RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

October 2, 2017

Prospective Vendor(s):

Subject: Solicitation Number: AHCA ITN 001–17/18 – Region 1

Title: Statewide Medicaid Managed Care Program

Addendum No. 2

The enclosed information has been provided for consideration in the preparation of your response to the above mentioned solicitation.

All other terms and conditions of the solicitation remain in effect.

To the extent this Addendum gives rise to a protest, failure to file a protest within the time prescribed in Section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

Sincerely,
Jennifer Barrett
Jennifer Barrett, Chief
Bureau of Support Services

Enclosures: Addendum No. 2 (13 Pages)
Questions and Answers (72 Pages)

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Item #1

Informational documents relative to this solicitation are provided in the SMMC Procurement Reference Document Library and the SMMC Data Book Reference Library at the following link:

http://ahca.myflorida.com/Procurements/index.shtml

Item #2

Attachment A, Instructions and Special Conditions, **Section D.**, Response Evaluation, Negotiations, and Contract Award, **Sub-Section 3.**, Non-Scored Requirements, is hereby amended to include **Item g.**, Cost Proposal as follows:

g. Cost Proposal

The Procurement Office and other Agency staff will review responses to this solicitation to determine if the respondent included in its response, **Attachment C,** Cost Proposal and Instructions, including applicable exhibits.

The Agency will review and consider the cost proposals submitted by respondents who are invited to negotiations during the negotiation phase. The Agency intends to negotiate common base rates for each region.

Item #3

Attachment A, Instructions and Special Conditions, **Section D.**, Response Evaluation, Negotiations, and Contract Award, **Sub-Section 4.**, Scored Requirements – Evaluation Criteria, **Item d.**, Cost Proposal, is hereby deleted in its entirety.

Item #4

Attachment A, Instructions and Special Conditions, **Section E.**, Contract Implementation, **Sub-Section 2.**, Readiness Review, **Item e.**, is hereby deleted in its entirety.

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Item #5

Attachment A, Instructions and Special Conditions, **Exhibit A-2-c**, Additional Required Certifications and Statements, **Item 14.**, Required Plan Readiness Documentation, the second checkbox is hereby deleted in its entirety. The updated exhibit is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #6

Attachment A, Instructions and Special Conditions, **Section E.**, Contract Implementation, **Sub-Section 4.**, Transition Enrollment, **Item c.**, Enrollees Who Do Not Make an Active Plan Choice, **Sub-Item 3)**, the first sentence is amended to now read as follows:

The Agency will assign Managed Medical Assistance enrollees, who do not make an active plan choice, into their existing plan if that plan was awarded a Contract to provide services in the same region under the resulting Contract from this solicitation in order to meet the criteria established in Section 409.977(2), Florida Statutes.

Item #7

Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, **Section B.**, Agency Goals, SRC# 6 – HEDIS Measures (Statewide), **Exhibit A-4-a-1**, SRC# 6 – General Performance Measurement Tool, is hereby deleted in its entirety and replaced with **Exhibit A-4-a-1**, SRC# 6 – General Performance Measurement Tool (10-2-2017). The updated exhibit is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #8

Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, **Section C.**, Recipient Experience, SRC# 9 – Expanded Benefits (Regional), is hereby amended to now read as follows. An updated version of **Exhibit A-4-a**, General Submission Requirements and Evaluation Criteria is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

SRC# 9 – Expanded Benefits (Regional):

Based upon the expanded benefits listed in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent shall identify the benefits it proposes to offer its enrollees for all eligible populations (TANF, ABD, dual eligible, and LTC populations). **Exhibit A-4-a-2**, Expanded Benefits Tool outlines specific expanded benefits, including category, procedure code descriptions and procedure codes. When electing to offer expanded benefits included in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in **Exhibit A-4-a-2**.

Response: The respondent shall select the following expanded benefits it will offer, as listed in **Exhibit A-4-a-2**, Expanded Benefits Tool (Respondent shall check all that apply):

☐ Dental benefits for adults
☐ Over-the-counter benefits
☐ Occupational Therapy benefits for adults

☐ Physical Therapy benefits for adults
☐ Hearing benefit for adults
☐ Vision benefit for adults
☐ Prenatal benefit
☐ Respiratory Therapy benefit for adults
☐ Speech Therapy benefit for adults
☐ Additional Primary Care services benefit
☐ Newborn Circumcision benefit

Evaluation Criteria:

Score: This section is worth a maximum of 190 raw points as outlined below.

(a)	Election of the Dental benefit for adults:	50 pts
(b)	Election of the Over-the-counter benefit:	25 pts
(c)	Election of the Occupational Therapy benefits for adults:	20 pts
(d)	Election of the Physical Therapy benefit for adults:	20 pts
(e)	Election of the Prenatal benefit:	20 pts
(f)	Election of the Hearing benefit for adults:	10 pts
(g)	Election of the Vision benefit for adults:	10 pts
(h)	Election of the Respiratory Therapy benefit for adults:	10 pts
(i)	Election of the Speech Therapy benefit for adults:	10 pts
(j)	Election of the Additional Primary Care services benefit:	10 pts
(k)	Election of the Newborn Circumcision benefit:	5 pts

Item #9

Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, **Section C.**, Recipient Experience, SRC# 9 – Expanded Benefits (Regional), **Exhibit A-4-a-2**, SRC# 9 – Expanded Benefits Tool (Regional), is hereby deleted in its entirety and replaced with **Exhibit A-4-a-2**, SRC# 9 – Expanded Benefits Tool (Regional) (10-2-2017). The updated exhibit is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #10

Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, **Section F.**, Oversight and Accountability, SRC# 30 – Encounter Submission for Sub-Capitated, Subcontracted, Non-Pay and Atypical (Statewide), the SRC title is hereby amended to now read as follows. An updated version of **Exhibit A-4-a**, General Submission Requirements and Evaluation Criteria is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

SRC# 30 – Encounter Submission for Sub-Capitated, Subcontracted, Non-Par and Atypical (Statewide)

Item #11

Technical Correction (Region 11 Only)

Exhibit A-4-b, MMA Submission Requirements and Evaluation Criteria, **Section B.**, Agency Goals, MMA SRC #6 – Provider Network Agreements/Contracts (Regional)**,** is hereby amended as follows:

Score: This section is worth a maximum of 220 raw points based on the above point scale.

Item #12

Exhibit A-4-b, MMA Submission Requirements and Evaluation Criteria, **Section B.**, Agency Goals, **SRC# 6** – Provider Network Agreements/Contracts (Regional), **Exhibit A-4-b-1**, MMA SRC# 6 - Provider Network Agreements/Contracts (Regional), is hereby deleted in its entirety and replaced with **Exhibit A-4-b-1**, MMA SRC# 6 - Provider Network Agreements/Contracts (Regional) (10-2-2017). The updated exhibit is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #13

Exhibit A-4-b, MMA Submission Requirements and Evaluation Criteria, **Section E.**, Delivery System Coordination, MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide), is hereby amended to now read as follows. An updated version of **Exhibit A-4-b**, MMA Submission Requirements and Evaluation Criteria is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. Include in table format, the target population (TANF, ABD, dual eligibles), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-b-2**, MMA Performance Measurement Tool (10-2-2017) to provide results for the following HEDIS measures:

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;

- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.

2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 70 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 60 points as described below:

Exhibit A-4-b-2, MMA Performance Measurement Tool (10-2-2017), provides for forty-two (42) opportunities for a respondent to report prior experience in meeting quality standards (seven (7) measure rates, three (3) states each, two (2) years each).

For each of the seven (7) measure rates, a total of 5 points is available per state reported (for a total of 105 points available). The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean and 1 point if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 1 point for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 60 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 105 points, the final score will be 60 points (100%). If a respondent receives 95 (90%) of the available 105 points, the final score will be 54 points (90%). If a respondent receives 10 (10%) of the available 105 points, the final score will be 6 points (10%).

Item #14

Exhibit A-4-b, MMA Submission Requirements and Evaluation Criteria, **Section E.**, Delivery System Coordination, MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide), **Exhibit A-4-b-2**, MMA Performance Measurement Tool, is hereby deleted in its entirety and replaced with **Exhibit A-4-b-2**, MMA Performance Measurement Tool (10-2-2017). The updated exhibit is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #15

Exhibit A-4-c, LTC Submission Requirements and Evaluation Criteria, **Section B.,** Agency Goals, LTC SRC# 4 – Provider Network Agreements/Contracts (Regional), is hereby deleted in its entirety and replaced as follows. An updated version of **Exhibit A-4-c**, LTC Submission Requirements and Evaluation Criteria is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

LTC SRC# 4 – Provider Network Agreements/Contracts (Regional)

The Agency has identified some the key network provider types that will be critical in order for the respondent to promote the Agency's goals.

The respondent shall demonstrate its progress with executing agreements or contracts it had with providers in the region by submitting **Exhibit A-4-c-1**, Provider Network Agreements/Contracts (Regional) (10-2-2017):

Response:

Evaluation Criteria:

For each service type the respondent may receive up to 60 points as described below. There are four (4) service types available in a region.

Percentage of agreements/contracts for each service type	Points
0.0%	0
1.0% - 25%	15
25.1% - 50%	30
50.1% - 75%	45
75.1% or greater	60

Score: This section is worth a maximum of 240 raw points based on the above point scale.

Item #16

Exhibit A-4-c, LTC Submission Requirements and Evaluation Criteria, **Section B.,** Agency Goals, LTC SRC# 4 – Provider Network Agreements/Contracts (Regional), **Exhibit A-4-c-1,** Provider Network Agreements/Contracts (Regional), is hereby deleted in its entirety and replaced with **Exhibit A-4-c-1,** Provider Network Agreements/Contracts (Regional) (10-2-2017). The updated exhibit is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

Item #17

Attachment B, Scope of Services – Core Provisions, **Section IX**, Quality, **Sub-Section A.**, Quality Improvement, **Item 5.**, Quality Improvement Plan, **Sub-Item (4)**, the hyperlink to access CMS protocols is amended to now read as follows:

http://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

Item #18

Attachment B, Scope of Services – Core Provisions, **Section XV.**, Special Terms and Conditions, **Sub-Section E.**, Readiness, **Item 2.**, is hereby deleted in its entirety.

Item #19

Attachment B, Scope of Services – Core Provisions, **Section XV.**, Special Terms and Conditions, **Sub-Section G.**, Termination Procedures, **Item 8.**, is hereby amended to now read as follows:

8. If the Managed Care Plan received an additional award pursuant to s. 409.966(3)(e), F.S., and fails to meet plan readiness criteria in Region 1 or Region 2, the Managed Care Plan's additional awarded region(s) shall be terminated within one hundred eighty (180) days after the respective Region 1 and/or Region 2 termination from this Contract.

Item #20

Attachment B, Scope of Services – Core Provisions, **Section XV.**, Special Terms and Conditions, **Sub-Section W.**, Performance Bond, **Item 3.**, second sentence is hereby amended to now read as follows:

Thereafter, the bond shall be furnished on an annual basis, thirty (30) calendar days prior to the new Contract year for the same amount as required for the initial performance bond.

Item #21

Attachment B, Scope of Services – Core Provisions, **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VI.**, Coverage and Authorization of Services, **Sub-Section A.**, Required MMA Benefits, **Item 1.**, Specific MMA Services to be Provided, **Sub-Item a(2)**, Clinic Services, is hereby amended to now read as follows:

(2) Clinic Services

(a) The Managed Care Plan shall provide RHC services. Rural Health Clinics provide ambulatory primary care to a medically underserved population in a rural geographical area. An RHC provides primary health care and related diagnostic services.

(i) RHC services reimbursed through the clinic encounter rate include:

- Adult health screening services
- Well-child visits
- Chiropractic services
- Family planning services
- HIV counseling services
- Medical primary care services
- Mental health services
- Optometric services
- Podiatric services.

(ii) RHC services reimbursed outside the clinic encounter rate include:

- Emergency services
- Immunization services
- Any health care services rendered away from the RHC, at a hospital, or a nursing facility, including off-site radiology services and off-site clinical laboratory services
- Radiology and other diagnostic imaging services
- Home health services
- Prescribed drug services
- WIC certifications or recertifications
- Clinic visits for the sole purpose of obtaining lab specimens or to obtain results from a diagnostic test
- Clinic visits for the sole purpose of obtaining immunizations
- Mental health services for chronic conditions without acute exacerbation

(b) The Managed Care Plan shall provide FQHC Services. An FQHC provides primary health care and related diagnostic services.

(i) FQHC services reimbursed through the clinic encounter rate include:

- Adult health screening services

- Well-child visits
- Chiropractic services
- Family planning services
- Medical primary care
- Mental health services
- Optometric services
- Podiatric services
- Diagnostic and treatment radiology services

(ii) FQHC services reimbursed outside the clinic encounter rate include:

- Emergency services
- Services rendered away from the FQHC clinic or satellite clinic
- Immunization services
- Home health services
- Prescription drug services
- WIC certifications and recertifications
- Mental health services for chronic conditions without acute exacerbation

(c) The Managed Care Plan shall provide CHD Services. County Health Departments provide public health services in accordance with Chapter 154, F.S. A CHD provides primary and preventive health care, and related diagnostic services, including but not limited to:

- Adult health screening services
- Well-child visits
- Family planning services
- Immunization services
- Medical primary care services

- Registered nurse services.

Item #22

Attachment B, Scope of Services - Core Provisions, **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VI.**, Coverage and Authorization of Services, **Sub-Section G.**, Authorization of Services, **Item 2.**, Utilization Management Program Description, **Sub-Item g.**, is hereby amended to now read as follows:

g. The Managed Care Plan shall make available those drugs and dosage forms listed on the Agency's Medicaid PDL, and shall comply with the following requirements listed in s. 409.912(5), F.S.:

(1) The requirements of s. 409.912(5)(a)1., F.S., regarding responding to requests for prior authorization and 72-hour drug supplies;

(2) The requirements of s. 409.912(5)(a)14., 15., and 16., F.S., regarding prior authorization.

Item #23

Attachment B., Scope of Services – Core Provisions, **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services, **Sub-Section A.**, Network Adequacy Standards, **Item 5.**, Public Health Providers, is hereby amended to now read as follows:

5. Public Health Providers

a. The Managed Care Plan make a good faith effort to execute memoranda of agreement, as specified in this Sub-Section, with public health providers, including:

(1) CHDs qualified pursuant to rule 59G-4.055, F.A.C.;

(2) RHCs qualified pursuant to rule 59G-4.280, F.A.C.; and

(3) FQHCs qualified pursuant to rule 59G-4.100, F.A.C.

The Managed Care Plan shall provide documentation of its good faith effort upon the Agency's request.

b. The Managed Care Plan shall pay at the contracted rate or the Medicaid FFS rate, without authorization, all authorized claims for the following services provided by a CHD, migrant health center funded under Section 329 of the Public Health Services Act, or community health center funded under Section 330 of the Public Health Services Act. The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD encounter rate as specified by the County Health Department Clinic Rule and the associated Florida Medicaid fee schedule for applicable rates for the following services:

(1) Office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis.

(2) The diagnosis and treatment of sexually transmitted diseases and other reportable infectious diseases, such as tuberculosis and HIV;

(3) The provision of immunizations;

(4) Family planning services and related pharmaceuticals;

(5) School health services provided by CHDs, and for services rendered on an urgent basis by such providers; and

(6) In the event that a vaccine-preventable disease emergency is declared, claims from the CHD for the cost of the administration of vaccines.

The Managed Care Plan may require prior authorization for all other covered services provided by CHDs.

c. The Managed Care Plan shall reimburse the CHD when the CHD notifies the Managed Care Plan and provides the Managed Care Plan with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.

d. The Managed Care Plan shall pay, without prior authorization, at the contracted rate or the Medicaid FFS rate, all valid claims initiated by any CHD for office visits, prescribed drugs, laboratory services directly related to DCF emergency shelter medical screening, and tuberculosis. The Managed Care Plan shall reimburse the CHD when the CHD notifies the Managed Care Plan and provides the Managed Care Plan with copies of the appropriate medical/case records and provides the enrollee's PCP with the results of any tests and associated office visits.

e. The Managed Care Plan shall not deny claims for services delivered by CHD providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) days.

f. The Managed Care Plan shall not deny reimbursement for failure to prior authorize services rendered pursuant to s. 392.62 F.S.

g. The Managed Care Plan shall reimburse FQHCs and RHCs at rates comparable to those rates paid for similar services in the community.

h. When billing for prescribed drug services outside of the cost-based reimbursement rate, the Managed Care Plan shall reimburse CHDs for authorized prescription drugs in accordance with Rule 59G-4.251, F.A.C., Prescribed Drugs Reimbursement Methodology.

i. The Managed Care Plan shall report quarterly to the Agency as part of its quarterly financial reports (as specified in Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide), the payment rates and the payment amounts made to FQHCs and RHCs for contractual services provided by these entities.

j. The Managed Care Plan shall make a good faith effort to execute memoranda of agreement with private schools, charter schools, and school districts participating in the certified match program regarding the coordinated provision of school-based services pursuant to ss. 1011.70, 409.9071, F.S., 409.908(22), F.S., and 409.9072, F.S.

