable (after a good faith effort) to identify the patient as a plan enrollee and, therefore, fails to notify the contractor of the enrollee's presence – the contractor shall be obligated to pay for mental health-related medical stabilization lasting no more than three days from the date the enrollee presented at the receiving facility, as documented in the patient's medical record and in accordance with medical necessity, unless there is evidence in the clinical record that a longer period was required.

2. The contractor shall include the provisions governing the use and payment of an enrollee's out-of-plan emergency mental health services provided by a non-contracted provider. The contractor's use and payment provisions for a member's out-of-plan emergency mental health services usage shall also include out-of-area and out-of-state providers. Use of and payments to non-contracted providers shall be for the treatment of a member's emergency mental health condition until that member can be safely transported to an appropriate contractor service location. The contractor's responsibility for the use and payment of a member's out-of-plan emergency mental health services include medically necessary inpatient, outpatient, physician, and community mental health services. Emergency mental health services are those services required to meet the needs of an individual who is experiencing an acute crisis which is at a level of severity that would meet the requirements for involuntary hospitalization pursuant to Section 394.467, Florida Statutes, and who, in the absence of a suitable alternative, would require hospitalization. This is an emergent situation in which the member is in need of assessment and treatment in a safe and therapeutic setting, is a danger to self or others, or exhibits significant clinical deterioration of a chronic mental health condition rendering the member unmanageable and unable to cooperate with treatment. Such emergency mental health services shall not be subject to prior authorization by the contractor.
 - a. The out-of-plan non-contract provider must notify the contractor within 24 hours of the enrollee presenting for emergency mental health services that the enrollee has come to the non-contract provider for treatment. In cases in which the enrollee has no identification or is unable to verbally identify himself when presenting for services, the provider must notify the contractor within 24 hours of learning the enrollee's identity. The provider must also provide clinical records to the contractor, which document that the identity of the enrollee could not be ascertained due to the enrollee's condition.
 - b. If the non-contract provider fails to provide the contractor with an accounting of the enrollee's presence and status within 24 hours after the enrollee presents for treatment and provides identification, the contractor

shall be obligated to pay only for the time period required for emergency services, as documented by the patient's clinical record.

- c. The contractor shall reimburse non-contract providers for properly completed and submitted claims for emergency mental health services, provided such claims are submitted within twelve months of the date of service as specified by federal law. The contractor must process such claims within 35 days of receipt.
3. The contractor must review and approve or disapprove out-of-plan emergency mental health service claims based on the definition of emergency mental health services specified in Section 1.1. The contractor, within ten (10) working days from receipt, must submit to the agency for review and final determination, appeals from providers for denied emergency mental health service claims. The contractor must pay within 35 days, previously denied emergency mental health service claims if the decision by the agency is to honor the claim. The 35-day period begins when the contractor receives notification of the final decision from the agency.

B. Out-of-Plan Use of Non-Emergency Services

When a member uses non-emergency out-of-plan mental health services that are available under the plan from a non-contract provider, the plan shall not be liable for the cost of such use unless the member was referred to the non-contract provider to receive authorized out-of-plan services. The enrollee shall be liable for the cost of unauthorized non-emergency contract covered mental health services, which they accessed and received from non-contract providers. The contractor shall include on any plan identification card or outreach materials the telephone number that the non-contract provider may call for billing and covered services information.

C. Transition Plan for New Enrollees:

The contractor will be required to minimize an enrollee's disruption of treatment from their current mental health treatment provider through an allowance for a member's use of out-of-plan services. For new members who have been receiving continuous mental health treatment for at least six months from another provider, the contractor will continue to authorize and pay valid claims for out-of-plan services until the contractor has reviewed the member's treatment plan and developed and implemented an appropriate written transition plan.

Continuous treatment is defined as: at least two outpatient individual or group sessions each month; or at least one outpatient psychiatric medical session per month; or at least two days of day treatment per week; or at least one hour of Intensive Therapeutic On-Site Services or Home and Community Based Rehabilitative Services per week.

However, if the previous treating provider is unable to allow the contractor access to the member's clinical record because the member refuses to release the record, then the contractor would only be responsible to reimburse the out-of-plan provider for four sessions of individual or group therapy, or one psychiatric medical session, or two one-hour Intensive Therapeutic On-Site or Home and Community-Based Rehabilitative sessions, or six days of Day Treatment Services.

Any disputes related to coverage of services necessary for transitioning enrollees from their current mental health treatment provider to a prepaid mental health plan provider shall be submitted to the agency for resolution.

The contractor shall reimburse non-contract providers for authorized out-of-plan non-emergency services, provided such claims are submitted within twelve months of the date of service as specified by Federal law. The contractor must process such claims within 35 days of receipt.

D. Out-of-Plan Claims Payment

In accordance with Section 409.912 (16), F.S., the contractor shall reimburse any hospital, physician, or community mental health provider for authorized and approved services provided to a plan's enrollees at a rate negotiated for the provision of mental health services in accordance with the lesser of the following:

1. The contractor's negotiated rate for the hospital, physician, or community mental health provider, or
2. The Florida Medicaid reimbursement rate established for the hospital, physician, or community mental health provider.

The contractor shall reimburse for authorized out-of-plan services within 35 days of receipt of a properly submitted non-contracted provider's claim. The contractor shall define "properly submitted claim" and shall inform the out-of-plan non-contracted provider of the definition. The contractor shall instruct the non-contract provider regarding the proper submittal of claims.

2.10 Marketing

In geographic areas where there is a Medicaid prepaid health plan, marketing of the plan by the contractor will be permitted only as scheduled by, and in a format approved by the agency. Medicaid recipients may not be offered material incentives, other than the benefits expressed in the contract, to enroll or remain enrolled. The contractor will be free to negotiate its own mailing with the Medicaid fiscal agent, subject to the ongoing rate.

2.11 Persons Eligible for Enrollment

- A. The contractor shall only enroll those Area One Medicaid recipients in the authorized categories specified in this section and having the eligibility program codes specified in Attachment 2. The county of residence shall be that county documented in the recipient's eligibility file. Only recipients not enrolled in a Medicaid HMO are eligible to participate. Eligible Medicaid recipients will either be enrolled in MediPass or in a Medicaid HMO. Medicaid recipients enrolled in MediPass will receive their mental health services through the prepaid mental health plan. The contractor will receive an enrollment report that lists each recipient's MediPass physician.

Eligible recipients include the following Medicaid recipients:

1. TANF Recipients. Individuals eligible for Medicaid based on their eligibility for Temporary Assistance to Needy Families;
2. Children in Foster Care. These are recipients eligible for Medicaid because they are placed in foster homes under the direction of the department;
3. Emergency Shelter. These are recipients eligible for Medicaid because they are in the care and custody of the state;
4. Adoption Subsidy. These are recipients eligible for Medicaid because they are children with special needs whose adoption was supported by the state or a private adoption agency;
5. SOBRA Eligible Children. These are recipients eligible for Medicaid because their families meet income requirements specified by the Second Omnibus Budget Reconciliation Act of 1987, or because they were born on or after October 1, 1983 and have incomes to 100 percent of the federal poverty level, as specified by the Omnibus Budget Reconciliation Act of 1990; and
6. Recipients in the SSI without Medicare category of eligibility.

B. The following categories describe recipients NOT eligible for enrollment under the plan:

1. Recipients in the SSI with Medicare (A and/or B) category of eligibility;
2. Medicaid eligible recipients who, at the time of enrollment, are domiciled or residing in an institution including nursing home, intermediate care facilities for the developmentally disabled, state mental hospitals or correctional institutions;
3. Medicaid eligible recipients who are receiving services through a hospice program;
4. Medicaid eligible recipients who are members of a Medicaid HMO or prepaid health plan;
5. Medicaid eligible recipients who are eligible due to meeting a share of their medical costs through the Medically Needy Program;
6. Newly eligible TANF recipients who have not completed the Medicaid enrollment process;
7. SOBRA eligible pregnant women;
7. Presumptively eligible pregnant women; and
8. Individuals with major medical coverage.

2.12 Enrollment

The agency shall enroll eligible Medicaid recipients in the prepaid mental health plan according to prescribed rules and procedures specified in the RFP. The contractor shall develop and implement procedures for the monthly receipt of enrollment information from the agency's fiscal agent and for the maintenance of membership records for each enrollee. Such procedures must be approved by the agency prior to enrollment of the first Medicaid recipient. The following enrollment rules and procedures shall apply.

A. Agency's Enrollment Rules and Procedures:

1. The agency will enroll all eligible Medicaid recipients. Enrollment will be mandatory for all recipients with the appropriate program codes as indicated in Section 2.11 A, and in the eligibility categories specified by the agency in Attachment 2.
2. The agency will not discriminate in enrollment or re-enrollment on the basis of mental health status or health care needs.
3. The agency will enroll all eligible Medicaid recipients in eligible categories who reside within the authorized service area (Area One) and who are not enrolled in an HMO.
4. New applicants for Medicaid will be given a brief overview of how to access mental health care and the appropriate use of emergency rooms under the waiver program as part of the eligibility determination interview. The agency will provide a Medicaid identification card, which will be sent by Medicaid's fiscal agent, to the enrollee.
5. Membership will begin at 12:01 a.m. on the first day of the calendar month that the enrollee's name appears on the automated enrollment report.
6. The agency's fiscal agent shall provide a listing of ongoing members, new enrollees, disenrollees and reinstatements to the contractor each month.

B. Contractor's Enrollment Rules and Procedures:

1. The contractor shall accept the Medicaid recipient in the mental health condition the recipient is in at the time of enrollment. The contractor shall not discriminate on the basis of mental health care needs.
2. The contractor shall provide a means by which recipients can readily contact the plan and obtain services.
3. To the maximum extent possible, the contractor shall assign enrollees to the plan's mental health care providers based upon the following:
 - a. Enrollee choice of direct service provider,
 - b. Placement with the enrollee's current mental health care provider, and/or

- c. Proximity of the enrollee's residence to the plan service provider's location.
4. The contractor shall provide a means for coordinating and monitoring services provided to the recipient in order to ensure efficient, efficacious and clinically sound mental health care.

For children in the care and custody of the state, the contractor should provide consultation to the appropriate DCF district representative to identify the appropriate direct service mental health care provider who will be responsible for monitoring all aspects of the recipient's care.

5. Upon enrollment, the contractor shall provide the following information to the new enrollee:
 - a. Effective date of enrollment;
 - b. Procedures for obtaining required services and a central point of access;
 - c. Location of assigned plan service site (including telephone numbers and office hours);
 - d. Member Handbook, which shall include the following:
 - (1) Terms and conditions of enrollment in the plan;
 - (2) A notice that clearly states that the enrollees may select an alternative direct service mental health care professional within the plan, if one is available. This notice shall also include specific information for the enrollee about the process to follow in selecting an alternative provider;
 - (3) Description of services covered including limitations, exclusions and out-of-plan use;
 - (4) Description of emergency mental health services and procedures available both in and out of the contractor's service area;
 - (5) Procedures for obtaining mental health care services, including an explanation of the applicable restrictions of the plan, especially that the member should use the contractor's plan providers and secure appropriate referrals and authorization before receiving out-of-plan care;
 - (6) Provider services center sites and ancillary providers if applicable, including location addresses and telephone numbers. If ancillary providers are available, information about how to access these providers shall be included;

- (7) A notice informing enrollees of their right to request one of the covered services when the plan offers another service, not covered by the contract, as a downward substitution;
- (8) Description of complaint and grievance procedures, including contact persons and telephone numbers of each service location;
- (9) Description of disenrollment rights and procedures, which includes information on Medicaid's choice counseling contractor;
- (10) Member responsibilities;
- (11) Information on emergency transportation and non-emergency transportation available under the plan;
- (12) Information regarding a "Living Will" pursuant to the requirements of Chapter 765, Florida Statutes;
- (13) Information related to "Advanced Directives"; and
- (14) Information on the Title XXI KidCare program for those children between the ages of zero up to the age of 19, who become ineligible for Medicaid. The handbook shall include information on how to apply for the Title XXI KidCare program in the event of a child losing their Medicaid eligibility and plan coverage benefits.

The contractor shall assure that appropriate foreign language versions of all materials are developed and available to members and potential members. Foreign language versions of materials are required if the population speaking a particular foreign (non-English) language in a county is greater than five percent. Information must also include telephone resources for the hearing impaired and information for resources to contact for assistance when necessary due to physical disabilities. Information must be available regarding the process for accessing translator services when necessary. The plan shall provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language.

6. Upon the initial request for services, the contractor shall provide the enrollee with the name of the assigned mental health provider and an appointment with the provider, which is within the required access times indicated in Section 2.5.

C. Enrollment Cycle

Enrollment shall be in whole months, beginning with the first day of the month in which the recipient's name appears on the list of enrollees provided by the agency to the contractor. The enrollee may only disenroll to enter an HMO, or due to one of the other reasons indicated in Section 2.13.

2.13 Disenrollment Rules and Procedures

- A. The following general disenrollment requirements apply.

1. The contractor may not disenroll an enrollee without just cause. It may, however, change the enrollee's direct service mental health care provider.
 2. The effective date for disenrollment shall be the last day of the month in which disenrollment was effected by the agency.
 3. If the contract is renewed, the enrollment status of all enrollees shall continue uninterrupted.
 4. The following are the reasons for automatic disenrollment by the agency:
 - a. Moving out of the service area;
 - b. Death;
 - c. Ineligibility for Medicaid;
 - d. Admission to a state hospital or other long term care facility, hospice, or correctional facility; and
 - e. Enrollment in a Medicaid HMO or prepaid health plan.
- B. In areas where there are no Medicaid HMOs, recipients may disenroll from the plan for good cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment.

An enrollee's rejection of one direct service mental health care professional, and refusal to accept services from an alternative direct service mental health care provider, if appropriate, is not considered to be just cause for disenrollment.

The agency shall be responsible for authorizing disenrollment for good cause related to quality of care. A disenrollment request, whether filed by the plan or by the enrollee, must contain the following minimum enrollee information:

- a. Name;
- b. Medicaid identification number;
- c. Address;
- d. Telephone number;
- e. Reason for requesting disenrollment;
- f. Enrollee signature (for voluntary request);
- g. Date;
- h. Acknowledgment signature by plan staff; and

- i. An indication as to whether or not the enrollee wishes to file a grievance (defined on the form as a “formal complaint”).

2.14 Outreach Requirements

At a minimum, the contractor shall have an outreach plan that is designed to encourage members to seek mental health care assistance with the plan when assistance is perceived to be needed. In addition, the outreach plan shall provide for the following:

- A. The distribution of an approved member handbook within thirty (30) days of enrollment, as indicated in Section 2.12 B.5. The contractor will be required to have alternative language versions of the handbook in counties where five (5) percent or more of the population speak languages other than English. The member services handbook shall meet the requirements listed in Section 2.12 B.5.d.
- B. The contractor will provide outreach mailings to remind enrollees why, where, and how to seek mental health services and indicate Medicaid recipients may not be offered material incentives, other than benefits expressed in the contract, to enroll or to remain enrolled.
- C. Outreach communications that are written at the fourth grade reading level.
- D. Outreach communications that are written in a language(s) spoken by the enrollee.
- E. The contractor shall develop and implement a program designed to assist MediPass physicians in identification and management of clinical depression.

The agency expects the development, implementation and management of outreach strategies that are well planned, tailored to meet the needs of the plan and the area to be served. The agency expects that the contractor will develop outreach proposals, which at a minimum will include efforts to coordinate with MediPass primary care providers, other local government agencies, and community groups and organizations. The contractor will target their outreach activities toward high-risk members who have special needs in the areas of family abuse and dual diagnoses. The contractor will establish outreach sites at the Department of Children and Families service units and any contracted community based care programs to serve and meet the needs of children in the care and custody of the State of Florida.

Outreach plan reporting requirements are specified in Section 2.29.

2.15 Complaint and Grievance Resolution Requirements

Every provider must have complaint and grievance procedures available to its members and providers or subcontractors for addressing complaints and grievances. The contractor shall develop and implement grievance procedures subject to agency written approval prior to implementation. Definitions of a complaint, grievance, and urgent grievance are specified in Section 641.47, F.S. and are included in Section 1.1 of this document. The grievance procedures shall be governed by Section 641.511, F.S. and the following rules and guidelines:

- A. There must be sufficient support staff (clerical and professional) available at each service site to process grievances within the required time frames, and to assist complainants in properly filing grievances.

- B. Staff must be educated concerning the importance of the procedure and the rights of the complainant.
- C. Someone with problem solving authority must be part of the complaint and grievance process. This shall be clearly identified in policy and communicated to enrolled members and providers. This person should be accessible to members and providers, and information shall be given to all members and providers about how to contact the person.
- D. The contractor shall have a grievance coordinator responsible for the overall grievance process. The grievance coordinator shall be responsible for communication between the providers, enrollees, and agency representatives.
- E. The names, telephone numbers and addresses of the grievance coordinator and the area Medicaid personnel responsible for client advocacy shall be posted at all service sites.
- F. Both informal and formal steps shall be available to resolve complaints and grievances. The intent of a complaint and grievance system is to responsibly triage and address member and provider complaints in a timely manner before they become formal grievances, and to ensure that clients have access to appropriate services when they are needed. Complaints can be received verbally, over the telephone, or by other such informal means. A complaint is not considered to be a grievance until the complaint is written and received by the provider or plan.
- G. The contractor must have a procedure for providing individuals who are unable to submit a written grievance with access to the grievance process. The procedure shall include assistance by the contractor in preparing the grievance and communicating back to the plan enrollee.
- H. Grievance information, filing instructions, and responses shall be communicated in a language spoken by the member. Grievance forms in English and any required alternative language shall be available at each site.
- I. Procedural steps shall be clearly specified in the member handbook, including name, address, telephone number and office hours of the grievance coordinator and of the area Medicaid personnel responsible for client advocacy. Additionally, the handbook shall include information about member rights related to requesting a formal hearing through the department's appeal process.
- J. Upon request, the complainant shall be provided with a grievance form(s). All complainants shall have the right to assistance from service providers and/or from a source of the complainant's choice during the grievance process. If requested, or if it is determined that there is a need, the contractor shall provide the complainant with assistance in completing the form.
- K. Upon receipt of the grievance, the contractor shall acknowledge to the member or provider, in writing, that the complaint has been received, and shall also indicate the expected time frame for processing.

- L. Grievances shall be resolved within a reasonable length of time, not to exceed thirty days from initial filing by the member or provider, unless information must be collected from providers located outside the authorized service area or from non-contract providers. In such exceptions, an additional thirty-day extension is authorized. In cases that require more time, the AHCA contract manager or designee shall be notified of the circumstances necessitating an extension.
- M. The contractor shall provide the complainant with written notice of the right to appeal upon completion of the full grievance process and supply the agency with a copy of the final decision letter. In addition, for expedited grievances, the contractor shall provide the complainant written notice of the right to appeal immediately upon request. The grievance procedure shall also state that at any time, regardless of whether a grievance has been filed or the status of any filed grievance, the complainant retains the right to pursue a Medicaid fair hearing as provided by Rule 65-2.042, F.A.C., in addition to pursuing the provider's grievance procedure.
- N. The contractor shall inform the member or provider in writing of the grievance resolution. The letter detailing the resolution shall be individualized and address all items related to the grievance.
- O. The contractor shall maintain a log of all grievances filed by members or providers in the program.
- P. The contractor shall not permit the filing of a grievance by a member to adversely affect the quantity or quality of medically necessary services provided to that member. The contractor shall document all efforts to assure that providers remain in compliance with this requirement.
- Q. The contractor shall implement a procedure for establishing methods for classifying grievances as urgent and for establishing time limits for an expedited review within which such grievances must be resolved. Procedures shall address how an expedited review of an urgent grievance will occur.
- R. The contractor shall inform the agency on a monthly basis, or as requested by the agency, of each grievance that it has received and its status. Refer to Section 2.28 for reporting requirements.
- S. The contractor shall maintain a record of informal complaints received, which are not grievances. This record shall include the date, the member's or provider's name, and the nature of the complaint and its disposition. When written documentation is sent to members or providers related to the disposition of an informal complaint, the letter shall be individualized, addressing specifically the issues presented by the enrollee. The use of form letters is prohibited.
- T. If the contractor cannot resolve the grievance to the member or provider's satisfaction, the member, provider, or the contractor may appeal to Medicaid for grievance resolution. Medicaid will review the grievance record, gather additional information as necessary, provide the member or provider and the plan an opportunity to restate their positions, and resolve the grievance within thirty days of receipt of the request for Medicaid involvement. Medicaid's decision shall be binding on all parties.

- U. Members and providers have the right to request a fair hearing from the Department of Children and Families at any time during the complaint or grievance process. The contractor shall inform the members and providers of this right, provide written information about how to use this process, and inform them that they may contact the Department of Children and Families at the following address to pursue a fair hearing: Office of Public Assistance Appeals Hearings, 1317 Winewood Boulevard, Building 5, Room 203, Tallahassee, Florida, 32399-0700.

2.16 Quality Improvement Requirements

- A. The contractor must have a quality improvement system in place to monitor and assure that services are available and provided in sufficient quantity, of acceptable quality, within the established standards of excellence, and appropriate for meeting the needs of the enrolled population. The system must also address quality improvement methods for assessment of the quality of care provided and available, identification of quality indicators, and development of quality improvement initiatives. The contractor shall develop and have in place clinical care criteria related to best practices for all major diagnoses and treatment modalities. These clinical care criteria shall be made available to all providers, AHCA contract managers, and consumers.

The plan must have a senior level staff person responsible for the following quality improvement activities:

1. Direct and review all quality improvement activities. Provide ongoing quality improvement staff development opportunities for providers;
2. Assure that quality improvement activities take place in all areas of the plan, including all subcontracted areas. The contractor shall provide providers with quality improvement guidelines and requirements related to monitoring for compliance with the guidelines;
3. Review and suggest new or revised improvement activities. The contractor shall include providers and consumer advocates in the development of quality improvement initiatives and implementation of new or revised activities;
4. Direct task forces/committees in the review of focused concerns (which shall include, at a minimum, special populations such as child protection members, management systems, levels of care, and utilization and under-utilization of clinical services);
5. Designate evaluation and study design procedures. The contractor shall identify clinical outcome measurements for the evaluation of provider performance;
6. Implement a utilization review and management protocol. Predictors or “triggers” to identify potential high risk or problematic cases that will require frequent utilization reviews shall be developed and a review process implemented. The contractor shall address the treatment issues related to identified cases and assure that appropriate services are provided to decrease the occurrences of trigger events and improve clinical outcomes;

7. Publicize findings related to clinical outcome measures to appropriate staff and departments within the plan;
 8. Report findings, outcomes, and recommendations related to clinical outcome measures and the utilization review and management protocol to the appropriate executive authority;
 9. Direct and analyze periodic reviews of the enrollees' service utilization patterns. Develop reports that incorporate the results of these reviews with established clinical guidelines. Include significant findings and recommendations for quality improvement or utilization management initiatives related to the findings;
 10. Report action plans. Prepare a quarterly quality improvement report that includes the results of all quality improvement activities, utilization management reviews, and service utilization patterns, with clinical outcomes and the status of current or proposed initiatives. This report will be submitted to the agency contract manager or designee as indicated in Section 2.29;
 11. Implement improvement activities; and
 12. Report outcomes as required in Section 2.29.
- B. The contractor shall submit to the agency a quality improvement plan that addresses the following:
1. Details how the contractor will meet contract requirements related to quality assessment and performance improvement standards;
 2. Mechanism for collecting and assessing clinical data;
 3. Standards used to measure performance; and
 4. Methods for identifying and addressing quality indicators related to clinical concerns, delivery system issues, and member services issues.
- C. The contractor shall assure that providers within the plan's network have a peer review component and a peer review authority responsible for the following scope of activities:
1. The review of the practice methods and patterns of individual mental health treatment professionals;
 2. The ability and responsibility to evaluate the appropriateness of care rendered by professionals;
 3. The authority to implement corrective action when deemed necessary;
 4. The development of policy recommendations to maintain or enhance the quality of care provided to plan participants;
 5. The development and maintenance of a review process which includes the appropriateness of diagnosis and subsequent treatment, maintenance of clinical records requirements, adherence to standards generally accepted by

professional group peers, and the process and clinical outcomes of care. The peer review process shall be documented in a peer review manual and provided to all service providers and the agency;

6. The maintenance of written minutes of the meetings related to the peer review process. These minutes will be submitted as part of the quarterly reporting requirements detailed in Section 2.29;
7. The examination of morbidity and mortality;
8. The processing and review of all grievances related to clinical treatment and the reviewing of all written and/or oral allegations of inappropriate or aberrant service; and
9. The advisement of enrollees and staff of the role of the peer review authority and the process to advise the authority of situations or problems. Documentation of all activities related to presentations to enrollees and staff about the peer review process shall be kept by the contractor and made available during contract compliance monitoring.

D. Managed Care Advisory Group

There will be an advisory group for the plan that convenes quarterly and reports to the agency on advocacy and programmatic concerns. The local advisory group is responsible for providing technical and policy advice to the agency regarding the plan's provision of services. The local advisory group does not have access to enrollee clinical records.

The role of the local advisory group is to report to the agency, information related to practical and real events that occur related to the activities of the Area One Medicaid mental health managed care plans. Concerns about services, program changes, quality of care, difficulties, advocacy issues, and reports about positive outcomes are presented by members of the advisory group and are addressed by the agency as part of the ongoing monitoring of the PMHP and HMO contracts. The agency presents information about actions taken related to issues presented by the group. If the group determines that it is appropriate, the advisory group members also vote to present their issues to the agency in writing.

The group may request information to be presented at each meeting that will keep the group up-to-date regarding the contract and activities of each plan. Minutes of the meetings are kept and distributed to all members and attendees. The voting membership of the group is updated periodically. This is a public meeting and may be attended by anyone in the community.

The local advisory group is coordinated by agency area staff (who are not part of the voting membership) and consists of providers, consumer representatives, advocacy groups, and other relevant groups as identified by the agency, which represent the counties within the service area. Such relevant groups include the Agency's Medicaid Office, including MediPass representatives; ADM and Family Safety representatives from District One; representatives from any community based care providers contracted with the department; the Florida Drop-In Center Association; the Human Rights

Advocacy Committee; the Alliance for the Mentally Ill; the Florida Consumer Action Council; and the Alcohol, Drug Abuse and Mental Health Planning Council. In addition, the contractor provides representation to the local advisory group. The advisory group elects a chairperson and vice-chairperson from the voting membership, who facilitates the meetings and prepares any written correspondence on behalf of the group.

The contractor's responsibility related to the advisory group is as follows:

- ❖ Assure representation at all scheduled meetings;
- ❖ Provide information requested by advisory group members;
- ❖ Follow up on identified issues of concern related to the provision of services or administration of the plan; and
- ❖ Share pertinent information about quality improvement findings and outreach activities with the group.

2.17 Administrative Staff Requirements

The administrative staffing for the prepaid mental health plan developed under the RFP must be capable of fulfilling all contractual requirements. The minimum administrative staff requirements are as follows:

- A. An administrator (project director) specifically identified to administer the day-to-day business activities of the prepaid mental health plan;
- B. Sufficient support staff to conduct daily business in an orderly manner, as determined through management and medical reviews;
- C. A board certified or board eligible psychiatrist to serve as medical director to oversee and be responsible for the proper provision of covered services to members;
- D. A designated person, qualified by training and experience, to be responsible for the clinical record system;
- E. A minimum of one consumer representative whose primary job is to assist and educate consumers, guardians, and families. Consumer representation should adequately address the needs of both children and adults enrolled in the plan;
- F. A designated person, qualified by training and experience, to serve as marketing director, if the plan will have a marketing function;
- G. A designated person, qualified by training and experience, to serve as an enrollment/disenrollment manager;
- H. A designated person, qualified by training and experience, to serve as a grievance coordinator;
- I. A person trained and experienced in data processing to serve as the management information systems director and to provide required data and timely reports to the agency.

- J. A designated person, qualified by training and experience, to serve as a quality improvement coordinator; and
- K. A designated person, qualified by training and experience, to serve as a utilization management coordinator.

2.18 Substituting Key Personnel

In the event the successful contractor desires to substitute any key personnel submitted with the proposal, either permanently or temporarily, the agency shall reserve the right to approve or disapprove the desired personnel change in advance in writing.

2.19 Licensure of Staff

The contractor shall be responsible for assuring that all persons, whether they be employees, agents, subcontractors or anyone acting for or on behalf of the contractor, are properly licensed and/or credentialed as required under applicable state law and/or regulations and Medicaid policy for providing the services covered in the plan. The contractor shall maintain copies of current licenses and credentials in a centralized local administrative file. The contractor shall also submit proof of valid licenses in good standing for staff and subcontracted mental health care providers to the agency prior to contract implementation and upon entering into new contracts or subcontracts during the prepaid mental health plan contract period. (Specific staff credentials are listed in Attachment 24.)

2.20 Mental Health Planning Process

The contractor shall participate fully, as required by the District Administrators, in each Department of Children and Families district's alcohol, drug abuse and mental health planning process pursuant to Chapter 394.75, F.S., and Public Law 99-660, as amended by Public Law 102-321.

2.21 Enrollee Information

The agency, contracted fiscal agent, or choice counseling contractor shall:

- A. Verify eligibility for Medicaid of each proposed enrollee under the resulting contract on a monthly basis, in accordance with the Florida Medicaid State Plan.
- B. Distribute Medicaid identification cards.
- C. Provide information on the benefit choices available to Medicaid recipients.
- D. Provide the contractor with a monthly summary list of plan enrollees, by category of eligibility, on or about the first day of the month.
- E. Provide the contractor with a monthly report of all plan enrollees that will include each enrollee's name, Medicaid recipient number, address, birth date, gender, race, county, and eligibility category.
- F. Provide the contractor, at the contractor's expense, access to a direct on-line provider inquiry screen to enable the contractor to verify the enrollee's current eligibility,

identification number, date of birth, and county of residence subject to the contractor's compliance with federal requirements for access to such files.

2.22 Clinical Records Requirements

The contractor shall maintain clinical records for each member enrolled under this contract. The record shall include documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed under this contract. Each member's record must be legible and maintained in detail consistent with good clinical and professional practice, which facilitates effective internal and external peer review, medical audit, and adequate follow-up treatment. Identification of the physician or other service provider, the date of service, the units of service and type of service must be clearly evident for each service provided. The contractor shall assure that all providers serving recipients covered by the plan comply with established clinical record requirements.

2.23 Subcontracts

The contractor shall be responsible for the administration and management of all aspects of the contract and the prepaid mental health plan resulting from the RFP. This includes all aspects of network management, subcontracts, employees, agents and anyone acting for or on behalf of the contractor. The contractor may, with the consent of the agency, enter into written subcontract(s) for performance of certain of its functions under the contract. The contractor must have subcontracts with all administrative and service providers who are not salaried employees of the plan prior to the commencement of services under this contract. The contractor shall abide by the requirements of Section 1128A(b) of the Social Security Act, prohibiting HMOs and other such providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit services provided to Medicaid enrollees.

The contractor must submit signed subcontracts, for a complete provider network in order to obtain agency approval for operation in an area, within sixty (60) days of the execution of this contract, for each proposed subcontracted service provider. Any additional subcontracts must be submitted to the agency twenty days prior to the subcontract effective date. Subcontracts must be approved in writing by the agency's contract manager prior to the effective date of any subcontract.

No subcontract that the contractor enters into with respect to performance under the contract resulting from the RFP shall in any way relieve the contractor of any responsibility for performance of its duties. Amendments to subcontracts must be approved by the agency before taking effect. The contractor shall notify the agency twenty (20) days in advance in writing before termination of approved subcontracts. The contractor will also notify stakeholders (e.g. direct care organizational providers) in writing twenty (20) days in advance of any subcontractor changes.

The contractor will agree to make payment to all subcontractors within 35 days of receipt of all invoices properly documented and submitted by the subcontractor to the plan. For subcontractor invoices that are not properly documented and submitted to the plan, the contractor will be required to send a written response stating the improprieties within 35 days of receipt of an invoice.