Item #24

Attachment B., Scope of Services – Core Provisions, **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services, **Sub-Section A.**, Network Adequacy Standards, **Item 7.**, Essential Providers, **Sub-Item f.**, the second sentence is hereby amended to now read as follows:

Essential providers include:

(a) SIPP providers

Item #25

Attachment B, Scope of Services – Core Provisions, **Exhibit B-3**, [Specialty Condition] Specialty Plan, **Section VIII.**, Provider Services, **Sub-Section A.**, Network Adequacy Standards, **Item 1.**, Specialty Plan-Specific Network Capacity Enhancements, **Sub-Item b.**, table entitled Managed Medical Assistance Provider Network Standards Table [Specialty Condition] Specialty Plan Enhancements, is hereby deleted in its entirety and replaced as follows:

Managed Medical Assistance Provider Network Standards Table [Specialty Condition] Specialty Plan Enhancements					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Primary Care Provider	30	20	30	20	1:750

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Item #26

Exhibit A-4-b, MMA Submission Requirements and Evaluation Criteria, **Section G.**, Statutory Requirements, SRC# 21 – Provider Network Agreements /Contracts Statewide Essential Providers (Statewide), **Exhibit A-4-b-3**, SRC# 21 – Provider Network Agreements /Contracts Statewide Essential Providers (Statewide), is hereby deleted in its entirety and replaced with **Exhibit A-4-b-3**, SRC# 21 – Provider Network Agreements/Contracts Statewide Essential Providers (Statewide) (10-2-2017). The updated exhibit is available for respondents to download at: http://ahca.myflorida.com/Procurements/index.shtml

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STATEWIDE MEDICAID MANAGED CARE PROGRAM
QUESTIONS AND ANSWERS

QUESTION NUMBER	VENDOR NAME	SRC #	SECTION CITE REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	SUB-SECTION CITE REFERENCE	ITEM CITE REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	RESPONSE
ATTACHMENT A									
1	Sean Schwinghammer		A. Overview	A-2-b			1	If a group of nursing homes can form a LTC Plus Plan, what incentives do they have to move members from the nursing home to Home based services?	There are multiple incentives built into the scope of services outlined in Exhibit B-2, including both performance and payment incentives and penalties.
2	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		A. Overview	N/A	8		3	Are all representations, authorizations, attestations, certifications, or statements respondents are required to submit with their proposals set forth in the ITN and supporting attachments and exhibits or are respondents also required to submit a response to PUR Section 9, Respondent's Representation and Authorization?	See Attachment A - Instructions and Special Conditions, Section A. Overview, Sub-Section 8. PUR 1001, General Instructions to Respondents.
3	Adventist Health Systems		A. Overview	N/A	6	N/A	4	The timeline appears to provide for a period of negotiation as to the terms of the contract to be entered between AHCA and the Respondent selected; however, Section 2-d-6 of Attachment A (at Page 14) appears to require the Respondent to sign the Contract provided by AHCA within 10 days, otherwise, the proposal guarantee is forfeited. Will there by a period of negotiations between the parties, and if so, will the proposal guarantee be returned to the respondent if the parties are unable to mutually agree on the terms of a contract?"	Negotiations will occur prior to contract award. See Attachment A - Instructions and Special Conditions, Section A. Overview, Sub-Section 6. Solicitation Timeline.
4	Quintairos, Prieto, Wood & Boyer		A. Overview	N/A	6	N/A	5	At what point will the link for the Agency Provider Comment Survey Tool be made active? Will we be provided a copy for review prior to link being made active?	No. See Attachment A - Instructions and Special Conditions, Section A. Overview Sub-Section 13. Provider Comments and Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award Sub-Section 4. Scored Requirements - Evaluation Criteria, b. (2)
5	Simply Healthcare		A. Overview	N/A	11		6	What is the website for the VBS and addenda to be posted?	http://www.myflorida.com/apps/vbs/vbs_www.main_menu
6	Simply Healthcare		A. Overview	N/A	11	N/A	6	ITN Section A.11 indicates the Agency will supplement, modify, or interpret any portion of this solicitation and that a written addendum will be posted if any changes are made. Please confirm the Agency will also post addenda to notify respondents if changes are made to any of the templates / files on the AHCA Procurements site below as well: http://ahca.myflorida.com/procurements/index.shtml	Confirmed.
7	Sunshine State Health Plan		A. Overview	N/A	13	N/A	7	Please clarify that the providers' comments will be limited to the products covered by the ITN.	No.
8	Sunshine State Health Plan		A. Overview	N/A	13	N/A	7	May other interested community stakeholders or agencies, outside of registered Medicaid providers, submit comments? Is there any mechanism for this? If yes, what would that process be?	No.
9	Humana		A. Overview	N/A	16	N/A	8	Please confirm that all references to "respondent" apply only to the legal entity seeking to contract directly with AHCA and not its parent company, subsidiaries, or affiliates.	Yes
10	Adventist Health Systems		A. Overview	N/A	17	a	9	This paragraph appears to prohibit Fee-for-Service PSNs from paying provider incentive payments or from reimbursing providers at a higher rate than the rates established by the Agency. Please confirm that the Agency does not intend to prohibit Fee-for-Service PSNs from making dividend payments, or similar distributions, to providers that have an ownership or similar interest in the PSN. Also, please explain whether this restricts a PSN from complying with the primary care physician, fee increase requirements of Section 409.967(2)(a), F.S.?	As to the first statement, Correct. See Attachment A - Instructions and Special Conditions, Section A. Overview Sub-Section 17. Type of Contract Contemplated, a (2)(a). As to the second statement, No. As to the third statement, Correct, See Attachment A - Instructions and Special Conditions, Section A. Overview Sub-Section 17. Type of Contract Contemplated, a (2)(a).
11	Adventist Health Systems		A. Overview	N/A	17	a	9	If an existing PSN merges into another entity, with the other entity being the survivor, will the new entity be able to operate under a fee-for-service payment model?	The question goes beyond the scope of the current procurement.

QUESTION NUMBER	VENDOR NAME	SRC #	SECTION CITE REFERENCE	EXHIBIT REFERENCE (IF APPLICABLE)	SUB-SECTION CITE REFERENCE	ITEM CITE REFERENCE (IF APPLICABLE)	PAGE NUMBER	QUESTION	RESPONSE
12	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		A. Overview	N/A	17	c	9	Will year one of the contract be the start of the contract period (i.e. January 2019, even if entity is formed in 2018)?	See Attachment A - Instructions and Special Conditions, Section A Overview, Sub-Section 19 Term of Contract, Item b
13	Adventist Health Systems		A. Overview	N/A	18	a	10	A Comprehensive Long-term Care Plan is able to service Medicaid populations that are eligible for MMA coverage, that are eligible for MLTC coverage, and that are eligible for both MMA and MLTC coverages. A Long-term Care Plus Plan is able to service Medicaid populations that are eligible for MLTC coverage and that are eligible for both MMA and MLTC coverages. However, a Long-term Care Plus Plan is not able to service Medicaid populations that only are eligible for MMA coverage. Please confirm that this understanding is correct. Also, please let explain if there are any other differences or limitations between these two types of plans.	Confirmed. See Attachment A - Instructions and Special Conditions, Section A. Overview Sub-Section 18.Type of Plan Contemplated.
14	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		A. Overview	N/A	18	d	10	As a provider service network for a Specialty Plan, can the respondent form a new entity to be the Specialty Plan?	See Attachment A - Instructions and Special Conditions, Section A Overview, Sub-Section 18 Type of Plans Contemplated, Item d
15	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		A. Overview	N/A	18	d	10	Can a fee-for-service provider service network be a Specialty Plan?	Yes. See Attachment A - Instructions and Special Conditions, Section A. Overview, Sub-section 17, Type of Contract Contemplated and Sub-Section 18, Type of Plans Contemplated.
16	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		A. Overview	N/A	19	a	10	Is the term as defined in 19A the same for Specialty Plans?	Yes.
17	Quintairos, Prieto, Wood & Boyer		A. Overview	N/A	19	b	10	Please confirm the beginning and end date of the first contract year.	See Attachment A - Instructions and Special Conditions, Section A Overview, Sub-Section 19 Term of Contract, Item b
18	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		A. Overview	N/A	19		10	Attachment A, Section A(19)(a) and (c) collectively state that the anticipated contract term is from the date of Contract execution through September 30, 2023 and that the Contract may not be renewed. Exhibit A-8, Section I(W)(6), however, states that "this Contract may be renewed for a period that may not exceed three (3) years or the term of the original Contract, whichever period is longer." May the Contract be renewed after the initial contract term ending on September 30, 2023; and if so, what is the renewal period?	No.
19	Adventist Health Systems		A. Overview	A-8	19	c	11	This provision states that the standard contract may not be renewed; however, Section I-W-6 of Exhibit A-8 at page 15 states that the contract may be renewed under certain circumstances. Which provision is correct?	See Attachment A - Instructions and Special Conditions, Section A. Overview, Sub-Section 19. Term of Contract, Item c.
20	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		A. Overview	N/A	2		13	Please advise which Region's Original Copies should be included with the Respondent's Proposal Guarantee payment.	An Original Response and an Original Proposal Guarantee is required for each plan type per Region.
21	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		A. Overview	N/A	2		15	Is a separate pro forma required for each individual region that is being bid on by a respondent (up to 11) or is a statewide pro forma for each line of business (aggregate financials of all regions being bid upon) acceptable?	Yes, a separate pro forma is required for each region, but can be limited to Medicaid lines of business.
22	Sean Schwinghammer		A. Overview	A-8			20	What additional penalties will the Agency place on providers that pay improperly? The ITN has a clear and admirable directive regarding the payment of claims, unfortunately, a large amount of claims begin to pay but are denied by MCO systems due to coding or related issues the problems propagate a provider errors when they are in fact MCO system errors. When such errors prevent payment of the claims, what is the consequence?	Page 20 of Exhibit A-8 - Standard Contract, pertains to Agency payments to Vendors.

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23	Sean Schwinghammer		A. Overview	A-8			20	Why is the interest tallied for late payments so low? Although, payment is required within 20 days, the interest rate is exceedingly low, 00033% per day. It must be noted, while a provider can be put out of business because of late payments, MCOs or their delegated authorities are collecting higher interest on the monies in their possession than penalty for not paying claims, thus creating a financial incentive to hold money from providers.	See Section 215.422(13), Florida Statutes.
24	Community Care Plan		B. Response Preparation and Content	A-2-a	1	N/A	1	If a plan intends to submit a response as an MMA and a Specialty Plan in the same Region, will it be required to submit multiple copies of this exhibit with each response?	Yes, Respondents must submit separate proposals for each plan type, including all certifications and statements.
25	Community Care Plan		B. Response Preparation and Content	A-2-b	1	N/A	1	If a PSN is owned by a "public agency" pursuant to section 409.962 (14), Florida Statutes and does not therefore have articles of incorporation, articles of organization, partnership agreement, certificate of limited partnership, what formation documents would AHCA require?	In such an event, provide copies of all documents evincing the creation/formation of the respondent. Additionally, such a respondent shall provide all documents showing who owns or controls the respondent, taking into consideration the affiliation criteria listed in the solicitation.
26	Adventist Health Systems		B. Response Preparation and Content	A-2-c	2	b	1	Exhibit A-2-c, paragraph 3 (page 1 of 8) reads as follows: "I hereby certify that neither my organization nor any person with an interest in the organization had any prior involvement in performing a feasibility study of the implementation of the subject Contract, in drafting of this solicitation or in developing the subject program." We believe this language is very ambiguous and do not understand what is to be certified. For example, what is a "person with an interest in the organization"? What is meant by "prior involvement in performing a feasibility study of the implementation of the subject Contract"?	See Title 48, Code of Federal Regulations, Subpart 9.5 – Organizational and Consultant Conflicts of Interest and Section 287.057(17), Florida Statutes.
27	Adventist Health Systems		B. Response Preparation and Content	A-2-b	2	b	2	The paragraph on Exhibit A-2-b 3 (page 2 of 6) lists the following providers or group of providers to be identified as having a controlling interest in the governing body of the PSN: licensed nursing homes, assisted living facilities with seventeen (17) or more beds, home health agencies, community care for the elderly lead agencies and hospices. Pursuant to the definition in section 409.901(17), F.S., we understand that the provider for purposes of ownership or control of a PSN can be any provider that meets this definition: "a person or entity that has a Medicaid provider agreement in effect with the agency and is in good standing with the agency." Please confirm that any provider that meets this definition qualifies for the ownership and control requirements for a PSN pursuant to Section 409.912(2)(b), F.S.	The question is unclear, in part because § 409.912(2)(b), Fla. Stat. provides: "The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance that will protect enrollees if the entity becomes unable to meet its obligations." For guidance on PSN eligibility, please see Exhibit A-2-b.
28	Adventist Health Systems		B. Response Preparation and Content	A-2-b	2	b	2	The paragraph on Exhibit A-2-b 4 (page 2 of 6) requires that PSNs provide identification information about their provider owners – including their "ultimate owner(s)." What is an ultimate owner for these purposes? If there are several layers of owners between the PSN and the ultimate owner(s), is the PSN required to also list these intermediary owners? This paragraph also asks for the affiliates of the health care providers or group of health care providers. Should the PSN list all of the affiliates for each provider owner? If the provider is a member of a large, multi-state, health care system, there could be a significant number of affiliated entities that will not have any transactions with the Florida PSN, and we do not believe that the Agency intends that PSNs list all entities that are affiliated with any of its owner/controlling providers.	The phrase "ultimate owners" is used in the solicitation as it may be used in normal, everyday business dealings. Yes, please list all affiliates.

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29	Adventist Health Systems		B. Response Preparation and Content	A-2-b	2	b	3	The paragraph on Exhibit A-2-b 7 (page 3 of 6) states that the Agency will consider factors in determining whether affiliation exists, including "previous relationships with or ties to another concern." This is very broad and ambiguous language. What types of "previous relationships" or "ties" would result in a determination that the entities are affiliated? Similarly, the Agency will also consider "contractual relationships." What types of "contractual relationships" would lead to a determination of affiliation?	"previous relationships with or ties to another concern" and "contractual relationships" that signify control may lead to a determination of affiliation
30	Adventist Health Systems		B. Response Preparation and Content	A-2-b	2	b	4	In general, persons may serve on more than one companies' boards of directors. It is not clear, but this paragraph on Exhibit A-2-b 10 (page 4 of 6) could be interpreted to prevent a person from serving on the boards of directors of more than one respondent. If that is correct, shouldn't this paragraph be revised to create a presumption of affiliation and control that can be rebutted by a demonstration that there is no control or power to control one or more of the respondents?	The solicitation will not be amended in response to this Question. Common directors is one consideration for affiliation.
31	Adventist Health Systems		B. Response Preparation and Content	A-2-c	2	b	4	Exhibit A-2-c, paragraph 11 (page 4 of 8) in disclosing all names under which “my organization” has operated over the past five years, how should a joint venture or other similar affiliation respond?	The provision applies to all members of the joint venture or other similar affiliation.
32	Community Care Plan		B. Response Preparation and Content	A-2-c	14	N/A	5	Does the Agency require the PSN to submit not only the application, but also the certificate of authority authorized by section 641.2019, Florida Statutes no later than 30 days from the time the contract is awarded? What happens if the certificate is not issued by the Office of Insurance Regulation within the 30 days period or is otherwise delayed?	Please see addendum, Item #4 and #5
33	Adventist Health Systems		B. Response Preparation and Content	A-2-c	2	b	5	In Exhibit A-2-c, paragraph 14 (page 5 of 8), if the respondent is a prepaid PSN, does it need to meet both of the listed conditions (check both boxes) or only the second one? If the entity is a prepaid PSN, it must submit applications within 30 days. Does this mean within 30 days of the date the contract between the PSN and the Agency is executed by both parties?	Please see addendum, Item #4 and #5
34	Simply Healthcare		B. Response Preparation and Content		1	c	11	Will the State accept 11x17 foldout sheets to see certain Attachments and Excel sheets, which will help display charts clearly?	Yes.
35	Best Care Assurance		B. Response Preparation and Content	A-2-a	2	b	12	In The March 27, 2017 Guidance Statement for this procurement it states that a PSN “is not required to have any certifications or applications related to PSN eligibility in place prior to submitting its response to the ITN.” However, the Qualification of Plan Eligibility (Exhibit A-2-a, pg. 1) of the ITN requires a statement that the PSN applicant possess a Florida third party administrator license or a letter of agreement with a Florida-licensed third party administrator upon submission of response to the ITN. Exhibit A-2-a also states that a failure to complete the Exhibit “may result in the rejection of response.” Please confirm that a PSN applicant will not be rejected if they relied upon the March 27 Guidance and did not pursue or obtain a TPA license prior to bid response submittal, but agree to obtaining a TPA license if needed, upon an award?	The March 27, 2017 Guidance Statement is not a part of the solicitation.
36	Our Children PSN of Florida, LLC		B. Response Preparation and Content	N/A	2	N/A	12	The requirement indicates, "The respondent shall include the documents listed in this Sub-Section with the submission of the Original Response." Please confirm this information is to be submitted with all copies of the response as well.	Yes. See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content, Sub-Section 2. Mandatory Response Content, b. 2)

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37	Staywell (WellCare)		B. Response Preparation and Content	A-2-a	2	b	12	Respondents may only submit a response as one type of plan (Comprehensive, Managed Medical Assistance and Long-term Care Plus) in any given region. The only exception is that a respondent may also submit a response as a Specialty plan in the same region. Will the State have the discretion to invite a respondent to negotiate regarding a Managed Medical Assistance plan if the respondent submitted a response as a Comprehensive plan? If so, under what circumstances might the State exercise that discretion?	No.
38	Quintairos, Prieto, Wood & Boyer		B. Response Preparation and Content	A-2-a	2	b	12	Language regarding the Qualification of Plan Eligibility states that each respondent shall select 1 plan type for which to submit a response in a region with the exception of respondents seeking also to submit a response as a Specialty Plan in the same region. Please confirm that a respondent may choose a different approach to each region to include comprehensive plan OR Managed Medical Assistance Plan (but not both), and that a respondent may select specialty plan in combination with comprehensive OR MMA Plan.	Yes, (1) pursuant to S. 409.966 (2), Separate and simultaneous procurements are being conducted in the 11 regions and (2) See Attachment A- Instructions and Special Conditions, Section B. Response Preparation and Content, Sub-section 2. Mandatory Response Content, b. 1) a)
39	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		B. Response Preparation and Content	N/A	2		12	Please confirm whether execution of Exhibit A-2-a is sufficient certification of respondent's eligibility to provide services under the SMMC pursuant to Section 409.962(7), Florida Statutes as required by Attachment A.	Per the terms of the solicitation, a properly executed Exhibit A-2-a is an item that must be included in a response.
40	Humana		B. Response Preparation and Content	A-2-a	2	b	12	Please confirm bidders are prohibited from submitting multiple bids in the same region under separate legal entities that either a.) share the same parent company, b.) are parties to a joint venture, or c.) otherwise hold an ownership share in one another.	Correct, excluding Specialty Plans. Additionally, affiliates, as defined per the solicitation's affiliation criteria, may only submit one response per region (i.e., only one of two or more affiliates may submit a response in each region).
41	Community Care Plan		B. Response Preparation and Content	N/A	2	b	13	If a Plan intends to submit a response to offer more than one specialty plan in the same region, will the Plan be required to submit separate General and MMA sections for each specialty it intends to offer?	Yes, Respondents must submit separate proposals for each plan type, including all certifications and statements, exhibits and attachments.
42	Our Children PSN of Florida, LLC		B. Response Preparation and Content	N/A	2	d	13	Does AHCA view a surety bond or performance bond as an acceptable form of bond for proposal guarantee purposes?	See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content, Sub-Section 2. Mandatory Response Content, Item d.3).
43	Staywell (WellCare)		B. Response Preparation and Content	A-3-b	2	c	13	Is there a way for a respondent to proactively indicate it does not use Milliman or is simply omitting Exhibit A-3-b from the response sufficient?	See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content Sub-section c. Milliman Organizational Conflict of Interest Mitigation Plan, 2)
44	Sunshine State Health Plan		B. Response Preparation and Content	A-3-a	2	c	13	Please confirm the following language regarding initial reply in Exhibit A-3-a is referencing the submission date of November 1st. "Any actual or prospective respondent who is using Milliman for this procurement must disclose this fact in its initial reply to the solicitation"	Correct, any actual or prospective respondent who is using Milliman for this procurement must disclose this fact in its November 1 submission.
45	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		B. Response Preparation and Content	N/A	2		13	If we are fortunate enough to be invited to negotiate a contract with the Agency, we anticipate the successful negotiation of a mutually agreeable contract. In the unlikely event the parties are unable to reach agreement, however, please confirm that as long as respondents' bids remain firm for 60 days after the November 1, 2017 opening date, a respondent may withdraw its bid at any time during the negotiations phase (anticipated to begin on January 16, 2018) and before a Contract has been presented to the respondent for signature, without forfeiting its proposal guarantee.	See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content, Sub-Section 2. Mandatory Response Content, Item d.5).
46	Humana		B. Response Preparation and Content	A-2-c	2	b	13	Please confirm that the requirement within Exhibit A-2-c to list all names under which the organization has operated during the past five years applies only to the legal entity of the respondent and not its parent company, subsidiaries, or affiliates.	Correct.

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47	Humana		B. Response Preparation and Content	A-2-c	2	b	13	Please confirm, for the purposes of this requirement, that the term "Managed Care Plan" is limited to entities that could qualify as a Comprehensive, MMA, LTC Plus, or Specialty health plans as defined in Exhibit A-2-a Qualification of Plan Eligibility and does not apply to provider contracts, subcontractors or vendors.	The meaning is as used in Section 409.66(3)(b), i.e., any other eligible plan that responds to the ITN.
48	Community Care Plan		B. Response Preparation and Content	N/A	2	d	14	Proposal Guarantee: If a Plan is submitting a response as an MMA plan and multiple Specialty Plans types in the same region, is the proposal guarantee amount of $1,000,000 for MMA and $200,000 for each identified specialty population?	Yes.
49	Adventist Health Systems		B. Response Preparation and Content	N/A	2	d	14	This paragraph requires that a respondent forfeit its proposal guarantee if the respondent fails to execute a contract within 10 calendar days after the Agency presents the contract to the respondent. If a respondent signs the contract, but it does not complete its readiness review, does the respondent keep its proposal guarantee? Is the Agency willing to consider a longer period of time than 10 days after a contract has been presented for a plan to sign or forfeit all proposal guarantees?	See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content, Sub-Section 2. Mandatory Response Content, Item d. There will be no change to this specification of the ITN.
50	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		B. Response Preparation and Content	N/A	2	d	14	Please confirm the requirement as a Specialty Plan means we submit a $200,000 payment to the State of Florida	See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content, Sub-Section 2. Mandatory Response Content, Item d.
51	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		B. Response Preparation and Content	N/A	2	d	14	What will the amount of the Performance Bond be for a Specialty Plan?	Specialty plans must provide a $1,000,000 bond per specialty plan contract awarded.
52	Simply Healthcare		B. Response Preparation and Content	N/A	2	e	14	Attachment A, Section B.2.e, requires respondents to submit for respondent and respondent's parent company, if applicable, most recent audited financial statements. However, financial statements for parent entities who are publicly traded companies are lengthy and part of the entity's annual 10-K filings with the SEC, which can be over 500 pages long. Given the 3 binder limit for hard copy responses, would the state consider receiving those statements electronically? Alternatively, can financial statements for those publicly traded entities be limited to an income statement, statement of changes in financial condition or cash flow, balance sheet, and notes to the financial statements so respondents can have adequate space to thoroughly address all of the SRCs?	Plans will be allowed to submit financial statements on CDs or DVDs which provide enough space for the 10-K in its entirety.
53	Staywell (WellCare)		B. Response Preparation and Content	N/A	2	d	14	If a respondent is bidding on both a comprehensive plan AND a specialty plan in the same region, how many proposal guarantees would be required in that region? In other words, would the respondent be responsible for a comprehensive plan guarantee and a specialty plan guarantee or will the higher of the two bonds satisfy the proposal guarantee requirement for the respondent in that region?	Two: the respondent would be responsible for both a comprehensive and specialty bond.
54	Staywell (WellCare)		B. Response Preparation and Content	N/A	2	d	14	To follow up on the previous question, if separate guarantees are required for the comprehensive plan and specialty plan proposals in a region, would the $200,000 specialty plan guarantee cover all specialty plans the respondent is proposing in the region or must it submit a $200,000 for EACH specialty plan it is proposing in that region?	Respondent must submit a guarantee for each specialty plan.
55	Staywell (WellCare)		B. Response Preparation and Content	N/A	2	d	14	May a respondent submitting proposals in more than one region submit a single guarantee for the aggregate amount? For example, a respondent submitting proposals to offer comprehensive plans in ten regions could submit a single bond in the amount of $10,000,000.	No. Proposal Guarantees must be submitted per plan type per region.

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56	Humana		B. Response Preparation and Content	N/A	2	e	14	Can respondents include the audited financial statements electronically as these documents typically exceed 600 double-sided pages in length and could potentially be handled electronically to save paper and allow plans to adhere to the binder limits.	Plans will be allowed to submit financial statements on CDs or DVDs which provide enough space for the 10-K in its entirety.
57	Adventist Health Systems		B. Response Preparation and Content	N/A	2	e	15	If a respondent does not have financial statements for three years, it is to provide the most recent audited financial statements of its parent entity. What is considered to be the "parent entity" for this purpose? How much ownership or control is necessary to be considered a parent entity? If two or more unrelated entities each own or control a substantial portion of the respondent, which of the two is considered the parent entity? How much ownership or control is necessary to be considered a parent? If the immediate parent(s) of the respondent also have one or more parent companies, which entity's financial statements should be filed – the immediate parent or the ultimate parent?	See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content Sub-section e. Financial Information 1. Financial Statements Table 2
58	Adventist Health Systems		B. Response Preparation and Content	N/A	2	e	15	This paragraph requires respondents to include pro forma financial statements ". . . for the first three (3) years (or until profitable) . . .." Are the pro forma financial statements to be provided until the earlier of three years or profitability, or are they to be provided until the later of three years or profitability? If the pro forma statements are to be provided until they project "profitability", what is the applicable period of time for which the respondent projects the entity to be profitable? One month? Three months? One year?	Respondent must submit a minimum of 3 years of pro forma financial statements even if profitability is reached prior to the end of 3 years. If profitability occurs after 3 years, pro forma financial statements should be submitted until that point is reached.
59	Simply Healthcare		B. Response Preparation and Content	N/A	2	e	15	Per AHCA ITN Attachment A, Section B.2.e.2, the respondent is required to provide “pro forma financial statements for the respondent’s pro forma operation, broken down by line of business.” Please address the following questions related to this requirement: a. Does AHCA have a preferred template for the respondent to use to provide the pro forma financial statements, or should the respondent use their own template? b. Can you please provide more clarity around “line of business”?	As to the first question, Respondent should use their own template. As to the second question, lines of business should include MMA, LTC and Specialty
60	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		B. Response Preparation and Content	N/A	2		15	Please clarify the definition of "line of business" as it pertains to this specific requirement. Is this to be a pro forma for each ITN plan type; e.g. Long-Term Care Plus Plans, Managed Medical Assistance Plans, and Specialty Plans? Or does the question refer to Medicare, Medicaid, and commercial lines of business?	Confirm aligns with other answer on Humana
61	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		B. Response Preparation and Content	N/A	2		15	Would consideration be given for the distribution of a template for the pro forma financial statement? This would result in the submission of the applicable financial information in a standard format.	Respondent should use their own template.
62	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		B. Response Preparation and Content	N/A	2	e	15	Would consideration be given for the distribution of a template for the pro forma financial statement? This would result in the submission of the applicable financial information in a standard format.	Respondent should use their own template.
63	Molina Healthcare of Florida		B. Response Preparation and Content	N/A	2	N/A	15	Please indicate whether respondents should provide a GAAP or Statutory balance sheet? Also, please let us know if there is a specific format that is preferred for the balance sheet.	See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content Sub-section e. Financial Information 1. Financial Statements
64	Molina Healthcare of Florida		B. Response Preparation and Content	N/A	2	N/A	15	Per page 15: "The respondent shall provide the following pro forma financial statements for the respondent's Florida operation, broken down by line of business." Please confirm that the line of business is only for Medicaid lines of business, such as MMA, LTC, Specialty, etc.	Confirm aligns with other answer on Humana

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65	Humana		B. Response Preparation and Content	N/A	2	e	15	Because the regions defined by FS 409.966 are specific to Florida Medicaid programs, please confirm that the regional monthly Pro Forma requirement is limited to the respondent's Medicaid line of business and that commercial and Medicare lines of business may be aggregated.	Do these all align? What is the benefit of this approach to us?
66	Best Care Assurance		B. Response Preparation and Content	N/A	2	b	16	Is a Managed Care Plan required to fund its insolvency protection account prior to receiving capitation payments from the Agency?	See Attachment B - Scope of Services, Section XII. Financial Requirements Sub-section A. Insolvency Protection 1. Insolvency Protection Requirements
67	Best Care Assurance		B. Response Preparation and Content	N/A	2	b	16	Is the balance of a Managed Care Plan's insolvency protection account included in the calculation of whether the Managed Care Plan is maintaining the required amount of surplus?	See Attachment B - Scope of Services, Section XII. Financial Requirements Sub-section B. Surplus 1. Surplus Requirement
68	Best Care Assurance		B. Response Preparation and Content	N/A	2	b	16	Is the Managed Care Plan required to fund the required surplus amount prior to the effective date of the initial recipient's enrollment in the Managed Care Plan? If so, how far in advance of the initial recipient's enrollment?	See Attachment B - Scope of Services, Section XII. Financial Requirements Sub-section B. Surplus 1. Surplus Requirement
69	Community Care Plan		B. Response Preparation and Content	N/A	4	a	16	Insolvency Protection Account: If a Plan is submitting a response as an MMA plan and multiple Specialty Plans types in the same region, does the plan need to establish a separate account?	No, separate accounts are not necessary as long as minimum requirements are maintained.
70	Community Care Plan		B. Response Preparation and Content	N/A	3	a	16	Surplus Account: If a Plan is submitting a response as an MMA plan and multiple Specialty Plans types in the same region, does the plan need to establish a separate account?	No, a separate surplus account is not necessary as long as minimum requirements are maintained in accordance with Attachment B - Scope of Services, Section XII. Financial Requirements Sub-section B. Surplus 1. Surplus Requirement.
71	Community Care Plan		B. Response Preparation and Content	N/A	2	f	17	If a Plan intends to submit a response to offer more than one specialty plan in the same region, will the Plan be required to submit separate General and MMA sections for each specialty it intends to offer?	Yes, Respondents must submit separate proposals for each plan type, including all certifications and statements, exhibits and attachments.
72	Quintairos, Prieto, Wood & Boyer		B. Response Preparation and Content	N/A	2	f	17	Please confirm that if a respondent is looking to submit as an LTC plan and Specialty plan, that the respondent is to submit an LTC proposal for each region to include both General and LTC SRCs and would also submit a separate proposal for each region for the specialty plan submission to include General, MMA and Specialty SRCs.	Yes, Respondents must submit separate proposals for each plan type, including all certifications and statements, exhibits and attachments.
73	Humana		B. Response Preparation and Content	N/A	2	f	17	Please confirm attachments are allowed to exceed 8.5"x11"?	Yes.
74	Community Care Plan		B. Response Preparation and Content	N/A	4	g	18	*What will be the model for the shared savings component within the Fee for Service PSN option?	See Attachment B - Scope of Services, Section XI. Method of Payment Sub-section C. Payment Provisions 9. Per Capita Service Benchmark (PCSB)
75	Staywell (WellCare)		B. Response Preparation and Content	A-5	2	h	18	Please confirm that the Summary of Respondent Commitments need only include those commitments that are not requirements within the contract/scope of service. For example, a description of an Information and Management System in compliance with the requirements of Section X.D of the Scope of Service would not have to be included on the log but if within that description the respondent committed to a unique and innovative system to deliver data to AHCA, then that would have to be included in the summary.	Confirmed.
76	Humana		B. Response Preparation and Content	N/A	2	g	18	In section g. Cost Proposal and Cost Proposal Rate Sheets, paragraph 1 indicates that the respondent must complete and submit Attachment C, Cost Proposal Instructions and Rate Methodology Narrative. However, this document appears to be an instructions only document. Please confirm that Exhibits C-1 and C-2 are the only documents respondents must complete and submit as part of the Cost Proposal.	ITN instruction documents do not need to be submitted along with the completed cost proposal and actuarial memorandum.
77	Humana		B. Response Preparation and Content	A-5	2	h	18	Please confirm that respondents should only list commitments on Exhibit A-5 that are considered "above and beyond" the contractual requirements (either identified by "shall", "must", or "will" in Attachment A or all terms in Attachment B).	Confirmed.