All subcontracts executed by the contractor under the resulting contract must meet the following requirements and be approved by the agency in advance of implementation. All subcontracts must adhere to the following requirements:

- A. All subcontracts and agreements must be in writing;
- B. Specify the functions of the subcontractor;
- C. Identify the population covered by the subcontract;
- D. Specify the amount, duration and scope of services to be provided by the subcontractor, including a requirement that the subcontractor continue to provide services through any post-insolvency period;
- E. Provide that the agency and the Health Care Financing Administration (HCFA) may evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed;
- F. Specify that the subcontractor has read and agreed to the subcontract and the service provision requirements under Section 2 of this RFP, for services to be provided under the subcontract, and to the contractor's admission and retention criteria for the services the subcontractor will provide as indicated in the subcontractor's response;
- G. Provide for inspection by the agency and HCFA, any records pertinent to the contract;
- H. Specify procedures and criteria for extension and re-negotiation;
- I. Provide prompt submission of information needed to make payment;
- J. Require that an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to recipients under the contract;
- K. Require that financial, administrative and medical records be maintained for a period not less than five years from the close of the contract, and retained further if the records are under review or audit, until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the contractor if the subcontract is continuous;
- L. Require safeguarding of information about recipients as specified in 42 CFR, Part 431, Subpart F;
- M. Require an exculpatory clause, which survives the termination of the subcontract, including breach of subcontract due to insolvency, that assures that recipients or the agency may not be held liable for any debts of the subcontractor;
- N. Provide for monitoring of services rendered to recipients sponsored by the contractor;
- O. Specify the procedures, criteria and requirements for termination of the subcontract;
- P. Provide for the participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by the contractor;

- Q. Make full disclosure of the method and amount of compensation or other consideration to be received from the contractor;
- R. Provide for submission of all reports and clinical information required by the contractor;
- S. Make provisions for a waiver of terms of the subcontract, if appropriate;
- T. Contain no provision that provides incentive, monetary or otherwise, for the withholding of medically necessary care;
- U. Require adherence to the Medicaid policies expressed in the PMHP contract;
- V. Must contain no provision restricting a provider's ability to communicate;
- W. Specify that if the subcontractor delegates or subcontracts, delegation must include all requirements of the main contract;
- X. No co-payments or cost sharing for Medicaid enrollees;
- Y. Require that the subcontractor secure and maintain during the life of the subcontract, worker's compensation insurance for all of its employees connected with the work under this contract unless such employees are covered by the protection afforded by the provider. Such insurance shall comply with Florida's Worker's Compensation Law; and
- Z. Contain a clause indemnifying, defending and holding the agency and the plan members harmless from costs or expenses, including court costs and reasonable attorney fees to the extent caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency.

Upon request from a subcontractor, the contractor will be required to submit a monthly list of plan members to the subcontractor by an agreed upon date, so that the subcontractor has an accurate list of plan enrollees each month.

The contractor shall give the agency immediate notification in writing by certified mail of any action or suit filed, and prompt notice of any claim made against the contractor by any subcontractor or vendor, which in the opinion of the contractor may result in litigation related to the contract with the agency. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor or the insolvency of said subcontractor, the contractor shall immediately advise the agency. The contractor shall assure that all tasks related to the subcontract are performed in accordance with the terms of the contract. The contractor shall identify any aspect of service that may be further subcontracted by the subcontractor. Subcontractors shall not be considered agents of the agency.

2.24 Management Information System

The contractor shall perform the following management information systems functions:

- A. Maintain client service utilization and expenditure profiles, and current and historical data with beginning and ending dates.

- B. Conduct claims processing and payment for all subcontracted providers.
- C. Maintain data documenting service utilization by service (including procedure code), encounter or claim information, date of service per encounter/claim, recipient name, recipient Medicaid ID number, diagnosis, designated groups of recipients, and providers.
- D. Maintain data documenting management, administrative, and service costs under the contract to enable the provider to submit required cost reports referenced in Section 2.37 of this RFP.
- E. Maintain data sufficient to reconcile capitation payments at the end of each reconciliation period.
- F. Maintain data sufficient to document services authorized but not yet claimed by direct service providers and by enrollees.
- G. Maintain data sufficient to document denied services, which have been requested by a direct service provider and/or an enrollee but not authorized by the contractor.
- H. Maintain critical incident data.
- I. Maintain clinical and functional client outcome data.

2.25 General Reporting Requirements

The contractor shall be responsible for complying with all the reporting requirements established by the agency. The agency will provide the contractor with the appropriate reporting format, instructions, submission timetables and technical assistance when required. Standard reporting requirements and specifications are outlined in Attachment 8 of this proposal. For purposes of the RFP, quarters are defined as July through September, October through December, January through March, and April through June. Unless otherwise specified, reports due quarterly are due within 45 days of the end of the quarter being reported. The agency may require additional reports during the evaluation phase of the project.

In order to allow for consistent data collection in a method that will allow the agency to integrate data and information with the Department of Children and Families, the following requirement must be implemented as part of this contract:

The organizational providers and all subcontracted managed care organizations shall submit demographic, admission, discharge, enrollment, placement, service and performance data electronically and in a manner specified in the Mental Health and Substance Abuse Measures and Data Handbook, 3rd Edition. This handbook may be accessed through the On Line Resource Center on the Florida Department of Children and Families web site:
http://www.state.fl.us/cf_web/adm/

The contractor shall cooperate with the entity performing the independent evaluation of the prepaid mental health plan project and shall provide any required reports to enable that entity to effectively evaluate the program. Specific reporting requirements will be given to the contractor as they are developed.

The agency reserves the right to modify the reporting requirements to which the contractor must adhere. Failure of the contractor to submit required reports accurately and within the time frames specified may result in the withholding of one percent of the next regular capitation payment pending receipt of the reports by the agency.

2.26 Enrollment/Disenrollment-Related Reporting

The agency, through its fiscal agent, will provide an enrollment/disenrollment report to the contractor each month. In addition, each month the agency's fiscal agent shall provide to the contractor a Medicaid prepaid mental health plan disenrollment summary report.

Allocation of Recipients Report: The contractor shall submit monthly a report that details the total number of recipients, by eligibility category and separated by age group, assigned to each mental health care provider. The draft format for the report is specified in Attachment 9. This report shall include the following data:

- ❖ Total number of recipients, by age group, in each Medicaid eligibility category assigned to each provider (age groups are children under age 21, and adults age 21 and older);
- ❖ Total number of recipients, by age group, assigned to each provider;
- ❖ Percentage of total recipients in the plan assigned to each provider;
- ❖ Total number of recipients by age group enrolled in the plan.

Targeted Case Management Caseload Report: The contractor shall submit quarterly a report that details the status of targeted case management caseloads. The draft format for the report is specified in Attachment 10. This report shall include the following information:

- ❖ Number of FTEs providing targeted case management services at each provider;
- ❖ Number of recipients receiving targeted case management services at each provider during the quarter;
- ❖ Average caseload size for each FTE at each provider;
- ❖ Numbers will be separated by type of case management, i.e., children, adult, and intensive team case management.

2.27 Satisfaction Reporting

The contractor shall conduct and report results of consumer satisfaction surveys on a quarterly basis. The report must be submitted within forty-five (45) days following the end of the quarter being reported. The sampling for the survey shall be a statistically significant sample of each eligibility category represented for members having received services during the quarter reflected in the report. The contractor must submit the survey document to the agency for approval, and must receive the agency's approval for use, prior to administering the survey. The draft format for this report is specified in Attachment 11.

The satisfaction survey report shall minimally include the following information:

- ❖ A copy of the survey document;

- ❖ The number of recipients who completed the survey;
- ❖ The number of surveys distributed during the quarter;
- ❖ The method used to obtain completed surveys, (i.e., mail, phone, or face-to-face);
- ❖ The results, per item, of survey responses; and
- ❖ Any significant findings with resulting recommendations or plans related to the findings.

Additional information may be requested by the agency as results are reviewed.

Stakeholders Satisfaction Survey Report Summary:

The contractor shall submit to the agency quarterly a report that summarizes the results of a Satisfaction Survey conducted of relevant stakeholders affected by the plan. At a minimum the stakeholders surveyed shall include the Department of Children and Families Protective Service Counselors and Family Services Counselors, community based care program staff (if applicable to the district), identified consumer advocacy groups, foster parents of recipients enrolled in the plan, parents or guardians of children experiencing serious emotional disturbances, and out-of-plan providers. The contractor must submit the survey form to the agency for approval prior to implementation. The draft format for the summary report is included in Attachment 12.

The Survey Report Summary shall include the following information:

- ❖ Types of stakeholders surveyed;
- ❖ Number of surveys distributed to each group;
- ❖ Number of surveys completed in each group;
- ❖ Method used;
- ❖ Summary of responses;
- ❖ Significant findings or results that will be addressed.

2.28 Grievance Reporting

The contractor shall submit grievance reports listing all current grievances and the status of each grievance on a monthly basis. The draft format for the report is specified in Attachment 13. A summary report for the month shall include the number of grievances received by type of grievance in the following categories:

- ❖ Access to care
- ❖ Clinical care (specify if provider or type of service related)
- ❖ Service provision (quality, quantity, or timeliness)
- ❖ Claims

❖ Benefit plan

A narrative report for each grievance shall be submitted monthly. This report will include the recipient's Medicaid ID number, the name of the provider, the date the grievance was filed, the date the grievance was resolved, a narrative description of the grievance including the source and circumstances, and a narrative description of actions taken and the resolution.

If the grievance was not resolved within the required timeframe, an explanation must be included in the report.

2.29 Quality Improvement Reporting

The contractor shall submit, on a quarterly basis, a summary of the plan's quality improvement activities and findings for that quarter, as well as a summary on the status of any unresolved prior quarter issues.

This report will include at least the following:

- ❖ Copies of quality improvement meeting minutes;
- ❖ Any new policies, procedures, or clinical guidelines developed during the quarter, and any changes to existing policies, procedures, or clinical guidelines;
- ❖ Results of clinical record reviews that are part of the required peer review process;
- ❖ Corrective action plans developed or implemented as the result of complaints/grievances, critical incidents, or quality improvement activities;
- ❖ Additional quality improvement initiatives that are active during the quarter.

The contractor shall submit, as part of the quality improvement report, a quarterly report that contains follow-up information about children placed in residential treatment. The report shall include the following information:

- ❖ The number of plan enrollees placed in residential treatment during the quarter;
- ❖ A list of monitoring activities completed during the quarter related to the above children as required in Sections 2.4 D., 2.4 E., and Sections 2.8 J. and K.

Outreach Plan Reporting Requirements:

The contractor shall submit quarterly outreach reports that contain the following information:

- ❖ Specific outreach activities completed during the quarter that addressed the needs of targeted high-risk members, specifically children in the care and custody of the state, children experiencing serious emotional disturbances, members with dual diagnoses, and the homeless and forensic populations;
- ❖ Reports must specify which populations were targeted, what needs were addressed, the participants in the activities, and any feedback received as a result of the outreach efforts;

- ❖ Reports should include the contractor's evaluation of the outreach effort, including significant findings, implications for the plan, and recommendations or plans for future outreach activities related to each population;
- ❖ Outreach reports shall include the status and activities related to the development of outreach sites at the Department of Children and Families service units and community based care programs;
- ❖ Outreach reports shall include information about a program designed to assist MediPass physicians in identification and management of clinical depression;
- ❖ Reports shall include any significant information about outreach activities completed that describe how requirements in Section 2.14 are met.

2.30 Service Utilization Reporting

The contractor shall report summary service utilization data on a quarterly basis, by eligibility group (see Section 2.11 A.), for all services provided directly by the plan. The draft format for the report is specified in Attachment 14. This summary report shall be submitted in a spreadsheet format with the following information included:

- ❖ Types of services to be reported are:
 - ◆ Inpatient hospital,
 - ◆ Outpatient hospital (emergency room services),
 - ◆ Medical psychiatric interventions,
 - ◆ Targeted case management for adults,
 - ◆ Targeted case management for children,
 - ◆ Intensive team case management,
 - ◆ Community mental health:
 - Evaluation and testing,
 - Counseling/therapy services,
 - Rehabilitative services,
 - Intensive Therapeutic On-Site Services,
 - Home and Community-Based Rehabilitative Services, and
 - Day Treatment services
 - ◆ Community treatment for enrollees discharged from state hospitals,
 - ◆ Community services for enrollees involved with the forensic and corrections systems,
 - ◆ Services for enrollees with medically complex psychiatric conditions,
 - ◆ Court ordered mental health assessments,
 - ◆ Psychiatric evaluations for enrollees applying for nursing home admission,
 - ◆ Opportunities for recovery and reintegration, and
 - ◆ Optional services:
 - List all additional services available and provided
- ❖ Number of units of each type of service provided; and
- ❖ Number of recipients receiving each type of service by Medicaid eligibility category.

The contractor must also submit a report detailing service utilization data, diagnoses and procedure codes for both the primary contractor's services and for services purchased through

referral and subcontract providers, for all of those services invoiced to the primary contractor during the quarter. Quarterly service utilization data must be received no later than 45 days after the end of the quarter or one percent of subsequent months' payments may be withheld pending receipt of the data. Attachment 15 indicates the services that must be reported on the detailed service utilization report and draft instructions for submission.

The detailed report shall be submitted in a spreadsheet format (i.e., Excel, etc.) with the following information included:

- ❖ Recipient Medicaid ID number;
- ❖ Recipient age;
- ❖ Service code of each service provided;
- ❖ Number of units of each service provided;
- ❖ Diagnosis code for which services were provided;
- ❖ Provider of service;
- ❖ Recipient's Medicaid eligibility group.

Recipients Served Report: The contractor shall submit a report monthly that summarizes the number of recipients receiving services. This report shall include the total number of recipients served, by provider. The draft format for this report is specified in Attachment 16. The following information shall be included:

- ❖ Name of provider;
- ❖ Total number of recipients served;
- ❖ Total number of recipients assigned;
- ❖ Penetration rate;
- ❖ Contractor overall totals of numbers and penetration rate.

2.31 Polypharmacy Data

The contractor shall report quarterly to the agency, in a format negotiated with the District One ADM Program Office and AHCA, information related to pharmacy usage by plan enrollees and the contractor's participation in the district's pharmacy algorithm project.

Quarterly, the contractor shall submit a report that details how protocol for coordinating care between multiple providers who are identified as prescribing drugs to plan enrollees is being used to address the treatment needs of the plan enrollees. Specifically, the requirements listed in Section 2.8F, G, and H. must be addressed and included in a quarterly report to the agency.

2.32 Hospital Inpatient Data

The contractor shall submit two reports to the agency, in a format prescribed by the agency, which reflect an accurate count of hospital inpatient mental health care days for all members. A draft of the format for these reports is provided as Attachment 17. One report is a monthly summary of units of service authorized and one is a quarterly detail report of units authorized versus units of service provided.

If crisis stabilization unit services are used as a downward substitution for hospital inpatient services, this data shall be submitted on these reports as well. The reports shall include the following information:

- ❖ Recipient Medicaid ID #;
- ❖ Number of units (days) authorized;
- ❖ Number of units (days) provided;
- ❖ Provider's name;
- ❖ Type of facility;
- ❖ For recipients who have more than one admission during the month, the admissions shall be listed separately; and
- ❖ When the number of units authorized and the number provided are not equal, a narrative describing the situation or reason shall be included as part of the report.

2.33 Staff Reporting

The contractor shall submit contracted and subcontracted staffing information by position, name, and FTE for all direct service positions on a quarterly basis. This report must be received by the agency no later than 45 days after the end of the quarter being reported. A draft of this report is provided as Attachment 18.

This report shall demonstrate that all required areas of expertise or experience required in Section 2.5 B. are satisfied. In instances where the contractor satisfies a required specialty provider through separate contracts, these individual contracted providers shall be included on a separate staffing report.

2.34 Certified and Non-Certified Minority Owned Business Reporting

The agency requires information regarding the successful proposer's use of certified and non-certified minority owned businesses as sub-contractors under the contract resulting from this RFP. This information will be used for assessment and evaluation of the agency's Minority Business Utilization Plan. During the term of this contract, it will be necessary to provide this information to the agency contract manager monthly by the 15th of each subsequent month. A minority owned business is defined as any business enterprise owned and operated by the following ethnic groups: African American (Code N), Hispanic American (Code O), Asian American (Code P), Native American (Code Q), or American Woman (Code R).

The provider is required to provide the following information on company letterhead:

- ❖ Minority subcontractor's company name and minority code (See above);
- ❖ Services subcontracted related to this contract;
- ❖ Dates of services (beginning and ending);
- ❖ Total dollar amount paid to subcontractor for services related to this contract; or
- ❖ A statement that no minority subcontractors were used during this period.

2.35 Critical Incident Reporting

For providers under contract with the Department of Children and Families, the State of Florida operating procedures for incident reporting and client risk protection (CF Operating Procedure No. 215-6, November 1, 1998) establishes departmental procedures and guidelines for reporting information related to the incidents specified in this section.

The reporting requirements in this section do not replace the abuse, neglect and exploitation reporting system established by the state. Allegations of abuse, neglect or exploitation must always be reported immediately to the Florida Abuse Hotline and appropriate district human rights advocacy committee as required by law.

The following definitions of reportable incidents apply specifically to the contractor, providers, and any subcontractors providing services to recipients under the plan.

- A. The contractor must report immediately, to the agency, the following events if such occur:
1. Death of a recipient due to one of the following:
 - ❖ Suicide;
 - ❖ Homicide;
 - ❖ Abuse or neglect; or
 - ❖ An accident or other incident that occurs while the recipient is in a facility operated or contracted by the plan or in an acute care facility.
 2. Recipient Injury or Illness – A medical condition of a recipient that requires medical treatment by a licensed health care professional and which was sustained or allegedly sustained due to an accident, act of abuse, neglect or other incident occurring while the recipient is in a facility operated or contracted by the department or while the recipient is in an acute care facility.
 3. Sexual Battery – An allegation of sexual battery by a recipient on a recipient, employee on a recipient, or a recipient on an employee as determined by medical evidence or law enforcement involvement.
- B. Additionally, the contractor shall immediately report to the agency if one of the following events occurs:
1. Medication errors in an acute care setting; and

2. Medication errors involving children in residential treatment, Specialized Therapeutic Foster Care, or children in the care or custody of the department.
- C. The contractor must report monthly to the agency, the following events if such occur:
1. Recipient Suicide Attempt – An act which clearly reflects the physical attempt by a recipient to cause his or her own death which results in bodily injury requiring medical treatment by a licensed health care professional.
 2. Altercations Requiring Medical Intervention - A physical confrontation occurring between a recipient and provider employee or two or more recipients at the time services are being rendered, or when a recipient is in a residential or acute care facility and the confrontation results in one or more recipients or employees receiving medical treatment by a licensed health care professional.
 3. Recipient Escape – The unauthorized absence as defined by statute, departmental operating procedure or manual of a recipient committed to, or securely detained in, a Department of Children and Families mental health or developmental services facility covered by Chapters 393, 394, or 916, F.S.
 4. Recipient Elopement – The unauthorized absence beyond eight hours, or other time frames as defined by a specific program operating procedure or manual, of a child or adult who is in a residential treatment or group care facility. [This does not include foster homes.]
 5. Other Incident – An unusual occurrence or circumstance initiated by something other than natural causes, or out of the ordinary such as a tornado, kidnapping, riot, or hostage situation, which jeopardizes the health, safety, and welfare of recipients receiving services under this contract.

Critical incident summary reporting to the agency must be completed in a monthly format. A draft format for this report is included in Attachment 19. Additionally, those critical incidents that require immediate notification to the agency must be completed in the format specified in Attachment 20.

2.36 Accounting Requirements

The contractor shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in the resulting contract and any other costs and expenditures made under the contract. The contractor's accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the contract period and for five years thereafter.

2.37 Financial Reporting

- A. The contractor is required to provide cost reports to the agency semi-annually. The contractor's cost report will list the actual administrative and service costs for both mandatory services and any optional services. The contractor will provide staffing position information and utilization information on the cost reports. Cost reports must be received by the agency no later than 45 days after the end of the period being reported.

If the cost report is not received within this time frame, the agency may withhold one percent of the subsequent month's capitation payment pending receipt of the data. Any amendments to the cost reports must be received by the filing date of the next subsequent cost report.

- B. The contractor shall submit to the agency annual audited financial statements, which summarize the contractor's financial activities under this contract for the contract period. These statements should be received by the agency no later than six calendar months after the end of the contractor's fiscal year.
1. These statements must be prepared or audited by an independent Certified Public Accountant on the accrual basis of accounting in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA). Audits performed to meet the requirements of OMB Circular 128 satisfy this requirement.
 2. For government owned and operated facilities operating on a cash method of accounting, data based on such a method of accounting will be acceptable. The CPA preparing the financial statements must sign statements as the preparer or auditor and in a separate letter state the scope of his work and opinion in conformity with generally accepted auditing standards and AICPA statements on auditing standards.
 3. In addition, the contractor shall submit to the agency the following unaudited quarterly financial statements:
 - (a) Balance Sheet,
 - (b) Statement of Revenues and Expenses,
 - (c) Statement of Changes in Financial Position and Net Worth, and
 - (d) Statement of solvency for continued operation of the prepaid mental health plan contract.

These statements shall be due 45 days after the end of each quarter in a contractor's fiscal year or one percent of subsequent months' payments may be withheld pending receipt of the data.

2.38 Availability of Records

The contractor shall make all records available at the contractor's expense for review, audit, or evaluation by authorized federal and agency personnel. The contractor subject to agency approval will determine the location. Access will be during normal business hours and will be either through on-site review of records or through the mail. All records, including medical records, will be sent to the agency by mail within seven working days of request at no expense to the agency. It is the contractor's responsibility to obtain sufficient authority, as provided for by applicable statute or requirement, to provide for the release of any patient specific information or records requested by the agency.

2.39 Audit Requirements

The contractor shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses of the contract as well as medical information relating to the individual recipients for the purposes of audit requirements. These records, books, documents, etc., shall be available for review by authorized federal and departmental personnel during the contract period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.

During the contract period these records shall be available at the contractor's office at all reasonable times. After the contract period and for five years following, the records shall be available at the contractor's chosen location subject to the approval of the agency. If the records need to be sent to the agency, the contractor shall bear the expense of delivery. Prior approval of the disposition of contractor and subcontractor records must be requested and approved by the agency if the contract or subcontract is continuous.

2.40 Independent Audit

The contractor shall comply with 45 CFR, Part 74, with respect to audit requirements of federal contracts administered through state and local public agencies. In these instances, audit responsibilities have been delegated to the State and are subject to the ongoing audit requirements of the State of Florida and of the agency.

2.41 Accessibility for Monitoring

The contractor shall make available to the agency and authorized federal personnel, all records, books, documents, and other evidence pertaining to the contract, as well as appropriate personnel, for the purpose of monitoring under this contract. The monitoring shall occur periodically during the contract period.

2.42 Monitoring

Upon awarding the contract, the agency shall periodically monitor the operation of the contractor for compliance with the provisions of the contract and applicable federal and state laws and regulations. Such monitoring activities shall include, but are not limited to, inspection of contractor's facilities; review of staffing patterns and ratios; audit and/or review of all records developed under this contract, including clinical and financial records; review of management information systems and procedures developed under the contract; desk audits of information and outreach provided by the plan; and review of any other areas or materials relevant to or pertaining to the contract. The agency shall prepare a report of its findings and recommendations and require the contractor to develop corrective action plans as appropriate.

A. Quality of Care Monitoring

The goals of the agency's quality of care monitoring for the prepaid mental health plan contract include:

- ❖ Promote the quality, effectiveness, and efficiency of services to recipients by supporting and strengthening the providers, consumer advocates, and others committed to improving quality of care;
- ❖ Monitor and improve the quality and utilization of care provided within the plan;

- ❖ Keep providers updated in a timely manner of changes to the review process or changes and/or additions to Medicaid policy; and
- ❖ Educate providers about Medicaid policy regarding utilization review, medical necessity, clinical criteria, quality of care, and practice guidelines.

Monitoring of Quality of Care will minimally include the following:

1. **Retrospective medical record review** of all providers contracted in the plan. The agency will designate a PMHP Quality Review Manager to conduct medical record audits of each plan provider at least once each fiscal year to ensure that quality and accessible mental health care are being provided to enrolled recipients.

The selection process for medical records will be done through review of the Service Utilization Report, Inpatient Report, Critical Incidents and Complaints/Grievance Reports. Records may also be chosen based on trends or patterns identified through review of these reports.

Notification of quality of care review audits will be submitted directly to the contractor. The contractor shall identify settings and service dates for all care rendered during the designated period of review for each recipient selected. The contractor shall assure that all supporting documentation from providers is available for review during the Prepaid Mental Health Plan Quality Review Manager's audit. Specific medical record review guidelines will be provided by the agency to the contractor upon implementation of the contract.

2. **Administrative record review** related to the above medical records will be conducted during the quality of care monitoring. Copies of recipient-related information and documentation about enrollment, provider assignment, outreach materials sent to the recipients, authorization decisions, out-of-plan care, complaints or grievances received, and critical incidents reports shall be submitted for review to the agency. Review of these items will be completed and used in determining compliance with contract requirements.
3. **On-site visits to provider facilities:** The agency will conduct on-site visits to each provider in the contract at least once each fiscal year. This frequency may be increased as deemed necessary by the agency to sufficiently monitor all providers in the contract. Medical records, policies and procedures, and corrective action plans implemented as a result of quality of care monitoring activities may be reviewed. On-site visit protocol will be developed and provided by the agency to the contractor upon implementation of the contract.

Each of the above reviews conducted will be followed by a written report (from the agency) of the findings, along with any quality improvement items identified or corrective action plans required. Additional documentation requests may be necessary to clarify items related to contract compliance issues or quality of care items and the contractor shall submit requested items to the agency within the timeframes specified in each request.

The contractor is responsible for communicating and sharing review information with its providers. Any technical assistance needed from the agency will be

provided after the results of reviews are reported. A follow-up meeting with the contractor, providers, and agency will be conducted upon request from any of the parties involved.

4. **Additional Reports** required for quality of care monitoring:

The contractor shall submit quarterly reports that detail the following:

- ❖ Findings of quality improvement clinical record reviews;
- ❖ Clinical guidelines developed or revised;
- ❖ Updated or new policies and procedures; and
- ❖ Outreach activity reports that are pertinent to issues identified by each review.

B. **Contract Compliance Monitoring:**

The agency shall be responsible for the management of the contract. The agency will conduct, periodically, audits of the contractor for assessment of compliance with contract requirements. The agency will monitor the contractor on the quality, appropriateness, and timeliness of services provided under the contract. The agency will inspect any records, papers, documents, facilities, and services, which are relevant to the contract. The contractor will provide reports as specified in Attachment 8, which will be used to monitor the performance of the contractual services. Minimally, the following items will be reviewed:

- ❖ Documentation that shows compliance with required access standards for provision of services;
- ❖ Logs required to be maintained in Section 2.4E. related to requests for services to children;
- ❖ Documentation that shows the number of mental health assessments, court ordered evaluations, court mandated parental mental health assessments, psychiatric evaluations for admission to nursing facilities, mental health assessments completed for enrollees involved in the forensic or corrections systems, and pre-booking and post-booking site activities;
- ❖ Documentation that shows activities and efforts to assist enrollees during the transition from one provider to another as required in Section 2.8 A. and 2.9 B.; and
- ❖ Policies and procedures related to quality improvement, management information systems, claims processing, complaints and grievances, critical incidents, and subcontracts.

2.43 Changes Resulting From Monitoring and Audit

Upon the agency's completion of any monitoring report or audit, the contractor shall address and resolve all areas of contract deficiencies found by the agency. A written plan to correct deficiencies and a time frame for completion (within 45 calendar days) must be submitted to the agency by the contractor within fifteen (15) working days after receipt of the notice of any

deficiencies. The agency may extend or reduce the time frame for corrective action where it is reasonable and advisable to do so. Contract deficiencies will be corrected to the agency's satisfaction within specified time frames, or one percent of the subsequent months' payments may be withheld, pending resolution of the contract deficiencies.

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3.0 TERMS, CONDITIONS, AND GENERAL INFORMATION

3.1 Procurement Rules

The agency has established certain requirements with respect to proposals to be submitted by proposers. The use of "shall", "must" or "will" (except to indicate simple futurity) in the RFP indicates a requirement or condition from which a material deviation may not be waived by the agency. A deviation is material if, in the agency's sole discretion, the deficient response is not in substantial accord with the RFP's requirements, provides an advantage to one proposer over other proposers, has a potentially significant effect on the quantity or quality of items proposed, or on the cost to the agency. Material deviations cannot be waived.

The words "should" or "may" in the Request for Proposals indicate desirable attributes or conditions, but are permissive in nature. Deviation from, or omission of, such a desirable feature, will not in itself cause rejection of a proposal.

3.2 Force Majeure

Neither party shall be liable for loss or damage suffered as a result of any delay or failure in performance under this Agreement or interruption of performance resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, war, riots, civil disturbances, insurrections, accidents, fire, explosions, earthquakes, floods, water, wind, lightning, strikes, labor disputes, shortages of suitable parts, materials, labor or transportation to the extent such events are beyond the reasonable control of the party claiming excuse from liability resulting there from.

3.3 Public Entity Crimes

A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, F.S., for category two for a period of 36 months from the date of being placed on the convicted vendor list.

3.4 Funding Source

The funding source for payment for services as a result of this proposal will be from state general revenue and federal financial participation (FFP). The FFP match rate beginning October 1, 2000 was 56.62 percent for services provided. The FFP match rate beginning October 1, 2001 will be 56.43 percent.

3.5 Type of Contract

This is a contract for capitated services. The agency, through its fiscal agent, shall pay the provider for the delivery of services provided in accordance with the terms of the contract and as specified in Section 3.6 of the RFP.

3.6 Payment

The contractor shall be obligated to provide services pursuant to the terms of the resulting contract for all enrollees. Responsibility for each enrollee begins with the first day of enrollment, including responsibility for enrollees currently under inpatient care. The agency or its appointed fiscal agent shall make payment to the contractor on a monthly basis for the contractor's satisfactory performance of its duties and responsibilities as described in this proposal once service provision begins. The agency shall pay the applicable capitation rate for each enrollee for each month. The rates to be paid under the resulting contract shall not exceed Medicaid's upper payment limit, which is that amount which would have been paid, on an aggregate basis, by Medicaid under fee-for-service for the same services to a demographically similar population of recipients. The agency will ensure this by setting the range of rates at which it will make payment at 92 percent of the upper payment limit.

Capitation rates will be age banded for the TANF population, OBRA children, foster care children, and the SSI without Medicare population. The capitation rate setting methodology and the capitation rates (the upper payment limit) applicable to each authorized eligibility group to be paid shall be based on actual monthly enrollment for each of the four eligibility categories as indicated in Attachment 1. The Medicaid eligibility categories making up these eligibility groups are indicated in Attachment 2.

3.7 Request for Payment

The monthly enrollment report created by the agency's fiscal agent for the contractor shall serve as a monthly request for payment. The payment amount will be the sum of capitation payments for the number of enrollees in each capitation category, at the specified rates. To accommodate these monthly payments, the contractor shall enroll as a Medicaid prepaid mental health plan provider prior to contract implementation. The agency shall provide necessary information to authorize the Medicaid fiscal agent to generate and process monthly invoices through electronic payment methods.

3.8 Payment in Full

The contractor shall accept the capitation payment received each month as payment in full by the agency for all services provided to enrollees covered under the plan and the administrative costs incurred by the contractor in providing or arranging for such services. Any and all costs incurred by the contractor in excess of the capitation payment will be borne in total by the contractor. There will be no additional payment to cover any "start up" or "phase down" costs to the contractor. The contractor shall be responsible for Social Security and income tax withholdings.

3.9 Return of Funds

The contractor shall agree to return to the agency any overpayments due or funds disallowed pursuant to the terms of the plan contract. Such funds shall be considered agency funds and shall be refunded to the agency. The refund shall be due within thirty (30) days after notification to the contractor by the agency unless otherwise authorized by the agency in writing.

3.10 Rate Adjustments

The capitation rates to be paid will be subject to approval by the federal government. Adjustments to funds to be paid may be required. Funds will be adjusted when the capitation rate revision is the result of legislatively mandated changes in Medicaid services or when capitation rate calculations are determined by the agency to have been in error. No time limit has been set for the discovery of errors. In such events, the contractor will be expected to refund any overpayment and the agency will pay any underpayment.

The agency may adjust the capitation rates annually (no later than July 1) for the upcoming state fiscal year, when the initial capitation payment is determined by the agency to be high or low when compared to more recent fee-for-service utilization data in a demographically similar area of the state.

The agency will also adjust capitation rates to reflect budgetary changes in the Medicaid fee-for-service program. The rate of payment and total dollar amount will be adjusted when Medicaid fee-for-service expenditure changes have been established through the appropriations process and subsequently identified in the agency's operating budget.

3.11 Contractor Risk and Medical Loss Ratio Requirements

Contractor Risk: The contractor shall bear the risk of the excess of allowable and reasonable actual costs over the agency's capitation payment.