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78	Adventist Health Systems		B. Response Preparation and Content	N/A	3	b	19	This paragraph states that "preferences shall be given to a response received from a respondent that certifies it has implemented a drug-free workplace program." What kind or amount of "preference" will be given?	See Section 287.087, Florida Statutes.
79	Simply Healthcare		B. Response Preparation and Content	N/A	4	b	27	Attachment A, Section D, Subsection 4.b.1 states that 500 is the maximum number of provider comments that will be considered. If greater than provider 500 comments are received, how will these be scored? (Eg, first 500 received, highest 500?)	The Agency will consider the first 500 comments received per respondent.
80	Simply Healthcare		B. Response Preparation and Content	N/A	4	b	27	If comments are received from providers who are also respondents to the ITN or providers affiliated through common ownership to respondents to the ITN, will these comments be disregarded for scoring purposes given the conflict of interest?	No. S. 409.966 (3) (a) 8. Florida Statutes requires that we consider "Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider."
81	Simply Healthcare		B. Response Preparation and Content	N/A	7	b	35	Please clarify what is meant by, "Whether a respondent that submits a response in Regions 1 or 2 agrees to serve enrollees in both Regions 1 and 2, even if the respondent is only awarded a Contract in one of these Regions." Is the Agency asking us to serve enrollees in both regions even if we are NOT awarded a contract in both regions? If so, what kind of arrangement/agreement would be in place with the Agency?	Yes, but it is not mandatory. For determining Best Value, the Negotiation Team may consider whether a respondent will serve enrollees in both Regions 1 and 2 even if the respondent is not awarded a contract in both. The kind of arrangement/agreement would be negotiable.
82	Community Care Plan		B. Response Preparation and Content	N/A	2	e	39	Are there additional or different requirements for a Provider Service Network to obtain a Health Care Provider Certificate as compared to the procedure outlined in Section 641.495, and if so, what are the additional or different requirements?	Please see addendum, Item #4 and #5
83	Community Care Plan		B. Response Preparation and Content	N/A	2	e	39	What requirements exist or will exist for a Provider Service Network to obtain a Health Care Provider Certificate that differ in any way from the requirements for Health Maintenance Organizations and Prepaid Health Clinics?	Please see addendum, Item #4 and #5
84	Simply Healthcare		B. Response Preparation and Content	N/A	4	b	40	How far in advance of the region going live will enrollees receive their enrollment packet? How many notices/reminders/letters will go to enrollees after the initial packet?	The Agency will determine the regional rollout schedule, including enrollee notification, at a later date.
85	Humana		B. Response Preparation and Content						
86	Humana		B. Response Preparation and Content						
87	Sunshine State Health Plan		C. Response Submission Requirements	N/A	1	b	19	In order to be more environmentally friendly, will AHCA consider allowing respondents to provide electronic only files for any attachments larger than 20 pages?	No.
88	Molina Healthcare of Florida		C. Response Submission Requirements	N/A	1	N/A	19	Part 1: In order to simplify the response process for the Agency and Evaluators, would the Agency consider allowing respondents to submit one (1) original hardcopy proposal, where respondents would clearly identify all regions for which they are submitting proposals? The statewide responses would remain the same for all regions (as already noted in the instructions) and the regional responses would delineate differences based on the regions for which proposals are being submitted. This would eliminate the need to review separate hardcopy proposals for each region, where much of the information remains the same (ex: statewide SRC responses; Financial Information; Exhibits A-2-a, A-2-b, A-2-c, A-3-a, A-3-b, A-7 and A-9), thus alleviating the burden on reviewers and resulting in a more environmentally friendly procurement.	No.

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89	Molina Healthcare of Florida		C. Response Submission Requirements	N/A	1	N/A	19	Part 2: As an alternative to the "Part 1" question above, would the Agency consider allowing respondents to submit one (1) original hardcopy proposal with all of the Statewide SRC responses along with all of the other required components (as noted in 3)b) on page 20) and then a separate original hardcopy proposal with all of the Regional SRC responses (one (1) hardcopy) with all of the Regional SRCs, per region in one proposal? This would alleviate the burden on reviewers and result in a more environmentally friendly procurement.	No.
90	Adventist Health Systems		C. Response Submission Requirements	N/A	1	b	20	Given the hardcopy limitations of three (3) binders, are there any specific limitations on margins or font size that will be enforced?	No. However, contents must be readable.
91	Molina Healthcare of Florida		C. Response Submission Requirements	N/A	1		20	Due to the size of our financial documentation, is it permissible to submit audited financial statements, annual reports, and other SEC filings in electronic PDF format only (or provide links to the SEC website)?	There will be no change to this specification of the ITN.
92	Molina Healthcare of Florida		C. Response Submission Requirements	N/A	1	N/A	20	Should Attachment C be placed after Exhibit A-4 or after Exhibit A-9?	See Attachment A - Instructions and Special Conditions, Section C. Response Submission Requirements, Sub-Section 1. Hardcopy and Electronic Submission Requirements, Item b.3).
93	Magellan Complete Care		C. Response Submission Requirements	N/A	3	c	21	This item requires that PDFs be searchable, which will not be possible for those documents that are scans of forms that contain an original signature. Can AHCA confirm that PDFs containing a signature be exempted from this requirement?	There will be no change to this specification of the ITN.
94	Magellan Complete Care		C. Response Submission Requirements	N/A	4	N/A	22	This item requires that Exhibit A-5, A-6, C-1 and C-2 to be provided only electronically in MS Excel 2016, but they were also requested as PDFs in item (3) above. Which format does AHCA prefer?	PDF and Excel 2016.
95	Magellan Complete Care		C. Response Submission Requirements	N/A	4	N/A	22	The ITN requires that several attachments be provided as Microsoft Excel 2016. Would the Agency accept attachments in Microsoft Excel 2013 as well?	No. Microsoft 2016 is required.
96	Our Children PSN of Florida, LLC		C. Response Submission Requirements	N/A	4	N/A	22	Please confirm all Excel attachments required are to be submitted on the same, single flashdrive as the PDF documents.	Confirmed.
97	Simply Healthcare		C. Response Submission Requirements	N/A	1	c	22	In Attachment A, Section C, subsection c, item 4, the ITN states: "In addition to the PDF submission, the following attachments and exhibits shall be submitted in Microsoft Excel 2016, utilizing the Agency provided templates and shall be saved on the USB flash drive." Does the state want the documents mentioned to be submitted in Microsoft Excel 2016 and/or in PDF on the USB flash drive? • Exhibits A-4-a-1, SRC# 6 - General Performance Measurement Tool; • Exhibit A-4-a-3, SRC# 10 – Additional Expanded Benefits Template (Regional); • Exhibit A-4-a-4, SRC# 14 - Standard CAHPS Measurement Tool; • Exhibit A-4-b-1, MMA SRC# 6 – Provider Network Agreements/Contracts (Regional); • Exhibit A-4-b-2, MMA SRC# 14 - MMA Performance Measurement Tool; • Exhibit A-4-b-3, MMA SRC# 21 – Provider Network Agreements/Contracts Statewide Essential Providers; • Exhibit A-4-c-1, LTC SRC# 4 - Provider Network Agreements/ Contracts (Regional)	PDF and Excel 2016.
98	Humana		C. Response Submission Requirements	N/A	1	c	22	Please confirm the Agency is only requesting electronic copies (USB) of the following Exhibits: Exhibit A-4-a-1, Exhibit A-4-a-3, Exhibit A-4-a-4, Exhibit A-4-b-1, Exhibit A-4-b-2, Exhibit A-4-b-3, and Exhibit A-4-c-1.	No. See Attachment A - Instructions and Special Conditions, Section C. Response Submission Requirements, Sub-Section 1. Hardcopy and Electronic Submission Requirements, Item c.

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99	Humana		C. Response Submission Requirements	N/A	1	c	22	Please confirm that Microsoft Excel 2010 format is an acceptable format for the electronic copy of the response?	No. Microsoft 2016 is required.
100	Magellan Complete Care		C. Response Submission Requirements	N/A	2	b	23	Please confirm that AHCA does not require that a vendor provide a table listing all instances where trade secret, confidential or exempt information is listed in the vendor's response, along with a rationale for the claim for each instance.	See Attachment A - Instructions and Special Conditions, Section C. Response Submission Requirements, Sub-Section 2. Confidential or Exempt Information.
101	Our Children PSN of Florida, LLC		C. Response Submission Requirements	N/A	5	a	23	Please confirm the single redacted PDF version of the response is required to be submitted on the same, single flashdrive as the PDF and Excel documents.	Confirmed.
102	Our Children PSN of Florida, LLC		C. Response Submission Requirements	N/A	5	a	23	Please confirm only an electronic copy of the redacted version is required (no hardcopy).	Confirmed.
103	Molina Healthcare of Florida		C. Response Submission Requirements	N/A	2	N/A	23	Please indicate where on the page respondents should mark sections as "trade secret", "exempt" or "confidential"? For example, Exhibit A-4, where the Agency issued templates are locked, please indicate where we should place the note indicating confidential or exempt information?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
104	Adventist Health Systems		C. Response Submission Requirements	N/A	2	d	24	Will the Agency notify a respondent of a public records request for its response to the submission, even if the requestor does not contest the redaction?	No.
105	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		C. Response Submission Requirements	N/A	2	d	24	Is a respondent automatically notified if a public records request is made for a copy of its submission – even if it is only for the redacted copy?	No.
106	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	A-8	9	b	3	Is the respondent viewed (Exhibit A-8, page 3), after signing the standard contract, a “federal contractor” within the meaning of Executive Order 11246? Section XV-A-1-m of Attachment B at page 188 requires Executive Order 11246 to be honored.	Attachment B, Section XV(A)(1)(m), at p. 188 of 212, provides: "The Managed Care Plan shall comply with all applicable federal and State laws, rules and regulations including but not limited to [. . .] Title 2 CFR part 200 and Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR part 60, **if applicable**[.]" (emphasis added).
107	Best Care Assurance		D. Response Evaluation, Negotiations, and Contract Award	A-2-a	2	b	12	Assume the administrative services organization (ASO) designated by a PSN applicant as part of its response submitted a third party administrator application for Certificate of Authority (“TPA License”) to the Florida Office of Insurance Regulation (“OIR”) prior to the July 14th release of the ITN. Further assume that in response to the application, the OIR informed the ASO last week that the ASO is not required to obtain a TPA License to provide administrative services to a provider service network (“PSN”) because a PSN is not included within Section 626.88 (1), Florida Statutes. As a result, the OIR is declining to further process the TPA application and issue a TPA license. Please advise whether it is sufficient for a PSN applicant to provide such correspondence in response to the certification for Qualification of Plan Eligibility (Section 2), and be deemed responsive and qualified to have its bid evaluated and scored and ultimately a contract granted?	There will be no change to this specification of the ITN.

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108	Best Care Assurance		D. Response Evaluation, Negotiations, and Contract Award	A-2-a	2	b	12	If the submittal of a TPA license or contract with a licensed TPA entity is still required for a respondent to be qualified to bid as a PSN, what alternatives will AHCA provide to applicants, who relied upon the March 27 Guidance in not pursuing a TPA license prior to bid response submittal, or who timely pursued a TPA license, and who have now had their applications refused to be processed because the OIR takes the position that neither a PSN nor an ASO servicing a PSN are within the statutory requirements of the TPA licensure act (Part VII of Chapter 626, Florida Statutes.), and do not need a TPA license to operate as a PSN or, if an ASO, to provide third party administrator services to a PSN.	There will be no change to this specification of the ITN.
109	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	A-8	9	b	12	Can AHCA provide an example of the type of article that AHCA envisions being acquired by a Respondent from the Prison Rehabilitative Industries and Diversified Enterprises, Inc. (Exhibit A-8 page 12)?	See Chapter 946, Florida Statues and www.pride-enterprises.org/.
110	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	A-8	9	b	12	Can AHCA provide an example of the type of articles that AHCA envisions being acquired by a Respondent from RESPECT of Florida (Exhibit A-8 page 12)? Is the use of the word “any” imposing a requirements contract on the Respondent?	See Chapter 413, Florida Statutes and www.respectofflorida.org.
111	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	A-8	9	b	20	ACHA is permitted to terminate the standard contract without cause on the giving of 30 days’ prior written notice (Section III-A-1 of Exhibit A-8 at page 20). May a reciprocal provision be added so that the Respondent has the same right to terminate?	No. See Attachment B - Scope of Services - Core Provisions, Section XV. Special Terms and Conditions, Sub-Section W. Performance Bond.
112	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	A-8	9	b	21	ACHA is permitted to terminate the standard contract the event there is a lack of funds (Section III-A-2 of Exhibit 8-A at page 21). May a reciprocal provision be added so that the Respondent has the same right to terminate under these circumstances?	No. See Attachment B - Scope of Services - Core Provisions, Section XV. Special Terms and Conditions, Sub-Section W. Performance Bond.
113	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	A-8	9	b	21	AHCA is permitted to terminate the standard contract for cause (e.g., breach by the Respondent). (Section III-A-3 of Exhibit A-8 at page 21) May a reciprocal provision be added so that the Respondent has the same right to terminate under these circumstances?	No. See Attachment B - Scope of Services - Core Provisions, Section XV. Special Terms and Conditions, Sub-Section W. Performance Bond.
114	Humana		D. Response Evaluation, Negotiations, and Contract Award	N/A	3	a	25	Please identify all parties that are required to submit a Transmittal Letter in each response.	See Attachment A- Instructions and Special Conditions, Section B. Response Preparation and Content, Sub-Section 1. General Instructions, f.
115	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	4	a	26	If the Agency determines that a respondent has insufficient financial resources, what are the respondent’s rights of appeal of the determination – if any?	Respondents with standing may be entitled to file a bid protest pursuant to § 120.57(3), Fla. Stat.
116	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	4	b	27	Why are "not applicable" comments included in the scoring? We believe that comments that are not applicable should not be counted or included. Will the Agency review comments that are applicable to a respondent, but that are focused more specifically on a subcontractor or affiliate that will provide services to the respondent?	There will be no change to this specification of the ITN.
117	Staywell (WellCare)		D. Response Evaluation, Negotiations, and Contract Award	N/A	4	b	27	Regarding Provider Comments, if more than 500 surveys are submitted, how are the 500 selected?	The Agency will consider the first 500 comments received per respondent.
118	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	4	b	28	The use of qualifiers such as “very positive” and “mostly positive” are very subjective. Can the Agency clarify further as to how these scores will be applied?	There will be no change to this specification of the ITN.
119	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	4	e	30	How did the Agency determine the maximum points for the various plan categories. Why is there a difference of over 1000 points that will be scored for a Comprehensive Plan over the scoring for a Long Term Care Plus Plan?	The scoring methodology used was determined to be in the Agency's best interest.

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120	Sunshine State Health Plan		D. Response Evaluation, Negotiations, and Contract Award	N/A	4	d	30	What is meant by "common base rates"? Does this mean that actual rates for the contract periods will be developed in a manner consistent with what is currently done? Said differently, will all MCO's be paid off of the same 1.0 rates by cell and region?	All plans will be paid using the same base rates for each Region and rate cell.
121	Sunshine State Health Plan		D. Response Evaluation, Negotiations, and Contract Award	N/A	4	d	30	It is unclear from Table 4 how many points are available for the Cost Proposal. Please provide this figure.	Please see addendum, Item #2 and #3
122	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		D. Response Evaluation, Negotiations, and Contract Award	N/A	4		31	Who are the four evaluators and what are their positions at AHCA?	The evaluators have not been determined.
123	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		D. Response Evaluation, Negotiations, and Contract Award	N/A	4		31	Once the ITN Response is submitted, will the reviewers ask questions of the vendor related to the response, or request any additional information?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations and Contract Award.
124	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	5	b	33	Will the Agency provide respondents with most favored price ranges prior to the time that negotiations will begin?	There will be no change to this specification of the ITN.
125	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	5	e	33	Will written best and final offers requested by the Agency be made available to other Respondents prior to the Agency's ultimate decision?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations and Contract Award, Sub-Section 5. Negotiation Process, Item e.
126	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		D. Response Evaluation, Negotiations, and Contract Award	N/A	5	a	33	Who will be on the negotiation team for Specialty Plans for chronically ill children?	The negotiation team has not been determined.
127	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		D. Response Evaluation, Negotiations, and Contract Award	N/A	5	c	33	The Agency will award contracts based upon the best value to the State, including price/cost. For respondents that are applying to become capitated vendors, when will the Agency publish the favored price ranges?	There will be no change to this specification of the ITN.
128	Quintairos, Prieto, Wood & Boyer		D. Response Evaluation, Negotiations, and Contract Award	N/A	5	g	34	Will the agency require a minimum score for a Specialty Plan or PSN to be considered for negotiations and contracting?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award, Sub-section 5. Negotiation Process, g. 4)
129	Quintairos, Prieto, Wood & Boyer		D. Response Evaluation, Negotiations, and Contract Award	N/A	5	g	34	ITN states that the top 2 ranking Specialty Managed Medical Assistance Plan per specialty population will be invited to negotiate. If only 2 Specialty Plans submit, would that mean both will automatically be invited to negotiate?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award, Sub-section 5. Negotiation Process, g. 4)
130	Sunshine State Health Plan		D. Response Evaluation, Negotiations, and Contract Award	N/A	5	g	34	If AHCA prefers comprehensive plans, would it consider not reserving a specific number of negotiation slots for MMA only and LTC Plus only bidders, as that could eliminate more qualified comprehensive plans from negotiations. In other words, would AHCA consider simply selecting the most qualified plans for negotiations, regardless of whether they bid as Comprehensive, LTC Plus, or MMA.	There will be no change to this specification of the ITN.
131	Humana		D. Response Evaluation, Negotiations, and Contract Award	N/A	5	g	34	Please confirm the Agency may invite additional plans to negotiate, above and beyond the number specified in the ITN, at its discretion.	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award, Sub-section 5. Negotiation Process, g.
132	Community Care Plan		D. Response Evaluation, Negotiations, and Contract Award	N/A	6	a	35	Can the Agency publish the weight a comprehensive plan would have over a standard MMA plan in scoring?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award, Sub-Section 4. Scored Requirements - Evaluation Criteria, Table 4.
133	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		D. Response Evaluation, Negotiations, and Contract Award	N/A	7		35	How many Specialty Plan awards will be made for Chronically Ill Children in this Region?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations and Contract Award, Sub-Section 7. Number of Awards, e.

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134	Staywell (WellCare)		D. Response Evaluation, Negotiations, and Contract Award	N/A	7	a	35	How does the number of anticipated contract awards reflect Comprehensive vs. MMA and LTC Plus? For example, in Region 1 three contract awards are anticipated. If two of those contracts are Comprehensive, would the remaining contract be an MMA contract OR an LTC Plus contract, or would an MMA contract and an LTC Plus contract count as "one" contract since they would essentially each be serving half of the SMMC program?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations and Contract Award, Sub-Section 7. Number of Awards
135	Humana		D. Response Evaluation, Negotiations, and Contract Award	N/A	7	a	35	Please confirm "Total Anticipated Contract Awards" include awards for all Comprehensive Plans, LTC Plus Plans, and MMA Plans.	See Attachment A- Instructions and Special Conditions, Section D. Response Evaluation, Negotiations and Contract Award, Sub-Section 7. Number of Awards, a.
136	Humana		D. Response Evaluation, Negotiations, and Contract Award	N/A	7	a	35	"Total Anticipated Contract Awards" are included in each Regional ITN. Please confirm Comprehensive Plans are counted as one single award, rather than two.	Confirmed. See Attachment A- Instructions and Special Conditions, Section D. Response Evaluation, Negotiations and Contract Award, Subsection 7. Number of Awards, Paragraph d.
137	Best Care Assurance		D. Response Evaluation, Negotiations, and Contract Award	N/A	7	c	36	Please clarify the number of PSN awards per region and how PSN awards will be determined based on the PSN's plan type (e.g., Comprehensive, LTC Plus, MMA, Specialty). As you know, Sections 409.974 and 409.981, Florida Statutes require one MMA PSN and one LTC PSN award per region (assuming a PSN is responsive) and the Agency has stated that an award to a Comprehensive Plan PSN will meet the requirements of both statutes. However, can the Agency further clarify whether other types of PSNs would meet the statutory requirements? Specifically, would a PSN LTC Plus award meet the requirements of Section 409.981, Florida Statutes? Similarly, would an award to a Specialty Plan PSN meet the requirements of Section 409.974, Florida Statutes?	See Attachment A - Instructions and Special Conditions, Section D Response Evaluations, Negotiations and Contract Award, Sub-Section 7 Number of Awards. Yes, a PSN LTC Plus award would meet the requirements of Section 409.981(2). A Specialty Plan PSN would not meet the requirements of Section 409.974(1).
138	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	7	d	36	If a PSN is awarded a contract as a Comprehensive Plan in a Region, will that satisfy the minimum number of PSN requirements for both MMA and MLTC for that Region?	Yes.
139	Staywell (WellCare)		D. Response Evaluation, Negotiations, and Contract Award	N/A	7	h	36	For the Region 1 and 2 Bonus, if an MCO wins both regions, does that result in 1 or 2 bonus Regions?	In the event a respondent wins both Regions 1 and 2, it shall receive 2 bonus contracts.
140	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	9	b	37	The provisions of Section D-9-b state that AHCA will not consider modifications to the documents listed in Exhibit A-3, Standard Contract; however, not all of the terms are found in the Standard Contract (e.g., page 20 provides that the compensation is to be inserted). Will proposals for modification of the terms of the Standard Contract be entertained by AHCA?	No.
141	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	8	a	37	May a respondent's Notice of Protest be submitted by email to the Agency? Should such notice be filed with the Agency Clerk in addition to the Procurement Officer? Will protest bonds (or similar securities) filed under this ITN be returned without request to the Respondent? If so, what is the timeframe for the return of the bond?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations and Contract Award, Sub-Section 8. Posting of Notice of Intent to Award.
142	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	8	b	37	If a vendor has not initiated an administrative challenge to a solicitation, but instead is only involved in the litigation to defend the Agency's selection, is that vendor prohibited from enrolling Medicaid members until the all of the administrative challenges to the solicitation have been finalized?	No.
143	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	A-2-b	9	e	38	Is there any requirement that a Provider Service Network be structured as a for profit “C” corporation? Item 2 of Exhibit A-2-b at Page 1 would appear to answer our question in the negative; however, if a Provider Service Network must obtain a Certificate of Authority from the Office of Insurance Regulation as an HMO, then state regulations would appear to require the provider to be established as a corporation (nonprofit or “C” corporation).	Please see addendum, Item #4 and #5

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144	Adventist Health Systems		D. Response Evaluation, Negotiations, and Contract Award	N/A	9	g	38	The provisions of Section D-9-g state that the obligation of the state of Florida to pay the Respondent is conditioned on funding from the Legislature. Is the obligation of the Respondent to perform likewise conditioned on it receiving payment from the state of Florida or will there by an obligation to continue to perform without receipt of payment?	See Exhibit A-8 - Standard Contract, Section III. The Vendor and Agency Hereby Mutually Agree, Sub-Section A. Termination, Item 2. Termination Due to Lack of Funds.
145	Adventist Health Systems		E. Contract Implementation	N/A	1	c	38	When will the anticipated rollout schedule for regional implementation be made available?	See Attachment A- Instructions and Special Conditions, Section E. Contract Implementation, Sub-Section 1. Proposed Implementation Schedule. The Agency will determine the regional rollout schedule, including enrollee notification, at a later date.
146	Quintairos, Prieto, Wood & Boyer		E. Contract Implementation	N/A	1	a	38	Please clarify the anticipated go-live date within the implementation schedule.	The Agency will determine the regional rollout schedule, including enrollee notification, at a later date.
147	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		E. Contract Implementation	N/A	1	N/A	38	When will the anticipated rollout schedule for regional implementation be released?	The Agency will determine the regional rollout schedule, including enrollee notification, at a later date.
148	Community Care Plan		E. Contract Implementation	N/A	2	e	39	Given existing statutes and applications concerning a Certificate of Authority and/or a Health Care Provider Certificate only apply to Health Maintenance Organizations and Prepaid Health Clinics, will the Agency be implementing additional procedures and providing an application form specific to Provider Service Networks pursuant to the ITN's Certificate of Authority requirement and section 641.2019, Florida Statutes? And if so, what is the timeline for publication of these forms in relation to the ITN?	Please see addendum, Item #4 and #5
149	Community Care Plan		E. Contract Implementation	N/A	2	e	39	* If a PSN obtains a Health Care Provider Certificate and meets the surplus requirements in Section 641.2019 Florida Statutes, will a Certificate of Authority be issued without an additional process?	Please see addendum, Item #4 and #5
150	Adventist Health Systems		E. Contract Implementation	A-2-c	2	e	39	Must a Provider Service Network be required to obtain a certificate of authority as an HMO or is the intent of Section E-2 to require a PSN to obtain a health care provider certificate? Section 14 of Exhibit A-2-c appears to require both a Health Care Provider Certificate and a Certificate of Authority as an HMO per 641.2019, FS.	Please see addendum, Item #4 and #5
151	Adventist Health Systems		E. Contract Implementation	N/A	2	a	39	When does the Agency intend to begin performing readiness reviews? It may take a significant length of time for a PSN to obtain a health care provider certificate and a certificate of authority. How long will the readiness review period last? (See also E.1. – Proposed Implementation Schedule on page 38 of 41).	The Agency will begin performing readiness reviews immediately following contract award.
152	Adventist Health Systems		E. Contract Implementation	A-2-c	2	e	39	These provisions appear to require that a capitated PSN apply for, and obtain, a certificate of authority pursuant to Section 641.2019, F.S., during the readiness review process. PSNs are defined in Section 409.912(1)(b), F.S. Section 409.912(1)(a), F.S., explicitly and specifically states that PSNs "are exempt from parts I and III of chapter 641." Section 641.2019, F.S., allows a PSN the choice of being regulated by the Florida Office of Insurance Regulation, but the statute does not require any PSN to make such a choice, and we do not believe that any PSN has made such a choice. We believe that this requirement was included in error, and potentially is an invalid and un-promulgated rule, and we respectfully request that the Agency remove any language that could be interpreted as requiring a PSN to seek regulation by the Florida Office of Insurance Regulation pursuant to Section 641.2019, F.S. (See also Attachment A, Exhibit A-2-c, 14, page 5 of 8) Will the Agency remove language requiring a PSN to seek regulation by the Florida Office of Insurance Regulation pursuant to Section 641.2019, F.S.?	Please see addendum, #4, #5, #18 and #19

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153	Adventist Health Systems		E. Contract Implementation	A-2-c	2	e	39	What application would a PSN be required to file with the Florida Office of Insurance Regulation to obtain a certificate of authority pursuant to Section 641.2019? (See also Attachment A, Exhibit A-2-c, 14, page 5 of 8).	Please see addendum, Item #4 and #5
154	Adventist Health Systems		E. Contract Implementation	A-2-c	2	e	39	What kind of certificate of authority would the PSN be issued? What, if anything, is the difference between a PSN with a certificate of authority issued pursuant to Section 641.2019, and an HMO with a certificate of authority issued pursuant to Section 641.22, F.S.? (See also Attachment A, Exhibit A-2-c, 14, page 5 of 8).	Please see addendum, Item #4 and #5
155	Adventist Health Systems		E. Contract Implementation	A-2-c	2	e	39	If the Florida Office of Insurance Regulation does not complete its review of the certificate of authority application during the readiness review time-frame, will the PSN be allowed to begin enrolling Medicaid members? If not, when would the PSN be allowed to begin enrolling Medicaid members? (See also Attachment A, Exhibit A-2-c, 14, page 5 of 8).	Please see addendum, Item #4 and #5
156	Adventist Health Systems		E. Contract Implementation	A-2-c	2	e	39	Section 641.2019, F.S., specifically refers to the surplus requirements of Section 641.225, F.S., when determining whether a PSN can obtain a certificate of authority. Will the Agency intervene on behalf of the PSN if the Florida Office of Insurance Regulation attempts to require that the PSN maintain a surplus in excess of the amount required pursuant to Section 641.225? (See also Attachment A, Exhibit A-2-c, 14, page 5 of 8).	Please see addendum, Item #4 and #5
157	Adventist Health Systems		E. Contract Implementation	A-2-c	2	e	39	If the PSN is unable to obtain a certificate of authority from the Florida Office of Insurance Regulation, will the Agency select another PSN for that Region? (See also Attachment A, Exhibit A-2-c, 14, page 5 of 8).	Please see addendum, Item #4 and #5
158	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		E. Contract Implementation	N/A	1	d	39	If Specialty Plans are not being rolled out between 10/18 and 1/19, what is their proposed implementation date?	See Attachment A - Instructions and Special Conditions, Section E. Contract Implementation, Sub-Section 1. Proposed Implementation Schedule, d.
159	Variety Children's Hospital d/b/a Nicklaus Children's Hospital		E. Contract Implementation	N/A	3	b	39	Specialty Plan for Chronically Ill Children have both mandatory and voluntary enrolllees. Based on the number of Chronically Ill Children in this region, do you anticipate any limit on enrollees based on this 10 percent maximum factor?	See Attachment A - Instructions and Special Conditions, Section E. Contract Implementation, Sub-Section 3. Enrollment Levels, b.
160	Bruce Platt		E. Contract Implementation	N/A	2	e	39	The ITN requires that capitated PSNs obtain a certificate of authority from the Office of Insurance Regulation. Please list and explain the differences between a PSN with a certificate of authority and an HMO with a certificate of authority. If a PSN with a certificate of authority essentially becomes an HMO, and the statutory preferences for PSNs remain during the next ITN release, will the PSN with a certificate of authority continue to be eligible for the PSN preferences in the statutes and ITN?	A PSN with a certificate of authority, which otherwise continues to meet the statutory requirements of a PSN, remains a PSN.
161	Community Care Plan		E. Contract Implementation	N/A	3	c	40	*(4.c.3) - Why is the Agency only assigning enrollees who do not make an active choice to "existing plans' and not "new plans"? This is not supported or specified in Section 409.977(2) Florida Statutes.	Please see addendum, Item #6
162	Adventist Health Systems		E. Contract Implementation	N/A	4	c	40	Are Letters of Agreement with providers acceptable for determining whether the network of providers is adequate? Or will the Agency only accept fully executed contracts? Also, can network adequacy be achieved by using Medicaid “eligible” providers? (with such providers not having a Medicaid provider number)	See Attachment B- Scope of Service- Core Provisions, Section VIII. Provider Services; Attachment B- Exhibit B-1, Managed Medical Assistance Program, Section VIII. Provider Services and Attachment B, Exhibit B-2, Long Term Care Program, Section VIII. Provider Services
163	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		E. Contract Implementation	N/A	4	N/A	40	This paragraph requires that Managed Care Plans demonstrate that it has an adequate network of providers to provide all covered services to enrollees. Are the providers required to have a Medicaid provider number at the time "adequacy" is to be demonstrated, or is it sufficient that the providers are Medicaid eligible at that time?	See Attachment B- Scope of Service- Core Provisions, Section VIII. Provider Services; Attachment B- Exhibit B-1, Managed Medical Assistance Program, Section VIII. Provider Services and Attachment B, Exhibit B-2, Long Term Care Program, Section VIII. Provider Services

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164	Community Care Plan		E. Contract Implementation	N/A	1	a	41	*(E.1.(a)) When AHCA states it will begin to roll out in October of 2018, can we assume that in some regions, members would be assigned to plans under the new contract by October 1, 2018?	The Agency will determine the regional rollout schedule, including enrollee notification, at a later date.
165	Humana		E. Contract Implementation	N/A	4	N/A	41	Does AHCA intend to apply rate reduction to capitation rates when a member is enrolled with the same plan for both services? If so, please describle the magnitude of the rate reduction and provide supporting information on how the assumption is developed.	There will be no change to this specification of the ITN.
166	Community Care Plan			A-2-b	1	N/A	1	If the PSN responding to the ITN is a newly formed entity, what should the PSN include as its first year of operation when responding to the request for additional information, and what documentation is required to demonstrate the first year of operation if the PSN is owed and/or controlled by a single health care system?	See Exhibit A-2-b - Provider Service Network Certification of Ownership and Controlling Interest, Items 1 and 2
167	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida			A-2-c			5	Most large managed care organizations have subsidiaries and/or affiliates conducting lines of business other than the Medicaid managed care business that is the subject of this procurement. Please confirm that the "Certification Regarding Terminated Contracts" applies only to Medicaid managed care contracts held by respondents' subsidiaries and/or affiliates.	The requirement states any contract.
168	Community Care Plan			A-2-b	3	N/A	16	*Will a PSN be subject to Office of Insurance Regulation oversight of its surplus account?	Please see addendum, Item #4 and #5
169	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida			A-8			22	Please confirm that the Preferred Pricing provision in Section III(C)(3) applies to prices for similar services offered in the State of Florida by the specific Vendor signing a contract with AHCA and that it does not apply to prices for similar services offered by Vendors' affiliated health plans to agencies in other states.	See Section 216.0113, Florida Statutes.
170	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida			A-8			22	Please confirm that any rate adjustments contemplated by Exhibit A-8, Section III(C)(2) will be accomplished through an amendment, in writing, and subject to mutual agreement of the parties consistent with the provisions in Exhibit A-8, Section III(C)(1) and Attachment B, Section XV(H)(5), such that if the new rates are not operationally viable, Vendors may terminate the contract without penalty or loss of their performance bonds.	See Exhibit A-8 - Standard Contract, Section III. The Vendor and Agency Hereby Mutually Agree:, Sub-Section A. Termination and Sub-Section C. Renegotiation or Modification. See Attachment B - Scope of Services - Core Provisions, Section XV. Special Terms and Conditions, Sub-Section W. Performance Bond.
ATTACHMENT B									
171	Sean Schwinghammer		X. Administration and Management		B.		119	Are delegated authorities that have exclusive contracts with providers subject to the same restrictions as delegated authorities that self refer? There are a number of delegated authorities that have exclusive or primary provider contract with providers to which they forward all or nearly all of their business. Some of those contracts, it is rumored involve kick backs. We hope there are restrictions on this practice of self referring.	See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection F. Fraud and Abuse Prevention.
172	Sean Schwinghammer				B.		9	If a MCO or delegated authoirty, authorizes a service and the service is rendered, and then the same MOC or delegated authority rejects the claims based on an improper authorization, is that no longer considered a "clean claim" and therefore, not subject to the timely payment requirements?	See Attachment B - Scope of Service - Core Provisions, Section I. Definitions and Acronyms, Clean Claim.