Medical Loss Ratio: The contractor's medical loss ratio will be set in accordance with the requirements of the Florida Department of Insurance as outlined in 4-191.054, Florida Administrative Code. The contractor shall make an annual filing to the Department of Insurance as specified in this same section. No rate shall be deemed excessive if the loss ratio is greater than or equal to eighty (80) percent. If the contractor's loss ratio is determined to be less than eighty (80) percent, then the contractor will be required to return the difference to the agency.

3.12 Proposal Bond or Proposal Guarantee

Each proposal shall be accompanied by a proposal guarantee payable to the State of Florida in the amount of \$5,000. The form of the Proposal Guarantee shall be a bond, cashier's check, treasurer's check, bank draft, or certified check. If the proposal guarantee is a bond, the bond shall be written by a surety company authorized to do business in the State of Florida and signed by the Florida Licensed Resident Agent. The unsuccessful proposers' proposal guarantee shall be returned upon execution of a legal contract with the successful proposer. If the successful proposer fails to execute a contract within ten (10) consecutive calendar days after a contract has been presented to the proposer for signature, the proposal guarantee shall be forfeited to the State.

3.13 Insolvency Protection

The contractor shall establish a restricted insolvency protection account for the purpose of settlement of claims from non-contracted providers in the event of the plan's insolvency. The contractor shall deposit into that account five percent of the capitation payments made by the agency each month until a maximum total of one percent of the total current contract amount is reached.

The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the contractor and two representatives of the agency. In the event that a determination is made by the agency that the contractor is insolvent, the agency may draw upon the amount solely with the two authorized signatures of representatives of the agency and funds may be disbursed to meet financial obligations incurred by the contractor under this contract. The contractor shall provide a statement of account balance within 15 days of request of the agency. If the resulting contract is terminated, expired, or not continued, the account balance shall be released by the agency to the contractor upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

The agency may waive the insolvency protection account requirement for the contractor if a public entity agrees to fund any deficit within the plan's operating budget or if the plan's performance and obligations are guaranteed in writing by a guaranteeing organization that complies with all of the following:

- A. Has been in operation for five (5) years or more and has a surplus of the greater of \$5 million or two times the total insolvency protection amount required under this section, except if the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations;
- B. Submits a written guarantee acceptable to the agency which is irrevocable during the term of this contract except with written authorization of the agency;
- C. Initially submits its audited financial statements, covering its two most current annual accounting periods; and
- D. Submits annually, within six (6) months after the end of its fiscal year, an audited financial statement, and such quarterly financial statements as the agency may require.

The letter of agreement by a public entity or the written guarantee by a guaranteeing organization will not absolve the contractor from honoring payment of all financial obligations incurred by the contractor under this contract. The agency also may waive the insolvency protection account requirement when evidence of adequate insolvency insurance and reinsurance are on file with the agency which will protect enrollees in the event the plan is unable to meet its obligations.

3.14 Interest

Interest generated through investments made by the contractor of funds paid to the contractor under the resulting contract shall be the property of the contractor and shall be used at the contractor's discretion.

3.15 Surplus Fund Requirement

Florida Statute 409.912(4) requires that a privately funded plan must have a financial plan that provides for working capital in the form of cash or equivalent liquid assets, excluding Medicaid revenues, equal to at least the first three months of operating expenses or \$200,000, whichever is greater. The proposer must divulge in its financial plan the source of such funds. Documentation must be received by the agency prior to the execution of a contract.

Florida Statutes also require that the plan must maintain in surplus, at all times, in the form of cash, short-term investments allowable as admitted assets by the Department of Insurance, or restricted funds or deposits controlled by either the Agency for Health Care Administration or the Department of Insurance, an amount equal to one and a half times the contractor's most recent monthly capitation payment. Monies in an insolvency protection account can be included in the surplus amount.

The contractor will be allowed to utilize the Statutory Guarantee Option set forth in Florida Statute 409.912(14)(b) to satisfy the Surplus Fund Requirement under this section.

3.16 Third Party Resources

The contractor shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this contract. The contractor has the same rights to recovery of the full value of services as the agency (See Section 409.910, F.S.). The following standards govern recovery:

- A. If the contractor determines that third party liability exists for part or all of the services provided directly by the contractor to a member, the contractor shall make reasonable efforts to recover from third party liable sources the value of services rendered.
- B. If the contractor determines that third party liability exists for part or all of the services provided to a member by a subcontractor or referral provider, and the third party is reasonably expected to make payment within 120 calendar days, the contractor may pay the subcontractor or referral provider only the amount, if any, by which the subcontractor's allowable claim exceeds the amount of the anticipated third party payment; or, the contractor may assume full responsibility for third party collections for service provided through the subcontractor or referral provider.
- C. The contractor shall not withhold payment for services provided to a member if third party liability or the amount of liability cannot be determined or if payment will not be available within a reasonable time, beyond 120 calendar days from the date of receipt.
- D. When both the agency and the contractor have liens against the proceeds of a third party resource, the agency shall prorate the amount due to Medicaid to satisfy such liens under Section 409.910, F.S., between the agency and the contractor. This prorated amount shall satisfy both liens in full.
- E. The agency may, at its sole discretion, offer to provide third party recovery services to the contractor. If the contractor elects to authorize the agency to recover on its behalf, the contractor shall be required to provide the necessary data for recovery in the format prescribed by the agency. All recoveries, less the agency's cost to recover shall be income to the contractor. The cost to recover shall be expressed as a percentage of recoveries and shall be fixed at the time the contractor elects to authorize the agency to recover on its behalf.
- F. All funds recovered from third parties will be treated as income for the contractor.

3.17 Indemnification

The contractor shall be liable and agree to be liable for and shall indemnify, defend, and hold the State and agency and their officers, employees and agents harmless from all claims, suits, judgments or damages, including court costs and attorney fees, arising out of the contractor's negligence. The contractor shall hold the State and agency harmless from all subcontractor liabilities as well as enrollee liabilities under the terms of the contract.

The contractor shall hold all enrolled Medicaid recipients harmless from all claims, suits, judgments or damages including court costs and attorney fees arising out of or in the course of this contract. In no case will the State, agency and/or Medicaid recipients be liable for any debts of the contractor.

The contractor shall agree to indemnify, defend, and save harmless the agency, its officers, agents, and employees from:

- A. Any claims or losses attributable to a service rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract, regardless of whether the agency knew or should have known of such improper service, performance, materials or supplies;
- B. Any claims or losses attributable to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation, disregard of federal or state Medicaid regulations or statutes by the contractor, its officers, employees, or subcontractors in the performance of the contract, regardless of whether the agency knew or should have known of such erroneous or negligent acts;
- C. Any claims or losses attributed to any person or firm injured or damaged by the contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the contract in a manner not authorized by the contract or by federal or state regulations or statutes, regardless of whether the agency knew or should have know of such publication, translation, reproduction, delivery, performance, use or disposition; and
- D. Any failure of the contractor, its officers, employees, or subcontractors to observe Florida law, including but not limited to labor laws and minimum wage laws, regardless of whether the agency knew or should have know of such failure.

With respect to the rights of indemnification given herein, each party claiming indemnification shall agree to provide the other party with timely notice of any loss or claim and the opportunity to mitigate, defend and settle such loss or claim as a condition to indemnification.

Any contractor who is a state agency or subdivision, as defined in Section 768.28, Florida Statutes, shall agree to be fully responsible for its negligent acts or omissions or intentional tortuous acts which result in claims or suits against the agency, and shall agree to be liable for any damages proximately caused by said acts or omissions. Nothing herein is intended to serve as a waiver of sovereign immunity by any contractor to which sovereign immunity applies. Nothing herein shall be construed as consent by a state agency or subdivision of the State of Florida to be sued by third parties in any matter arising out of any contract. The contractor shall agree that it is an independent contractor of the agency and not an agent or employee.

3.18 Fidelity Bonds

The contractor shall secure and maintain during the life of the resulting contract, a blanket fidelity bond from a company doing business in the State of Florida on all personnel in their employment. The bond shall be issued in the amount of at least \$250,000 per occurrence. Said bond shall protect the agency from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of the contractor and subcontractors, if any. Proof of coverage must be submitted to the contracting office within sixty (60) calendar days after execution of the contract and prior to the delivery of mental health care.

3.19 Contractor's Insurance

The contractor shall not commence any work in connection with the contract until the contractor has obtained all of the following types of insurance and such insurance has been approved by the agency, nor shall the contractor allow any subcontractor to commence work on a subcontract until all similar insurance required of the subcontractor has been so obtained and approved. All insurance policies shall be with insurers qualified and doing business in Florida. If the contractor is a state agency or subdivision as defined by Section 768.28, Florida Statutes, the contractor shall furnish the agency, upon request, written verification of liability protection in accordance with Section 768.28, Florida Statutes. Nothing herein shall be construed to extend any party's liability beyond that provided in Section 768.28, Florida Statutes. Documentation of insurance described below must be received by the agency prior to the execution of a contract.

A. Worker's Compensation Insurance

The contractor shall secure and maintain during the life of the contract, Worker's Compensation Insurance for all employees connected with the contract and, in case any work is subcontracted, the contract shall require the subcontractor similarly to provide Workers' Compensation Insurance for all of the latter's employees unless such employees are covered by the protection afforded by the contractor. Such insurance shall comply fully with Florida's Workers' Compensation Law. In case any class of employees engaged in hazardous work under this contract is not protected under the Worker's Compensation statute, the contractor shall provide, or cause each subcontractor to provide, adequate insurance satisfactory to the agency for protection of his or her employees not otherwise protected. Proof of insurance (such as a certificate of insurance) shall be provided within fifteen (15) consecutive days after the execution of the contract (including amount of coverage, effective date, ending period, and policy number).

B. Contractor's Public Liability and Property Damage Insurance

The contractor shall take out and maintain during the life of this agreement Comprehensive General Liability and Comprehensive Automobile Liability Insurance that will protect the contractor from claims for damage for personal injury, including accidental death, as well as agreement whether such operations are by the contractor or by anyone directly or indirectly employed by the contractor, and the amount of such insurance shall be the minimum limits as follows:

1. Contractor's Comprehensive General Liability Coverage, Bodily Injury & Property Damage

\$100,000 Each Occurrence, Combined Single Limit

2. Automobile Liability Coverage, Bodily Injury & Property Damage

\$50,000 Each Occurrence, Combined Single Limit

Insuring clause for both bodily injury and property damage shall be amended to provide coverage on an occurrence basis

C. Contractor's Fire Insurance

The contractor shall maintain fire insurance in an amount sufficient to provide for repair or replacement of facilities and equipment essential to the performance of the contract.

D. Subcontractor's Public Liability and Property Damage Insurance

The contractor shall require each subcontractor to secure and maintain during the life of the subcontract, insurance of the type specified above or insure the activities of each subcontractor in the contractor's policy, as specified above.

E. Loss Deductible Clause

The agency shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy. The payment of such deductible shall be the sole responsibility of the contractor providing such insurance.

3.20 Performance Bond

The contractor shall furnish the agency with a performance bond equal to \$500,000 payable to the State of Florida, written by a surety company authorized to do business in the State of Florida and signed by a Florida Licensed Resident Agent. The bond shall be furnished to the agency within thirty (30) calendar days after execution of the contract and prior to commencement of any work under this contract. No payments shall be made to the contractor until the performance bond is in place and approved by the agency in writing. The performance bond shall remain in effect for the full term of the contract, including renewals.

The cost of the performance bond shall be borne by the contractor. The bond shall be accompanied by a duly authenticated or certified document, in duplicate, evidencing that the person executing the bond on behalf of the surety company is a licensed Florida agent for the bonding company. In the usual case, the conferring of that authority has occurred prior to the date of the bond, and the document showing the date of appointment and enumeration of powers of the person executing the bond is accompanied by a certification that the appointment and powers have not been revoked and remain in effect. The date of that certification shall be dated the same as the bond.

3.21 Contractual Agreement

A proposer's proposal in response to the RFP shall be considered as the proposer's formal offer. When the contract is established between the agency and contractor for specific services, the contract between the state and the contractor shall consist of (1) the State's standard

contract; (2) the RFP and any addenda thereto; (3) the contractor's proposal submitted in response to the RFP; and (4) the RFP questions and answers. If there is a conflict in language, the provisions and requirements set forth and/or referenced in the agency's RFP shall govern. In the event that an issue is addressed in one document that is not addressed in another document or documents, no conflict in language shall be deemed to occur due to lack of reference.

3.22 Contract Variations

If any provision of the contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the agency and the contractor shall be relieved of all obligations arising under such provision. If the remainder of the contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed.

3.23 Period of Contract

The agency anticipates that the contract period will begin on October 1, 2001, with the provision of services to begin on October 1, 2001. The agency further anticipates that the contract will terminate on September 30, 2004, for a total contract term of 36 months.

This contract may be renewed on a yearly basis for no more than three (3) years beyond the initial contract (or for a period no longer than the term of the original contract, whichever is longer). Such renewals shall be made by mutual agreement and shall be contingent upon satisfactory fiscal and programmatic performance evaluations as determined by the agency, and shall be subject to the availability of funds. Each renewal shall be confirmed in writing and shall be subject to the same terms and conditions set forth in the initial contract. The capitation rates payable under the contract may be recomputed annually.

3.24 Confidentiality of Information

The contractor shall treat all information, and in particular information relating to recipients, which is obtained by or through its performance under the contract, as confidential information to the extent confidential treatment is provided under state and federal laws. The contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the contract.

All information as to personal facts and circumstances concerning recipients obtained by the contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the agency or the recipient, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning recipients will be limited to purposes directly connected with the administration of the resulting contract.

Upon the signing of the resulting contract by all parties, the terms of the contract shall become available to the public, pursuant to provisions of Chapter 119, Florida Statutes. The contractor shall agree to allow public access to all documents, papers, letters or other materials subject to the provisions of Chapter 119, Florida Statutes, which are made or received by the contractor in conjunction with this contract. It is expressly understood that substantial evidence of the contractor's refusal to comply with this provision shall constitute a breach of contract.

3.25 Sponsorship Statement

Pursuant to Section 286.25, Florida Statutes, all non-governmental contractors must assure that all notices, information pamphlets, press releases, advertisements, descriptions of the sponsorship of the program, research reports, and similar public notices prepared and released by the contractor shall include the statement: "Sponsored by (Name of Contractor) and the State of Florida, Agency for Health Care Administration." If the sponsorship reference is in written material, the words, "State of Florida, Agency for Health Care Administration" shall appear in the same size letters or type as the name of the organization.

3.26 Patents and Royalties

The proposer, without exception, shall indemnify and save harmless the agency and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unpatented invention, process, or article manufactured or supplied by the proposer. The proposer has no liability when such claim is solely and exclusively due to the combination, operation or use of any article supplied hereunder with equipment or data not supplied by contractor or is based solely and exclusively upon the agency's alteration of the article. The agency will provide prompt written notification of a claim of copyright or patent infringement and will afford the proposer full opportunity to defend the action and control the defense.

Further, if such a claim is made or is pending, the contractor may, at its option and expense procure for the agency the right to continue use of, replace or modify the article to render it non-infringing (if none of the alternatives are reasonably available the agency agrees to return the article on request to the contractor and receive reimbursement, if any, as may be determined by a court of competent jurisdiction). If the proposer uses any design, device, or materials covered by letter, patent or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or costs arising from the use of such design, device or materials in any way involved in the work.

3.27 Copyrights and Right to Data

Where activities supported by the contract(s) resulting from this procurement produce original writing, sound recordings, pictorial reproductions, drawings or other graphic representation and works of any similar nature, the agency has the right to use, duplicate and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others acting on behalf of the agency to do so. If the materials so developed are subject to copyright, trademark, or patent, legal title and every right, interest, claim, or demand of any kind in and to any patent, trademark or copyright, or application for the same, will vest in the State of Florida, Department of State for the exclusive use and benefit of the state. Pursuant to Section 286.021, Florida Statutes, no person, firm or corporation, including parties to this contract, shall be entitled to use the copyright, patent, or trademark without the prior written consent of the Department of State.

The agency shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the contractor under any contract resulting from the RFP.

3.28 Lobbying Disclosure

The contractor shall comply with applicable federal requirements for the disclosure of information regarding lobbying activities of the contractor, subcontractors or any authorized agent. Certification forms shall be filed by the contractor and all subcontractors, certifying that no federal funds have been or will be used in federal lobbying activities, and the disclosure forms shall be used by the contractor and all subcontractors to disclose lobbying activities in connection with the Medicaid program that have been or will be paid for with non-federal funds (Attachment 6).

The contractor shall comply with the provisions of Section 216.347, Florida Statutes, which prohibits the expenditure of contract funds for the purpose of lobbying the legislature or a state agency.

3.29 Contracting Officer

The Contracting Officer for this RFP is:

Secretary
Agency for Health Care Administration
2728 Mahan Drive, Building 3
Tallahassee, Florida 32308

3.30 Issuing Officer

Technical questions regarding the RFP should be addressed to the following individual:

Wendy Smith, L.C.S.W.
Medicaid Program Development
Agency for Health Care Administration
2728 Mahan Drive, Building 3
Tallahassee, Florida 32308
Telephone: (850) 487-2618; Fax: (850) 414-1721

The individual listed above is the sole point of contact from the date of release of the RFP until the selection of the contractor.

3.31 Calendar of Events

Listed below are the important actions and dates/times by which the actions must be taken or completed. If the agency finds it necessary to change any of these dates/times, it will be accomplished by addendum. All listed times are local in Tallahassee, Florida (Eastern Time)

| Date | Time | Action |
|--|-------------|---|
| June 1, 2001 | 9:00 AM | Request for Proposal released |
| June 22, 2001 | 4:00 PM | Notice of Intent to Submit a Proposal must be received by the agency on or before this date and time. (See Section 3.32) |
| August 1, 2001 | 4:00 PM | Deadline for Submission of Proposals. Technical Proposal Opening. Sealed Technical Proposals must be received by the agency on or before this date and time. (See Section 3.36) |
| August 10, 2001 | 4:00 PM | Notice of Contract Award (See Section 3.37) |
| (On or about) September 1, 2001 | | Anticipated contractor signing (subject to state and federal approval) |
| October 1, 2001 | | Anticipated contract start date |
| October 1, 2001 | Midnight | Anticipated date that contractor will begin providing services |

3.32 Notice of Intent to Submit a Proposal

Information regarding any addenda to the RFP and copies of written agency responses to questions resulting in clarifications or addenda to the RFP, will only be sent to those proposers submitting a Notice of Intent to Submit a Proposal and other interested persons who request, in writing, copies of the RFP and other additional information which is sent out regarding the RFP. Lack of submission of the Notice of Intent or written request on the part of a proposer does not eliminate the proposer from submitting a bid on the project. Notice of Intent to Submit a Proposal should be sent to the agency's Issuing Officer identified in Section 3.30, on or before the date and time specified in Section 3.31, Calendar of Events.

3.33 Inquiries

No negotiations, decisions, or actions shall be initiated or executed by the proposer as a result of any discussions with any agency employee. Only those communications, which are in writing from the agency's Issuing Officer identified in Section 3.30, shall be considered as duly authorized on behalf of the agency.

3.34 Acceptance of Proposals

The agency reserves the right to reject any or all proposals, cancel this procurement or waive minor irregularities when to do so would be in the best interest of the State of Florida. Minor irregularities are those, which will not have a significant adverse effect on overall competition, cost or performance. The state reserves the right to require proposers, at their own expense, to submit written clarification of a proposal in the manner and format the state shall require.

Each proposer, its subsidiaries, affiliates or related entities shall be limited to one proposal that is responsive to the requirements of the RFP. Failure to submit a responsive proposal will result in rejection of the proposer's proposal. Submission of more than one proposal will cause the rejection of all proposals submitted by the proposer.

3.35 Number of Copies Required

The agency requires ten (10) copies of the technical proposal in a sealed box or envelope. At least one copy of the technical proposal submitted to the agency should be marked "original" and must contain an original signature of an official of the provider organization who is authorized to bind the provider to their proposal.

3.36 How to Submit a Proposal

A proposer's technical proposal must be addressed to the agency's Issuing Officer identified in Section 3.30, by the date and time specified in Section 3.31, Calendar of Events. No changes, modifications or additions to proposals submitted will be accepted by the agency after the deadline for submitting technical proposals has passed. Proposals not received at either the specified place, or by the specified time, or both, will be rejected. One copy of any proposal rejected shall be retained by the state for documentation purposes.

3.37 Notice of Contract Award

The recommended award will be posted for review at the Agency for Health Care Administration, 2728 Mahan Drive, Building 3, Tallahassee, Florida, on or about the date shown in Section 3.31, Calendar of Events, and will remain posted for a period of seventy-two (72) hours (three business days).

- A. Any proposer who desires to protest the recommended award must file with the agency:
 - 1. A written notice of intent to protest within seventy-two (72) hours (3 business days) after posting of the award.
 - 2. A formal written protest by petition within ten (10) calendar days after the date on which the notice of protest is filed.
- B. Failure to file a protest within the time prescribed in Section 120, Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes. Either failure to file a notice of protest or failure to file a petition shall constitute such waiver.
- C. A bond payable to the State of Florida in the amount of \$5,000 must accompany a formal written protest. The form of the bond shall be a bond, cashiers check or money order.

- D. In accordance with the General Conditions on the cover sheet of this RFP (PUR 7033), the agency shall not be obligated to pay for information obtained from or through any proposer prior to entering into a contract with the successful proposer.

3.38 Specifications Final

Specifications shall be considered final. In accordance with Section 120.53, Florida Statutes and Florida Administrative Code Rule 60A-1.006, protest of the specifications contained in this RFP shall be made by filing a notice of protest in writing within 72 hours after receipt of the specifications. A formal written protest shall then be filed within ten (10) days after the date the notice of protest is filed. Failure to file a notice of protest or failure to file a formal written protest shall constitute a waiver of proceedings under this chapter. The formal written protest shall state the particular facts and law upon which the protest is based.

Any actual or prospective proposer who desires to file a formal protest to this RFP must accompany that protest with a bond payable to the State of Florida in an amount equal to one percent of the agency's estimate of the total volume of the contract or \$5,000, whichever is less, which bond shall be conditioned upon the payment of all costs which may be adjudged against him in the administrative hearing in which the action is brought and in any subsequent appellate court proceeding. For protest of decisions or intended decision of the agency pertaining to requests for approval of exceptional purchases, the bond shall be in an amount equal to one percent of the agency's estimate of the contract amount for the exceptional purchase request or \$5,000, whichever is less. In lieu of a bond, the agency may accept a cashier's check or a money order in the amount of the bond. Failure to file the proper bond at the time of filing the formal protest will result in a denial of the protest.

3.39 Cost of Preparation of Proposal

Each proposal shall be prepared simply and economically, providing a straightforward, concise delineation of the proposer's capabilities to satisfy the requirements of the RFP. Emphasis in each proposal must be on completeness and clarity of content. In order to expedite the evaluation of proposals, it is essential that proposers follow the format and instructions contained herein. The agency is not liable for any costs incurred by a proposer in responding to the RFP, including the costs for oral presentations.

3.40 Trade Secrets

The State of Florida is unable to assure confidentiality of information fitting the definition of "trade secrets" pursuant to Section 812.081, Florida Statutes, due to the lack of protection of "trade secrets" in Chapter 119, Florida Statutes.

3.41 Minority Business Enterprise Participation

The Agency encourages proposers to use certified and non-certified minority owned businesses as sub-contractors when procuring commodities or services to meet the requirements of the contract. The proposed use of certified and non-certified minority owned businesses, as sub-contractors will be evaluated by the Agency as part of the proposer's Ethnic Diversity Utilization Plan included in sub-section 4.1 C.4. of the Technical Proposal.

3.42 Proposal Rules for Withdrawal

A submitted proposal may be withdrawn by submitting a written request for its withdrawal to the agency, signed by the proposer, within 72 hours after the proposal due date indicated in the Calendar of Events.

Any submitted proposal not withdrawn shall remain a valid proposal for twelve (12) months after the proposal submission date.

3.43 Disposition of Proposals

All proposals become the property of the State of Florida and will be a matter of record subject to the provisions of Chapter 119, Florida Statutes. The State of Florida shall have the right to use all ideas, or adaptations of those ideas, contained in any proposal received in response to the RFP. Selection or rejection of the proposal will not affect this right.

3.44 Documentation Made Available

- A. In addition to attachments listed elsewhere in the RFP, the agency will provide the following references as attachments to the RFP.
1. Area One Utilization and Expenditure Data for FY 1998-1999; Capitation Rates for FY 2000-2001 (Attachment 1)
 2. Medicaid program eligibility groups for the Prepaid Mental Health Plan (Attachment 2)

All possible efforts have been made to ensure that the references made available are complete and current. However, the agency does not warrant that the references are, indeed, complete or current.

3.45 State Licensing Requirements

All corporations seeking to do business with the state shall, at the time of submitting a proposal in response hereto, be on file with the Florida Department of State in accordance with the provisions of Chapter 607 or 617, Florida Statutes. Similarly, partnerships seeking to do business with the state shall, at the time of submitting such a proposal, have complied with the applicable provisions of Chapter 620, Florida Statutes, and set forth the particular reason(s) therefore. A statement shall be required indicating that the proposer is a corporation or other legal entity. If subcontractors are used, the proposer shall also submit a statement indicating that all subcontractors are registered with the state in accordance with Chapter 607, 617, or 620, Florida Statutes, and the proposer shall also provide their subcontractors' corporate charter numbers. In addition, the Department of Insurance requires that the contractor be licensed under Chapter 624, Chapter 636, or Chapter 641, as specified in Section 409.912(3)(b), Florida Statutes.

3.46 Accreditation Requirements

The prepaid mental health plan organizational providers and subcontracted managed care organizations must be accredited by a nationally recognized accrediting organization such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Commission

on Accreditation of Rehabilitation Facilities (CARF), the National Committee for Quality Assurance (NCQA), or the Utilization Review Accreditation Commission (URAC), or must apply for accreditation within one year of the contract start date. Providers shall become fully accredited within two years of the contract start date. Failure to receive accreditation may result in termination of the contract

4.0 PROPOSAL FORMAT INSTRUCTIONS

This section prescribes the format of the proposals that are to be submitted during the procurement process. There is no intent to limit the content of the proposal. Additional information deemed appropriate by the proposer should be included. However, the proposal should be succinct and contain only material essential in order to facilitate evaluation.

4.1 Technical Proposal

The proposer shall provide one (1) original and nine (9) copies of the technical proposal. The technical proposal shall be in a sealed package. The technical proposal shall be clearly marked "Technical Proposal – AHCA-0108". The proposal must be bound on the left-hand margin using a three-ring, loose-leaf binder. Tabs must be inserted for each of the major sections listed below. The response for each section must reference the section number and use the same subtitles as provided within the section. Lack of a response to any section may render the proposal non-responsive. Additional supporting documents and attachments should be placed in a separate binder. The additional documents and attachments should be given the same number as the narrative section they reference. When all pages have been numbered, a Table of Contents must be completed.

- A. **Title Page** – Each copy of the proposal should have a title page with the following information:
1. RFP number;
 2. Title of proposal;
 3. Proposer's name;
 4. Organization to which proposal is submitted;
 5. Name, title, phone number and address of person who can respond to inquiries regarding the proposal; and,
 6. Name of project director.
- B. **Section #1. Executive Summary**– The proposer shall provide an overview of their plan to provide the required services. This should be a summary that is no more than ten (10) pages in length.
- C. **Section #2. Organization and Corporate Capabilities** – The proposer shall provide a description of its organizational and corporate capabilities. The purpose of this section is to provide the agency with a basis for determining the contractor's and its subcontractors' financial and technical capability for undertaking a project of this size. For the purpose of this section, the term proposer shall refer to both the contractor and its subcontractors. It does not refer to the plan's "parent company" unless specifically indicated.

The proposer should provide the following information (Items 1 – 14) for all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of five (5) percent or

more in the disclosing entity. "Direct ownership" and "indirect ownership" are defined in Section 1.1.

1. Legal Entity

- a. In chronological order, describe the legal history of the entity contracting for the Medicaid prepaid mental health plan including predecessor corporations, mergers, reorganizations and changes of ownership. The details of the background of the corporation, its size, and resources, shall cover:
 - (1) Date established.
 - (2) The entity's Federal Employer's Identification Number (FEIN). Corporations must include their Florida Corporate Charter Number.
 - (3) Ownership (public company, partnership, subsidiary, etc.)
 - (4) Primary business.
 - (5) Total number of employees.
 - (6) Number of personnel engaged in activities relevant to this RFP.
 - (7) Any applicable licensures.
- b. In the last five years, has the proposer executed a contract with a government entity (i.e., federal, state or local)? If yes, please briefly describe each contract, including the name of the government entity, name of the entity project officer (contact person for the contract), address, telephone number, and beginning and ending dates of the contract.
- c. In the last five (5) years, has the proposer ever defaulted or voluntarily withdrawn on a contract, or had a contract terminated for cause? If yes, please describe each such contract, including the reason for default, withdrawal, or termination, the name of the government entity, name of the entity project officer, address, telephone number, and beginning and ending dates of the contract.

2. Financial Interest

- a. List the names, addresses and official capacities of the officers and directors, trustees, and partners of the contracting entity.
- b. List the names, addresses and official capacities of the managing employees who are to be responsible for the prepaid mental health plan.
- c. List the name and address of each person with a five (5) percent or more ownership or controlling interest in the contracting entity or in any

subcontractor or supplier in which the contracting entity has direct or indirect ownership of five (5) percent or more.

- d. List any mental health-related subcontractors or suppliers owned by the contracting entity and other mental health-related subcontractors with whom the contracting entity has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the application. Denote the percent of financial interest in the contracting entity held by the contractor.
- e. List the name of any officer, director, agent or owner of the contracting entity or its branches, who is an employee of the State of Florida or any of its agencies. Denote the percent of financial interest in the contracting entity held by the individual.

3. **Organizational Structure**

- a. Is the proposed prepaid mental health plan a subsidiary or component of the contracting entity? If yes, show the structure of the contracting entity and its relationship to the plan.
- b. Show the structure of the organization, including organizational relationships with subcontractors, with detailed lines of authority including the relationships among the Board of Directors, the administrative component and the medical/mental health service delivery component of the plan. Explain how the organizational structure depicted is appropriate for the provision of services under the contract. Include the key staff positions as described in Section 2.5. of this RFP.

4. **Minority Business Enterprise**

Provide a detailed description of the proposer's organization and its location, organizational structure, history, legal structure, *ownership and affiliations.

*Ownership: certified or non-certified minority owned businesses should include this information in their description of the company's ownership and indicate their ethnic orientation, African American (Code N), Hispanic American (Code O), Asian American (Code P), Native American (Code Q), or American Woman (Code R).

5. **Ethnic Diversity Utilization Plan**

The proposer will detail any plans to utilize certified or non-certified minority owned businesses as sub-contractors in relation to this contract. The proposer should include the following information:

- a. Name and address of the sub-contractor;
- b. Indicate whether or not the sub-contractor is a Certified Minority Business Enterprise (CMBE). If so provide a copy of the letter of certification

issued by the State Of Florida Minority Business Advocacy and Assistance office;

- c. Ethnic code (See #4 above);
- d. A description of the services to be performed by the sub-contractor;
- e. The total amount that will be paid to the sub-contractor;
- f. A copy of the written agreement between the proposer and the sub-contractor. The agreement must clearly state the services that will be performed by the sub-contractor and the amount to be paid.

6. Mental Health Care Experience

Describe how the proposer and its subcontractors' experience will facilitate the plan's understanding of this population and positively affect the plan's capacity to provide services to this population.

- a. What is the total of the proposer's current unduplicated fee-for-service and prepaid patient count for mental health services as of the date of this proposal?
- b. For each state in the country (U.S.), provide information on the size and timeframes for relevant contracts. Provide a breakdown of the patient count under the following categories: Medicaid patients; Medicare patients; other economically disadvantaged patients, by type; commercial group patients; commercial individual patients; and other patients.
- c. How many years has the proposer been providing mental health care services to the following categories of patients: Medicaid patients; Medicare patients; other economically disadvantaged patients, by type; commercial group patients; commercial individual patients; and other patients?
- d. How many years has the proposer been providing mental health care services to persons with severe and persistent mental illness?
- e. Approximately how many persons with a severe and persistent mental illness has the proposer had responsibility for providing mental health care services?
- f. Does the proposer have experience in providing mental health services to children and their families who are under the supervision of the Dependency Court? If so, how many years has the proposer been providing mental health services to this population?
- g. Approximately how many children under the supervision of the Dependency Court has the proposer had responsibility for providing mental health services?