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173	Sean Schwinghammer		VIII. Provider Services		B.		46	What is a qualified provider? The ITN requests that Managed Care Plans' provider networks shall include a sufficient number of qualified providers to cover all services in accordance with the services - specific coverage policy. What is a qualified provider and does experience in Medicaid count as a qualification?	See: • Attachment B Scope of Services – Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits. [ITN pdf page 292 through 293] • Attachment B Scope of Services – Core Provisions, Section VIII. Provider Services. [ITN pdf page 313 through 335] • Exhibit B-1 Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required MMA Benefits. [ITN pdf page 453 through 483] • Exhibit B-1 Managed Medical Assistance (MMA) Program, Section VIII. Provider Services. [ITN pdf page 486 through 505] • Exhibit B-2 Long-term Care (LTC) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required MMA Benefits. [ITN pdf page 541 through 543] • Exhibit B-2 Long-term Care (LTC) Program, Section VIII. Provider Services. [ITN pdf page 557 through 566]
174	Sean Schwinghammer		VI. Coverage and Authorization of Services		B.		8	Can Nurse Registries be used in the LTC Plus Program? Currently Nurse Registries are permitted to be providers of personal care services in the Long Term Care SMMC program. The new ITN does not specifically reference Nurse Registries in Long Term Care, therefore the question was asked above.	See Attachment B - Scope of Services -Core Provisions, Exhibit B-2 - Long-term Care (LTC) Program, Section VIII. Provider Services, Sub-Section C. Provider Credentialing and Contracting, Item 2. Credentialing and Recredentialing, sub-item c. [Page 559 of the pdf]
175	Sean Schwinghammer		VIII. Provider Services		B.		41	Why is there a proximity requirement for home health company PT, OT St services and can it be removed? There is no need for a member to report to a home health agency or nurse registry, as all services are rendered by an aide or nurse, etc who travels to the home. Services are scheduled in advance so there is no need for time based distance parameters. Therefore this requirement is unnecessary.	There will be no change to this specification of the ITN.
176	Sean Schwinghammer		VIII. Provider Services		B.		41	Why is distance to a Durable Medical Equipment Provider a requirement within the MMA program? Can the Durable Medical Equipment Provider distance requirement be removed? The question is asked because no member has to travel to a provider's office to receive medical equipment because it is all delivered. Having a distance requirement, especially in some rural areas is impossible to meet. Additionally, there is no distance requirement for the LTC program, which caters to a sicker and more needy population. This negates requirements in the MMA.	There will be no change to this specification of the ITN.
177	Sean Schwinghammer		VIII. Provider Services	6 facilities and ancillary providers	B.		46	How can a DME be ranked for quality as a qualified provider? As MCOs PSNs and alike are offering prices far below the cost of services, the only providers they are able to recruit are those with little to no Medicaid experience who will accept the rates, not knowing they are incompatible with providing the services. How than can a Provider be ranked for quality when it has little to no Medicaid experience?	There will be no change to this specification of the ITN.
178	Sean Schwinghammer		XV. Special Terms and Conditions		B.		194	Will the Agency demand accurate pricing as it evaluates network readiness as required by the ITN?	See Attachment B - Scope of Service - Core Provisions, Section X. Administration and Management, Sub-Section C. Subcontracts, Item 1. General Provisions

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179	Sean Schwinghammer		VIII. Provider Services		B.		38	Will the Agency evaluate reliability and history of those in the network to verify their quality and ability, considering the prices offered?	See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section B. Network Management, Item 1. General Provisions
180	Sean Schwinghammer		X. Administration and Management				119	Lastly, thank you for inputting restriction on sub-contract eligibility, specifically that MCOs shall not delegate provider network management, to entities that own the companies to whom they refer business to, and limit enrollee's choice of providers through the authorization process. Companies that operate as Univita did, the largest failure in the history of Florida Medicaid, endangers member's lives and destroy quality local busienss, which are both costly to the Florida tax payer.	No response required.
181	Community Care Plan		X. Administration and Management				115	*Minimal staffing - Can the Plan delegate the minimum staffing to a delegated vendor?	See Attachment B - Scope of Service - Core Provisions, Section X. Administration and Management, Sub-Section B. Organizational Governance and Staffing, Item 2. Minimum Staffing
182	Community Care Plan		XV. Special Terms and Conditions		W.		207	If a Plan submitting a response as an MMA Plan and multiple Specialty Plan types in the same region, is the performance bond requirement $5,000,000 for the MMA and separate $1,000,000 bonds for each identified specialty population?	No. See Attachment B - Scope of Service - Core Provisions, Section XV. Special Terms and Conditions, Sub-Section W. Performance Bond
183	Community Care Plan		XV. Special Terms and Conditions		X.		208	If a Plan submitting a response as an MMA Plan and multiple Specialty Plan types in the same region, is the fidelity bond requirement 60 days after execution of the contract $250,000 for MMA and separate $250,000 bonds for each identified specialty population?	No. See Attachment B - Scope of Service - Core Provisions, Section XV. Special Terms and Conditions, Sub-Section X. Fidelity Bond
184	Community Care Plan		X. Administration and Management		B.		116	Can a plan delegate the Medical Director duties and responsibilities to a subcontractor providing the Medical Director is designated 100% to the plan's membership?	See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection B. Organizational Governance and Staffing, Item 2. Minimum Staffing.
185	Community Care Plan		X. Administration and Management		C.		116	Can a plan delegate the Compliance Officer duties and responsibilities to a subcontractor providing the Compliance Officer is designated 100% to the plan's membership?	See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection B. Organizational Governance and Staffing, Item 2. Minimum Staffing.
186	Community Care Plan		X. Administration and Management		D.		116	Can a plan delegate the required staffing to subcontractors providing that those subcontractors are designated to the plan's membership, and providing the Plan conducts subcontractor oversight?	See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection B. Organizational Governance and Staffing, Item 2. Minimum Staffing.
187	Adventist Health Systems		X. Administration and Management		B.		115	This provision requires the full-time Contract Manager to be a full-time employee of the Managed Care Plan. Will an individual that is leased from a third party to the Managed Care Plan meet the requirements of Section X-B-2?	See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection B. Organizational Governance and Staffing, Item 2. Minimum Staffing.
188	Adventist Health Systems		X. Administration and Management		C.		118	If a Respondent is structured as a limited liability company, may the Respondent delegate the performance of certain work required under the standard contract to a member-owner of the limited liability company without submitting the proposed delegation to AHCA (i.e., is the non-delegation provision of Section X-C-1-a.limited to third parties who are not otherwise owners of the Respondent)?	No. See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection C. Subcontracts, Item 1. General Provision, Sub-item a.
189	Florida Hospice and Palliative Care Association		VI. Coverage and Authorization of Services		G.		65	Please confirm that the evidence-based guidelines and/or the national standardized set of criteria upon which the Managed Care Plan bases authorization decisions should be made available to providers and Enrollees upon request.	Confirmed. See Attachment B. Scope of Service - Core Provisions, Section V. Enrollee Services, Subsection B. Enrollee Material, Item 8. Enrollee Handbook Requirements See Attachment B. Scope of Service - Core Provisions, Section VIII. Provider Services, Section D. Provider Services, Item 2. Provider Handbook and Bulletin Requirements

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190	Florida Hospice and Palliative Care Association		VIII. Provider Services		E.		97	Please confirm that Managed Care Plans should not require a Medicare Explanation of Benefits or other similar documentation from a hospice provider in order to pay hospice room and board.	Confirmed. See Attachment B. Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section E. Claims and Provider Payment, Item m.
191	Florida Hospice and Palliative Care Association		XII. Financial Requirements		D.		167	Please clarify how patient responsibility amounts should be captured on a claim.	See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section C. Provider Credentialing and Contracting, Item 5. Provider Agreement Requirements, Sub-Item a.(12) and (13) See Attachment B - Scope of Service, Exhibit B-2 LTC Program, Section XII. Financial Requirements, Sub-Section D. Third Party Resources, Item 3. Patient Responsibility See Attachment A - Instructions and Special Conditions, Exhibit A-4-c LTC Submission Requirements and Evaluation Criteria, Section D. Provider Experience, SRC# 9
192	Florida Hospice and Palliative Care Association		VIII. Provider Services		E.		97	Please confirm that MMA plans and Comprehensive Plans are required to pay the hospice provider for hospice services and/or the per diem rate set by the Agency for hospice services for Medicaid only enrollees residing in a nursing facility prior to the enrollee being enrolled in a Managed Care Plan that covers LTC services or being designated as an enrollee eligible for LTC services.	Confirmed. See Exhibit B-1 Managed Medical Assistance (MMA) Program, Section X. Administration and Management, Sub-Section E. Claims and Provider Payment, Item 7. [ITN pdf page 503] See Exhibit B-2 Long-term Care (LTC) Program, Section X. Administration and Management, Sub-Section E. Claims and Provider Payment, Item 1. [ITN pdf page 582]
193	Florida Hospice and Palliative Care Association		VIII. Provider Services	B-1	E.		56	Please confirm that Managed Care Plans are required to comply with the 2016 & 2017 Wage Index Rule Implementation & Service Intensity Add-on, as well as any subsequent changes in hospice payment methodology.	Confirmed. See Attachment B - Scope of Service - Core Provisions, Section XV, Specialty Terms and Conditions, Sub-Section A. Applicable Laws and Regulations. See Exhibit B-1 Managed Medical Assistance (MMA) Program, Section VIII. Provider Services, Sub-Section E. Claims and Provider Payment, Item 7. See Exhibit B-2 Long-term Care (LTC) Program, Section VIII. Provider Services, Sub-Section E. Claims and Provider Payment, Item 1.
194	Florida Community Care		II. General Overview		A.		31	II.A.2.b states that Long-term Care Plus Plans shall comply with the provisions of Attachment B, Exhibit B-1 and Exhibit B-2 for all enrollees. Please confirm that the final contract will exclude requirements to provide programs/services that do not apply to a LTC-eligible population (e.g., Children's Programs).	See Attachment B. Scope of Service - Core Provisions, Section II. General Overview, Subsection A. Purpose, Item 2.
195	Simply Healthcare		X. Administration and Management		C.		119	Under Attachment B, Section X, subsection C.2.c, is an entity still eligible to provide network management services as a subcontractor, if, the only providers that have satisfied the subcontractors established and approved credentialing criteria are providers that are owned or controlled by the subcontractors, as long as the sub contractor does not preclude other providers from seeking to become credentialed?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
196	Simply Healthcare		X. Administration and Management		C.		119	Please define "Provider Network Management."	As defined in Section VIII. Provider Services in this Contract and its Exhibits. See Attachment B. Scope of Service - Core Provisions, Section VIII. Provider Services, Subsection B. Network Management

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197	Simply Healthcare		X. Administration and Management		C.		119	As it relates to Attachment B, Section X, subsection C.2.c, if the Health Plan is contracted with a subcontractor who owns providers included in their network but does not limit enrollee choice because this provider will not re-direct care, but only review referrals/authorizations, will this still apply?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
198	Simply Healthcare		VI. Coverage and Authorization of Services		E.		62	Attachment B, Section VI, subsection E.3-5, states that the Managed Care Plan shall conduct an initial visit as specified in the applicable exhibits. In Exhibit B-1, there are no additional initial visit provisions unique to the MMA managed care program. Please clarify whether it is the intent of the Agency to require initial visits for enrollees in the MMA managed care program who are enrolled in case management or receiving care coordination services to receive an initial visit.	See Exhibit B-1 Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-section E. Care Coordination/Case Management, Item 3. Initial Visit
199	Simply Healthcare		VI. Coverage and Authorization of Services		A.		57	In Attachment B-1, Section A, Subsection VI Coverage and Authorization of Services, the ITN contract does not make reference to coverage of immunizations for MediKids, currently covered by the Medicaid FFS program. Under the new ITN contract, will MMA plans be responsible for payment of immunizations for the MediKids population?	Yes.
200	Simply Healthcare		X. Administration and Management		F.		139	In Attachment B, Section X, Subsection F.4.d.4.b, the ITN Contract requires implementation of EVV effective 1/1/2019 as required by federal law in the "21st Century Cures Act." The requirement is that EVV system plans implement needs to offer interoperability and compatibility among EVV platforms and be compatible with the Agency's EVV systems as prescribed by the Agency. What EVV system does the Agency currently use and will be using in 2019? and how can the Plan determine compatibility?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN. For information about electronic visit verification in the Agency's fee-for-service delivery system, see Rule 59G-4.132, Florida Administrative Code, titled Home Health Electronic Visit Verification Program. You can locate information on the Agency's current EVV vendor at http://ahca.myflorida.com/Medicaid/Utilization_Review/index.shtml.
201	Simply Healthcare		VI. Coverage and Authorization of Services		A.		57	Regarding Attachment B-1, Section A, Subsection VI Coverage and Authorization of Services, may the plan enter into contracts with FQHCs and RHCs that include mutually agreed upon reimbursement rates and methodology different from that of the Medicaid FFS Program, different from that indicated in this section of the ITN Contract?	Please see addendum, Item #23
202	Simply Healthcare		IX. Quality		A.		103	In Attachment B, Section IX, subsection 5, the State requires the QI plan to follow CMS protocols regarding staff training and PIP methodology. The hyperlink provided to the protocols leads to "Page Not Found." Where can these protocols be found?	The link re: training should be https://www.medicaid.gov/medicaid/quality-of-care/index.html The linke re: PIP methodology/protocols should be http://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html
203	Simply Healthcare		VIII. Provider Services		A.		28	Regarding Table 1 LTC Provider Network Standards Table: The following providers are requiring Time/Distance requirements – Caregiver Training, Medication Administration, Medication Management, Nutritional Assessment and Risk Reduction. The providers who perform these services are not typically facility based providers but providers who would go to the members home to perform the service. Can AHCA reconsider removing T/D from these services since these services are performed not at a facility but performed in the members' home?	There will be no change to this specification of the ITN.

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204	Simply Healthcare		X. Administration and Management		C.		119	Does C.2.c(1), apply to a subcontractor that is affiliated with a network provider through common ownership, when the subcontractor itself does not own or have a controlling interest in the Provider?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
205	Simply Healthcare		X. Administration and Management		C.		119	Under subparagraph C.2.c(2), is it considered to be a limitation of enrollee choice of network providers through a requirement for a referral/authorization process to access network providers, where any provider that satisfies the established and approved credentialing criteria of the subcontractor may be eligible to be included in the network?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
206	Sunshine State Health Plan		X. Administration and Management	N/A	D.		135	Regarding the Smartphone Applications requirement in Attachment B, Section X.D.11.b.(1) "The smartphone application shall disclaim that the app being used is not private and that no PHI or personally identifying information should be published on this application by the Managed Care Plan or end user" Please confirm that this requirement does not apply to Smartphone Applications (apps) that publish or otherwise make PHI or personally identifying information accessible via an AHCA approved, appropriately secured app requiring a secure log in, and with a member unique username and password in compliance with HIPAA Security rules.	This provision applies when the Managed Care Plan uses apps to allow enrollees direct access to Agency-approved member materials. See Attachment B - Scope of Service - Core Provisions, Section X. Administration and Management, Sub-Section D. Information and Management Systems, Item 11. Smartphone Applications, Sub-Item b.
207	Sunshine State Health Plan		XII. Financial Requirements	N/A	D.		166	Regarding the phrase in 1.c: "The Managed Care Plan shall enter into a coordination of benefits agreement with Medicare and participate in the automated claims crossover process. (42 CFR 438.3(t))": If the Managed Care Plan is currently receiving Medicare Crossover Claims from AHCA, via AHCA's existing Medicare Coordination of Benefits Agreement (COBA), please clarify why it is necessary for Managed Care Plans to enter into a COBA with Medicare? We assume that a Managed Care Plan must be able to receive and process Medicare Crossover Claims it receives from AHCA (via AHCA's existing COBA with CMS). Are we correct in our assumption? If not, please clarify ACHA's expectation of Managed Care Plans.	Operational details regarding receipt of automated cross over claims will be provided to successful venders by the Agency at a later date.
208	Sunshine State Health Plan		X. Administration and Management	N/A	E.		136	Regarding the phrase in 1.b.(1): "The Managed Care Plan shall receive: (1) No notice for Medicaid Companion Guide updates that are informational and/or limited to clarification of existing standards, or setting an edit from deny to pay." Please confirm that the above should read (1) Notice - as opposed to "(1) No Notice."	No, it should read "(1) No notice." There will be no change to this specification of the ITN.

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209	Sunshine State Health Plan		VIII. Provider Services	N/A	E.		98	Item 2.a.(2) reads: "Pursuant to s. 409.982(5), F.S., within ten (10) business days of receipt of nursing facility and hospice clean claims, pay or notify the provider or designee that the claim is denied or contested." Item 2.a.(3) reads: "Within fifteen (15) days after receipt of a non-nursing facility/non-hospice claim, pay the claim or notify the provider or designee that the claim is denied or contested." Please confirm that Items 2.a.(2) and 2.a.(3) should read: "Within fifteen (15) days after receipt of a non-nursing facility/non-hospice clean claim, pay the claim or notify the provider or designee that the claim is denied or contested". Similarly, we assume that Item 2.b.(2) should include the word "clean" as well - so that 2.b.(2) should read: "Within twenty (20) days after receipt of the clean claim, pay the claim or notify the provider or designee that the claim is denied or contested." Similarly, we assume that Item 2.b.(3) should include the word "clean" as well - so that 2.b.(3) should read: "Pay or deny the clean claim within one hundred twenty (120) days after receipt of the claim. " Are we correct in our 3 assumptions above with respect to Items 2.a.(3), 2.b.(2) and 2.b.(3)? Please clarify if we are incorrect.	You are incorrect. There will be no change to this specification of the ITN. Please see http://m.flsenate.gov/Statutes/409.982.
210	Sunshine State Health Plan		I. Definitions and Acronyms	N/A	A.		5	Understanding that applicable federal/State statutes (such as CFR 438.400(b)) and State documents are incorporated as referenced in Attachment B, Section 1.A. Definitions for Authorized Representative and Grievance are not specifically included in that section's list of definitions, but definitions such as Complaint and Plan Appeal are included. Please provide the definitions for "Authorized Representative" and "Grievance."	See Attachment B - Scope of Service, Section V. Enrollee Services, A. General Provisions, sub-item 4. See Attachment B - Scope of Service, Section I. Definitions and Acronyms, Sub-Section A. Definitions.
211	Sunshine State Health Plan		VI. Coverage and Authorization of Services	N/A	G.		68	Will expedited PA turnaround time remain at 48 hours for urgent pharmacy PA requests and seven days for standard pharmacy PA requests and not adhere to the new MegaReg?	Please see addendum, Item #22
212	Sunshine State Health Plan		IX. Quality	N/A	G.		65	P&T and DUR section says the MCO "shall participate". Does this mean that the MCO must have a pharmacist who sits on the committee? If that pharmacist is on vacation on the date of the committee, will the MCO be able to send a delegate? Will MCO be allowed to have a pharmacist and Medical Director serve on P&T and on DUR (i.e. two reps on each committee)?	The plan will only be required to participate on P & T and DUR if formally appointed to those boards.
213	Sunshine State Health Plan		VIII. Provider Services	N/A	A.		41	Exhibit B-1 MMA: Did the state intend for the Geo Access requirements for pharmacy to be different for MMA and Specialty plans? ITN has 60 minutes /45 miles for urban and rural for MMA and N/A for regional provider ratios. For specialty plans it has 60 minutes/45 miles for urban and 75 minutes/60 miles for rural and 2 per county for regional provider ratios.	Please see addendum, Item #25
214	Sunshine State Health Plan		VIII. Provider Services	N/A	A.		12	Exhibit B-3 Specialty: Did the state intend for the Geo Access requirements for pharmacy to be different for MMA and Specialty plans? ITN has 60 minutes /45 miles for urban and rural for MMA and N/A for regional provider ratios. For specialty plans it has 60 minutes/45 miles for urban and 75 minutes/60 miles for rural and 2 per county for regional provider ratios.	Please see addendum, Item #25

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215	Sunshine State Health Plan		VIII. Provider Services	N/A	A.		45	Exhibit B-1 MMA: The ITN states, in regard to 340B, that the managed care plan shall reimburse CHDs for authorized prescription drugs at Medicaid's standard pharmacy rate. Does this mean we are to reimburse using non-340B methodology?	Please see addendum, Item #23
216	Sunshine State Health Plan		XI. Method of Payment	N/A	C.		155	Are Utilization and Expenditures for Emergency Services by a provider outside of the US included in the development of the capitation rates?	See Attachment B - Scope of Service - Core Provisions, Section X. Administration and Management, Sub-Section F. Fraud and Abuse Prevention, Item 1. General Provisions, Sub-item a.
217	Sunshine State Health Plan		XI. Method of Payment	N/A	C.		156	Please confirm any rate adjustments (as described in b (2)) must be certified as actuarially sound by the state's actuary prior to implementation.	See Attachment B - Scope of Service - Core Provisions, Section XI. Method of Payment, Sub-Section C. Payment Provisions, Item 2. Capitated Managed Care Plans, Sub-Item a. Capitation Payments, Paragraphs (4) and (6)
218	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XI. Method of Payment		C.		154	Please confirm that to the extent rates certified by the actuary and approved by CMS are different from the rates included in the Contract, any such rate change will be accomplished through an amendment, in writing, and subject to mutual agreement of the parties consistent with the provisions in Exhibit A-8, Section III(C)(1) and Attachment B, Section XV(H)(5), such that if the new rates are not operationally viable, Vendors may terminate the contract without penalty or loss of their performance bonds.	There will be no change to these specifications of the ITN. See Attachment B - Scope of Service - Core Provisions, Section XI. Method of Payment, Sub-Section C. Payment Provisions, Item 2. Capitated Managed Care Plans, Sub-Item a. Capitation Payments, Paragraphs (4) and (6)
219	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		VI. Coverage and Authorization of Services		B.		59	Please clarify if the over-the-counter expanded drug benefits are cumulative for an enrollee with both MMA and LTC coverage, for a total of $40.	Yes. See Attachment B -Scope of Service - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section B. Expanded Benefits Item 2. Types of Expanded Benefits, Sub-Item a.
220	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		VI. Coverage and Authorization of Services	Exhibit A-1	E.		62	Please clarify that the requirements for an initial visit, comprehensive assessment, initial plan of care/reviews, and monthly contact only apply to MMA enrollees who have been identified as requiring case management.	See Exhibit B-1 - Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Section E. Care Coordination/Case Management
221	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XV. Special Terms and Conditions		H.		197	Please confirm that any such Contract amendment is subject to the mutual consent of the parties such that if the Vendor does not agree to the amendment, it may terminate the Contract without penalty or loss of its performance bond.	See Attachment A - Instructions and Special Conditions, Exhibit A-8 Standard Contract, Section III. The Vendor and Agency Hereby Mutually Agree
222	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XV. Special Terms and Conditions		H.		197	Please confirm that Contract amendments resulting in a material change to the Contract, including, but not limited to changes to rates or the scope of work, are subject to mutual agreement of the parties such that if the Vendor does not agree to the amendment it may terminate the contract without penalty or loss of its performance bond.	Contracts awarded under this ITN will be conditioned upon negotiating an agreement on initial rates. The agency will not comment on potential future disputes regarding rate changes.
223	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XV. Special Terms and Conditions		C.		190	Please confirm that the disclosures required in Attachment B, Section C, Ownership and Management Disclosure, are not required to be submitted with respondents' proposals and that this is an operational requirement only.	See Attachment A - Instructions and Special Conditions, Section B. Response Preparation and Content, Sub-Section 2. Mandatory Response Content.
224	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XV. Special Terms and Conditions		C.		190	Due to the highly sensitive nature of social security numbers, if the Agency's response to our prior question indicates that the Ownership and Management Disclosures in Attachment B, Section XV(C) are to be submitted with respondents' proposals, may respondents provide social security numbers in a separate, appropriately marked envelope and exclude them entirely from their unredacted proposal copies to avoid accidental public disclosure of those numbers.	There will be no change to this specification of the ITN.
225	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XV. Special Terms and Conditions		W.		207	Please provide the percent of the current annual Contract that will be used to calculate the annual bond amount.	Please see addendum, Item #22

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226	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		X. Administration and Management		B.		116	Please confirm that it is acceptable for the Compliance Officer and Medical Director to dedicate 100% of their time to both the SMMC and Florida Healthy Kids contracts, as long as they are solely dedicated to Medicaid/CHIP and do not spend any percentage of time supporting other lines of business, such as Commercial or Medicare.	See Attachment B - Scope of Service - Core Provisions, Section X. Administration and Management, Sub-Section B. Organizational Governance and Staffing, Item 2. Minimum Staffing, Sub-Items b. and c. There will be no change to the specification of this ITN.
227	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XII. Financial Requirements		F.		77	For a comprehensive plan or a LTC-plus plan, please confirm our understanding that the medical loss requirement is calculated for MMA and LTC services on a combined basis. For a plan with multiple regions, please confirm our understanding that the medical loss ratio requirement will be calculated for all serviced regions on a combined basis.	Contract requirements apply to the entire contract unless otherwise specified in the Scope of Service.
228	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XII. Financial Requirements		F.		77	Please clarify the exact Medical Loss Ratio formula, including the items to be included in the numerators, the items that can be deducted from the denominators, and the applicable additive credibility adjustment factors and thresholds.	See Attachment B - Scope of Service, Exhibit B-1 MMA Program, Section XII. Financial Requirements, Sub-Section F. Financial Reporting, Item 1. Medical Loss Ratio, Sub-Item b.
229	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		X. Administration and Management		E.		139	In the current State contract the requirement is that NCPDP encounter data transactions must be resubmitted within thirty days of the respective action. Is the requirement for NCPDP now changing to seven days?	See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection E. Encounter Data Requirements, Item 3. Encounter Data Submission, Sub-Item d. Encounter Resubmissions - Adjustments, Reversals or Corrections, Paragraph (3)
230	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida		XI. Method of Payment		C.		158	If the Managed Care Plan operates in multiple regions with multiple lines of business, is the intent that the Managed Care Plan submits a consolidated ASR combining all regions and applicable lines of business?	Plans will be required to report as outlined in the ASR Finance Report SMMC component of the SMMC Report Guide. http://ahca.myflorida.com/Medicaid/statewide_mc/report_guide_2017-10-01.shtml
231	HN1, LLC		VI. Coverage and Authorization of Services	B-1	A.		9	Is it AHCA's intent for successful ITN MMA Plans in regards to Early Intervention/Early Steps to require providers to be paid strictly on Medicaid Fee schedule or based upon rates otherwise agreed?	Specific payment arrangements apply only when specified in Attachment B, Scope of Services or its Exhibits. See Attachment B, Section VII. Provider Services, Sub-Section E. Claims and Provider Payment See Exhibit B-1, Section VII. Provider Services, Sub-Section E. Claims and Provider Payment
232	HN1, LLC		VI. Coverage and Authorization of Services	B-1	A.		10	Does AHCA expect that successful ITN MMA Plans will have a separate Early Intervention/Early Steps network?	See Attachment B, Section VIII. Provider Services, Sub-Section A. Network Adequacy Standards, Item 1. - General Provisions See Exhibit B-1,Section VIII. Provider Services, Sub-Section A. - Network Adequacy Standards
233	HN1, LLC		VI. Coverage and Authorization of Services	B-1	A.		10	?What are the new requirements placed upon the successful ITN MMA Plan under Early Intervention/Early Steps that MMA Plans currently operating are not required to perform under the existing AHCA Contract with MMA Plans?	See Exhibit B-1, Section VI. Coverage and Authorization of Services, Section A, Required MMA Benefits, Sub-Section 1. Specific MMA Services to be Provided
234	Molina Healthcare of Florida		IX. Quality	Exhibit B-1	B.		61	In the MMA section of the contract under Performance Measures both #33 and #38 state “Contraceptive Care – Postpartum Women”. Is this to split the measures between the child and adult core sets? If so, are there different specifications for the two measures?	The specifications for this measure are available in the Technical Specifications and Resource Manuals for the Child and Adult Core Sets on the Medicaid.gov website.

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235	Molina Healthcare of Florida		VI. Coverage and Authorization of Services	Exhibit B-2	G.		35	In the LTC portion of the contract there are 33 brand new performance measures listed. Can AHCA share with us the specifications for these measures that 'CMS has developed in collaboration with Mathematica'?	There is no additional information available at this time. The Agency will share final specifications with vendors once they are made available by federal CMS. See Exhibit B-2, Long-term Care (LTC) Program, Section IX. Quality, Sub-Section B. Performance Measures (PMs), Item 2. Required Performance Measures.
236	Molina Healthcare of Florida		III. Eligibility and Enrollment		D.		33	The ITN Contract indicates the MCP shall not provide or assist in member disenrollment requests except as specified in the SMMC Plan Report Guide. Is it the expectation that the Plan will be assisting in some disenrollment requests? If so, what functions will the Plan be expected to provide?	See Attachment B Scope of Service - Core Provisions, Section III. Eligibility and Enrollment, Sub-Section D. Disenrollment
237	Molina Healthcare of Florida		V. Enrollee Services		B.		51	The printed provider directory requires that the provider's specialty credentials and other certifications be listed. What credentials/certifications are required? Example: Fellowships. Are all the certifications required?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
238	Molina Healthcare of Florida		VI. Coverage and Authorization of Services		B.		59	For a comprehensive member would the over the counter expanded benefit limit per month be $15 (LTC), $25 (MMA) or $40 (LTC + MMA)?	Yes. See Attachment B -Scope of Service - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section B. Expanded Benefits Item 2. Types of Expanded Benefits, Sub-Item a.
239	Molina Healthcare of Florida		VIII. Provider Services		C.		82	This section discusses "limited enrollment and fully enrolled agreements". There is no mention of Plans submitting treating provider applications on behalf of the provider. Is the treating provider process eliminated?	This is an operational detail that will be worked out with awarded plans.
240	Molina Healthcare of Florida		VIII. Provider Services		C.		83	When does the 120 days timeframe begin? Does it start at the time the provider provides all the required/complete credentialing documentation or at the time of signature and submission to the Plan?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
241	Molina Healthcare of Florida		VIII. Provider Services		C.		82	This contract section mentions Plans shall deem providers with a valid limited enrolled of fully enrolled agreement with the Agency as having met all requirements described. Could the Agency clarify want constitutes "deeming a provider"?	The plain meaning of "deeming" should be used in preparing a response. The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
242	Molina Healthcare of Florida		VIII. Provider Services		C.		82	This Contract section mentions Plans shall deem providers with a valid limited enrolled of fully enrolled agreement with the Agency as having met all requirements described. Is it the intent that if a provider meets the requirements 1-5 that the provider can participate in the Plan for up to 120 days prior to being fully credentialed with the Plan?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN. See Attachment B Scope of Services – Core Provisions, Section VIII. Provider Services, Sub-Section C Provider Credentialing and Contracting, Item 2. Credentialing and Recredentialing, Sub-Item f. and Sub-Item g. See also 42 CFR 438.602(b)(2), incorporated by reference in Sub-Item f. above.
243	Molina Healthcare of Florida		X. Administration and Management		B.		116	For the designated positions outlined in the minimum staffing, by functional area, is it the expectation that each role should be filled individually or could one person represent two functional areas. For example, could the Plan 's designated Contract Manager also fill the Plan's designated Medicaid Policy position?	The plain meaning of "one hundred percent" should be used in preparing a response. See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection B. Organizational Governance and Staffing, Item 1.f.
244	Molina Healthcare of Florida		VIII. Provider Services	Exhibit B-1	A.		48	The Plan must ensure that appointments for medical services and behavioral health services are available on a timely basis. Urgent services shall be provided: (1)(b) Within 96 hours of a request for medical or behavioral health care services that do require prior authorization Is it the intent of the Agency that the authorization and service all occur within 96 hours or is it that the service needs to occur within 96 hours of authorization?	See Attachment B Scope of Services – Core Provisions, Exhibit B-1 Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required MMA Benefits, Item 1. Specific MMA Services to be Provided, Sub-Item a.(6)(d).

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245	Molina Healthcare of Florida		VIII. Provider Services	Exhibit B-1	A.		48	We would like to clarify that the following requirement applies to all specialists? 1) Appointments for urgent medical or behavioral health care services shall be provided: (a) Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.	See Attachment B Scope of Services – Core Provisions, Exhibit B-1 Managed Medical Assistance (MMA) Program, Section VIII. Provider Services, Sub-Section A Network Adequacy Standards, Item 8. Timely Access Standards, Sub-Item a. and Sub item a.(1).
246	Humana		VI. Coverage and Authorization of Services	N/A	E.		62	Please confirm scope of Section VI's "Initial Plan of Care/Reviews" - specifically, do the requirements listed for the conduct and establishment of initial care plans apply only to MLTC enrollees or to all managed Medicaid (SMMC) enrollees in alignment with the current SMMC contracts and needs of enrollees ("Coverage and Authorization of Services, E. Care Coordination/Case Management, 5. Initial Plan of Care/Reviews, items a-d")?	See Attachment B - Scope of Services, Section II, General Overview, Sub-section A, Purpose, Paragraph 2.
247	Humana		X. Administration and Management	N/A	D.		129	Please clarify the business functions for which supporting technology must be recovered in 24 hours per the BC-DR plan requirements (Attachment B, Section X, D,4.,h) aligns with the CMS definition of Essential Business Functions.	See Attachment B. Scope of Service - Core Provisions, Section X. Administration and Management, Subsection D. Information Management and Systems, Item 4. System Availability, Performance and Problem Management Requirement, Sub-Item h.(3)
248	Humana		VI. Coverage and Authorization of Services	N/A	B.		58	Do the Expanded Benefit criteria outlined in Section VI., Coverage of Authorization of Services, B. Expanded Benefits, also apply to Additional Expanded Benefits?	See Exhibit A-4-a-3, SRC# 10 - Additional Expanded Benefits Template (Regional)
ATTACHMENT C									
249	Our Children PSN of Florida, LLC			Exhibit C-1 and C-2			1	Please confirm for record that only Exhibit C-1 OR Exhibit C-2, as applicable, need to be submitted for the Cost Proposal and that Attachment C - Cost Proposal Instructions and Rate Methodology Narrative do not need to be included with the respondent's submission.	Respondents do not need to submit Attachment C - Cost Proposal Instructions and Rate Methodology Narrative.
250	Our Children PSN of Florida, LLC			Exhibit C-1 and C-2			1	Please provide updated Excel spreadsheets that enable fields to be filled out. For example, when filling out the "Respondent Organization Name" field on the first tab, an error appears noting that the Excel sheet is protected and that a password is necessary.	To fill out the fields on a given tab, please ensure that only one tab in the Excel workbook is selected at a time. If multiple tabs are selected, the inputs may not work properly.
251	Simply Healthcare			Attachment C			1	Would the state consider receiving the Cost Proposal in a separate 4th binder?	No. See Attachment A - Instructions and Special Conditions, Section C. Response Submission Requirements Sub-Section 1.b.(3). Packaging and Delivery, Item A
252	Staywell (WellCare)			Exhibit C-1, tab L.1 - LTC			1	Is the base data in worksheet L.1 - LTC repriced at 100% of the Medicaid fee schedule? If not, please describe the unit cost underlying the data.	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section C. LTC Base Data. The base data is a combination of ASR reporting and encounter data. No repricing has been performed on this data and therefore reflects health plan provider reimbursement levels.
253	Staywell (WellCare)			Exhibit C-6			1	Please provide Exhibit C-6 "Historical Capitated Plan Provider Contracting Levels During SFY 15/16 Time Period" for the LTC base data. We believe that this information is necessary to complete the cost proposal.	There will be no change to this specification of the ITN.
254	Staywell (WellCare)			Attachment C			10	Please provide instructions on the file naming convention for the Actuarial Memorandum(s). Although one memorandum is sufficient for all regions it needs to be submitted for each region - should the same file therefore be provided multiple times with "Region XX" in the filename?	Yes, the file name should include the region and should be submitted with each regional response.