- h. Does the proposer have experience in providing mental health services to migrant and homeless individuals? If yes, provide a narrative indicating how this experience would positively affect the plan's provision of services to this population.
- i. Does the proposer have experience in providing mental health services to individuals involved in the forensic/corrections system? If yes, provide a narrative indicating how this experience would positively affect the plan's provision of services to this population.

7. **Community Coordination and Partnerships**

The proposer must describe how they will partner with other community programs such as the United Way, county social services, state funded programs, faith-based organizations, neighborhood programs, law enforcement, the business community, etc. The proposer must show how they will work with these organizations for the overall improvement of the status of the community. The proposer should show innovative ways that they will involve community stakeholders in the overall planning and coordination of their services and ways in which they will help promote prevention and early intervention through community initiatives.

8. **Management Information System**

The proposer must describe its capacity to fulfill the reporting requirements and management information system functions listed in Section 2.24 as follows:

- a. Describe the operational procedures used for reporting service utilization data.
- b. Describe the operational procedures used for reporting enrollment and disenrollment data.
- c. Describe the operational procedures used for maintaining data for services authorized but not claimed.
- d. Describe the operational procedures used for maintaining data related to denied services requested by direct service providers and/or the enrollee.
- e. Describe the operational procedures used for maintaining critical incident data.
- f. Describe the operational procedures used for maintaining clinical and functional client outcome data.
- g. Describe the operational procedures used for reconciling capitation payments at the end of each reconciliation period.
- h. Describe the operational procedures used for reporting quarterly financial data, including annual audits, annual financial statements, and quarterly unaudited financial statements.

- i. Describe the operational procedures used for maintaining data related to cost reporting as specified in Section 2.37.
- j. Describe the organization's proposed operational procedures for submitting data as specified in the Mental Health and Substance Abuse Measures and Data Handbook detailed in Section 2.25.
- k. Describe the organization's proposed operational procedures for determining third party liability for services rendered to enrollees and for handling third party collections.
- l. Describe the organization's claims management system, including existing policies and procedures for handling out of plan claims. If the plan does not have policies and procedures for handling out of plan claims, describe how the plan proposes to handle claims as a prepaid mental health plan.
- m. Describe the organization's accounting system, including staffing levels for the accounting sections, and how the plan will ensure that no funds received by the contractor from the agency under this contract will be co-mingled with other funds. Identify all funding streams for the provision of care for plan recipients.
- n. Describe the organization's management information system (MIS), including hardware and the source of the plan's software. Describe the staffing levels and qualifications of the organization's MIS section.

9. **Administrative Reporting**

The proposer must describe the organization's administrative and technical capabilities and protocol for complying with all reporting requirements established by the agency.

- a. Describe operational procedures and administrative capacity or experience for submitting data electronically and as specified in the Mental Health and Substance Abuse Measures and Data Handbook (referenced in Section 2.25)
- b. Describe the organization's procedures and administrative capacity for gathering, maintaining, and organizing the data and information necessary to meet the following reporting requirements:
 - ❖ Section 2.26 – Allocation of Recipients Report; Case Management Caseload Report
 - ❖ Section 2.27 – Satisfaction Reporting
 - ❖ Section 2.28 – Grievance Reporting
 - ❖ Section 2.29 – Quality Improvement Reporting

- ❖ Section 2.30 – Service Utilization Reporting
- ❖ Section 2.31 – Polypharmacy Data Reporting
- ❖ Section 2.32 – Hospital Inpatient Data Reporting
- ❖ Section 2.33 – Staff Reporting
- ❖ Section 2.35 – Critical Incident Reporting
- ❖ Section 2.37 – Financial Reporting

10. **Financial Statements**

Attach copies of the most recent two (2) years of independently certified audited financial statements of the organization, and the parent company. Audits should include: opinion of a certified public accountant; statement of revenue and expenses; balance sheet; statement of changes in financial position; and management letters. If the organization is too new to have audited financial statements, the proposer shall attach copies of audited financial statements from each of the principal entities involved with the plan.

11. **Legal Actions**

- a. Have there been any legal actions taken within the last two (2) years, or any legal actions pending against the contracting entity or any predecessor entity? If yes, give a brief explanation and the status of each action.
- b. The proposer shall submit to the agency any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent of the applicant who has been found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in Section 435.03, F.S. The agency shall not contract with an applicant that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five (5) percent of the applicant, who has committed any of the above listed offenses. In order to avoid a determination that the proposal is non-responsive, the proposer must submit a corrective action plan, acceptable to the agency, that ensures that such person is divested of all interest and/or control and has no role in the operation and management of the applicant.

The proposer must provide the requested information or attest that no officer, director, agent, managing employee, or owner of stock in excess of five percent of the applicant has committed any of the above listed offenses. The applicant must further attest that the applicant will promptly notify the agency at any time it becomes aware of such an occurrence.

The state reserves the right to reject a proposal from a bidder who has had a legal judgment made against one or more of such persons if the

judgment made would materially affect the proposer from performing its responsibilities under the contract.

12. Financial Risk and Insolvency Protection

The proposer is required to provide arrangements against loss and liability as indicated under Surplus Fund Requirement, and insurance as indicated in Sections 3.15 and 3.19.

- a. How does the proposed organization intend to protect itself from insolvency, pursuant to Section 3.13 of the RFP? If the plan elects to establish a restricted insolvency protection account, describe how the account will be established and managed.
- b. If the contractor chooses to insure itself against loss and liability, describe the self insurance plan; entity covered; description of coverage including deductibles, co-insurance, minimum and maximum benefits; premium in effect; additional policies to cover the risks of performance under the contract.
- c. The proposer must describe the carrier, entity covered, premium in effect, and a description of coverage including deductibles, co-insurance, and minimum and maximum benefits for the following types of insurances: reinsurance; risk of insolvency (if applicable); medical malpractice; public liability and property damage; casualty and fire; fidelity bond; and worker's compensation.

13. Surplus Fund Requirement

- a. Florida Statutes require that a privately funded plan submit to the agency a financial plan that provides for working capital in the form of cash or equivalent liquid assets, excluding Medicaid revenues, equal to at least the first three months of operating expenses or \$200,000, whichever is greater. The plan must divulge in its financial plan the source of such funds, including proof of availability. The proposer must submit its financial plan with its proposal to the agency.
- b. Florida Statutes also require that the organization must maintain at all times in the form of cash, short-term investments allowable as admitted assets by the Department of Insurance, or restricted funds or deposits controlled by either the Agency for Health Care Administration or the Department of Insurance, an amount equal to the plan's most recent one and a half months monthly capitation payment in surplus. Monies in an insolvency protection account can be included in the surplus amount. Provide an explanation of how the plan intends to meet this requirement.

14. Contractor's and Subcontractor's Facilities and Network Management

- a. The proposer shall attach its facilities standards plan. This plan should describe how the plan will ensure that its facilities, including the facilities of its subcontractors, will be or will have the following:

- (1) Accessible to the Medicaid enrollees in the plan;
- (2) Accessible to the handicapped;
- (3) Have adequate space;
- (4) Have good sanitation;
- (5) Have fire/safety inspections;
- (6) Are well equipped to provide the services the plan will provide;
and
- (7) Are prepared in the event of a natural disaster or force majeure.

The proposer shall include protocol for how the contractor will monitor providers and subcontractors for compliance with these requirements.

- b. Additionally, the proposer shall attach a copy of the organization's draft disaster preparedness and recovery procedures.
- c. The proposer shall include its plan for management of the network of subcontractors. The plan must explain how its organizational providers and subcontracted managed care organizations will be accredited by year 2003.

15. **References/Surveys**

The proposer shall attach at least five (5) references that have been provided by previous or current purchasers of mental health care services or other care to attest to current expertise in the provision of the services it proposes in its proposal. The references must be dated January 1, 2001 or later. The references shall include the company name, contact person and telephone number. The agency reserves the right to contact references not listed in the proposal. Additional letters of reference are not required.

- a. The references shall be for experience occurring within the five years preceding the issuance of this RFP. If the organization is too new to have references, the proposer shall indicate this and provide three references that relate to the administration, service provision, and finance components of the organization.
- b. The references should describe the experience in sufficient detail so that the agency is able to judge its relevance.

- D. **Section 3. Proposed Staffing Patterns and Licensure of Staff and Facilities** – In accordance with the requirements of the RFP, the proposer shall provide the following documentation as specifically related to staffing and licensure for positions under this contract. The plan's staffing pattern should reflect the ethnic and racial composition of the community.

1. Provide in a table format, information entitled “Proposed Administrative Staffing Pattern Table”, listing the position; the name of the staff person who will be responsible for the function; the percentage of FTEs devoted to the plan; years of functional experience in the field related to the responsibility; and years of mental health care experience required for individuals responsible for the plan’s following key management functions:
 - a. Project Director
 - b. Medical Director
 - c. Clinical Records
 - d. Consumer Representation
 - e. Marketing (if the plan will do marketing)
 - f. Enrollment/Disenrollment
 - g. Grievances/Complaints
 - h. Quality Improvement
 - i. Utilization Management
 - j. Management Information Systems
2. Attach position descriptions for the positions listed, and resumes for the individuals listed on the Proposed Key Staffing Pattern Table, citing education, training, experience relative to the delivery of mental health care and to the type of position, and provide a description of how the FTE percentage, if less than 100 percent, is adequate to meet the needs of the plan.
3. Demonstrate that the organization will have bi-lingual direct service providers necessary to provide services at each location at which there are enrollees whose primary language is other than English. Additionally, describe how the organization will address the needs of enrollees who require accommodations to access services due to a language barrier or physical disability.
4. To demonstrate that the organization will have the staffing resources necessary for the provision of services, provide in a table format, information titled “Prepaid Mental Health Plan Service Provider Staffing Table”, denoting, for each county in the service area, the number of actual managers; psychiatrists; psychologists; psychiatric nurses; licensed clinical social workers; other licensed mental health care professionals and bilingual staff in each profession. Explain the contractor’s rationale for the staffing levels indicated for such staff and how the requirements listed under Section 2.5 B. and 2.19 are addressed. Provide brief position descriptions for each such staffing type. Indicate the number of staff members who are network providers and the number that are subcontractors in each category.

5. Provide a special issues staffing resources plan that describes, under separate headings, how the plan will ensure that it has the staff resources appropriately trained and experienced to handle issues identified in Section 2.5B.3.a. The plan must have available staff resources to address the following:
 - ❖ Treatment of individuals experiencing problems related to adoption;
 - ❖ Provision of psychological testing and evaluation of children;
 - ❖ Specialty experience with individuals in the child protection or foster care system;
 - ❖ Treatment of individuals experiencing problems with dual diagnosis (mental health and substance abuse);
 - ❖ Treatment of individuals with developmental disabilities;
 - ❖ Treatment of individuals experiencing problems due to separation and loss;
 - ❖ Treatment of individuals who are victims and/or perpetrators of sexual abuse, physical abuse, or victims of domestic violence and violent crimes;
 - ❖ Provision of court ordered mental health evaluations including parental mental health status and expert witness testimony.
 - ❖ Include a description of the capacity to provide behavior analysis, behavior management services and alternative therapies for children.

Provide a brief one or two line description of the training and experience of such persons who will provide each of these services under the plan.

6. Provide details as to how the organization will ensure that staff are certified to administer the CFARS or other functional assessments required by the agency or department.
7. Provide detail as to how the organization will ensure that the staff training and experience requirements outlined in Attachment 24 will be met. Also include information on how the training and experience requirements for targeted case managers and case management supervision will be addressed.
8. Describe how the organization will ensure that it has the staff resources appropriately trained and experienced to provide rehabilitative and support services to adults with a severe and persistent mental illness and, under separate heading, to children with a severe emotional disturbance. Denote the number and percent of total FTEs which will be filled by persons with this type of experience and who will be providing these types of services. Explain the contractor's rationale for the staffing patterns indicated and provide a brief one or two line description of the training and experience of such persons who will provide these services under the plan.

9. Describe how the organization will ensure that it has the appropriate treatment resources to address the treatment and coordination of care for individuals involved in the forensic/corrections system.
10. Describe how the organization will ensure that it has the appropriate treatment resources to address the treatment of complex conditions that involve both mental health and physical health involvement as described in Section 2.4C.
11. Describe how the 24-hour a day, 7 days a week, crisis hot line will be staffed. The proposer should include the training and experience requirements of the staff that will handle calls.

List the name, address, service locations (to the extent known), and the staffing of locations where 24-hour a day, 7 days a week, emergency services are to be provided by the plan. The proposer should include the training and experience requirements of staff at these locations.

12. Client Load Capacity
 - a. What is the organization's clinical and administrative rationale for determining caseload limitations?
 - b. What is the organization's proposed ratio of direct service mental health care professionals to enrollees?
 - c. What is the organization's proposed ratio of FTE mental health targeted case managers to children requiring mental health targeted case management services?
 - d. What is the organization's proposed ratio of FTE mental health targeted case managers to adults requiring mental health targeted case management services?
 - e. What is the organization's proposed ratio of FTE mental health targeted case managers and specialty staff to adults requiring Intensive Team Case Management services?
 - f. What is the organization's proposed ratio of FTE mental health targeted case managers to recipients if the contractor is allowing caseloads that include both children and adults requiring case management services?
 - g. What is the organization's proposed ratio of supervisory staff to direct service mental health care staff?
 - h. What is the organization's proposed ratio of supervisory staff to targeted case management staff?
13. Describe the system used by the proposer to ensure that all persons acting for or on behalf of the plan are properly licensed under applicable federal and state laws or regulations. Include the organization's monitoring process for assuring that providers and subcontractors remain in compliance with requirements.

- a. Provide a description of the organization's credentialing process.
 - b. The proposal must contain a certification in writing that all licensed staff are in good standing with state licensing authorities and are eligible to participate in the Medicaid program pursuant to Florida Statutes and federal law and rules.
14. List the name(s) of the hospitals with which the proposer has contracted or expects to contract for inpatient mental health care. Indicate for each hospital the number of hospital beds available and the bed occupancy rate for the last twelve months.
 15. Provide evidence that the organization is a receiving facility under Chapter 394, Part 1, Florida Statutes in Escambia, Okaloosa, Santa Rosa, and Walton Counties or has access through contracting to at least one receiving facility in each county.
- E. **Section 4. Operational Functions** – The proposer shall explicitly address its operational capacity to serve Medicaid recipients. Separately, the proposer shall address the member services the plan will offer, complaint and grievance procedures, quality improvement procedures, the contractor's proposed reporting systems and the contractor's proposed handling of subcontracts, including ongoing monitoring of subcontractors.
1. **Service Area of Proposed Plan.** The 30-minute typical travel time requirement specified below is a maximum travel time. Proposers are encouraged to provide shorter travel times.
 - a. Describe, for each county, how the proposer will meet throughout the lifetime of the contract the 30-minute typical travel time requirement for all services.
 - b. Describe, for each county, how the proposer will meet throughout the lifetime of the contract the 30-minute typical travel time requirement for child psychiatrists.
 - c. Describe, for each county, how the proposer will meet throughout the lifetime of the contract the 30-minute typical travel time requirement for adult psychiatrists.
 2. **Outreach Requirements**

The proposer must attach its intended outreach plan designed to encourage plan enrollees to seek assistance with the plan when needed. Also attach copies of any draft outreach materials, brochures, fact sheets, lectures, and presentations that will be provided.

The outreach plan should include the following:

- a. A description of how the proposer will provide mental health education for its enrollees. This should include how the plan will inform enrollees about plan benefits and coverage.
 - b. A description of how the proposer intends to use the drug report provided monthly to the plan by the agency for outreach to plan enrollees and providers in the community.
 - c. An indication of how the proposer will ensure that outreach communications will be written in a language spoken by the enrollee.
 - d. A description of how the proposer will provide outreach to migrant farm communities, homeless individuals, and high-risk members with special needs in the areas of family abuse, children in the care and custody of the department, children experiencing severe emotional disturbances, and individuals with a dual diagnoses (substance abuse and mental health, developmental disabilities and mental health).
 - e. A description of how the proposer intends to provide outreach to members who are involved with or at risk of involvement with the forensic or corrections system. Include in the description how the proposer will provide linkage to pre- and post-booking sites for assessment, screening or diversion related to mental health services and access to psychiatric medical services upon the enrollees' release from forensic and corrections facilities.
 - f. A description of how the proposer will establish outreach sites at service units operated by the department or a community based care provider to meet the needs of children in care or custody of the department.
 - g. A description of how the proposer will implement a program designed to assist MediPass physicians in identification and management of clinical depression.
 - h. A description of how the proposer intends to provide outreach to MediPass primary care providers, other local government agencies, and community groups and organizations.
3. Marketing
- If the organization will engage in marketing activities, submit the proposer's anticipated marketing protocol.
4. Mental Health Care Provider Assignment Procedures
- a. The proposer must describe the operational procedure for assigning enrollees to a plan provider, addressing the following items:
 - (1) Describe how the contractor will distribute enrollees to its direct service mental health care providers.

- (2) Describe how members will access their direct service mental health care providers.
 - b. The proposer must provide a description of how enrollees may exercise choice of their direct service mental health care professional. The following should be addressed:
 - (1) Describe how enrollees will be given the opportunity to choose a particular direct service mental health care professional, or have input related to the assignment of a provider.
 - (2) Describe how members in the care and custody of the state will be given a choice related to a particular direct service mental health care provider.
 - (3) Describe how the contractor will assist the Department of Children and Families, or the community based care provider, representatives in the process of choosing a direct service mental health care professional.
 - (4) Describe the process the enrollee will go through in order to change direct service mental health care providers, and how this process will be communicated to enrollees.
 - (5) Describe how the plan will assure continuation of an existing therapeutic relationship with a direct service mental health care provider when a change in level of care is necessary.
5. Member Services
 - a. Attach a draft copy of the proposed member services handbook. The member services handbook should address the issues required in Section 2.12B.5.d., as well as the following questions.
 - (1) How will the contractor orient enrollees in the use of their services?
 - (2) How will enrollees be informed of procedures for obtaining out-of-plan services?
 - b. Indicate how the contractor will handle disenrollment requests.
 - c. Describe the levels of authority for resolution of problems encountered by member services staff.
 - d. Describe the minimum qualifications and experience for member services staff.
 - e. Describe plans for training member services staff.

6. Complaint and Grievance Procedures
 - a. Attach the proposed written complaint and grievance protocol, which should address all items indicated in Section 2.15. The protocol should also respond to the following:
 - (1) What will be the organization's definition of a complaint?
 - (2) What will be the organization's definition of a grievance?
 - (3) Describe the organization's methods for handling urgent grievances.
 - (4) What methods will be used to inform enrollees about the operation of the contractor's complaint and grievance system?
 - (5) What methods will be used to provide assistance to enrollees throughout the entire complaint and grievance process? The protocol should specifically address the assistance available for individuals who are unable to access the system due to literacy difficulties.
 - (6) How does the proposer propose to coordinate complaint and grievance procedures with its subcontractors?
 - (7) How will the contractor monitor its subcontractors and providers related to complaints and grievance protocols?
 - (8) Describe how the contractor will assure that the quantity and quality of care for a member is not adversely affected by the filing of a complaint or grievance.
 - (9) How will the contractor handle complaints from providers (both inside and outside of the network) who are dissatisfied with the plan?
 - (10) Who will be the personnel responsible for receiving, processing, channeling and responding to complaints and grievances?
 - (11) Describe plans to produce and track internal reports on complaints and grievances.
 - (12) Describe any features of the organization's proposed complaint and grievance procedures that exceed the requirements specified in Section 2.15.
7. Quality Improvement Requirements
 - a. Attach written proposed quality improvement protocols for both clinical and administrative areas, addressing all items in Section 2.16 except for item D. This should include copies of policies, standards and procedures,

clinical care criteria, corrective action plan protocol, committee structures and requirements for quarterly reviews. In addition, the quality improvement protocols should address the following issues:

- (1) Describe the quality improvement committee(s) structure and list membership with professional identification. Are there any non-plan committee members, consumers, or consumer advocates? If yes, list those members with their respective professional identification.
 - (2) How often will the committee(s) meet?
 - (3) What will be the areas reviewed by the committee(s)? How will the results of the reviews be used within the quality improvement system?
 - (4) Will critical incident reports be reviewed? If so, how will the results be used within the quality improvement system?
 - (5) Will complaints and grievances be reviewed? If so, how will the results be used within the quality improvement system?
 - (6) What method will be used to record committee meetings? How will the results of the meetings be used?
 - (7) Will the contractor maintain written procedures, protocols, and clinical guidelines regarding mental health care and the rehabilitation of persons with mental health issues? If yes, please describe.
 - (8) Will the quality improvement procedures, protocols, and clinical guidelines be subject to mandatory periodic review? If yes, how often? Who will do the review? How will the results of the reviews be used?
 - (9) How will the contractor communicate and share quality of care review findings with providers and subcontractors? Describe how corrective action plans will be coordinated with providers and subcontractors?
 - (10) Describe the proposer's peer review committee structure and peer review process.
 - (11) Describe the proposer's approach to ensuring quality client care.
 - (12) Describe the proposer's approach to responding to agency requests for corrective action.
- b. Attach a copy of the proposer's draft consumer satisfaction survey, and indicate how it will be administered, by whom, and to whom it will be administered, and how its results will be used. Special attention should

- be paid to children and families served through the child protection system.
- c. Attach a copy of the proposer's draft stakeholder's satisfaction survey, and indicate how it will be administered, by whom, to whom it will be administered, and how the results will be used.
 - d. Provide a narrative description of the proposer's approach to measuring clinical and functional outcomes. This description should include copies of any instruments for collecting and analyzing such data, and how such data will be used. The description should also include the proposer's approach to evaluating provider(s) performance against contract requirements and quality of care protocol.
 - e. Provide a description of the provider's plan to assess community satisfaction and obtain recommendations from the community for improvements.
 - f. Attach a copy of the proposer's utilization review and management protocol. The protocol should include a description of predictors or "triggers" that will be used in identifying potential high risk or problematic cases that will require frequent utilization reviews. Additionally, include a description of how treatment issues will be addressed related to these cases to improve clinical outcomes.
8. Care Coordination
- a. Attach the proposer's plan for care coordination, which should address, utilization review, assuring continuity of care, service planning, channeling to appropriate levels of treatment, and development of treatment alternatives when effective, less intensive services are unavailable. The protocol must address all items in Section 2.8 and should also address the following questions:
 - (1) How will the proposer assure that the overall mental health care provided to enrollees will be responsibly coordinated?
 - (2) Describe your organization's proposed plan linkages to supports needed by the members, including the Department of Children and Families, Department of Juvenile Justice, the school system, the Social Security Administration, Office of Disability Determination, Family Service Planning Teams and other family support programs, Case Review Committees, Criminal Justice System, Baker Act Receiving Facilities, State Mental Hospitals, Homeless Service Agencies, Area Agencies on Aging, Primary Care Physicians, etc.
 - (3) How will the contractor assure that the time standards indicated in Section 2.5 for the provision of emergency mental health care, assessment, urgent care, routine care, and follow-up treatment will be met?

- (4) When an enrollee is admitted to the hospital by a health care provider for a non-mental health condition, how will the contractor monitor, coordinate, and provide mental health care, if needed, while the enrollee is in the hospital?
 - (5) When an enrollee is determined to be in need of substance abuse treatment, how will the contractor ensure that the enrollee is linked to the appropriate services, and that mental health, physical health, and substance abuse related care are coordinated?
 - (6) What is the proposer's plan for linkages to housing and work programs?
 - (7) What will the proposer's coordination be with state funded Alcohol, Drug Abuse, and Mental Health Programs?
- b. Attach the proposer's proposed written protocol for the admission and transfer of enrollees under the plan to and from receiving facilities, both public and private, as specified in Section 2.5 C.
- c. The proposer must provide information as to how the following issues will be handled:
- (1) Describe how the contractor will handle "no show" appointments? What type of follow-up will be provided and how will the protocol be monitored?
 - (2) Describe the proposer's proposed protocol for handling voluntary walk-in enrollees, including methods of triage and typical waiting time to see a direct service mental health care provider.
 - (3) If a walk-in enrollee is not seen by his or her usual direct service mental health care provider, describe how information about this visit will be transmitted to the enrollee's usual direct service mental health care provider.
 - (4) Describe how the contractor will handle referrals from the school system.
- d. Attach the proposer's proposed written protocol describing the procedures for handling referrals. The protocol should address the following questions for both in plan and out-of-plan referrals:
- (1) The proposer's proposed procedures for processing a referral appointment.
 - (2) Where and how referrals will be recorded and which staff will be responsible for making the entry in the member's clinical record.
 - (3) Who will be responsible for making referral appointments, and will it always be the same person?

- (4) Who will be responsible for the transfer of information to the referral provider?
- (5) What steps will be followed in the plan's system for feedback from the referral source?
- (6) What happens to reports received from the referral source?
- (7) What will happen when the plan's enrollees do not keep their referral appointments?
- (8) In what ways will the plan's staff handle the management of a member who requires concurrent care by multiple mental health care providers?
- (9) In the case of members who require long term residential or institutional care, how will the plan handle the transition from plan coverage?

9. Clinical Records Requirements

Attach the proposer's written protocol describing the clinical records system, which should address the following issues and include the following documents.

- a. Description of the proposer's clinical records system.
- b. Standards or guidelines for maintenance of clinical records.
- c. To what extent will the contractor have computerized maintenance of clinical records? How will confidentiality and security issues be addressed related to computerized clinical information?
- d. Who will be responsible for making sure that each enrollee's treatment record is complete and up to date?
- e. Where will clinical records be located?
- f. What information will be routinely recorded regarding services delivered through the plan?
- g. How will crisis services or call-in information for enrollees who are not "established" patients without an "open" clinical record be recorded? How will this documentation be accessible to direct service providers who may serve the enrollee?
- h. How will the contractor ensure confidentiality of the member's clinical record?
- i. How will the clinical record system be made available to appropriate professionals?

- j. What will be the contractor's system for assuring inclusion in the clinical record, reports of crisis services, assessments, or diagnostic evaluations performed in a referral setting?
- k. What will be the contractor's system for entering 24-hour call-in information into the clinical record?
- l. Attach a copy of the proposer's protocol for reviewing clinical records, including identification of high-risk individuals as noted in Section 2.16.B.4.

10. Out-of-Plan Services

Attach the proposer's proposed protocol for out-of-plan services. The protocol should address the following issues:

- a. What procedures will the contractor follow for payment of out-of-plan emergency mental health services utilized by an enrollee?
- b. What procedures will the contractor follow, governing out-of-plan use of clinical services, for payment when an enrollee uses authorized services from non-contracted providers?
- c. What procedures will the contractor follow regarding information to enrollees about the rules and guidelines governing the use of authorized services from a non-contract provider?
- d. What procedures will the contractor follow regarding the use of out-of-plan services to minimize a member's disruption to their current mental health treatment provider?
- e. Describe the process for transitioning into the plan, new enrollees who have been receiving continuous mental health treatment from an out-of-plan provider. The process should include the steps required to request authorization and payment for services, limitations, and the clinical protocol for transitioning between providers.

11. Cost Sharing Policy

Attach the proposer's written protocol describing the plan's policy regarding co-payment requirements or any other charges to enrollees.

12. After Hours Telephone Access

Attach the proposer's written protocol describing the plan's policy concerning emergency and non-emergency after-hours call-in system. The protocol should address the following issues.

- a. How will the 24-hour a day, 7 day a week, crisis hotline be operated?
- b. What is the organization's protocol for handling emergency calls?

- c. What staff will answer the telephone after hours?
- d. What will be the typical clinical response time when an enrollee requests mental health care assistance after hours?
- e. How will after hours phone calls be documented?
- f. What will be the contractor's procedures for informing enrollees about the call-in system?

13. Reports

Attach the proposer's proposed report development procedures, which should describe the steps utilized in compiling the reports required in Sections 2.26 – 2.37.

14. Subcontracts/Provider Network

The proposer must address all issues stated in Section 2.23. The proposer must include a detailed network management plan, which includes how the proposer will manage the network, the types of providers to be included in the network, how providers will be selected, referrals to and within the network, and payment methods. If risk is to be shared, the proposer must submit details as to how this risk will be shared. Attach a statement certifying that all subcontractors are or will be appropriately certified and/or licensed and eligible, if applicable, to participate in the Medicaid program. Explain the process for assuring that this occurs. Include a copy of a sample standard contract.

F. **Section 5. Mental Health Service Delivery Requirements** – This section shall include a detailed discussion of the proposer's approach to providing mental health care. The proposer must be able to document a demonstrated ability to provide a comprehensive range of appropriate services for both children and adults who experience impairments ranging from mild to severe and persistent mental illness.

1. Each service that will be available for plan enrollees must have a service description and clinical guidelines for the appropriate use of the service. The guidelines must include "medical necessity" criteria, admission criteria, continuing stay criteria, exclusion criteria, and discharge criteria. Criteria must be specific to recipient ages and diagnoses. These clinical guidelines and service criteria must be submitted as part of the RFP response. If the plan will have limitations or restrictions related to a service, these items must be detailed in the guidelines, and in no instance may they be more restrictive than those in the Medicaid fee-for-service program. The plan is encouraged to exceed those service limits. Medicaid must approve the final clinical guidelines and service criteria prior to implementation of the contract.
2. Complete in a table format, the mandatory services the contractor will provide. (See Sections 2.3 and 2.4 for a description of the mandatory services.)
3. List and describe the optional services the contractor will provide. Optional services include those that may be provided under the prepaid mental health

plan contract as a downward substitution of care. When a service will be provided as a downward substitution, the proposal should list the service that is being substituted and the clinical rationale that describes how the service can provide a benefit to enrollees. The proposer must submit the clinical guidelines and service criteria as described above for each of the optional services. None of those services will be compensated for separately by Medicaid.

NOTE: All services described in the proposal as enhancements to the plan will become covered services under the plan upon implementation of the contract. The term "Optional Services" will no longer be relevant upon award of the contract.

4. Service Provision

- a. Provide a detailed description of how the contractor's array of mandatory services and optional services will provide comprehensive mental health care services for the Medicaid recipients enrolled in their plan. Describe how the entire service delivery system will operate. Discuss points of access, assessments, treatment planning, service delivery, care management and other issues related to the array of services.
- b. Describe the system of care available for the following:
 - (1) Adults with severe mental illness;
 - (2) Children with serious emotional disturbances;Persons with concurrent conditions as follows:
 - (3) Persons with mental health and substance abuse/dependence disorders;
 - (4) Persons with developmental disabilities and mental health disorders;
 - (5) Persons with developmental disabilities, mental health disorders and substance abuse/dependence disorders; and
 - (6) Persons with mental health disorders due to or involving a general medical condition.
- c. Describe emergency mental health services that will be provided by the plan. In addition the proposer should indicate the following:
 - (1) How emergency mental health services will be obtained both within and outside the service area.
 - (2) How the contractor will manage the care of individuals receiving emergency mental health services to address follow-up care and continuity of care between emergency services and routine care.

- d. Describe the system of care for enrollees who are designated eligible by the Department of Children and Families, Alcohol, Drug Abuse, and Mental Health Office to be served within an Assertive Community Treatment Team.
- e. Provide a detailed description of how children's services will be provided and coordinated. Describe the service design and address the following:
 - (1) How will the plan provide a system of care for children who are high risk, served in the child protection system or juvenile justice system, involved in the school Serious Emotionally Disturbed program, or exhibiting symptoms and behaviors of serious emotional disturbance?
 - (2) Describe the provision of medically necessary court related assessments and services, including parental (enrollees) mental health status and services.
 - (3) How will the plan provide medically necessary services that are recommended as the result of a comprehensive assessment? The description should include how the plan will coordinate the review of completed assessments and the provision of services with the department or its community based care provider(s).
 - (4) How will the plan provide medically necessary services for children in Specialized Therapeutic Foster Care programs?
 - (5) How the plan will provide case management services and minimize duplication of services and promote the establishment of one case manager?
 - (6) Describe the provision of in-home and community-based services for children. How will the plan design these services so that a child may be maintained in the home? How will the service design assist in preventing the need for more intensive, restrictive, and costly mental health placements?
 - (7) Describe methods that indicate how the plan will provide and coordinate services collaboratively with the Department of Children and Families community based care providers. A proposed cooperative agreement and mutual outcomes should be included in the submittal.
 - (8) How will the plan maintain contact with children who are disenrolled from the plan due to placement in a residential treatment facility? Describe how the plan will assure linkage to medically necessary services upon the child's return to the plan.
- f. Describe how the proposer will complete the responsibilities to provide psychiatric evaluations for enrollees applying for nursing home admissions.
- g. Describe how the proposer will provide case management services based on the individual needs of enrollees. How will the system allow movement within a continuum so that the changing needs and abilities of enrollees are addressed? Address the following:

- (1) What approach will be used to assess the enrollees' case management needs?
 - (2) How will the plan provide case management services to enrollees who are hospitalized in an acute care setting?
 - (3) Describe the methods of providing case management services, including types of interventions and how the plan will address issues related to frequency and intensity of the service.
- h. Describe how the proposer will fulfill the responsibilities related to enrollees who have been discharged from state mental hospitals (as detailed in Section 2.4 A.) A proposed cooperative agreement with the state hospital(s) should be included in the submittal.
 - i. Describe the services that the plan will provide to offer opportunities for recovery and reintegration for adults experiencing serious mental illness. What methods will the plan use to encourage and empower individuals upon completion of "active" treatment? How will the plan support consumer-driven activities?
 - j. How will the proposer use new and innovative services to expand the array of services available and meet the ongoing needs of enrollees?
- G. **Section 6. Transition Work Plan** – The proposer is required to provide a detailed transition plan. A timetable must be included which indicates the administrative tasks and the target dates for those tasks that must be met in order for the provision of mental health care services to begin no later than the date listed in the timetable in Section 3.31. This work plan should also indicate the steps the plan will take to coordinate the transition of services for recipients currently receiving services in the fee-for-service Medicaid program or from another managed care provider as described in Section 2.12.B. Special attention must be paid to existing therapeutic relationships and programs.
- H. **Section 7. Proposal Bond** – The proposer shall attach the required proposal bond or proposal guarantee.
- I. **Section 8. Performance Bond** – The proposer shall attach an explicitly stated agreement to a performance bond.
- J. **Section 9. Cover Sheet** – The proposer shall complete, sign and submit the "Request For Proposals Contractual Services Acknowledgment Form" – PUR 7033.
- K. **Section 10. Certification Regarding Lobbying** – The proposer shall sign, date, and submit Attachment 4.
- L. **Section 11. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts** –The proposer shall sign, date, and submit Attachment 5.

- M. **Section 12. Statement of No Involvement** – The proposer shall sign, date, and submit Attachment 6.
- N. **Section 13. Drug Free Work Place Certification** – The proposer shall sign, date, and submit Attachment 7.
- O. **Section 14. Public Entity Crimes** – The proposer shall attach a signed and dated statement attesting that no person or affiliate has been placed on the convicted vendor list following a conviction for a public entity crime.
- P. **Section 15. Transmittal Letter** – The proposer shall attach a letter stating: 1) that the primary contractor is registered to do business in Florida; 2) that any subcontractor proposed is licensed to do business in Florida; 3) that the contractor is licensed under Chapter 624, Chapter 636, or Chapter 641; and 4) that the prepaid mental health plan organizational providers and subcontracted managed care organizations are accredited by a nationally recognized accrediting organization, or that they agree to apply for accreditation within one year of the contract start date, if awarded the contract.
- Q. **Section 16. RFP Cross Reference** – The contractor shall prepare cross-references between its proposal and the RFP requirements. The cross reference for each section shall be a matrix with a row for each requirement in the section and columns for:
1. Number/letter/bullet/paragraph number of the specific requirement;
 2. The RFP title, or if no RFP title was given, a contractor devised short name, for the requirement;
 3. The contractor's proposal page number(s) where the RFP requirement is addressed; and
 4. The contractor's proposal section number/paragraph number, and name where the RFP requirement is addressed.

If the contractor's proposal can address more than one RFP requirement within a certain page or section of the proposal, this should be done and should be indicated on the matrix. The proposal should attempt to effectively address all the RFP requirements without unnecessary duplication and redundancy.

5.0 PROPOSAL EVALUATION

The agency will conduct a comprehensive, fair, and impartial evaluation of all proposals received in response to this RFP in compliance with the due dates specified in Section 3.31, Calendar of Events.

5.1 Evaluation Overview

Evaluation criteria for the technical proposal are grouped into seven (7) categories, each of which will be discussed further in this section. A maximum of one thousand five hundred (1,500) points will be available for each proposer's technical proposal. The areas to be evaluated are:

| | |
|---|--------------|
| Technical Proposal Mandatory Requirements | 0 points |
| Executive Summary | 0 points |
| Organization and Corporate Capabilities | 300 points |
| Proposed Staffing Patterns, Licensure of Staff and Facilities | 300 points |
| Operational Functions | 300 points |
| Mental Health Care Service Delivery | 400 points |
| Transition Work Plan | 200 points |
| <hr/> | |
| Total Possible Points – Technical Proposal | 1,500 points |

Selection of the successful proposer will be based on the proposal that is determined to be in the best interest of the agency, based on the criteria set forth in the RFP. The agency reserves the right to reject any or all proposals received, or cancel this RFP, regardless of evaluation.

5.2 Evaluation Organization

The agency will conduct a comprehensive evaluation of proposals received in response to the procurement effort.

This evaluation will be conducted in three (3) phases:

- ❖ Phase 1 - Evaluation of Mandatory Requirements of Technical Proposals
- ❖ Phase 2 - Evaluation of Technical Proposals
- ❖ Phase 3 - Ranking of Proposals

A Technical Evaluation Committee and a Steering Committee will be established to assist the state in the selection of a contractor. The agency will request that Department of Children and Families and Department of Juvenile Justice staff assist in the evaluation process. The agency reserves the right to alter the composition of the two committees and their respective responsibilities when necessary.

The Technical Evaluation Committee will consist of a minimum of three (3) members. The committee will evaluate and score the corporate capabilities, proposed staffing patterns and licensure information, operational functions, mental health care service delivery, and the work plan of all technical proposals. The committees will rank proposers by the resulting scores and provide this information to the Steering Committee.

The Steering Committee will be comprised of a minimum of five (5) members from the Agency for Health Care Administration (agency). The Steering Committee will be responsible for recommending the selection of the winning proposer to the Secretary of the agency.

The Secretary of the agency will review the recommendation, pertinent supporting materials, and make the determination of the final award. The Secretary of the agency reserves the right to take any additional administrative steps deemed necessary in determining the final award.

5.3 Evaluation of Technical Proposals

Technical Proposal Mandatory Requirements – Phase 1

The agency and other evaluators will review each proposal for responsiveness to the mandatory requirements set forth in the RFP. This will be a yes/no evaluation.

The purpose of this step is to determine if each technical proposal is sufficiently responsive to the RFP to permit its complete evaluation.

Proposals will be evaluated to determine if they comply with the instructions to proposers provided in the RFP. Failure to comply with the instructions will deem a proposal non-responsive. The agency reserves the right to waive minor irregularities. The agency reserves the right to reject any or all proposals or cancel this procurement, according to the best interest of the state.

Only those proposals passing the mandatory requirements will be considered in Phase 2. No points will be awarded for passing the mandatory requirements. The following criteria will be used to determine if a proposal passes the mandatory requirements of the RFP:

1. Was the technical proposal received by 4:00 p.m. on August 1, 2001?
2. Did the proposer submit nine (9) copies and one (1) original of the technical proposal in a sealed package?
3. Did the proposer provide a title page that included: the RFP number; the title of the proposal; the proposer's name; the organization to which the proposal is submitted; the name, title, phone number and address of the person who can respond to inquiries regarding the proposal; and, the name of the project director?
4. Did the proposer provide an executive summary of the PMHP proposal?
5. Did the proposer attach the required proposal bond or proposal guarantee?
6. Did the proposer attach an explicitly stated agreement to a performance bond?

7. Did the proposer complete, sign, and submit the Request for Proposals Contractual Services Acknowledgment form (PUR 7033)?
8. Did the proposer sign, date, and submit the Certification Regarding Lobbying form?
9. Did the proposer sign, date, and submit the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts form?
10. Did the proposer complete, sign, date and submit the Statement of No Involvement?
11. Did the proposer sign, date, and attach the Drug Free Work Plan Certification?
12. Did the proposer attach a letter stating that the primary contractor is registered to do business in Florida; that any subcontractor proposed is licensed to do business in Florida; that the contractor is licensed under Chapter 624, Chapter 636, or Chapter 641; and that the contractor's organization providers and subcontracted managed care organizations are accredited by a nationally recognized accrediting organization or agree to apply for accreditation within one year of the contract start date, if awarded the contract?
13. Did the contractor prepare a cross-reference between its proposal and the RFP requirements?

Evaluation of Technical Proposal – Phase 2

Evaluation of technical proposals will involve the point scoring of each proposal by the Technical Evaluation Committee. Phase 2 may also include oral presentations of proposers successfully completing mandatory requirements. All such proposers will be notified of whether or not there will be oral presentations.

1. Executive Summary (0 Points)

The purpose of this section is to provide an overview of the proposal. No points will be awarded for the Executive Summary section.

2. Organization and Corporate Capabilities (300 points)

Organization and Corporate Capabilities will be evaluated based on the proposer-supplied information in response to the section entitled "Section 2. Organization and Corporate Capabilities." The criteria which will be used in evaluating this category area is as follows:

- a. The appropriateness and capability of the proposer to become a prepaid mental health plan.
- b. The appropriateness of the proposer's overall organizational structure.
- c. The proposer's financial and corporate stability.
- d. The proposer's experience in the mental health care field and in contracting with governmental agencies.

- e. The proposer's plans for partnering with other community programs for planning and coordination of services.
- f. The comprehensiveness, reasonableness, and adequacy of the proposer's Management Information System.
- g. The adequacy of the proposer's operational procedures for providing utilization, administrative and performance reporting.
- h. The adequacy of the proposer's financial insolvency protection arrangements, the proposer's insurance coverage, and the proposer's arrangements of how it will meet the RFP's surplus fund requirements.
- i. The appropriateness, applicability and quality of the proposer's references.
- j. The adequacy, accessibility and quality of the proposed plan facilities as indicated in the proposer's facility standards plan, and the adequacy, accessibility and quality of the proposed plan disaster preparedness and recovery procedures.

3. Proposed Staffing Patterns and Licensure of Staff and Facilities (300 Points)

Proposed Staffing Pattern and Licensure of Staff and Facilities will be evaluated based on the proposer-supplied information in response to the section entitled "Section 3. Proposed Staffing Pattern and Licensure of Staff and Facilities." The criteria that will be used in evaluating this category are as follows:

- a. The quality and adequacy of the staffing plans to ensure the proposer's ability to handle contractor responsibilities.
- b. The quality, appropriateness and responsiveness of the proposer's staffing levels, positions, and years of experience required, relative to the RFP staffing qualifications.
- c. The ability of the proposer to ensure it has, and will continue to have, the resources necessary to provide mental health rehabilitation and support to children who are in the care and custody of the state or who have special needs.
- d. The ability of the proposer to ensure it has, and will continue to have, the resources necessary to provide mental health rehabilitation and support to children and adults with mental illness throughout the life of the contract.
- e. The ability of the proposer to ensure it has, and will continue to have, the resources necessary to identify and coordinate substance abuse treatment for individuals with substance abuse/dependence disorders throughout the life of the contract.
- f. The ability of the proposer to ensure it has, and will continue to have, the resources necessary to provide mental health treatment and coordination of care for individuals involved in the forensic or corrections system.
- g. The quality, appropriateness and responsiveness of the proposer's hospital inpatient mental health care network or plan to meet the required RFP hospital and emergency mental health services requirements.

- h. The quality, appropriateness, and responsiveness of the proposer's system for ensuring access to at least one receiving facility (that complies with Chapter 394, Part 1, F.S.) in Escambia, Okaloosa, Santa Rosa, and Walton Counties.
- i. The adequacy and quality of the proposer's system for ensuring proper staff licensure and credentialing.
- j. The adequacy and quality of the proposer's plan to ensure that qualified providers are available within the network in the event that the agency adds the Comprehensive Assessment service to the contract.

4. Operational Functions (300 points)

Operational Functions will be evaluated based on the proposer-supplied information in response to the section entitled "Section 4. Operational Functions." The criteria, which will be used in evaluating responses to this category, are as follows:

- a. The adequacy of the proposer's operational capacity to serve Medicaid recipients.
- b. The adequacy and appropriateness of the proposed staffing resources.
- c. The proposer's historical experience in providing mental health care services to Medicaid recipients and other low-income populations and the ability of this experience to positively affect the provision of plan services.
- d. The comprehensiveness and reasonableness of the proposer's outreach plan, including the plan's ability to communicate, its approach to communications in languages other than English for non-English speaking Medicaid populations, and its plan to encourage current enrollees to access services.
- e. The comprehensiveness and quality of the proposer's outreach plan to provide assistance to special populations, including migrant farm communities, homeless individuals, high-risk members with special needs, children in the care and custody of the department, children experiencing severe emotional disturbances, individuals with dual diagnoses, and individuals involved in the forensic or corrections system.
- f. The comprehensiveness, reasonableness, and adequacy of the proposer's outreach plan to provide outreach to MediPass primary care physicians, local government agencies, and community groups and organizations.
- g. The comprehensiveness, reasonableness, and quality of the proposer's member services and provider assignment process, as well as the proposer's responsiveness to the RFP member services and provider assignment requirements.
- h. If applicable, the quality, adequacy, and acceptability of the proposer's marketing protocol.
- i. The quality, comprehensiveness, and acceptability of the proposer's complaint and grievance policies and procedures.

- j. The quality, comprehensiveness, and acceptability of the proposer's quality improvement policies and procedures for both clinical and administrative areas, including clinical care criteria, corrective action plan protocol, committee structures, concurrent review process, utilization management and review, and peer review.
- k. The quality, adequacy and acceptability of the proposer's satisfaction survey protocol, policies, and procedures, including a draft Consumer Satisfaction Survey tool and a draft Stakeholder's Satisfaction Survey tool.
- l. The quality, comprehensiveness and acceptability of the proposer's clinical records system.
- m. The appropriateness and comprehensiveness of the proposer's approach to care coordination and the proposer's linkages with community supports.
- n. The adequacy, quality and reasonableness of the proposer's plan of assuring that time standards for the provision of emergency mental health care, assessment, urgent care and follow-up treatment will be met.
- o. The adequacy, accessibility, quality and responsiveness of the proposer's appointment and referral system.
- p. The quality, adequacy, acceptability and responsiveness of the proposer's protocol, policies and procedures regarding out-of-plan services.
- q. The adequacy and acceptability of the proposer's policies and procedures regarding cost sharing.
- r. The quality, adequacy, acceptability and responsiveness of the proposer's protocol, policies and procedures regarding after hours telephone access.
- s. The quality, adequacy, acceptability and responsiveness of the proposer's data collection procedures regarding report compilation.
- t. The quality, adequacy, acceptability and responsiveness of the proposer's protocol, policies and procedures for network management, including the types of providers selected, the selection process, and risk determination.
- u. The responsiveness of the proposal to the contract requirements for the process of reimbursing direct service providers.

5. Mental Health Service Delivery Requirements (400 points)

Mental Health Service Delivery will be evaluated based on the proposer-supplied information in response to the section entitled "Section 5. Mental Health Service Delivery Requirements." The criteria, which will be used in evaluating responses to this category, are as follows:

- a. The reasonableness, adequacy, comprehensiveness and responsiveness of the proposer's approach of managing mental health services.

- b. The demonstrated ability of the proposer to provide a comprehensive range of appropriate mental health services for both children and adults who experience impairment ranging from mild to severe and persistent.
- c. The feasibility and quality of the proposer's service descriptions and clinical guidelines, including "medical necessity" criteria, admission, continuing stay, exclusion, and discharge criteria planned for each service, and the use, if any, of downward substitution of services.
- d. The quality, comprehensiveness, and reasonableness of the proposer's approach to providing mental health care to special needs children, and children in the care and custody of the state.
- e. The comprehensiveness and quality of the proposer's approach to the rehabilitation of adults with a severe and persistent mental illness.
- f. The comprehensiveness and quality of the proposer's approach to the rehabilitation of children with a serious emotional disturbance.
- g. The comprehensiveness and quality of services to high-risk children served in the child protection or juvenile justice system, or involved in a school SED program.
- h. The feasibility and quality of the proposer's approach to the treatment of adults who have been dually diagnosed (substance abuse and mental illness).
- i. The feasibility and quality of the proposer's approach to the treatment of children and adolescents who have been dually diagnosed (substance abuse and mental illness).
- j. The feasibility and quality of the proposer's approach to the rehabilitation of persons who have been diagnosed with a mental illness and developmental disability.
- k. The feasibility and quality of the proposer's approach to the rehabilitation of persons who have been diagnosed with concurrent disorders related to mental illness, substance abuse/dependence, and developmental disability.
- l. The comprehensiveness and quality of the proposer's approach to the treatment of individuals with mental health disorders and complex medical conditions.
- m. The adequacy of medically necessary services for children in Specialized Therapeutic Foster Care.
- n. The comprehensiveness and feasibility of the proposer's plan to provide case management services to enrollees and to minimize the duplication of services.
- o. The comprehensiveness and feasibility of the proposer's plan to provide services collaboratively with the Department of Children and Families community based care providers.
- p. The adequacy of medically necessary court-related assessments and services, including parental (enrollees) mental health status and services.

- q. The adequacy of the proposer's plan for coordination and discharge planning with children's residential providers, state hospitals, and correctional facilities.
- r. The comprehensiveness and quality of the proposer's plan to provide services based on individual needs of enrollees and to allow movement within a continuum so that changing needs and abilities of enrollees are addressed.
- s. The adequacy of the proposer's plan to encourage and empower individuals through the use of consumer-driven activities.
- t. The adequacy of the proposer's plan to use new and innovative services to expand the array of services available and meet the ongoing needs of enrollees.

6. Transition Work Plan (200 points)

The transition work plan will be evaluated based on the proposer-supplied information in response to the section "Section 6. Transition Work Plan." The criteria, which will be used in evaluating responses to this category, are as follows:

- a. The appropriateness, comprehensiveness, and responsiveness of the proposer's transition work plan to the needs of the state.
- b. The clinical acceptability and sensitivity of the transition plan to the needs of Medicaid recipients.
- c. The appropriateness, comprehensiveness, and responsiveness of the proposer's transition plan in demonstrating the proposer's ability and capacity to begin provision of all required services on the established date.
- d. The responsiveness and sensitivity of the transition plan to coordinating the transition of services for recipients moving from the fee-for-service Medicaid program or from another managed care provider.
- e. The appropriateness, comprehensiveness, and responsiveness of the proposer's transition plan in processing out-of-plan claims during the transition period.

5.4 Technical Proposal Scoring

Scoring of the seven (7) areas in each technical proposal will be completed using pre-established criteria and predefined scoring values. Evaluators will independently score each criterion within a category. For each criterion for each bidder's proposal, raw scores from individual evaluators will then be averaged. The averaged values for all criteria in a proposer's proposal will then be totaled. The final score for each proposal is calculated using the following methodology:

A maximum of one thousand five hundred (1,500) points will be assigned to the highest passing technical proposal.

Points for other proposals will be assigned using the formula:

$$(N/X) \times 1,500 = Z$$

Where:

N = actual points awarded to the proposer's proposal

X = highest actual points awarded to a proposal

Z = final technical score for proposer

5.5 Oral Presentations

Proposers who submit a proposal in response to the RFP may, in the course of the selection process, be requested to supplement their proposal with an oral presentation. If the agency determines that it would be beneficial to include oral presentations, it will schedule the time and location of the oral presentations. The agency will notify proposers in the event that an oral presentation is necessary. In such an event, the state will expect proposed key staff to be available. If a proposer fails to agree to an oral presentation, the agency will evaluate the proposer's proposal based solely on its written technical proposal and supporting references.

5.6 Evaluation Ranking

After the proposals have been evaluated, the Technical Evaluation Committee will rank proposers in order by their resulting scores. The proposals will be ranked from the highest score to the lowest, in order of total points scored. The committee will summarize their findings and provide the Steering Committee with the ranking of proposals and a supporting evaluation report.

5.7 State Selection

The Steering Committee will make the recommendation for the selection of the contractor to the Secretary of the agency. The Secretary will make the final decision related to the successful proposer. The Secretary reserves the right to take any additional steps deemed necessary.

Immediately after the Secretary's decision is made, the state will notify the selected proposer. Other proposers will be notified of the Secretary's decision and of their status.

5.8 Federal Approval

Approval of the contract by HCFA is a requirement of this waiver project. If HCFA does not give its approval, neither the agency nor the contractor has any obligations pursuant to this RFP.

5.9 Contract Award

Immediately after obtaining all federal and state approvals, the agency will forward the contract to the selected proposer. If no signed contract is received from the selected proposer within ten (10) consecutive calendar days of the selected proposer's receipt of the contract forms, the proposal bond may be forfeited, and the Secretary of the agency may make another selection. These procedures may be repeated if deemed necessary in the agency's sole discretion. If all proposals are rejected, the agency will promptly notify all proposers.

ATTACHMENTS

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

PAGE 1

AREA I AGE GROUP: Under 1
 COMMUNITY BASED ELIGIBLES: 5,574
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 24,558
 ELIGIBILITY CATEGORY: TANF

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|---------------------|------------|------------|-------------|-----------|---------------|--------------------|---------------|--------------|--------------|
| OUTPATIENT HOSPITAL | | 3 | 3 | 15 | 497.29 | 0.0006 | 1.0000 | 33.15 | 0.020 |
| PHYSICIAN SERVICES | | 6 | 7 | 7 | 211.00 | 0.0002 | 1.0000 | 30.14 | 0.009 |
| TOTAL | | 9 | 10 | 22 | 708.29 | 0.0008 | 1.0054 | 32.19 | 0.029 |
| | | | | | | 92% OF RATE | | | 0.022 |

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

AREA I AGE GROUP: Under 1
 COMMUNITY BASED ELIGIBLES: 2,311
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 8,574
 ELIGIBILITY CATEGORY: OBRA CHILDREN

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|---------------------|------------|------------|-------------|----------|--------------|--------------------|---------------|--------------|--------------|
| OUTPATIENT HOSPITAL | | 1 | 1 | 3 | 4.55 | 0.0003 | 1.0000 | 1.51 | 0.001 |
| PHYSICIAN SERVICES | | 2 | 3 | 3 | 86.76 | 0.0003 | 1.0000 | 28.92 | 0.010 |
| TOTAL | | 3 | 4 | 6 | 91.31 | 0.0007 | 1.0328 | 15.21 | 0.011 |
| | | | | | | 92% OF RATE | | | 0.008 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

PAGE 2

AREA I AGE GROUP: 1 - 5
 COMMUNITY BASED ELIGIBLES: 9,201
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 51,156
 ELIGIBILITY CATEGORY: TANF

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|---------------------------------------|------------|------------|--------------|--------------|------------------|--------------------|---------------|--------------|--------------|
| INP. HOSP. | | 2 | 2 | 10 | 5,903.00 | 0.0001 | 1.0000 | 590.30 | 0.115 |
| OUTPATIENT HOSPITAL | | 21 | 24 | 80 | 1,223.74 | 0.0015 | 1.0000 | 15.29 | 0.024 |
| PHYSICIAN SERVICES | | 126 | 186 | 186 | 4,989.55 | 0.0036 | 1.0000 | 26.82 | 0.098 |
| CH CASE MGT | | 16 | 391 | 1,778 | 15,391.25 | 0.0347 | 1.0000 | 8.65 | 0.301 |
| MENTAL HEALTH DAY TREATMENT | | 3 | 183 | 183 | 7,455.42 | 0.0035 | 1.0000 | 40.74 | 0.146 |
| PSYCHOSOCIAL EVA | | 30 | 30 | 30 | 1,007.18 | 0.0005 | 1.0000 | 33.57 | 0.020 |
| PSYCHIATRIC EVALUATION | | 11 | 11 | 11 | 944.84 | 0.0002 | 1.0000 | 85.89 | 0.018 |
| INDIVIDUAL MEDICAL THERAPY | | 1 | 1 | 1 | 36.76 | 0.0000 | 1.0000 | 36.76 | 0.001 |
| PHARMACOLOGIC MANAGEMENT | | 17 | 36 | 36 | 969.48 | 0.0007 | 1.0000 | 26.93 | 0.019 |
| INTERPRETATION/EXPLANATION OF RESULTS | | 17 | 37 | 37 | 1,315.46 | 0.0007 | 1.0000 | 35.55 | 0.026 |
| SOCIAL REHABILITATION/COUNSELING | | 5 | 9 | 9 | 148.41 | 0.0001 | 1.0000 | 16.49 | 0.003 |
| MEDICAL/PSYCHIATRIC SERVICES | | 1 | 1 | 1 | 39.00 | 0.0000 | 1.0000 | 39.00 | 0.001 |
| DEVELOPMENT OF INDIVIDUALIZED TREAME | | 28 | 28 | 28 | 2,664.50 | 0.0005 | 1.0000 | 95.16 | 0.052 |
| DEVELOPMENT OF INDIVIDUALIZED TREATM | | 2 | 2 | 2 | 145.50 | 0.0000 | 1.0000 | 72.75 | 0.003 |
| INDIVIDUALIZED TREATMENT PLAN REVIEW | | 24 | 33 | 33 | 1,600.50 | 0.0006 | 1.0000 | 48.50 | 0.031 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 22 | 26 | 26 | 291.00 | 0.0005 | 1.0000 | 11.19 | 0.006 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 18 | 151 | 165 | 8,001.50 | 0.0032 | 1.0000 | 48.49 | 0.156 |
| COMMUNITY BASED REHABILITATIVE | | 7 | 74 | 247 | 2,492.90 | 0.0048 | 1.0000 | 10.09 | 0.049 |
| INDIVIDUAL THERAPY | | 48 | 221 | 221 | 8,464.10 | 0.0043 | 1.0000 | 38.29 | 0.165 |
| GROUP THERAPY | | 10 | 36 | 36 | 531.75 | 0.0007 | 1.0000 | 14.77 | 0.010 |
| TOTAL | | 227 | 1,482 | 3,120 | 63,615.84 | 0.0609 | 1.0003 | 20.38 | 1.244 |
| | | | | | | 92% OF RATE | | | 0.972 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

PAGE 3

AREA I AGE GROUP: 1 - 5
 COMMUNITY BASED ELIGIBLES: 362
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 2,613
 ELIGIBILITY CATEGORY: SSI - NO MEDICARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|--------------------------------------|------------|------------|-------------|--------------|------------------|--------------------|---------------|--------------|---------------|
| INP. HOSP. | | 2 | 2 | 29 | 17,118.70 | 0.0110 | 1.0000 | 90.30 | 6.551 |
| OUTPATIENT HOSPITAL | | 12 | 12 | 30 | 508.33 | 0.0114 | 1.0000 | 16.94 | 0.195 |
| PHYSICIAN SERVICES | | 9 | 34 | 34 | 1,052.85 | 0.0130 | 1.0000 | 30.96 | 0.403 |
| CH CASE MGT | | 8 | 195 | 903 | 7,848.75 | 0.3455 | 1.0000 | 8.69 | 3.004 |
| MENTALHEALTH DAY TREATMENT | | 2 | 24 | 24 | 977.76 | 0.0091 | 1.0000 | 40.74 | 0.374 |
| PSYCHOSOCIAL EVA | | 8 | 9 | 9 | 272.54 | 0.0034 | 1.0000 | 30.28 | 0.104 |
| PSYCHIATRIC EVALUATION | | 8 | 8 | 8 | 769.86 | 0.0030 | 1.0000 | 96.23 | 0.295 |
| PHARMACOLOGIC MANAGEMENT | | 21 | 56 | 56 | 1,508.08 | 0.0214 | 1.0000 | 26.93 | 0.577 |
| INTERPRETATION/EXPLANATION RESULTS | | 21 | 48 | 48 | 1,753.22 | 0.0183 | 1.0000 | 36.52 | 0.671 |
| SOCIAL REHABILITATION/COUNSELING | | 3 | 4 | 4 | 65.96 | 0.0015 | 1.0000 | 16.49 | 0.025 |
| REHABILITATION DAY TREATMENT | | 1 | 1 | 1 | 32.98 | 0.0003 | 1.0000 | 32.98 | 0.013 |
| DEVELOPMENT INDIVIDUALIZED TREATMENT | | 11 | 11 | 11 | 1,067.00 | 0.0042 | 1.0000 | 97.00 | 0.408 |
| INDIVIDUALIZED TREATMENT PLAN | | 16 | 26 | 26 | 1,261.00 | 0.0099 | 1.0000 | 48.50 | 0.483 |
| CLINIC/CENTER VISIT, UNSCHED | | 11 | 16 | 16 | 186.24 | 0.0061 | 1.0000 | 11.64 | 0.071 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 16 | 277 | 354 | 17,072.00 | 0.1354 | 1.0000 | 48.22 | 6.533 |
| COMMUNITY BASED REHABILITATIVE | | 2 | 35 | 94 | 911.80 | 0.0359 | 1.0000 | 9.70 | 0.349 |
| INDIVIDUAL THERAPY | | 12 | 76 | 76 | 2,631.01 | 0.0290 | 1.0000 | 34.61 | 1.007 |
| GROUP THERAPY | | 3 | 9 | 9 | 132.54 | 0.0034 | 1.0000 | 14.72 | 0.051 |
| TOTAL | | 43 | 843 | 1,732 | 55,170.62 | 0.6628 | 1.0000 | 31.85 | 21.114 |
| | | | | | | 92% OF RATE | | | 16.511 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

PAGE 4

AREA I AGE GROUP: 1 - 5
 COMMUNITY BASED ELIGIBLES: 8,449
 REGULAR MEDICAID (NOT HMO) CASE MONTHS: 42,998
 ELIGIBILITY CATEGORY: OBRA CHILDREN

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|-------------|------------|------------------|--------------------|---------------|--------------|--------------|
| OUTPATIENT HOSPITAL | | 10 | 23 | 41 | 1,422.06 | 0.0009 | 1.0000 | 34.68 | 0.033 |
| PHYSICIAN SERVICES | | 91 | 122 | 122 | 3,147.76 | 0.0028 | 1.0000 | 25.80 | 0.073 |
| CH CASE MGT | | 3 | 26 | 149 | 1,251.25 | 0.0034 | 1.0000 | 8.39 | 0.029 |
| MENTAL HEALTH DAY TREATMENT | | 2 | 36 | 36 | 1,466.64 | 0.0008 | 1.0000 | 40.74 | 0.034 |
| PSYCHOSOCIAL EVA | | 26 | 26 | 26 | 997.42 | 0.0006 | 1.0000 | 38.36 | 0.023 |
| PSYCHIATRIC EVALUATION | | 8 | 8 | 8 | 734.87 | 0.0001 | 1.0000 | 91.85 | 0.017 |
| INDIVIDUAL MEDICAL THERAPY | | 1 | 4 | 4 | 147.04 | 0.0000 | 1.0000 | 36.76 | 0.003 |
| PHARMACOLOGIC MANAGEMENT | | 9 | 20 | 20 | 538.60 | 0.0004 | 1.0000 | 26.93 | 0.013 |
| INTERPRETATION/EXPLANATION RESULTS | | 11 | 24 | 24 | 877.42 | 0.0005 | 1.0000 | 36.55 | 0.020 |
| REHABILITATION/COUNSELING | | 1 | 1 | 1 | 16.49 | 0.0000 | 1.0000 | 16.49 | 0.000 |
| MEDICAL/PSYCHIATRIC SERVICES | | 1 | 1 | 1 | 39.00 | 0.0000 | 1.0000 | 39.00 | 0.001 |
| DEVELOPMENT INDIVIDUALIZED TREAME | | 20 | 20 | 20 | 1,940.00 | 0.0004 | 1.0000 | 97.00 | 0.045 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 19 | 30 | 30 | 1,455.00 | 0.0006 | 1.0000 | 48.50 | 0.034 |
| HEALTH CLINIC/CENTER VISIT, UNSCHE | | 13 | 16 | 16 | 186.24 | 0.0003 | 1.0000 | 11.64 | 0.004 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 9 | 95 | 111 | 5,383.50 | 0.0025 | 1.0000 | 48.50 | 0.125 |
| COMMUNITY BASED REHABILITATIVE | | 1 | 2 | 2 | 19.40 | 0.0000 | 1.0000 | 9.70 | 0.000 |
| PSYCHOLOGICAL TESTING | | 1 | 1 | 2 | 38.80 | 0.0000 | 1.0000 | 19.40 | 0.001 |
| INDIVIDUAL THERAPY | | 33 | 198 | 198 | 7,577.10 | 0.0046 | 1.0000 | 38.26 | 0.176 |
| GROUP THERAPY | | 7 | 29 | 29 | 450.57 | 0.0006 | 1.0000 | 15.53 | 0.010 |
| TOTAL | | 154 | 682 | 840 | 27,689.16 | 0.0195 | 0.9953 | 32.96 | 0.641 |
| | | | | | | 92% OF RATE | | | 0.501 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

PAGE 5

AREA I AGE GROUP: 1 - 5
 COMMUNITY BASED ELIGIBLES: 277
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 1,856
 ELIGIBILITY CATEGORY: FOSTER CARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|--------------|--------------|------------------|--------------------|---------------|--------------|---------------|
| INP. HOSP | | 2 | 2 | 6 | 3,541.80 | 0.0032 | 1.0000 | 590.30 | 1.908 |
| OUTPATIENT HOSPITAL | | 4 | 4 | 11 | 130.34 | 0.0059 | 1.0000 | 11.84 | 0.070 |
| PHYSICIAN SERVICES | | 5 | 9 | 9 | 392.59 | 0.0048 | 1.0000 | 43.62 | 0.212 |
| CH CASE MGT | | 15 | 385 | 1,999 | 17,491.25 | 1.0770 | 1.0000 | 8.75 | 9.424 |
| MENTAL HEALTH-PSYCHOSOCIAL EVA | | 15 | 16 | 16 | 585.76 | 0.0086 | 1.0000 | 36.61 | 0.316 |
| PSYCHIATRIC EVALUATION | | 14 | 16 | 16 | 1,224.81 | 0.0086 | 1.0000 | 76.55 | 0.660 |
| PHARMACOLOGIC MANAGEMENT | | 18 | 52 | 52 | 1,398.43 | 0.0280 | 1.0000 | 26.89 | 0.753 |
| INTERPRETATION/EXPLANATION/RESULTS | | 8 | 13 | 13 | 474.45 | 0.0070 | 1.0000 | 36.49 | 0.256 |
| SOCIAL REHABILITATION/COUNSELING | | 2 | 2 | 2 | 32.98 | 0.0010 | 1.0000 | 16.49 | 0.018 |
| DEVELOPMENT INDIVIDUALIZED TREAME | | 21 | 21 | 21 | 2,037.00 | 0.0113 | 1.0000 | 97.00 | 1.098 |
| DEVELOPMENT INDIVIDUALIZED TREATM | | 1 | 1 | 1 | 72.75 | 0.0005 | 1.0000 | 72.75 | 0.039 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 26 | 40 | 40 | 1,940.00 | 0.0215 | 1.0000 | 48.50 | 1.045 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 11 | 13 | 13 | 151.32 | 0.0070 | 1.0000 | 11.64 | 0.082 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 12 | 102 | 120 | 5,820.00 | 0.0646 | 1.0000 | 48.50 | 3.136 |
| COMMUNITY BASED REHABILITATIVE | | 2 | 315 | 630 | 6,111.00 | 0.3394 | 1.0000 | 9.70 | 3.293 |
| PSYCHOLOGICAL TESTING | | 2 | 2 | 2 | 38.80 | 0.0010 | 1.0000 | 19.40 | 0.021 |
| INDIVIDUAL THERAPY | | 29 | 269 | 269 | 9,546.71 | 0.1449 | 1.0000 | 35.48 | 5.144 |
| GROUP THERAPY | | 10 | 19 | 19 | 292.35 | 0.0102 | 1.0000 | 15.38 | 0.158 |
| TOTAL | | 46 | 1,281 | 3,239 | 51,282.34 | 1.7451 | 1.0000 | 15.83 | 27.633 |
| | | | | | | 92% OF RATE | | | 21.609 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

PAGE 6

AREA I AGE GROUP: 6 - 13
 COMMUNITY BASED ELIGIBLES: 9,588
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 58,035
 ELIGIBILITY CATEGORY: TANF

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|--------------|---------------|-------------------|--------------------|---------------|--------------|--------------|
| INP. HOSP. | | 18 | 23 | 201 | 118,650.30 | 0.0034 | 1.0000 | 590.30 | 2.044 |
| OUTPATIENT HOSPITAL | | 68 | 72 | 202 | 2,256.44 | 0.0034 | 1.0000 | 11.17 | 0.039 |
| PHYSICIAN SERVICES | | 184 | 408 | 408 | 12,324.86 | 0.0070 | 1.0000 | 30.20 | 0.212 |
| CH CASE MGT | | 63 | 1,322 | 5,558 | 48,457.50 | 0.0957 | 1.0000 | 8.71 | 0.835 |
| MENTAL HEALTH DAY TREATMENT | | 29 | 888 | 888 | 36,177.12 | 0.0153 | 1.0000 | 40.74 | 0.623 |
| PSYCHOSOCIAL EVA | | 151 | 154 | 154 | 5,838.08 | 0.0026 | 1.0000 | 37.90 | 0.101 |
| PSYCHIATRIC EVALUATION | | 69 | 71 | 71 | 6,543.84 | 0.0012 | 1.0000 | 92.16 | 0.113 |
| PSYCHIATRIC EVALUATION/HOSP. RECOR | | 2 | 3 | 3 | 77.85 | 0.0000 | 1.0000 | 25.95 | 0.001 |
| INDIVIDUAL MEDICAL THERAPY | | 11 | 26 | 26 | 955.76 | 0.0004 | 1.0000 | 36.76 | 0.016 |
| INDIVIDUAL MEDICAL THERAPY | | 1 | 1 | 1 | 51.51 | 0.0000 | 1.0000 | 51.51 | 0.001 |
| PHARMACOLOGIC MANAGEMENT | | 170 | 432 | 432 | 11,633.08 | 0.0074 | 1.0000 | 26.92 | 0.200 |
| INTERPRETATION/EXPLANATION/RESULTS | | 160 | 375 | 375 | 13,667.65 | 0.0064 | 1.0000 | 36.44 | 0.236 |
| OFFICE/OUTPATIENT VISIT-NEW | | 1 | 1 | 1 | 43.62 | 0.0000 | 1.0000 | 43.62 | 0.001 |
| LIMITED FUNCTIONAL ASSESSMENT | | 2 | 2 | 2 | 30.00 | 0.0000 | 1.0000 | 15.00 | 0.001 |
| BASIC LIVING SKILLS TRAINING | | 14 | 17 | 17 | 280.33 | 0.0002 | 1.0000 | 16.49 | 0.005 |
| SOCIAL REHABILITATION/COUNSELING | | 39 | 74 | 74 | 1,220.26 | 0.0012 | 1.0000 | 16.49 | 0.021 |
| MEDICAL/PSYCHIATRIC SERVICES | | 4 | 4 | 4 | 156.00 | 0.0000 | 1.0000 | 39.00 | 0.003 |
| REHABILITATION DAY TREATMENT | | 3 | 36 | 36 | 1,187.28 | 0.0006 | 1.0000 | 32.98 | 0.020 |
| DEVELOPMENT INDIVIDUALIZED TREAME | | 108 | 108 | 108 | 10,476.00 | 0.0018 | 1.0000 | 97.00 | 0.181 |
| DEVELOPMENT INDIVIDUALIZED TREATM | | 13 | 13 | 13 | 945.75 | 0.0002 | 1.0000 | 72.75 | 0.016 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 194 | 327 | 327 | 15,907.50 | 0.0056 | 1.0000 | 48.64 | 0.274 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 106 | 144 | 144 | 1,664.52 | 0.0024 | 1.0000 | 11.55 | 0.029 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 97 | 1,321 | 1,829 | 88,085.70 | 0.0315 | 1.0000 | 48.16 | 1.518 |
| COMMUNITY BASED REHABILITATIVE | | 32 | 382 | 994 | 9,641.30 | 0.0171 | 1.0000 | 9.69 | 0.166 |
| PSYCHOLOGICAL TESTING | | 2 | 2 | 2 | 38.80 | 0.0000 | 1.0000 | 19.40 | 0.001 |
| INDIVIDUAL THERAPY | | 246 | 1,531 | 1,531 | 58,977.98 | 0.0263 | 1.0000 | 38.52 | 1.016 |
| GROUP THERAPY | | 69 | 430 | 430 | 6,594.88 | 0.0074 | 1.0000 | 15.33 | 0.114 |
| TOTAL | | 662 | 8,167 | 13,831 | 451,883.91 | 0.2383 | 1.0000 | 32.67 | 7.787 |
| | | | | | | 92% OF RATE | | | 6.089 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

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AREA I AGE GROUP: 6 - 13
 COMMUNITY BASED ELIGIBLES: 1,145
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 10,321
 ELIGIBILITY CATEGORY: SSI - NO MEDICARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|---|------------|------------|---------------|---------------|-------------------|--------------------|---------------|--------------|---------------|
| INP. HOSP. | | 29 | 46 | 400 | 236,113.79 | 0.0387 | 1.0000 | 590.28 | 22.877 |
| OUTPATIENT HOSPITAL | | 65 | 93 | 259 | 3,768.16 | 0.0250 | 1.0000 | 14.54 | 0.365 |
| PHYSICIAN SERVICES | | 53 | 424 | 424 | 15,649.62 | 0.0410 | 1.0000 | 36.90 | 1.516 |
| INP. HOSP. OVER 45/D | | 1 | 1 | 6 | 3,541.80 | 0.0005 | 1.0000 | 590.30 | 0.343 |
| CH CASE MGT | | 100 | 4,364 | 19,719 | 172,459.55 | 1.9105 | 1.0000 | 8.74 | 16.710 |
| MENTAL HEALTH DAY TREATMENT | | 72 | 3,793 | 3,793 | 154,526.82 | 0.3675 | 1.0000 | 40.74 | 14.972 |
| PSYCHOSOCIAL EVA | | 81 | 85 | 85 | 3,032.12 | 0.0082 | 1.0000 | 35.67 | 0.294 |
| PSYCHIATRIC EVALUATION | | 45 | 50 | 50 | 4,514.21 | 0.0048 | 1.0000 | 90.28 | 0.437 |
| PSYCHIATRIC EVALUATION/HOSPITAL REC. | 4 | 4 | 4 | 4 | 103.80 | 0.0003 | 1.0000 | 25.95 | 0.010 |
| INDIVIDUAL MEDICAL THERAPY | | 14 | 30 | 30 | 1,102.80 | 0.0029 | 1.0000 | 36.76 | 0.107 |
| INDIVIDUAL MEDICAL THERAPY | | 1 | 1 | 1 | 51.51 | 0.0000 | 1.0000 | 51.51 | 0.005 |
| PHARMACOLOGIC MANAGEMENT | | 198 | 732 | 732 | 19,695.20 | 0.0709 | 1.0000 | 26.90 | 1.908 |
| INTERPRETATION/EXPLANATION/RESULTS | | 166 | 529 | 529 | 19,295.41 | 0.0512 | 1.0000 | 36.47 | 1.870 |
| OFFICE/OUTPATIENT VISIT/NEW | | 3 | 3 | 3 | 130.86 | 0.0002 | 1.0000 | 43.62 | 0.013 |
| OFFICE/OUTPATIENT VISIT/ESTAB | | 1 | 1 | 1 | 37.26 | 0.0000 | 1.0000 | 37.26 | 0.004 |
| LIMITED FUNCTIONAL ASSESSMENT | | 1 | 1 | 1 | 15.00 | 0.0000 | 1.0000 | 15.00 | 0.001 |
| BASIC LIVING SKILLS TRAINING | | 13 | 19 | 19 | 313.31 | 0.0018 | 1.0000 | 16.49 | 0.030 |
| SOCIAL REHABILITATION/COUNSELING | | 43 | 169 | 169 | 2,786.81 | 0.0163 | 1.0000 | 16.49 | 0.270 |
| MEDICAL/PSYCHIATRIC SERVICES | | 6 | 6 | 6 | 234.00 | 0.0005 | 1.0000 | 39.00 | 0.023 |
| REHABILITATION DAY TREATMENT | | 12 | 142 | 142 | 4,650.18 | 0.0137 | 1.0000 | 32.74 | 0.451 |
| DEVELOPMENT/INDIVIDUALIZED TREATMENT | | 44 | 44 | 44 | 4,268.00 | 0.0042 | 1.0000 | 97.00 | 0.414 |
| DEVELOPMENT/INDIVIDUALIZED TREATMENT | | 20 | 20 | 20 | 1,455.00 | 0.0019 | 1.0000 | 72.75 | 0.141 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 202 | 408 | 408 | 19,836.50 | 0.0395 | 1.0000 | 48.61 | 1.922 |
| HEALTH CLINIC/CENTER VISIT, UNSCHEDULED | | 63 | 123 | 123 | 1,431.72 | 0.0119 | 1.0000 | 11.64 | 0.139 |
| INTENSIVE THERAPEUTIC ON SITE SERVICES | | 125 | 2,321 | 3,018 | 145,742.50 | 0.2924 | 1.0000 | 48.29 | 14.121 |
| COMMUNITY BASED REHABILITATIVE | | 44 | 1,847 | 5,006 | 48,698.90 | 0.4850 | 1.0000 | 9.72 | 4.718 |
| PSYCHOLOGICAL TESTING | | 10 | 12 | 12 | 281.30 | 0.0011 | 1.0000 | 23.44 | 0.027 |
| INDIVIDUAL THERAPY | | 117 | 831 | 831 | 30,940.05 | 0.0805 | 1.0000 | 37.23 | 2.998 |
| GROUP THERAPY | | 49 | 431 | 431 | 6,695.58 | 0.0417 | 1.0000 | 15.53 | 0.649 |
| TOTAL | | 354 | 16,530 | 36,266 | 901,371.76 | 3.5138 | 1.0000 | 24.85 | 87.335 |
| | | | | | | 92% OF RATE | | | 68.295 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

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AREA I AGE GROUP: 6 - 13
 COMMUNITY BASED ELIGIBLES: 9,022
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 46,297
 ELIGIBILITY CATEGORY: OBRA CHILDREN

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|--------------------------------------|------------|------------|--------------|--------------|-------------------|--------------------|---------------|--------------|--------------|
| INP. HOSP. | | 5 | 5 | 42 | 19,923.44 | 0.0009 | 1.0000 | 474.36 | 0.430 |
| OUTPATIENT HOSPITAL | | 42 | 53 | 146 | 2,561.98 | 0.0031 | 1.0000 | 17.54 | 0.055 |
| PHYSICIAN SERVICES | | 90 | 156 | 156 | 3,997.62 | 0.0033 | 1.0000 | 25.62 | 0.086 |
| CH CASE MGT | | 39 | 626 | 3,104 | 27,151.25 | 0.0670 | 1.0000 | 8.74 | 0.586 |
| THYROID PANEL | | 1 | 1 | 1 | 30.50 | 0.0000 | 1.0000 | 30.50 | 0.001 |
| BLOOD COUNT | | 1 | 1 | 1 | 8.50 | 0.0000 | 1.0000 | 8.50 | 0.000 |
| MENTAL HEALTH DAY TREATMENT | | 24 | 426 | 426 | 17,355.24 | 0.0092 | 1.0000 | 40.74 | 0.375 |
| PSYCHOSOCIAL EVA | | 140 | 140 | 140 | 5,421.54 | 0.0030 | 1.0000 | 38.72 | 0.117 |
| PSYCHIATRIC EVALUATION | | 42 | 43 | 43 | 4,024.28 | 0.0009 | 1.0000 | 93.58 | 0.087 |
| PSYCHIATRIC EVALUATION/HOSPITAL REC. | | 1 | 1 | 1 | 25.95 | 0.0000 | 1.0000 | 25.95 | 0.001 |
| INDIVIDUAL MEDICAL THERAPY | | 9 | 20 | 20 | 725.39 | 0.0004 | 1.0000 | 36.26 | 0.016 |
| PHARMACOLOGIC MANAGEMENT | | 120 | 281 | 281 | 7,567.33 | 0.0060 | 1.0000 | 26.93 | 0.163 |
| INTERPRETATION/EXPLANATION/RESULTS | | 96 | 212 | 212 | 7,740.06 | 0.0045 | 1.0000 | 36.50 | 0.167 |
| OFFICE/OUTPATIENT/VISIT/NEW | | 2 | 2 | 2 | 87.24 | 0.0000 | 1.0000 | 43.62 | 0.002 |
| BASIC LIVING SKILLS TRAINING | | 8 | 11 | 11 | 181.39 | 0.0002 | 1.0000 | 16.49 | 0.004 |
| REHABILITATION/COUNSELING | | 22 | 38 | 38 | 626.62 | 0.0008 | 1.0000 | 16.49 | 0.014 |
| MEDICAL/PSYCHIATRIC SERVICES | | 4 | 4 | 4 | 156.00 | 0.0000 | 1.0000 | 39.00 | 0.003 |
| DEVELOPMENT/INDIVIDUALIZED TREAME | | 115 | 115 | 115 | 11,155.00 | 0.0024 | 1.0000 | 97.00 | 0.241 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 9 | 9 | 9 | 654.75 | 0.0001 | 1.0000 | 72.75 | 0.014 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 158 | 221 | 221 | 10,912.50 | 0.0047 | 1.0000 | 49.37 | 0.236 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 75 | 115 | 115 | 1,338.60 | 0.0024 | 1.0000 | 11.64 | 0.029 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 63 | 697 | 873 | 42,143.50 | 0.0188 | 1.0000 | 48.27 | 0.910 |
| COMMUNITY BASED REHABILITATIVE | | 18 | 240 | 940 | 8,852.04 | 0.0203 | 1.0000 | 9.41 | 0.191 |
| PSYCHOLOGICAL TESTING | | 5 | 6 | 6 | 116.40 | 0.0001 | 1.0000 | 19.40 | 0.003 |
| INDIVIDUAL THERAPY | | 199 | 1,106 | 1,106 | 43,056.92 | 0.0238 | 1.0000 | 38.93 | 0.930 |
| GROUP THERAPY | | 59 | 198 | 198 | 3,044.43 | 0.0042 | 1.0000 | 15.37 | 0.066 |
| TOTAL | | 476 | 4,727 | 8,211 | 218,858.47 | 0.1773 | 0.9999 | 26.65 | 4.727 |
| | | | | | | 92% OF RATE | | | 3.696 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE) 03/14/2001

AREA I AGE GROUP: 6 - 13
 COMMUNITY BASED ELIGIBLES: 534
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 4,567
 ELIGIBILITY CATEGORY: FOSTER CARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|--------------|---------------|-------------------|--------------------|---------------|--------------|---------------|
| INP. HOSP. | | 11 | 13 | 136 | 80,280.80 | 0.0297 | 1.0000 | 590.30 | 17.578 |
| OUTPATIENT HOSPITAL | | 18 | 20 | 60 | 741.14 | 0.0131 | 1.0000 | 12.35 | 0.162 |
| PHYSICIAN SERVICES | | 20 | 149 | 149 | 5,742.40 | 0.0326 | 1.0000 | 38.53 | 1.257 |
| CH CASE MGT | | 83 | 2,843 | 13,594 | 118,918.25 | 2.9765 | 1.0000 | 8.74 | 26.039 |
| MENTAL HEALTH DAY TREATMENT | | 20 | 804 | 804 | 32,714.22 | 0.1760 | 1.0000 | 40.68 | 7.163 |
| PSYCHOSOCIAL EVA | | 35 | 37 | 37 | 1,297.18 | 0.0081 | 1.0000 | 35.05 | 0.284 |
| PSYCHIATRIC EVALUATION | | 29 | 30 | 30 | 2,694.53 | 0.0065 | 1.0000 | 89.81 | 0.590 |
| INDIVIDUAL MEDICAL THERAPY | | 4 | 11 | 11 | 404.36 | 0.0024 | 1.0000 | 36.76 | 0.089 |
| PHARMACOLOGIC MANAGEMENT | | 57 | 217 | 217 | 5,789.95 | 0.0475 | 1.0000 | 26.68 | 1.268 |
| INTERPRETATION/EXPLANATION/RESULTS | | 36 | 117 | 117 | 4,276.39 | 0.0256 | 1.0000 | 36.55 | 0.936 |
| OFFICE/OUTPATIENT VISIT NEW | | 2 | 2 | 2 | 87.24 | 0.0004 | 1.0000 | 43.62 | 0.019 |
| BASIC LIVING SKILLS TRAINING | | 1 | 1 | 1 | 16.49 | 0.0002 | 1.0000 | 16.49 | 0.004 |
| SOCIAL REHABILITATION/COUNSELING | | 7 | 12 | 12 | 197.88 | 0.0026 | 1.0000 | 16.49 | 0.043 |
| MEDICAL/PSYCHIATRIC SERVICES | | 5 | 5 | 5 | 195.00 | 0.0010 | 1.0000 | 39.00 | 0.043 |
| REHABILITATION DAY TREATMENT | | 5 | 85 | 85 | 2,803.30 | 0.0186 | 1.0000 | 32.98 | 0.614 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 36 | 36 | 36 | 3,492.00 | 0.0078 | 1.0000 | 97.00 | 0.765 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 7 | 7 | 7 | 509.25 | 0.0015 | 1.0000 | 72.75 | 0.112 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 110 | 240 | 240 | 11,640.00 | 0.0525 | 1.0000 | 48.50 | 2.549 |
| HEALTH CLINIC/CENTER VISIT, UNSCHE | | 28 | 50 | 50 | 570.36 | 0.0109 | 1.0000 | 11.40 | 0.125 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 43 | 860 | 1,087 | 52,192.30 | 0.2380 | 1.0000 | 48.01 | 11.428 |
| COMMUNITY BASED REHABILITATIVE | | 25 | 2,655 | 5,536 | 53,757.10 | 1.2121 | 1.0000 | 9.71 | 11.771 |
| PSYCHOLOGICAL TESTING | | 6 | 8 | 8 | 145.50 | 0.0017 | 1.0000 | 18.18 | 0.032 |
| INDIVIDUAL THERAPY | | 85 | 751 | 751 | 27,632.54 | 0.1644 | 1.0000 | 36.79 | 6.050 |
| GROUP THERAPY | | 47 | 366 | 366 | 5,696.88 | 0.0801 | 1.0000 | 15.56 | 1.247 |
| TOTAL | | 169 | 9,319 | 23,341 | 411,795.06 | 5.1107 | 1.0000 | 17.64 | 90.168 |
| | | | | | | 92% OF RATE | | | 70.511 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

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AREA I AGE GROUP: 14 - 20
 COMMUNITY BASED ELIGIBLES: 5,151
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 28,490
 ELIGIBILITY CATEGORY: TANF

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|--------------|--------------|-------------------|--------------------|---------------|--------------|--------------|
| INP. HOSP. | | 32 | 38 | 196 | 115,698.80 | 0.0068 | 1.0000 | 590.30 | 4.061 |
| INP. HOSP. | | 2 | 2 | 8 | 1,763.61 | 0.0002 | 1.0000 | 220.45 | 0.062 |
| OUTPATIENT HOSPITAL | | 34 | 38 | 157 | 4,429.27 | 0.0055 | 1.0000 | 28.21 | 0.155 |
| PHYSICIAN SERVICES | | 129 | 340 | 340 | 11,205.46 | 0.0119 | 1.0000 | 32.95 | 0.393 |
| INP. HOSP. | | 1 | 1 | 21 | 12,396.30 | 0.0007 | 1.0000 | 590.30 | 0.435 |
| MENTAL CASE MANAGEMENT | | 8 | 83 | 468 | 4,095.00 | 0.0164 | 1.0000 | 8.75 | 0.144 |
| CH CASE MGT | | 27 | 580 | 2,962 | 25,917.50 | 0.1039 | 1.0000 | 8.75 | 0.910 |
| MENTAL HEALTH DAY TREATMENT | | 7 | 198 | 198 | 8,066.52 | 0.0069 | 1.0000 | 40.74 | 0.283 |
| PSYCHOSOCIAL EVA | | 59 | 60 | 60 | 2,242.16 | 0.0021 | 1.0000 | 37.36 | 0.079 |
| PSYCHIATRIC EVALUATION | | 20 | 20 | 20 | 1,784.69 | 0.0007 | 1.0000 | 89.23 | 0.063 |
| INDIVIDUAL MEDICAL THERAPY | | 7 | 10 | 10 | 367.60 | 0.0003 | 1.0000 | 36.76 | 0.013 |
| PHARMACOLOGIC MANAGEMENT | | 40 | 102 | 102 | 2,746.86 | 0.0035 | 1.0000 | 26.93 | 0.096 |
| INTERPRETATION/EXPLANATION/RESULTS | | 26 | 55 | 55 | 2,009.29 | 0.0019 | 1.0000 | 36.53 | 0.071 |
| OFFICE/OUTPATIENT VISIT NEW | | 3 | 3 | 3 | 130.86 | 0.0001 | 1.0000 | 43.62 | 0.005 |
| OFFICE/OUTPATIENT VISIT ESTAB | | 1 | 1 | 1 | 37.26 | 0.0000 | 1.0000 | 37.26 | 0.001 |
| BASIC LIVING SKILLS TRAINING | | 10 | 12 | 12 | 197.88 | 0.0004 | 1.0000 | 16.49 | 0.007 |
| SOCIAL REHABILITATION/COUNSELING | | 1 | 69 | 69 | 1,137.81 | 0.0024 | 1.0000 | 16.49 | 0.040 |
| MEDICAL/PSYCHIATRIC SERVICES | | 2 | 2 | 2 | 78.00 | 0.0000 | 1.0000 | 39.00 | 0.003 |
| DEVELOPMENT/INDIVIDUALIZED TREAME | | 39 | 39 | 39 | 3,737.50 | 0.0013 | 1.0000 | 95.83 | 0.131 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 5 | 5 | 5 | 363.75 | 0.0001 | 1.0000 | 72.75 | 0.013 |
| IDIVIDUALIZED TREATMENT PLAN REV. | | 46 | 71 | 71 | 3,443.50 | 0.0024 | 1.0000 | 48.50 | 0.121 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 39 | 59 | 59 | 686.76 | 0.0020 | 1.0000 | 11.64 | 0.024 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 32 | 415 | 619 | 29,730.50 | 0.0217 | 1.0000 | 48.02 | 1.044 |
| COMMUNITY BASED REHABILITATIVE | | 9 | 91 | 266 | 2,580.20 | 0.0093 | 1.0000 | 9.70 | 0.091 |
| PSYCHOLOGICAL TESTING | | 3 | 6 | 20 | 388.00 | 0.0007 | 1.0000 | 19.40 | 0.014 |
| INDIVIDUAL THERAPY | | 67 | 354 | 354 | 13,395.26 | 0.0124 | 1.0000 | 37.83 | 0.470 |
| GROUP THERAPY | | 20 | 111 | 111 | 1,702.26 | 0.0038 | 1.0000 | 15.33 | 0.060 |
| TOTAL | | 293 | 2,765 | 6,228 | 250,332.60 | 0.2186 | 1.0002 | 40.19 | 8.789 |
| | | | | | | 92% OF RATE | | | 6.872 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

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AREA I AGE GROUP: 14 - 20
 COMMUNITY BASED ELIGIBLES: 1,184
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 10,613
 ELIGIBILITY CATEGORY: SSI - NO MEDICARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|-------------------------------------|------------|------------|-------------|-------|-------------|--------------|---------------|-----------|------------|
| INP. HOSP. | | 1 | 1 | 1 | 696.05 | 0.0000 | 1.0000 | 696.05 | 0.066 |
| INP. HOSP. | | 35 | 57 | 337 | 199,199.84 | 0.0317 | 1.0000 | 591.09 | 18.769 |
| INP. HOSP. | | 1 | 4 | 23 | 16,802.42 | 0.0021 | 1.0000 | 730.54 | 1.583 |
| INP. HOSP. | | 1 | 2 | 8 | 5,810.64 | 0.0007 | 1.0000 | 726.33 | 0.548 |
| INP. HOSP. | | 1 | 1 | 9 | 4,720.68 | 0.0008 | 1.0000 | 524.52 | 0.445 |
| INP. HOSP. | | 5 | 6 | 55 | 32,530.80 | 0.0051 | 1.0000 | 591.46 | 3.065 |
| INP. HOSP. | | 4 | 6 | 57 | 35,990.94 | 0.0053 | 1.0000 | 631.42 | 3.391 |
| OUTPATIENT HOSPITAL | | 55 | 135 | 331 | 5,487.80 | 0.0311 | 1.0000 | 16.57 | 0.517 |
| PHYSICIAN SERVICES | | 74 | 582 | 582 | 22,218.27 | 0.0548 | 1.0000 | 38.17 | 2.093 |
| MENTAL CASE MANAGEMENT | | 34 | 1,076 | 4,623 | 40,371.90 | 0.4355 | 1.0000 | 8.73 | 3.804 |
| CH CASE MGT | | 56 | 2,004 | 9,994 | 87,388.75 | 0.9416 | 1.0000 | 8.74 | 8.234 |
| BASIC METABOLIC PANEL | | 1 | 2 | 2 | 15.00 | 0.0001 | 1.0000 | 7.50 | 0.001 |
| HEPATIC FUNCTION PANEL | | 1 | 2 | 2 | 16.00 | 0.0001 | 1.0000 | 8.00 | 0.002 |
| THYROID PANEL | | 1 | 1 | 1 | 30.50 | 0.0000 | 1.0000 | 30.50 | 0.003 |
| DRUG, SCREEN; MULTIPLE DRUG CLASSES | | 1 | 1 | 5 | 65.00 | 0.0004 | 1.0000 | 13.00 | 0.006 |
| DIPROPYLACETIC ACID (VALPROIC ACID) | | 1 | 1 | 1 | 14.00 | 0.0000 | 1.0000 | 14.00 | 0.001 |
| URINALYSIS | | 1 | 2 | 2 | 6.54 | 0.0001 | 1.0000 | 3.27 | 0.001 |
| URINE PREGNANCY TEST | | 1 | 2 | 2 | 13.00 | 0.0001 | 1.0000 | 6.50 | 0.001 |
| GONADOTROPIN CHRONIC (HCG) | | 1 | 1 | 1 | 7.00 | 0.0000 | 1.0000 | 7.00 | 0.001 |
| BLOOD COUNT HEMOGRAM AND PLATELET | | 1 | 2 | 2 | 17.00 | 0.0001 | 1.0000 | 8.50 | 0.002 |
| MENTAL HEALTH DAY TREATMENT | | 55 | 3,678 | 3,678 | 149,719.50 | 0.3465 | 1.0000 | 40.70 | 14.107 |
| PSYCHOSOCIAL EVA | | 56 | 56 | 56 | 2,027.38 | 0.0052 | 1.0000 | 36.20 | 0.191 |
| PSYCHIATRIC EVALUATION | | 41 | 48 | 48 | 4,304.24 | 0.0045 | 1.0000 | 89.67 | 0.406 |
| PSYCHIATRIC EVALUATION/HOSPITAL REC | | 1 | 1 | 1 | 25.95 | 0.0000 | 1.0000 | 25.95 | 0.002 |
| MEDICAL THERAPY | | 40 | 88 | 88 | 3,234.88 | 0.0082 | 1.0000 | 36.76 | 0.305 |
| INDIVIDUAL MEDICAL THERAPY | | 1 | 1 | 1 | 51.51 | 0.0000 | 1.0000 | 51.51 | 0.005 |
| PHARMACOLOGIC MANAGEMENT | | 112 | 367 | 367 | 9,883.31 | 0.0345 | 1.0000 | 26.93 | 0.931 |
| INTERPRETATION/EXPLANATION/RESULTS | | 67 | 168 | 168 | 6,130.88 | 0.0158 | 1.0000 | 36.49 | 0.578 |
| OFFICE/OUTPATIENT VISIT NEW | | 4 | 4 | 4 | 174.48 | 0.0003 | 1.0000 | 43.62 | 0.016 |

(Continued Next Page)

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

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AREA I AGE GROUP: 14 - 20
 COMMUNITY BASED ELIGIBLES: 1,184
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 10,613
 ELIGIBILITY CATEGORY: SSI - NO MEDICARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|---------------|---------------|-------------------|--------------------|---------------|--------------|---------------|
| LIMITED FUNCTIONAL ASSESSMENT | | 1 | 1 | 1 | 15.00 | 0.0000 | 1.0000 | 15.00 | 0.001 |
| BASIC LIVING SKILLS TRAINING | | 33 | 517 | 517 | 8,525.33 | 0.0487 | 1.0000 | 16.49 | 0.803 |
| SOCIAL REHABILITATION/COUNSELING | | 23 | 718 | 718 | 11,839.82 | 0.0676 | 1.0000 | 16.49 | 1.116 |
| MEDICAL/PSYCHIATRIC SERVICES | | 1 | 1 | 1 | 39.00 | 0.0000 | 1.0000 | 39.00 | 0.004 |
| REHABILITATION DAY TREATMENT | | 21 | 1,150 | 1,150 | 37,795.08 | 0.1083 | 1.0000 | 32.86 | 3.561 |
| DEVELOPMENT/INDIVIDUALIZED TREAM | | 32 | 32 | 32 | 3,104.00 | 0.0030 | 1.0000 | 97.00 | 0.292 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 8 | 8 | 8 | 582.00 | 0.0007 | 1.0000 | 72.75 | 0.055 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 150 | 294 | 294 | 14,259.00 | 0.0277 | 1.0000 | 48.50 | 1.344 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 56 | 219 | 219 | 2,525.88 | 0.0206 | 1.0000 | 11.53 | 0.238 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 65 | 1,209 | 1,805 | 86,834.40 | 0.1700 | 1.0000 | 48.10 | 8.182 |
| COMMUNITY BASED REHABILITATIVE | | 15 | 634 | 1,660 | 16,099.80 | 0.1564 | 1.0000 | 9.69 | 1.517 |
| PSYCHOLOGICAL TESTING | | 3 | 10 | 29 | 562.60 | 0.0027 | 1.0000 | 19.40 | 0.053 |
| INDIVIDUAL THERAPY | | 78 | 486 | 486 | 19,664.10 | 0.0457 | 1.0000 | 40.46 | 1.853 |
| GROUP THERAPY | | 24 | 160 | 160 | 2,466.33 | 0.0150 | 1.0000 | 15.41 | 0.232 |
| TOTAL | | 291 | 13,738 | 27,529 | 831,266.60 | 2.5938 | 0.9999 | 30.19 | 78.325 |
| | | | | | | 92% OF RATE | | | 61.250 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

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AREA I AGE GROUP: 14 - 20
 COMMUNITY BASED ELIGIBLES: 3,303
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 15,543
 ELIGIBILITY CATEGORY: OBRA CHILDREN

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|--------------|--------------|-------------------|--------------------|---------------|--------------|--------------|
| INP. HOSP. | | 15 | 22 | 105 | 61,981.50 | 0.0067 | 1.0000 | 590.30 | 3.988 |
| OUTPATIENT HOSPITAL | | 18 | 21 | 73 | 1,450.69 | 0.0046 | 1.0000 | 19.87 | 0.093 |
| PHYSICIAN SERVICES | | 60 | 198 | 198 | 7,243.09 | 0.0127 | 1.0000 | 36.58 | 0.466 |
| MENTAL CASE MANAGEMENT | | 1 | 3 | 8 | 70.00 | 0.0005 | 1.0000 | 8.75 | 0.005 |
| CH CASE MGT | | 18 | 425 | 2,118 | 18,532.49 | 0.1362 | 1.0000 | 8.75 | 1.192 |
| MENTAL HEALTH DAY TREATMENT | | 4 | 88 | 88 | 3,585.12 | 0.0056 | 1.0000 | 40.74 | 0.231 |
| PSYCHOSOCIAL EVA | | 30 | 31 | 31 | 1,260.20 | 0.0019 | 1.0000 | 40.65 | 0.081 |
| PSYCHIATRIC EVALUATION | | 18 | 18 | 18 | 1,574.73 | 0.0011 | 1.0000 | 87.48 | 0.101 |
| INDIVIDUAL MEDICAL THERAPY | | 2 | 3 | 3 | 110.28 | 0.0001 | 1.0000 | 36.76 | 0.007 |
| PHARMACOLOGIC MANAGEMENT | | 26 | 55 | 55 | 1,481.15 | 0.0035 | 1.0000 | 26.93 | 0.095 |
| INTERPRETATION/EXPLANATION/RESULTS | | 21 | 43 | 43 | 1,570.17 | 0.0027 | 1.0000 | 36.51 | 0.101 |
| OFFICE/OUTPATIENT VISIT NEW | | 4 | 4 | 4 | 174.48 | 0.0002 | 1.0000 | 43.62 | 0.011 |
| LIMITED FUNCTIONAL ASSESSMENT | | 1 | 1 | 1 | 15.00 | 0.0000 | 1.0000 | 15.00 | 0.001 |
| BASIC LIVING SKILLS TRAINING | | 2 | 2 | 2 | 32.98 | 0.0001 | 1.0000 | 16.49 | 0.002 |
| SOCIAL REHABILITATION/COUNSELING | | 1 | 4 | 4 | 65.96 | 0.0002 | 1.0000 | 16.49 | 0.004 |
| MEDICAL/PSYCHIATRIC SERVICES | | 2 | 2 | 2 | 78.00 | 0.0001 | 1.0000 | 39.00 | 0.005 |
| DEVELOPMENT/INDIVIDUALIZED TREAME | | 26 | 26 | 26 | 2,522.00 | 0.0016 | 1.0000 | 97.00 | 0.162 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 2 | 2 | 2 | 145.50 | 0.0001 | 1.0000 | 72.75 | 0.009 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 24 | 30 | 30 | 1,455.00 | 0.0019 | 1.0000 | 48.50 | 0.094 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 23 | 44 | 44 | 512.16 | 0.0028 | 1.0000 | 11.64 | 0.033 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 13 | 170 | 224 | 10,863.50 | 0.0144 | 1.0000 | 48.49 | 0.699 |
| COMMUNITY BASED REHABILITATIVE | | 3 | 103 | 235 | 2,279.50 | 0.0151 | 1.0000 | 9.70 | 0.147 |
| PSYCHOLOGICAL TESTING | | 1 | 2 | 2 | 38.80 | 0.0001 | 1.0000 | 19.40 | 0.002 |
| INDIVIDUAL THERAPY | | 48 | 245 | 245 | 9,892.19 | 0.0157 | 1.0000 | 40.37 | 0.636 |
| GROUP THERAPY | | 6 | 40 | 40 | 602.67 | 0.0025 | 1.0000 | 15.06 | 0.039 |
| TOTAL | | 153 | 1,582 | 3,601 | 127,537.16 | 0.2316 | 0.9998 | 35.41 | 8.204 |
| | | | | | | 92% OF RATE | | | 6.415 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01

BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

PAGE 14

AREA I AGE GROUP: 14 - 20
 COMMUNITY BASED ELIGIBLES: 553
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 3,359
 ELIGIBILITY CATEGORY: FOSTER CARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|---|------------|------------|--------------|--------------|-------------------|--------------------|---------------|--------------|---------------|
| INP. HOSP. | | 3 | 5 | 49 | 28,924.70 | 0.0145 | 1.0000 | 590.30 | 8.611 |
| INP. HOSP. | | 1 | 1 | 7 | 3,983.28 | 0.0020 | 1.0000 | 569.04 | 1.186 |
| OUTPATIENT HOSPITAL | | 12 | 18 | 58 | 783.69 | 0.0172 | 1.0000 | 13.51 | 0.233 |
| PHYSICIAN SERVICES | | 18 | 478 | 482 | 16,871.47 | 0.1434 | 1.0000 | 35.00 | 5.023 |
| MENTAL CASE MANAGEMENT | | 1 | 1 | 1 | 8.75 | 0.0002 | 1.0000 | 8.75 | 0.003 |
| CH CASE MGT | | 35 | 760 | 3,561 | 31,263.55 | 1.0601 | 1.0000 | 8.77 | 9.307 |
| BASIC METABOLIC PANEL | | 1 | 2 | 2 | 15.00 | 0.0005 | 1.0000 | 7.50 | 0.004 |
| HEPATIC FUNCTION PANEL | | 1 | 2 | 2 | 16.00 | 0.0005 | 1.0000 | 8.00 | 0.005 |
| THYROID PANEL | | 1 | 2 | 2 | 61.00 | 0.0005 | 1.0000 | 30.50 | 0.018 |
| BLOOD COUNT; HEMOGRAM AND PLATELET | | 1 | 2 | 2 | 17.00 | 0.0005 | 1.0000 | 8.50 | 0.005 |
| MENTAL HEALTH DAY TREATMENT | | 28 | 1,629 | 1,629 | 66,365.46 | 0.4849 | 1.0000 | 40.74 | 19.758 |
| PSYCHOSOCIAL EVA | | 18 | 22 | 22 | 820.42 | 0.0065 | 1.0000 | 37.29 | 0.244 |
| PSYCHIATRIC EVALUATION | | 11 | 11 | 11 | 874.86 | 0.0032 | 1.0000 | 79.53 | 0.260 |
| PSYCHIATRIC EVALUATION/HOSPITAL REC. | | 1 | 10 | 10 | 233.55 | 0.0029 | 1.0000 | 23.35 | 0.070 |
| INDIVIDUAL MEDICAL THERAPY | | 2 | 5 | 5 | 183.80 | 0.0014 | 1.0000 | 36.76 | 0.055 |
| PHARMACOLOGIC MANAGEMENT | | 23 | 54 | 54 | 1,454.22 | 0.0160 | 1.0000 | 26.93 | 0.433 |
| INTERPRETATION/EXPLANATION/RESULTS | | 6 | 12 | 12 | 437.46 | 0.0035 | 1.0000 | 36.45 | 0.130 |
| OFFICE/OUTPATIENT VISIT NEW | | 4 | 4 | 4 | 174.25 | 0.0011 | 1.0000 | 43.56 | 0.052 |
| LIMITED FUNCTIONAL ASSESSMENT | | 3 | 5 | 5 | 75.00 | 0.0014 | 1.0000 | 15.00 | 0.022 |
| BASIC LIVING SKILLS TRAINING | | 1 | 52 | 52 | 857.48 | 0.0154 | 1.0000 | 16.49 | 0.255 |
| SOCIAL REHABILITATION/COUNSELING | | 3 | 83 | 83 | 1,368.67 | 0.0247 | 1.0000 | 16.49 | 0.407 |
| REHABILITATION DAY TREATMENT | | 1 | 13 | 13 | 428.74 | 0.0038 | 1.0000 | 32.98 | 0.128 |
| DEVELOPMENT/INDIVIDUALIZED TREATMENT | | 37 | 37 | 37 | 3,589.00 | 0.0110 | 1.0000 | 97.00 | 1.068 |
| DEVELOPMENT/INDIVIDUALIZED TREATMENT | | 2 | 2 | 2 | 145.50 | 0.0005 | 1.0000 | 72.75 | 0.043 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 29 | 62 | 62 | 3,007.00 | 0.0184 | 1.0000 | 48.50 | 0.895 |
| HEALTH CLINIC/CENTER VISIT, UNSCHEDULED | | 21 | 70 | 70 | 814.80 | 0.0208 | 1.0000 | 11.64 | 0.243 |
| INTENSIVE THERAPEUTIC ON SITE SERVICES | | 33 | 775 | 1,002 | 48,548.50 | 0.2983 | 1.0000 | 48.45 | 14.453 |
| COMMUNITY BASED REHABILITATIVE | | 23 | 933 | 1,998 | 19,402.56 | 0.5948 | 1.0000 | 9.71 | 5.776 |
| PSYCHOLOGICAL TESTING | | 14 | 51 | 192 | 3,724.80 | 0.0571 | 1.0000 | 19.40 | 1.109 |
| INDIVIDUAL THERAPY | | 39 | 255 | 255 | 9,456.40 | 0.0759 | 1.0000 | 37.08 | 2.815 |
| GROUP THERAPY | | 24 | 258 | 258 | 3,963.78 | 0.0768 | 1.0000 | 15.36 | 1.180 |
| TOTAL | | 141 | 5,614 | 9,942 | 247,870.69 | 2.9598 | 0.9999 | 24.93 | 73.791 |
| | | | | | | 92% OF RATE | | | 57.704 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE)

03/14/2001

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AREA I AGE GROUP: 21 - 54
 COMMUNITY BASED ELIGIBLES: 10,657
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 56,978
 ELIGIBILITY CATEGORY: TANF

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|--------------|---------------|-------------------|--------------------|---------------|--------------|--------------|
| INP. HOSP. | | 38 | 45 | 185 | 109,139.77 | 0.0032 | 1.0000 | 589.94 | 1.915 |
| INP. HOSP. | | 20 | 22 | 152 | 90,216.74 | 0.0026 | 1.0000 | 593.53 | 1.583 |
| INP. HOSP. | | 12 | 14 | 93 | 58,716.06 | 0.0016 | 1.0000 | 631.35 | 1.031 |
| INP. HOSP. | | 1 | 1 | 7 | 3,858.68 | 0.0001 | 1.0000 | 551.24 | 0.068 |
| OUTPATIENT HOSPITAL | | 116 | 135 | 490 | 14,611.20 | 0.0086 | 1.0000 | 29.81 | 0.256 |
| PHYSICIAN SERVICES | | 409 | 1,076 | 1,079 | 27,136.13 | 0.0189 | 1.0000 | 25.14 | 0.476 |
| MENTAL HEALTH DAY TREATMENT | | 4 | 157 | 157 | 6,157.44 | 0.0027 | 1.0000 | 39.21 | 0.108 |
| PSYCHOSOCIAL EVA | | 128 | 132 | 132 | 4,474.28 | 0.0023 | 1.0000 | 33.89 | 0.079 |
| PSYCHIATRIC EVALUATION | | 89 | 99 | 99 | 8,134.57 | 0.0017 | 1.0000 | 82.16 | 0.143 |
| INDIVIDUAL MEDICAL THERAPY | | 105 | 206 | 206 | 7,378.56 | 0.0036 | 1.0000 | 35.81 | 0.129 |
| INDIVIDUAL MEDICAL THERAPY | | 1 | 1 | 1 | 51.51 | 0.0000 | 1.0000 | 51.51 | 0.001 |
| PHARMACOLOGIC MANAGEMENT | | 111 | 336 | 336 | 8,673.41 | 0.0058 | 1.0000 | 25.81 | 0.152 |
| INTERPRETATION/EXPLANATION/RESULTS | | 1 | 1 | 1 | 34.67 | 0.0000 | 1.0000 | 34.67 | 0.001 |
| OFFICE/OUTPATIENT VISIT NEW | | 4 | 4 | 4 | 174.48 | 0.0000 | 1.0000 | 43.62 | 0.003 |
| BASIC LIVING SKILLS TRAINING | | 52 | 128 | 128 | 2,048.23 | 0.0022 | 1.0000 | 16.00 | 0.036 |
| SOCIAL REHABILITATION/COUNSELING | | 11 | 69 | 69 | 1,051.81 | 0.0012 | 1.0000 | 15.24 | 0.018 |
| MEDICAL/PSYCHIATRIC SERVICES | | 5 | 8 | 8 | 304.00 | 0.0001 | 1.0000 | 38.00 | 0.005 |
| REHABILITATION DAY TREATMENT | | 6 | 247 | 247 | 7,822.06 | 0.0043 | 1.0000 | 31.66 | 0.137 |
| DEVELOPMENT/INDIVIDUALIZED TREAME | | 96 | 96 | 96 | 9,208.00 | 0.0016 | 1.0000 | 95.91 | 0.162 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 10 | 10 | 10 | 723.50 | 0.0001 | 1.0000 | 72.35 | 0.013 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 144 | 247 | 247 | 11,761.50 | 0.0043 | 1.0000 | 47.61 | 0.206 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 72 | 100 | 100 | 1,048.36 | 0.0017 | 1.0000 | 10.48 | 0.018 |
| INDIVIDUAL THERAPY | | 187 | 596 | 596 | 21,137.51 | 0.0104 | 1.0000 | 35.46 | 0.371 |
| GROUP THERAPY | | 47 | 229 | 229 | 3,087.53 | 0.0040 | 1.0000 | 13.48 | 0.054 |
| MENTAL CASE MANAGEMENT | | 75 | 1,209 | 6,384 | 55,606.25 | 0.1120 | 1.0000 | 8.71 | 0.976 |
| INDIVIDUAL THERAPY | | 1 | 1 | 1 | 45.10 | 0.0000 | 1.0000 | 45.10 | 0.001 |
| TOTAL | | 857 | 5,169 | 11,057 | 452,601.35 | 0.1940 | 0.9998 | 40.93 | 7.942 |
| | | | | | | 92% OF RATE | | | 6.210 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE) 03/14/2001

AREA I AGE GROUP: 21 - 54
 COMMUNITY BASED ELIGIBLES: 5,076
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 48,657
 ELIGIBILITY CATEGORY: SSI - NO MEDICARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|-------------|--------|--------------|--------------|---------------|-----------|------------|
| INP. HOSP. | | 6 | 10 | 61 | 41,824.52 | 0.0012 | 1.0000 | 685.64 | 0.860 |
| INP. HOSP. | | 167 | 257 | 1,857 | 1,095,878.10 | 0.0381 | 1.0000 | 590.13 | 22.523 |
| INP. HOSP. | | 69 | 108 | 1,061 | 616,148.60 | 0.0218 | 1.0000 | 580.72 | 12.663 |
| INP. HOSP. | | 37 | 48 | 376 | 221,641.48 | 0.0077 | 1.0000 | 589.47 | 4.555 |
| OUTPATIENT HOSPITAL | | 261 | 1,084 | 2,480 | 34,805.47 | 0.0509 | 1.0000 | 14.03 | 0.715 |
| PHYSICIAN SERVICES | | 422 | 2,840 | 2,840 | 82,472.42 | 0.0583 | 1.0000 | 29.03 | 1.695 |
| MENTAL HEALTH DAY TREATMENT | | 153 | 9,327 | 9,327 | 363,470.78 | 0.1916 | 1.0000 | 38.96 | 7.470 |
| PSYCHOSOCIAL EVA | | 139 | 145 | 145 | 4,894.82 | 0.0029 | 1.0000 | 33.75 | 0.101 |
| PSYCHIATRIC EVALUATION | | 235 | 315 | 315 | 27,899.05 | 0.0064 | 1.0000 | 88.56 | 0.573 |
| PSYCHIATRIC EVALUATION | | 1 | 1 | 1 | 23.95 | 0.0000 | 1.0000 | 23.95 | 0.000 |
| INDIVIDUAL MEDICAL THERAPY | | 560 | 1,494 | 1,494 | 53,056.68 | 0.0307 | 1.0000 | 35.51 | 1.090 |
| INDIVIDUAL MEDICAL THERAPY | | 7 | 8 | 8 | 408.08 | 0.0001 | 1.0000 | 51.01 | 0.008 |
| PHARMACOLOGIC MANAGEMENT | | 473 | 2,436 | 2,436 | 62,201.76 | 0.0500 | 1.0000 | 25.53 | 1.278 |
| OFFICE/OUTPATIENT VISIT NEW | | 4 | 4 | 4 | 174.48 | 0.0000 | 1.0000 | 43.62 | 0.004 |
| LIMITED FUNCTIONAL ASSESSMENT | | 6 | 9 | 9 | 125.00 | 0.0001 | 1.0000 | 13.88 | 0.003 |
| BASIC LIVING SKILLS TRAINING | | 333 | 6,678 | 6,678 | 102,043.73 | 0.1372 | 1.0000 | 15.28 | 2.097 |
| SOCIAL REHABILITATION/COUNSELING | | 139 | 4,221 | 4,221 | 62,330.33 | 0.0867 | 1.0000 | 14.76 | 1.281 |
| MEDICAL/PSYCHIATRIC SERVICES | | 26 | 30 | 30 | 1,150.00 | 0.0006 | 1.0000 | 38.33 | 0.024 |
| REHABILITATION DAY TREATMENT | | 159 | 11,066 | 11,066 | 345,992.27 | 0.2274 | 1.0000 | 31.26 | 7.111 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 97 | 96 | 96 | 9,333.00 | 0.0019 | 1.0000 | 97.21 | 0.192 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 53 | 53 | 53 | 3,791.75 | 0.0010 | 1.0000 | 71.54 | 0.078 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 783 | 2,028 | 2,028 | 96,177.00 | 0.0416 | 1.0000 | 47.42 | 1.977 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 285 | 1,674 | 1,674 | 17,159.36 | 0.0344 | 1.0000 | 10.25 | 0.353 |
| PSYCHOLOGICAL TESTING | | 1 | 1 | 1 | 19.40 | 0.0000 | 1.0000 | 19.40 | 0.000 |
| INDIVIDUAL THERAPY | | 269 | 1,339 | 1,339 | 48,049.47 | 0.0275 | 1.0000 | 35.88 | 0.988 |
| GROUP THERAPY | | 64 | 564 | 564 | 7,897.74 | 0.0115 | 1.0000 | 14.00 | 0.162 |
| MENTAL CASE MANAGEMENT | | 605 | 20,423 | 99,822 | 872,027.01 | 2.0515 | 1.0000 | 8.73 | 17.922 |
| MENTAL HEALTH DAY TREATMENT | | 2 | 27 | 27 | 1,099.98 | 0.0005 | 1.0000 | 40.74 | 0.023 |

(continued next page)

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE) 03/14/2001

AREA I AGE GROUP: 21 - 54
 COMMUNITY BASED ELIGIBLES: 5,076
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 48,657
 ELIGIBILITY CATEGORY: SSI - NO MEDICARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|--------------|---------------|----------------|---------------------|--------------------|---------------|--------------|---------------|
| PSYCHOSOCIAL EVA | | 1 | 1 | 1 | 25.22 | 0.0000 | 1.0000 | 25.22 | 0.001 |
| PSYCHIATRIC EVALUATION | | 1 | 1 | 1 | 69.99 | 0.0000 | 1.0000 | 69.99 | 0.001 |
| INDIVIDUAL MEDICAL THERAPY | | 1 | 1 | 1 | 36.76 | 0.0000 | 1.0000 | 36.76 | 0.001 |
| PHARMACOLOGIC MANAGEMENT | | 2 | 10 | 10 | 269.30 | 0.0002 | 1.0000 | 26.93 | 0.006 |
| BASIC LIVING SKILLS TRAINING | | 2 | 12 | 12 | 197.88 | 0.0002 | 1.0000 | 16.49 | 0.004 |
| SOCIAL REHABILITATION/COUNSELING | | 1 | 6 | 6 | 98.94 | 0.0001 | 1.0000 | 16.49 | 0.002 |
| REHABILITATION DAY TREATMENT | | 5 | 60 | 60 | 1,978.80 | 0.0012 | 1.0000 | 32.98 | 0.041 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 2 | 2 | 2 | 97.00 | 0.0000 | 1.0000 | 48.50 | 0.002 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 2 | 3 | 3 | 34.92 | 0.0000 | 1.0000 | 11.64 | 0.001 |
| INTENSIVE THERAPEUTIC ON SITE SVCS | | 1 | 1 | 2 | 97.00 | 0.0000 | 1.0000 | 48.50 | 0.002 |
| GROUP THERAPY | | 1 | 5 | 5 | 80.70 | 0.0001 | 1.0000 | 16.14 | 0.002 |
| TOTAL | | 1,398 | 66,388 | 150,116 | 4,175,082.74 | 3.0851 | 1.0000 | 27.81 | 85.809 |
| | | | | | | 92% OF RATE | | | 67.102 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE) 03/14/2001

AREA I AGE GROUP: 55 +
 COMMUNITY BASED ELIGIBLES: 100
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 439
 ELIGIBILITY CATEGORY: TANF

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|-------------|-----------|-----------------|--------------------|---------------|--------------|--------------|
| OUTPATIENT HOSPITAL | | 2 | 2 | 21 | 556.72 | 0.0478 | 1.0000 | 26.51 | 1.268 |
| PHYSICIAN SERVICES | | 2 | 3 | 3 | 62.95 | 0.0068 | 1.0000 | 20.98 | 0.143 |
| PHARMACOLOGIC MANAGEMENT | | 1 | 1 | 1 | 24.93 | 0.0022 | 1.0000 | 24.93 | 0.057 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 1 | 1 | 1 | 70.75 | 0.0022 | 1.0000 | 70.75 | 0.161 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 1 | 1 | 1 | 46.50 | 0.0022 | 1.0000 | 46.50 | 0.106 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 1 | 1 | 1 | 11.64 | 0.0022 | 1.0000 | 11.64 | 0.027 |
| INDIVIDUAL THERAPY | | 2 | 4 | 4 | 118.28 | 0.0091 | 1.0000 | 29.57 | 0.269 |
| MENTAL CASE MANAGEMENT | | 1 | 10 | 36 | 315.00 | 0.0820 | 1.0000 | 8.75 | 0.718 |
| TOTAL | | 6 | 23 | 68 | 1,206.77 | 0.1548 | 1.0000 | 17.74 | 2.749 |
| | | | | | | 92% OF RATE | | | 2.149 |

AREA ONE UTILIZATION AND EXPENDITURE DATA FOR FY 1998-1999; CAPITATION RATES FOR FY 2000-2001

MENTAL HEALTH CAPITATION RATE SETTING USING 98-99 DATA FOR FY 00-01
 BY DISTRICT (EXCLUDES SUBSTANCE ABUSE) 03/14/2001

AREA I AGE GROUP: 55 +
 COMMUNITY BASED ELIGIBLES: 1,908
 REGULAR MEDICAID(NOT HMO) CASE MONTHS: 17,634
 ELIGIBILITY CATEGORY: SSI - NO MEDICARE

| SERVICE CATEGORY | PROVI/PROC | RECIPIENTS | PAID-CLAIMS | UNITS | AMOUNT PAID | UTLIZTN RATE | INFLTN FACTOR | UNIT-COST | CAPITATION |
|------------------------------------|------------|------------|---------------|---------------|-------------------|--------------------|---------------|--------------|---------------|
| INP. HOSP. | | 1 | 1 | 2 | 1,392.10 | 0.0001 | 1.0000 | 696.05 | 0.079 |
| INP. HOSP. | | 1 | 1 | 5 | 4,108.35 | 0.0002 | 1.0000 | 821.67 | 0.233 |
| INP. HOSP. | | 19 | 28 | 339 | 200,075.04 | 0.0192 | 1.0000 | 590.19 | 11.346 |
| INP. HOSP. | | 8 | 11 | 179 | 105,710.15 | 0.0101 | 1.0000 | 590.55 | 5.995 |
| INP. HOSP. | | 7 | 10 | 81 | 51,133.02 | 0.0045 | 1.0000 | 631.27 | 2.900 |
| OUTPATIENT HOSPITAL | | 41 | 96 | 316 | 7,066.69 | 0.0179 | 1.0000 | 22.36 | 0.401 |
| PHYSICIAN SERVICES | | 153 | 975 | 975 | 23,155.90 | 0.0552 | 1.0000 | 23.74 | 1.313 |
| MENTAL HEALTH DAY TREATMENT | | 29 | 2,133 | 2,133 | 82,936.58 | 0.1209 | 1.0000 | 38.88 | 4.703 |
| PSYCHOSOCIAL EVA | | 18 | 18 | 18 | 610.20 | 0.0010 | 1.0000 | 33.90 | 0.035 |
| PSYCHIATRIC EVALUATION | | 23 | 31 | 31 | 2,448.23 | 0.0017 | 1.0000 | 78.97 | 0.139 |
| INDIVIDUAL MEDICAL THERAPY | | 106 | 292 | 292 | 10,383.92 | 0.0165 | 1.0000 | 35.56 | 0.589 |
| INDIVIDUAL MEDICAL THERAPY | | 2 | 2 | 2 | 103.02 | 0.0001 | 1.0000 | 51.51 | 0.006 |
| PHARMACOLOGIC MANAGEMENT | | 63 | 382 | 382 | 9,819.26 | 0.0216 | 1.0000 | 25.70 | 0.557 |
| OFFICE/OUTPATIENT VISIT ESTAB | | 1 | 1 | 1 | 37.26 | 0.0000 | 1.0000 | 37.26 | 0.002 |
| BASIC LIVING SKILLS TRAINING | | 66 | 907 | 907 | 14,070.43 | 0.0514 | 1.0000 | 15.51 | 0.798 |
| SOCIAL REHABILITATION/COUNSELING | | 34 | 758 | 758 | 11,419.34 | 0.0429 | 1.0000 | 15.06 | 0.648 |
| MEDICAL/PSYCHIATRIC SERVICES | | 7 | 8 | 8 | 300.00 | 0.0004 | 1.0000 | 37.50 | 0.017 |
| REHABILITATION DAY TREATMENT | | 29 | 2,457 | 2,457 | 76,076.02 | 0.1393 | 1.0000 | 30.96 | 4.314 |
| DEVELOPMENT/INDIVIDUALIZED TREAME | | 9 | 9 | 9 | 859.00 | 0.0005 | 1.0000 | 95.44 | 0.049 |
| DEVELOPMENT/INDIVIDUALIZED TREATM | | 13 | 13 | 13 | 929.75 | 0.0007 | 1.0000 | 71.51 | 0.053 |
| INDIVIDUALIZED TREATMENT PLAN REV. | | 152 | 413 | 413 | 19,686.50 | 0.0234 | 1.0000 | 47.66 | 1.116 |
| HEALTH CLINIC/CENTER VISIT,UNSCHE | | 35 | 274 | 274 | 2,749.72 | 0.0155 | 1.0000 | 10.03 | 0.156 |
| INDIVIDUAL THERAPY | | 30 | 104 | 104 | 3,943.14 | 0.0058 | 1.0000 | 37.91 | 0.224 |
| GROUP THERAPY | | 7 | 48 | 48 | 655.74 | 0.0027 | 1.0000 | 13.66 | 0.037 |
| MENTAL CASE MANAGEMENT | | 105 | 4,143 | 21,925 | 191,730.00 | 1.2433 | 1.0000 | 8.74 | 10.873 |
| TOTAL | | 314 | 13,115 | 31,672 | 821,399.36 | 1.7960 | 1.0000 | 25.93 | 46.583 |
| | | | | | | 92% OF RATE | | | 36.427 |

Prepaid Mental Health Plan Medicaid Eligibility Codes

| Code | Description |
|------|---|
| MAI | Low Income Families (LIF) Medicaid (Incapacitated Parent) |
| MAR | Low Income Families (LIF) Medicaid (Deprived Child) |
| MAU | Low Income Families (LIF) Medicaid (Unemployed Parent) |
| MEC | Extended Medicaid Due to Child Support |
| MEI | Transitional Medicaid Due to Caretaker Earned Income |
| MET | Transitional Medicaid Due to Loss of \$30 or 1/3 Disregard |
| MN | Presumptively Eligible Newborn Medicaid (PEN) |
| MOA | "AFDC" Failed Due to Alien Status Medicaid |
| MOD | "AFDC" Failed Due to Deemed Income Medicaid |
| MOP | "AFDC" Failed Due to PI Sanctions Medicaid |
| MOS | "AFDC" Failed Due to Sibling Income Medicaid |
| MOT | "AFDC" Failed Due to Transfer of Assets Medicaid |
| MOU | LIF Medicaid for Pregnant Women |
| MOY | LIF Medicaid for Age 18-21 Deprived Children |
| MPC | PMA for Children Under 21 in an Intact Family |
| MPN | PMA for Children Born After 9/30/83 Living with Non-relatives |
| MPU | PMA for Unemployed Parents with Children Under 18 |
| MREI | RAP/CHEP Extended Medicaid for Earned Income |
| MRR | RAP/CHEP Direct Assistance Medical Assistance |
| MMC | MEDS for Children Born after 9/30/83 |
| MMI | MEDS for Infants Under One |
| MMS | MEDS for Aged or Disabled |
| MS | SSI Medicaid |

Prepaid Mental Health Plan Medicaid Eligibility Codes (cont.)

| Code | Description |
|------|--|
| MTA | Protected Medicaid for Widows I & Kids |
| MTC | Regular Protected Medicaid (COLA) |
| MTD | Protected Medicaid for Disabled Adult Children |
| MTS | Protected Medicaid Due to SSI Disability Definition Change |
| MTW | Protected Medicaid for Widows II |
| MWA | Home and Community Based Services (AIDS, etc.) |
| MWC | Home and Community Based Services (Channeling) |
| MCAE | IV-E Adoption Subsidy Medicaid |
| MCAN | Non IV-E Adoption Subsidy Medicaid |
| MCFE | IV-E Foster Care Medicaid |
| MCFN | Non IV-E Foster Care Medicaid |
| MRMC | RAP/CHEP MEDS for Children Born After 9/30/83 |
| MRMI | RAP/CHEP MEDS for Infants Under One |
| MRMP | RAP/CHEP MEDS for Pregnant Women |
| MRMS | RAP/CHEP MEDS for Aged or Disabled |
| MRN | RAP/CHEP Presumptive Eligibility for Newborns (PEN) |
| MROT | RAP/CHEP Failed Due to Transfer of Assets |
| MRPN | RAP/CHEP PMA Children Born After 9/30/83 Living with Non-relatives |
| MRTA | RAP/CHEP Protected Medicaid for Widows I & kids |
| MRTC | RAP/CHEP Regular Protected Medicaid (COLA) |
| MRTD | RAP/CHEP Protected Medicaid for Disabled Adult Children |
| MRTW | RAP/CHEP Protected Medicaid for Widows II |
| MCE | Emergency Shelter Medicaid |

FINANCIAL AND COMPLIANCE AUDIT

The administration of funds awarded by the Agency for Health Care Administration to the recipient may be subject to audits and/or monitoring by the Agency as described in this section.

MONITORING

In addition to reviews of audits conducted in accordance with OMB Circular A-133, as revised (see "AUDITS" below), monitoring procedures may include, but not be limited to, on-site visits by Agency staff, limited scope audits as defined by OMB Circular A-133, as revised, and/or other procedures. By entering into this agreement, the recipient agrees to comply and cooperate with any monitoring procedures/processes deemed appropriate by the Agency. In the event the Agency determines that a limited scope audit of the recipient is appropriate, the recipient agrees to comply with any additional instructions provided by the Agency to the recipient regarding such audit. The recipient further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by the Comptroller or Auditor General.

AUDITS

PART I: FEDERALLY FUNDED

This Attachment is applicable if the recipient is a State or local government or a non-profit organization as defined in OMB Circular A-133, as revised.

1. In the event that the recipient expends \$300,000 or more in Federal awards in its fiscal year, the recipient must have a single or program-specific audit conducted in accordance with the provisions of OMB Circular A-133, as revised. **PART VI** of this agreement indicates Federal funds awarded through the Agency. In determining the Federal awards expended in its fiscal year, the recipient shall consider all sources of Federal awards, including Federal funds received from the Agency. The determination of amounts of Federal awards expended should be in accordance with the guidelines established by OMB Circular A-133, as revised. An audit of the recipient conducted by the Auditor General in accordance with the provisions OMB Circular A-133, as revised, will meet the requirements of this part.
2. In connection with the audit requirements addressed in Part I, paragraph 1., the recipient shall fulfill the requirements relative to auditee responsibilities as provided in Subpart C of OMB Circular A-133, as revised.
3. If the recipient expends less than \$300,000 in Federal awards in its fiscal year, an audit conducted in accordance with the provisions of OMB Circular A-133, as revised, is not required. In the event that the recipient expends less than \$300,000 in Federal awards in its fiscal year and elects to have an audit conducted in accordance with the provisions of OMB Circular A-133, as revised, the cost of the audit must be paid from non-Federal funds (i.e., the cost of such an audit must be paid from recipient funds obtained from other than Federal entities).

PART II: STATE FUNDED

This part is applicable if the recipient is a non-state entity as defined by Section 215.97(2)(l), Florida Statutes.

1. In the event that the recipient expends a total amount of State Financial Assistance (i.e., State financial assistance provided to the recipient to carry out a State project) equal to or in excess of \$300,000 in any fiscal year of such recipient, the recipient must have a State single or project-specific audit for such fiscal year in accordance with Section 215.97, Florida Statutes; applicable rules of the Executive Office of the Governor and the Comptroller, and Chapter 10.650, Rules of the Auditor General. **PART VI** of this agreement indicates State Financial Assistance awarded

through the Agency by this agreement. In determining the State Financial Assistance expended in its fiscal year, the recipient shall consider all sources of State Financial Assistance, including State funds received from the Agency except that State Financial Assistance received by a non-state entity for Federal program matching requirements shall be excluded from consideration.

2. In connection with the audit requirements addressed in Part II, paragraph 2, the recipient shall ensure that the audit complies with the requirements of Section 215.97 (7), Florida Statutes. This includes submission of a reporting package as defined by Section 215.97(2)(d), Florida Statutes, and Chapter 10.650, Rules of the Auditor General.
3. If the recipient expends less than \$300,000 in State Financial Assistance in its fiscal year, an audit conducted in accordance with the provisions of Section 215.97, Florida Statutes, is not required. In the event that the recipient expends less than \$300,000 in State Financial Assistance in its fiscal year and elects to have an audit conducted in accordance with the provisions of Section 215.97, Florida Statutes, the cost of the audit must be paid from non-State funds (i.e., the cost of such an audit must be paid from recipient funds obtained from other than State entities).

PART III: OTHER AUDIT REQUIREMENTS

1. 45 CFR, Part 74.26(d) extends OMB requirements, as stated in Part I above, to for-profit organizations.

PART IV: REPORT SUBMISSION

1. Copies of audit reports for audits conducted in accordance with OMB Circular A-133, as revised, and required by PART I of this agreement shall be submitted, when required by Section .320 (d), OMB Circular A-133, as revised, by or on behalf of the recipient directly to each of the following:
 - A. The Agency for Health Care Administration at the following address:

See AHCA Standard Contract document, Section III,C,1
 - B. The Federal Audit Clearinghouse designated in OMB Circular A-133, as revised (the number of copies required by Sections .320 (d)(1) and (2), OMB Circular A-133, as revised, should be submitted to the Federal Audit Clearinghouse), at the following address:

Federal Audit Clearinghouse
Bureau of the Census
1201 East 10th Street
Jeffersonville, IN 47132
 - C. Other Federal agencies and pass-through entities in accordance with Sections .320 (e) and (f), OMB Circular A-133, as revised.
2. Pursuant to Section .320 (f), OMB Circular A-133, as revised, the recipient shall submit a copy of the reporting package described in Section .320 (c), OMB Circular A-133, as revised, and any management letters issued by the auditor, to the Agency at the following address:
 - A. The Agency for Health Care Administration at the address indicated in the Standard Contract document,
Section III, C, 1.
 - B. To the Federal Agency or pass-through entity making the request for a copy of the reporting package.

3. Copies of reporting packages required by PART II of this agreement shall be submitted by or on behalf of the recipient directly to each of the following:
 - A. The Agency for Health Care Administration at the address indicated in the Standard Contract document,
Section III, C.1.
 - B. The Auditor General's Office at the following address:

State of Florida Auditor General
Room 574, Claude Pepper Building
111 West Madison Street
Tallahassee, Florida 32302-1450
4. Copies of reports or management letters required by PART III of this agreement shall be submitted by or on behalf of the recipient directly to:
 - A. The Agency for Health Care Administration at the address indicated in the Standard Contract document,
Section III, C.1.
 - B. The Federal Department of Health and Human Services

National External Audit Resources Unit
323 West 8th St., Lucas Place-Room 514
Kansas City, MO 64105.
 - C. The Federal Audit Clearinghouse designated in OMB Circular A-133, as revised (the number of copies required by Sections .320 (d)(1) and (2), OMB Circular A-133, as revised, should be submitted to the following address:

Federal Audit Clearinghouse
Bureau of the Census
1201 East 10th Street
Jeffersonville, IN 47132
5. Any reports, management letters, or other information required to be submitted to the Agency pursuant to this agreement shall be submitted timely in accordance with OMB Circular A-133, Florida Statutes, and Chapter 10.650, Rules of the Auditor General, as applicable.
6. Recipients, when submitting audit reports to the Agency for audits done in accordance with OMB Circular A-133, Florida Statutes, and Chapter 10.650, Rules of the Auditor General, should indicate the date that the audit report was delivered from the auditor to the recipient in correspondence accompanying the audit report. This can be done by providing the cover letter from the audit report received from the auditor or a cover letter indicating the date the audit reporting package was received by the recipient.

PART V: RECORD RETENTION

1. The recipient shall retain sufficient records demonstrating its compliance with the terms of this agreement for a period of five (5) years from the date the audit report is issued, and shall allow the Agency or its designee, access to such records upon request. The recipient shall ensure that audit working papers are made available to the Agency or its designee, upon request for a period of five (5) years from the date the audit report is issued unless extended in writing by the Agency.

NOTE: Section .400(d) of the OMB Circular A-133, as revised, and Section 215.97 (5), Florida Statutes, require that the information about Federal and State Programs included in Part VI of this attachment be provided to the Provider organization if the Provider is determined to be a recipient. If Part VI is not included the Provider has not been determined to be a recipient as defined by the above referenced federal and state laws.

PART VI: SCHEDULE OF FEDERAL AND STATE FUNDING

(Mandatory to be completed by Agency Contract Manager and included as part of Attachment II, if Provider is determined to be a recipient of either state or federal financial assistance as defined in the OMB Circular A-133 as revised or Section 215.97(2)(m) F.S.. Contract Managers can utilize either the Federal funding or State funding Checklists for Evaluating Non-state Organization as a tool to assist in making this determination)

1. Compliance requirements for Federal Financial Assistance, State Matching and State Financial Assistance awarded pursuant to this agreement are included in the Agency Standard Contract document and the Attachment I, Special Provisions section.

a) **Federal Financial Assistance** awarded to the recipient pursuant to this agreement are as follows:

(Check appropriate Federal Program funding source(s) and provide amount per source.)

Department of Health and Human Services, Health Care Finance Administration

Medicaid Title 19 (CFDA# 93.778) Amount: \$
Medical Assistance Payments

Medicaid Title 21 (CFDA# 93.767) Amount: \$
Children’s Health Insurance program

Medicaid Title 18,19,CLIA Amount: \$
Survey and Certification (CFDA# 93.777)

b) **State matching funds** awarded to the Recipient pursuant to this agreement are as follows:

(Check appropriate Federal Program funding source and provide State matching amount per source.)

Department of Health and Human Services, Health Care Finance Administration

Medicaid Title 19 (CFDA# 93.778) Amount: \$
Medical Assistance Payments

Medicaid Title 21 (CFDA# 93.767) Amount: \$
Children’s Health Insurance Program

Medicaid Title 18,19, CLIA (CFDA# 93.777) Amount: \$
Survey and Certification

c) **State Financial Assistance** awarded pursuant to Section 215.97, F.S., Florida Single Audit Act

(If this section is checked provide CSFA #)

State Program (CSFA#) Amount: \$
State Project Title:

CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

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

- (1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

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

Signature

Date

Name of Authorized Individual

Application or Contract Number

Name and Address of Organization

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

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

INSTRUCTIONS

1. Each provider whose contract/subcontract equals or exceeds \$25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, providers who audit federal programs must also sign, regardless of the contract amount. The Agency for Health Care Administration cannot contract with these types of providers if they are debarred or suspended by the federal government.
2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.
3. The provider shall provide immediate written notice to the contract manager at any time the provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.
5. The provider agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.
6. The provider further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed \$25,000 in federal monies, to submit a signed copy of this certification.
7. The Agency for Health Care Administration may rely upon a certification of a provider that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.
8. This signed certification must be kept in the contract manager's contract file. Subcontractor's certifications must be kept at the contractor's business location.

CERTIFICATION

- (1) The prospective provider certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.
- (2) Where the prospective provider is unable to certify to any of the statements in this certification, such prospective provider shall attach an explanation to this certification.

Signature

Date

Name and Title of Authorized Individual

STATEMENT OF NO INVOLVEMENT

I, _____, as an authorized representative of _____, certify that no member of this firm nor any person having interest in this firm has been awarded a contract by the Agency for Health Care Administration on a noncompetitive basis to:

- (1) develop this Request For Proposals;
- (2) perform a feasibility study concerning the scope of work contained in this RFP; or
- (3) develop a program similar to what is contained in this RFP.

Authorized Representative Signature

Date

AGENCY FOR HEALTH CARE ADMINISTRATION
Drug-free Workplace Certification

IDENTICAL TIE BIDS/PROPOSALS-Preference shall be given to business with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free work place program shall be given preference in the award process. Established procedures for processing tied awards will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

- 1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.
- 2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.
- 3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).
- 4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.
- 5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by, any employee who is so convicted.
- 6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

Authorized Signature

Date

PMHP STANDARD REPORTING REQUIREMENTS

| Report | Specific Data Elements | Format | Frequency Requirements | Submit to: |
|--|--|--------------------------------|--|----------------------------------|
| Allocation of Recipients | See Attachment 9 | Hardcopy | Monthly - Due on the 15th of the month - Contains previous calendar month's data | AHCA Contract Manager & designee |
| Targeted Case Management Caseload | See Attachment 10 | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Consumer Satisfaction Survey Summary | See Attachment 11; Also requires submission of copy of survey tool used. | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Stakeholders Satisfaction Survey Summary | See Attachment 12; Also requires submission of copy of survey tool used. | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Grievances, Summary & Details | See Attachment 13 | Hardcopy | Monthly - Due on the 15th of the month - Contains previous calendar month's data | AHCA Contract Manager & designee |
| Service Utilization Summary | See Attachment 14 | Hardcopy | Monthly - Due on the 15 th of the month – Contains previous calendar month's data | AHCA Contract Manager & designee |
| Details of Service Utilization | See Attachment 15 | On Disk; Spreadsheet format | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Recipients Served | See Attachment 16 | Hardcopy | Monthly - Due on the 15th of the month - Contains previous calendar month's data | AHCA Contract Manager & designee |

PMHP STANDARD REPORTING REQUIREMENTS

| Report | Specific Data Elements | Format | Frequency Requirements | Submit to: |
|--------------------------------------|---|----------|--|----------------------------------|
| Hospital Inpatient Data | See Attachment 17 | Hardcopy | Monthly - Due on the 15th of the month - Contains previous calendar month's data | AHCA Contract Manager & designee |
| Required Staff/Providers | See Attachment 18 | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Critical Incident Summary | See Attachment 19 | Hardcopy | Monthly - Due on the 15th of the month - Contains previous calendar month's data | AHCA Contract Manager & designee |
| Individual Critical Incidents | See Attachment 20 | Hardcopy | Immediately upon occurrence | AHCA Designated Quality Manager |
| Quality Improvement Reporting | Minutes of QI Meetings; Updates of policies, procedures, clinical guidelines | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Quality Improvement Reporting | Clinical record review results - Must include review of 10% or 50 records whichever is fewer; 30% or 15 records must include children in care or custody; Reviews must reflect screening for high risk conditions as specified in the contract. | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Quality Improvement Reporting | Corrective action plans developed or implemented | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |

PMHP STANDARD REPORTING REQUIREMENTS

| Report | Specific Data Elements | Format | Frequency Requirements | Submit to: |
|---|---|----------|--|----------------------------------|
| Quality Improvement Reporting | QI Initiatives active during the report period. | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Quality Improvement Reporting | Plan enrollees placed in Residential Treatment monitoring activities in accordance with contract requirements | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Quality Improvement Reporting | Protocol development and implementation related to the coordination of mental health services with substance abuse services and other multiple diagnoses. | Hardcopy | Monthly - Due on the 15th of the month - Contains previous calendar month's data | AHCA Contract Manager & designee |
| Outreach Reporting | Outreach activities completed; Status of outreach sites at DCF Service Units; Specific mailings sent to recipients, providers, and others; All activities targeted at complying with contract requirements. | Hardcopy | Quarterly - Due 45 days after the end of the quarter being reported - Contains data for entire quarter | AHCA Contract Manager & designee |
| Cost Reporting | Overhead and service costs for mandatory services and any other services provided; Staffing position and utilization information | Hardcopy | Semi-annual and annual – Due 45 days after the end of the period being reported | AHCA Contract Manager & designee |
| Financial Reporting | Audited financial statement; See Section 2.38 of the RFP for requirements | Hardcopy | Annual - Due no later than six calendar months after the end of the contractor fiscal year | AHCA Contract Manager & designee |
| Monthly Out-of-Plan Claims Inventory | See Attachment 21 | Hardcopy | Quarterly - Due at the Contract Compliance Monitoring | AHCA Contract Manager & designee |
| Out-of-Plan Claims Adjudication | See Attachment 22 | Hardcopy | Quarterly - Due at the Contract Compliance Monitoring | AHCA Contract Manager & designee |

**Prepaid Mental Health Plan – Allocation of Recipients Report
Monthly**

NUMBER OF RECIPIENTS ASSIGNED TO EACH PROVIDER

| | Medicaid Eligibility Category | Provider Name | Provider Name | Provider Name | Provider Name |
|----------------------|--|----------------------|----------------------|----------------------|----------------------|
| Age Group - Children | TANF | | | | |
| Age Group - Adults | TANF | | | | |
| Age Group - Children | FOSTER CARE | | | | |
| Age Group – Children | SOBRA CHILDREN | | | | |
| Age Group – Children | SSI | | | | |
| Age Group – Adults | SSI | | | | |
| | Total assigned to Provider | | | | |
| | Percentage of total assigned to Provider | | | | |
| | Total children in plan | | | | |
| | Total adults in plan | | | | |

**Prepaid Mental Health Plan – Targeted Case Management Caseload Report
Quarterly**

Children’s Targeted Case Management

| | Provider Name | Provider Name | Provider Name | Provider Name | Total in Plan |
|-----------------------|---------------|---------------|---------------|---------------|----------------------|
| # FTEs | | | | | |
| # Recipients | | | | | |
| Average Caseload Size | | | | | |

Adult Targeted Case Management

| | Provider Name | Provider Name | Provider Name | Provider Name | Total in Plan |
|-----------------------|---------------|---------------|---------------|---------------|----------------------|
| # FTEs | | | | | |
| # Recipients | | | | | |
| Average Caseload Size | | | | | |

Intensive Team Case Management

| | Provider Name | Provider Name | Provider Name | Provider Name | Total in Plan |
|-----------------------|---------------|---------------|---------------|---------------|----------------------|
| # FTEs | | | | | |
| # Recipients | | | | | |
| Average Caseload Size | | | | | |

Case Management of “Mixed” populations (i.e., children & adults)

| | Provider Name | Provider Name | Provider Name | Provider Name | Total in Plan |
|---------------------------------|---------------|---------------|---------------|---------------|----------------------|
| #FTEs | | | | | |
| # adult Recipients | | | | | |
| # child Recipients | | | | | |
| Average # adults per caseload | | | | | |
| Average # children per caseload | | | | | |

**Prepaid Mental Health Plan – Stakeholders Satisfaction Survey Report Summary
Quarterly**

| Types of stakeholders surveyed | DCF Counselors | Community Based Care Providers | Foster Parents | Consumer Advocacy Groups | Parents of SED children | Out-of-plan Providers (specify) | Others |
|---|-----------------------|---------------------------------------|-----------------------|---------------------------------|--------------------------------|--|---------------|
| Number of surveys distributed | | | | | | | |
| Number of surveys completed in each type | | | | | | | |
| Method used | | | | | | | |

| |
|--|
| <p>Summary of Responses:</p> |
| <p>Significant findings or results that will be</p> |

**Prepaid Mental Health Plan – Grievance Report
Monthly**

| Type of Grievance | Number received |
|--------------------------------|------------------------|
| Access to Care | |
| Clinical Care (provider) | |
| Clinical Care (service) | |
| Service provision (quality) | |
| Service provision (quantity) | |
| Service provision (timeliness) | |
| Claims | |
| Benefit plan | |
| Total | |

Narrative for each grievance includes:

Recipient Medicaid ID#

Name of assigned provider

Date grievance was filed

Date grievance was received

Description of grievance, including source and circumstance

Description of actions taken and the actual resolution

**Prepaid Mental Health Plan – Service Utilization Summary Report
Monthly**

| Number of Recipients by Category | | | | | | | |
|---|--------------------------------------|-----------------------|-----------------------|------------------------|------------------------|------------------------|------------------------|
| Types of Services | Total Number of units | TANF CHILD | TANF ADULT | FOSTER CARE | SOBRA CHILD | SSI - CHILD | SSI - ADULT |
| Inpatient hospital | | | | | | | |
| Outpatient hospital | | | | | | | |
| Psychiatric physician | | | | | | | |
| TCM – children | | | | | | | |
| TCM – adults | | | | | | | |
| TCM – Intensive | | | | | | | |
| CMH – Evaluation/testing | | | | | | | |
| CMH - Counseling/therapy | | | | | | | |
| CMH – Rehab. | | | | | | | |
| CMH – Children's MH | | | | | | | |
| CMH – DTX | | | | | | | |

**Prepaid Mental Health Plan – Detail Service Utilization Report
Quarterly**

| Recipient Medicaid ID # | Recipient Age | Recipient Medicaid Eligibility Group | Service Code | Number of Units | Diagnosis Code | Pay-to-Provider Name |
|-------------------------|---------------|--------------------------------------|--------------|-----------------|----------------|----------------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Services that must be reported are as follows:

- Inpatient Acute Care
- Crisis Acute Care
- Emergency Room Services
- Crisis Intervention Services
- Court Ordered evaluations
- Medical Psychiatric Services
- Adult Targeted Case Management
- Children’s Targeted Case Management
- Intensive Team Case Management
- Functional Assessments (CFARS, etc.)
- Evaluation and Testing services
- Counseling and Therapy services
- Rehabilitative Services
- Intensive Therapeutic services for children
- Home and community-based services for children
- Day Treatment services
- Community Treatment for State Hospital Discharges
- Community Treatment services for Forensic enrollees
- Psychiatric Evaluations for enrollees applying for nursing home admission
- Opportunities for Recovery and Reintegration services
- Services for Medically complex enrollees

Additional services identified as covered by the plan must be specified and reported.

**Prepaid Mental Health Plan – Staff Report
Quarterly**

| Number of FTEs in Specialty Areas | | | | | | | | | | | | | | | | | |
|-----------------------------------|---------------|----------|---------------|------------------|------------------|-----------------|---------------------------|---------------|----------------------|----------------------|--------------------|--------------------|------------------------------|----------------------------|----------------------|----------------|------------|
| Positions | Total # FTE's | Adoption | Child Protect | Dual Dx. - MI/SA | Dual Dx. - MI/DD | Dev. Disability | Bx. Mgmt/ Altern. Therapy | Separ. & Loss | Sexual abuse – child | Sexual abuse - adult | Phys abuse – child | Phys abuse - adult | Domestic violence - children | Domestic violence - adults | Court order ed evals | Expert witness | Bi-Lingual |
| Adult Psychiatrists | | | | | | | | | | | | | | | | | |
| Child Psychiatrists | | | | | | | | | | | | | | | | | |
| Other Physicians | | | | | | | | | | | | | | | | | |
| Physician Assistants & ARNP's | | | | | | | | | | | | | | | | | |
| Psychologists | | | | | | | | | | | | | | | | | |
| Masters | | | | | | | | | | | | | | | | | |
| Social Workers | | | | | | | | | | | | | | | | | |
| Bachelor Level | | | | | | | | | | | | | | | | | |
| Associates Level | | | | | | | | | | | | | | | | | |
| Non-Degreed Techs | | | | | | | | | | | | | | | | | |
| RN | | | | | | | | | | | | | | | | | |
| LPN | | | | | | | | | | | | | | | | | |
| Other positions as applicable | | | | | | | | | | | | | | | | | |
| Unduplicated Totals | | | | | | | | | | | | | | | | | |

**Bi-Lingual: Staff who are able to communicate in the languages identified as required by the contract due to 5% or more of the population speaking a language other than English.*

**Prepaid Mental Health Plan – Critical Incidents Summary Report
Monthly**

| Incident Type | # of Events |
|--|--------------------|
| Recipient Death – Suicide | |
| Recipient Death – Homicide | |
| Recipient Death – Abuse/Neglect | |
| Recipient Death – other | |
| Recipient Injury or Illness | |
| Sexual Battery | |
| Medication Errors – acute care | |
| Medication Errors – children | |
| Recipient Suicide Attempt | |
| Altercations requiring Medical Interventions | |
| Recipient Escape | |
| Recipient Elopement | |
| Other reportable incidents | |
| Total | |

**Prepaid Mental Health Plan
Critical Incident Report Form**

Date of Report: _____

| | |
|--|--|
| Recipient Medicaid ID#: | |
| Date of Incident: | |
| Location of Incident: | |
| Critical Incident Type: | |
| Details of Incident: (Include recipient's age, sex, diagnosis, current medication, source of information, all reported details about the event, action taken by contractor or provider, and any other pertinent information) | |
| Follow up planned or required: (Include information related to any contractor or provider protocol that applies to event.) | |
| Assigned provider: | |
| Report submitted by: | |
| Date of submission: | |

**PMHP Contract Compliance Monitoring
Out-of-Plan Claims Inventory Report
Status of Claims Received by the Contractor**

Month of:

Inventory History

| Status | 0 – 15 days | 16 - 30 days | 31 - 35 days | 36 - 60 days | > 60 days | Total |
|--------------------|-------------|--------------|--------------|--------------|-----------|-------|
| Claims Adjudicated | | | | | | |
| Claims Open | | | | | | |

Month of:

Inventory History

| Status | 0 – 15 days | 16 - 30 days | 31 - 35 days | 36 - 60 days | > 60 days | Total |
|--------------------|-------------|--------------|--------------|--------------|-----------|-------|
| Claims Adjudicated | | | | | | |
| Claims Open | | | | | | |

Month of:

Inventory History

| Status | 0 – 15 days | 16 - 30 days | 31 - 35 days | 36 - 60 days | > 60 days | Total |
|--------------------|-------------|--------------|--------------|--------------|-----------|-------|
| Claims Adjudicated | | | | | | |
| Claims Open | | | | | | |

Month of:

Inventory History

| Status | 0 – 15 days | 16 - 30 days | 31 - 35 days | 36 - 60 days | > 60 days | Total |
|--------------------|-------------|--------------|--------------|--------------|-----------|-------|
| Claims Adjudicated | | | | | | |
| Claims Open | | | | | | |

**AGENCY FOR HEALTH CARE ADMINISTRATION
SUMMARY OF THE FLORIDA PATIENT'S BILL OF
RIGHTS AND RESPONSIBILITIES**

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- * A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- * A patient has the right to a prompt and reasonable response to questions and requests.
- * A patient has the right to know who is providing medical services and who is responsible for his or her care.
- * A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- * A patient has the right to know what rules and regulations apply to his or her conduct.
- * A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- * A patient has the right to refuse treatment, except as otherwise provided by law.
- * A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- * A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- * A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- * A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- * A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- * A patient has the right to treatment of any emergency medical condition that will deteriorate from failure to provide treatment.

- * A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- * A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to appropriate licensing agency.
- * A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- * A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- * A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- * A patient is responsible for following the treatment plan recommended by the health care provider.
- * A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- * A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- * A patient is responsible for assuring that the financial obligations of his or her health care fulfilled as promptly as possible.
- * A patient is responsible for following health care and facility rules and regulations affecting patient care and conduct.

FILING COMPLAINTS:

If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-3456 (Press #1) or write to the address listed below:

AGENCY FOR HEALTH CARE ADMINISTRATION
CONSUMER ASSISTANCE UNIT
2727 MAHAN DRIVE, BLDG. #1
TALLAHASSEE, FL 32308

If you have a complaint against a health care professional and want to receive a complaint form, call the Consumer Services Unit at 1-888-419-3456 (Press #2) or write to the address below:

AGENCY FOR HEALTH CARE ADMINISTRATION
CONSUMER ASSISTANCE UNIT
P.O. BOX 14000
TALLAHASSEE, FL 32317-4000

**Prepaid Mental Health Plan
Staff Training and Experience Requirements
for Services Provided by the Contractor**

The contractor must have an adequate number of staff members at each level who possess the appropriate credentials to render the following services as specified:

| | |
|---------------------------------|---|
| Treatment Planning and Review | Licensed Practitioner of the Healing Arts or Psychiatrist or other Treating Physician (for initial face-to-face Interview and authorization of plan) Treating physician and Multi-disciplinary Treatment Team (develops) |
| Evaluation and testing services | The contractor must establish privileging protocols that address the qualifications and competency levels required to administer, score and interpret the instruments that will be used. The protocols must address the use of both standardized and non-standardized assessments. All findings, clinical judgments or impressions and treatment recommendations must be reviewed and approved by a Licensed Practitioner of the Healing Arts |
| Assessments | Senior Community Mental Health Practitioner |
| Medical interventions | Psychiatrist, Psychiatric ARNP, Physician’s Assistant or treating physician within the scope of training and protocols. |
| Therapy services | Senior Community Mental Health Practitioner, or Licensed Practitioner of the Healing Arts The contractor must establish privileging protocols that address the qualifications and competency levels required to perform these functions for specific populations. |
| Rehabilitative services | Community Mental Health Technician or Community Mental Health Practitioner under the supervision of a Senior Community Mental Health Practitioner or Licensed Practitioner of the Healing Arts. |
| Day Treatment services | Community Mental Health Practitioner and Community Mental Health Technician under the supervision of a Senior Community Mental Health Practitioner or a Licensed Practitioner of the Healing Arts. Licensed Practitioner or a Senior Community Mental Health Practitioner must provide therapy services when necessary. The contractor shall have protocols to clarify the need for clinical consultation and availability of licensed practitioners. |

Intensive Therapeutic On-site Services for Children

Community Mental Health Practitioner under direct supervision of a Licensed Practitioner or a Senior Community Mental Health Practitioner.

Home and Community Based Rehabilitative Services

Community Mental Health Practitioner or Technician under the direct supervision of a Licensed Practitioner or a Senior Community Mental Health Practitioner

Psychiatric Evaluations for Enrollees applying for Nursing Home Admission

Psychiatrist or Treating Physician

Opportunities for Recovery and Reintegration

Community Mental Health Technician and other professionals appropriate to the type of services provided. The contractor shall establish protocols that address the qualifications and competency requirements for performing the functions that will be available for this service.

Optional Services

Contractor shall indicate and establish protocol to address the minimum qualifications and competency levels required for each service that will be available.

In the event that the agency adds Comprehensive Assessment services to the Prepaid Mental Health Plan contract, the contractor must be prepared to demonstrate adequate staff resources with the appropriate credentials to provide the service. Credentials are as follows:

Licensed Psychiatric Nurse,
Licensed Clinical Social Worker,
Licensed Mental Health Counselor,
Licensed Marriage and Family Therapist,
Licensed Psychologist, or
Psychiatrist

Staff members must have at least two years of direct experience working with children and families who are victims of physical abuse, sexual abuse, neglect, or youth who have been adjudicated delinquent and committed and are emotionally disturbed. Each staff member must also have a list of current conferences or workshops attended and Continuing Education Units earned, dedicated to relevant child and family treatment issues.

A non-licensed Mental Health Professional with a master's degree in the field of counseling, social work, psychology, rehabilitation, special education or a human services field with a minimum of five years experience working with the above mentioned population, two years experience working with foster parents, and the documented conferences or workshops above may also provide this service.

Definitions:

Staff Training and Experience: Where specific training or experience is required, staff must have training or experience working with the assigned age group (i.e., recipients under or over age 21) and disability (i.e., specific mental health diagnoses and severity of illness). Staff must provide services within the scope of their professional licensure, training, protocols and competence and within the purview of statutes applicable to their respective profession.

Treating Physician

A treating physician is the psychiatrist or other physician who authorizes mental health services. The treating physician also personally renders services and functions as a member of the multidisciplinary treatment team.

Licensed Practitioner of the Healing Arts

Licensed practitioners of the healing arts include the following professionals who are licensed pursuant to Florida statute: psychiatric nurses (registered nurses or advanced registered nurse practitioners), physician assistants, clinical social workers, mental health counselors, marriage and family therapists, and psychologists.

Psychiatric ARNP

A psychiatric ARNP is a licensed advanced registered nurse practitioner who works in collaboration with a physician according to protocol, to provide diagnostic and clinical interventions. The psychiatric ARNP must also have education or training in psychiatry, and be authorized to provide these services by Chapter 464, F.S. and protocols filed with the Board of Medicine.

Psychiatric Nurse

A psychiatric nurse is a registered nurse with a master's degree or a doctor's degree in psychiatric nursing and two years of post-master's clinical experience under the supervision of a physician (Chapter 394.455(23), F.S.).

Advanced Registered Nurse Practitioner

An ARNP is a licensed advanced registered nurse practitioner who works in collaboration with a physician according to protocol, to provide diagnostic and clinical interventions. An ARNP must be authorized to provide these services by Chapter 464, F.S. and protocols filed with the Board of Medicine.

Senior Community Mental Health Practitioner

A senior community mental health practitioner is an individual with a master's degree in the field of counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field. The individual must have two years of professional experience in providing services to persons with serious mental illness and training in the following areas:

Evaluations and assessments, treatment planning, treatment interventions, documentation, psychopharmacology, abuse regulations, patient rights and special clinical circumstances such as emergencies, suicide, and out-of-control behavior.

or

An individual with a master's degree in the field of counseling, social work, psychology, nursing, rehabilitation, special education, health education or a human services field who is under the direct supervision of a licensed practitioner of the healing arts.

Community Mental Health Practitioner

A community mental health practitioner must, at a minimum, have a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field. The individual must also have training in the following:

- treatment of mental health disorders,
- human growth and development,
- evaluations and assessments,
- treatment planning,
- basic counseling and behavioral management interventions,
- case management,
- documentation,
- psychopharmacology,
- abuse regulations, patient rights and
- special clinical circumstances such as emergencies, suicide, and out-of-control behavior.

Community Mental Health Technician

A community mental health technician must have a high school degree or equivalent and in-service training in the treatment of mental health disorders, abuse regulations and confidentiality. The community mental health technician must be able to function as a member of a multidisciplinary team, provide basic support services and perform behavioral management duties. The community mental health technician must be familiar with documentation requirements and patient rights and be able to respond to special clinical circumstances such as emergencies, suicide, and out-of-control behavior.