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255	Staywell (WellCare)			Exhibit C-1			1	Referencing tabs M.1-M.10 Sec A: is the base data in rows 135-244 inclusive of program changes (e.g., DRG, EAPG, physician fee schedules, etc.)?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions
256	Staywell (WellCare)			Attachment C			12	Actuarial Certification: Respondents are asked to state that rates in the cost proposal are actuarially sound, however they are also told to exclude certain known items from the rates. Please confirm that respondents should write the certification to indicate that rates are actuarially sound as a base rate for the applicable program and period before the application of items in Attachment C II. F. (page 29) and Attachment C III. F. (page 38).	Yes
257	Sunshine State Health Plan			MMA Specific Cost Proposal Instructions			14	Will the state be negotiating rates across all selected MCO's (i.e. common base rates, before risk adjustment, as they do today) or will rates be truly MCO specific?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award, Sub-Section 4. Scored Requirements - Evaluation Criteria, Item D
258	Sunshine State Health Plan			Exhibit C-7			15	MMA Databook Narrative: Can the state please share detailed analysis of the CDPS + Rx Risk Score Model calibration? We would like to independently assess how well the risk score model predicts costs at various ranges of risk scores as well as for certain demographic/disease conditions.	There will be no change to this specification of the ITN.
259	Sunshine State Health Plan			Exhibit C-7			2	Will the Children's Medical Services Network (CMSN) continue to be on a managed FFS basis? Is their base data included in the cost proposal template?	S. 409. (4), Florida Statutes states that participation by the Children's Medical Services Network is not subject to the procurement requirements or regional plan number limits Part IV of Chapter 409. See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section C. MMA Base Data, paragraph 3
260	Sunshine State Health Plan			Exhibit C-1				The broad service category in column H for service category 2.6 (Subcapitated Hospital services) is being mapped to Outpatient (Non-ASC). Please describe what is included in Subcapitated Hospital Services category (e.g., inpatient, outpatient, etc.)?	See Exhibit C-7 Statewide Medicaid Managed Care Data Book, Florida SMMC MMA Data Book Narrative, Appendix M-3 - SMMC MMA Data Book Supplemental Information, Exhibit M-10 Data Sources Included by Benefit Expense ASR Line
261	Sunshine State Health Plan			Table 1			5	If health plan is bidding a comprehensive plan for a region, must it submit a separate actuarial memorandum and cost template for pre-defined special populations (e.g. Child Welfare)?	Respondents submitting for a standard and specialty plan in the same region should submit a single actuarial memorandum and separate cost proposal templates.
262	Sunshine State Health Plan			Exhibit C-1				In every region it appears that the cost per delivery for FFS Express is lower than the cost per delivery for capitated plans. Is there anything about the FFS Express population that would result in lower delivery costs? The non-case rate (e.g. PMPM costs) appear to be higher, and we thought it was unusual that the cost/delivery was consistently lower for FFS Express.	There will be no change to this specification of the ITN.
263	Sunshine State Health Plan						9	What is the health plan required to certify the actuarial soundness of - the pricing for the standard benefit package, or the standard package plus expanded benefits?	Respondents should certify to the actuarial soundness of rates for the standard benefit package.
264	Sunshine State Health Plan			Table 1			9	Can AHCA provide exhibits on historical mix severity within a service category (e.g. inpatient severity mix within TANF non-SMI)?	There will be no change to this specification of the ITN.
265	Sunshine State Health Plan			Exhibit C-1			32	The Nursing Facility versus HCBS penetration varies quite a bit by region, but the 3% state mandated transition rate does not vary. How has the 3% transition requirement been validated as actuarially sound by region, and what is AHCAs view on achievability by region given the different "starting points" of HCBS penetration?	Milliman considers the 3% transition rate, which is applied until 35% or less of the population is treated in an institutional setting, to be an appropriate assumption in the development of actuarially sound rates for all regions.
266	Sunshine State Health Plan			Exhibit C-1			27	AHCA provides base period reimbursement levels for some categories of service but not others. Please provide reimbursement levels as a percent of the Medicaid fee schedule for all service categories as a point of reference.	There will be no change to this specification of the ITN.

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267	Sunshine State Health Plan			Exhibit C-1			10	Where should we include medical admin for managed care costs (e.g. disease management program costs)? We would assume that they should go in the non-benefit expense template, but wanted to confirm.	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section IV. Non-Benefit Expense Cost Proposal Template Instructions, Table 6.
268	Sunshine State Health Plan			Exhibit C-1			11	Where should the impact of subcapitated benefits be included within the cost proposal?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions. Respondents should include all base claim costs in column M of the non-maternity MMA portion of the MMA cost proposal and column K for the maternity MMA portion of the cost proposal. See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions. Respondents should include all base claim costs in column K for the LTC cost proposal.
269	Sunshine State Health Plan			Exhibit C-1			11	Does AHCA have any standard scenarios for membership sensitivity testing?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
270	Sunshine State Health Plan			Exhibit C-1			24	Will AHCA please divide the Hepatitis C relativities for before and after the removal of fibrosis score restrictions into unit cost and utilization?	There will be no change to this specification of the ITN.
271	Sunshine State Health Plan			Exhibit C-1			24	What does AHCA mean when it refers to maternity kick payments as being for a "fixed basket of services". Presumably, although there is always one birth associated with each payment, the basket of services associated with the payment is always changing, including different lengths of stay and different costs outside of the facility charges. Carriers would need to account for these changes when developing cost projections.	See Exhibit C-7 Statewide Medicaid Managed Care Data Book, Florida SMMC MMA Data Book Narrative
272	Sunshine State Health Plan			Exhibit C-1			30	What is the relationship between MMA costs and the organ transplant kick payment? Are transplant costs included in the current databook, to be carved out later, or are they excluded from the databook entirely?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section F. Rate Adjustments Excluded from MMA Cost Proposal, Item 14
273	Sunshine State Health Plan			Exhibit C-1				Please describe the AHCAs methodology for verifying that the aggregate base period data included in the cost proposal template is correct.	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section C. MMA Base Data See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section C. LTC Base Data
274	Sunshine State Health Plan			Exhibit C-1				Will AHCA please provide a reconciliation between the aggregate base period data in the databook and filed financial statements?	There will be no change to this specification of the ITN.
275	Sunshine State Health Plan			Exhibit C-1				In the case that AHCA does not release its actuarially sound rate ranges, what will be the procedure if a plan submits a cost proposal that is outside of the range?	See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award, Sub-Section 4. Scored Requirements - Evaluation Criteria, Item D
276	Sunshine State Health Plan			Exhibit C-1				Will AHCA please provide its range for actuarially sound rates for each region and rate cell?	There will be no change to this specification of the ITN.

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277	Sunshine State Health Plan			Exhibit C-1			29	What methodology will AHCA use to develop trend to trend rates from the projection period in the cost proposal to the contract period?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section E. MMA Projection Assumptions, Item 1. Trend Adjustments. See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section E. LTC Projection Assumptions, Item 1. Trend Adjustments.
278	Sunshine State Health Plan			Exhibit C-1				How will AHCA consider the impact of new pipeline and blockbuster drugs in the construction of future rates?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section F. Rate Adjustments Excluded from MMA Cost Proposal
279	Sunshine State Health Plan			Exhibit C-1				How is the cost proposal scored?	The cost proposal will not be scored. See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award, Sub-Section 4. Scored Requirements - Evaluation Criteria, Item D
280	Sunshine State Health Plan			Exhibit C-1				Given AHCA intends to contract at a common base rate, is the respondent bound to any component in the cost model (e.g. management savings)?	Respondents will be bound to each individual component of the final negotiated rates.
281	Sunshine State Health Plan			Exhibit C-1				Should the carrier's planned offering of expanded benefits be included in the cost proposal, or is the bidder just developing costs for the base package of services?	Respondents should exclude expanded benefits from the MMA Claim Cost or LTC Service Cost. See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section D. MMA Base Data Adjustments, Item 1. Expanded Benefit Adjustment.
282	Sunshine State Health Plan			Exhibit C-1				Will AHCA please provide an additional year of emerging experience to assist plans in evaluating recent trends? If not available in databook format, a summary of aggregated ASR's would be appreciated.	There will be no change to this specification of the ITN.
283	Sunshine State Health Plan			Exhibit C-1				Will AHCA please provide the means to normalize the databook's SFY 14/15 data to the same basis (reimbursement, program changes, etc.) as SFY 15/16?	There will be no change to this specification of the ITN.
284	Sunshine State Health Plan			Exhibit C-1				Will AHCA please provide coding and logic to group base period data into the service categories included in the cost proposal?	There will be no change to this specification of the ITN.
285	Sunshine State Health Plan			Exhibit C-7			9	LTC Databook Narrative: According to Page 9, encounters submitted without an eligible recipient on the service day were excluded from the databook; can AHCA please quantify how many encounters (on an allowed/paid basis) were excluded based on this criteria?	There will be no change to this specification of the ITN.
286	Sunshine State Health Plan			MMA Cost Proposal Template Overview			24	Are MCO's required to use the factors shown in Table 5 if they believe a more appropriate value is warranted based on their actual experience?	Respondents must consider the information in the MMA data book when developing their cost proposals and completing the cost proposal template, but they are not obligated to rely on it in developing their own proposals. Respondents are encouraged to develop and use other data sources as needed to prepare a competitive cost proposal.

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287	Sunshine State Health Plan			Managed Care Savings Adjustments			28	Should respondents be considering potential "efficiency adjustments" in their rate development (similar to what Milliman does today)? Or is this outside of the scope of the requirements for this section?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section E. MMA Projection Assumptions, Item 3. Managed Care Savings Adjustments See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section E. LTC Projection Assumptions, Item 3. Managed Care Savings Adjustments
288	Sunshine State Health Plan			Proposed Administrative Allowance			39	Instructions require including a PMPM amount only for this section. Given these costs are typically developed as a combination of fixed and variable components, please confirm that respondents will not be held accountable for these values beyond the first year of the proposed contract.	Respondents will be bound to each individual component of the final negotiated rates.
289	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida							Please confirm that cost proposals will not be used in determining which bidders will be invited to the negotiation phase.	There will be no change to this specification of the ITN.
290	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida							Please clarify what mechanism AHCA will use to determine the actuarially sound rate range for each region.	There will be no change to this specification of the ITN. See Attachment A - Instructions and Special Conditions, Section D. Response Evaluation, Negotiations, and Contract Award
291	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida						34	Please advise when the base data re-pricing to 9/1/2018 per diems will be completed and released. Please clarify whether bidders should hold off developing the cost proposal until the release of re-priced data or should develop cost proposal using the existing data book data assuming the final rates will be adjusted for the base data repricing?	There will be no change to this specification of the ITN.
292	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida						39	Please clarify the future monthly transition percentage adjustment factors, so that bidders can reflect that in their three year monthly pro forma.	Currently the requirement for transition from institutional services to non-institutional services in the community will begin with the distribution of business and 0.25% is added to the non-institutionalized distribution for the first month of the rate year and increases 0.25% for each subsequent month until a 3% transition is achieved by the end of the rate year. However, no transition or further transition will be required once the portion of non-institutionalized enrollees reaches 65%.
293	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida							If capitation rates for the subsequent rate years are to be established by the Agency, please confirm that the capitation rates are subject to mutual agreement of the parties, such that if the capitation rates established by the Agency are not viable for the Contractor and the Contractor is unwilling or unable to perform services at those rates, the Contractor is not bound to renew the contract and the performance bond will not be forfeited.	Contracts awarded under this ITN will be conditioned upon negotiating an agreement on initial rates. The agency will not comment on potential future disputes regarding rate changes.
294	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida							Would AHCA consider reimbursing newly approved high cost low frequency drugs, such as Spinraza, outside the base capitation rate through either a kick payment or managed care carve out? This would not only ensure that the capitation rates are actuarially sound overall, but also ensure that MCOs with a disproportinate share of high cost drug utilization will be approriately reimbursed.	There will be no change to this specification of the ITN.
295	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida			Exhibit C-1				In Exhibit C-1, tabs M1.Sec A - M10.Sec A, cells Y140:Y177 show the contracting adjustment factors. If the factor is 0.95, please clarify whether the base data PMPM should be multiplied by 0.95 or divided by 0.95?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section E. MMA Projection Assumptions, Item 2. Provider Contracting Adjustments

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296	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			32	Please confirm that, as is the case with the current program, the transition requirement will ramp up 0.25% per month to achieve 3% at the end of the first rating year.	Currently the requirement for transition from institutional services to non-institutional services in the community will begin with the distribution of business and 0.25% is added to the non-institutionalized distribution for the first month of the rate year and increases 0.25% for each subsequent month until a 3% transition is achieved by the end of the rate year. However, no transition or further transition will be required once the portion of non-institutionalized enrollees reaches 65%.
297	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			8	Please confirm that AHCA will apply seasonality to capitation rates.	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section F. Rate Adjustments Excluded from MMA Cost Proposal, Item 1 See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section F. Rate Adjustments Excluded from LTC Cost Proposal, Item 5. Seasonality Adjustment
298	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			28	Please confirm that for managed care savings adjustments, the expectation is that respondents shall align their responses to Potential Avoidable items identified by AHCA.	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section E. MMA Projection Assumptions, Item 3 Managed Care Savings Adjustments. See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section E. LTC Projection Assumptions, Item 3. Managed Care Savings Adjustments. Respondents should enter a descriptive title for each adjustment and include any managed care savings adjustments that they believe they can achieve.
299	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			24	In the section where we provide our contracting percentages, do we list the physicians we have contracted at Medicare rates converted to a percentage of Medicaid FFS rates?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section I. Overview of Cost Proposal Instructions, Sub-Section 6. Actuarial Memorandum and Certification Requirement - Capitated Plans, Item 4
300	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			30	Under exclusions, CMSN members moved to MMA plans are listed. Should respondents omit those members and associated costs from 2015 forward to reflect our historical experience?	The SFY 15/16 data from the MMA data book that is pre-populated in Exhibit C-1, Capitated Plan Cost Proposal Template, includes members who were rescreened from CMSN to MMA capitated plans for the period of time when they were enrolled in MMA capitated plans, but not for the period of time when they were enrolled in CMSN. Respondents should include the periods for which these members were enrolled in capitated plans in the historical period as part of the cost proposal. Plans should not adjust the cost proposal to include the period where these members were not enrolled in an MMA capitated plan. The Agency will adjust final negotiated rates to reflect the inclusion of these members across the entire period.

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301	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			12	There is a requirement for non-specialty SMMC plans to submit an unqualified certification of actuarial soundness for the cost proposal. According to ASOP 49, certification of actuarial soundness requires that the projected cost reflect the period covered by the certifcation and provide for all reasonable, appropriate and attainable costs. Given that there are still a number of quantifiable known adjustments (e.g., September 1, 2017 nursing facility and hospice per diem adjustments) and quantifiable or unquantifiable less defined adjustments (e.g., transition of participants in the Traumatic Brain and Spinal Injury waiver, Project Aids Care Waiver and Adult Cystic Fibrosis waiver effective January 1, 2018; costs for future benefits to be covered by MMA plans; final rate cell factors, etc.), an unqualified certification of actuarial soundness may not be possible. Can the Agency provide additional direction on this requirement to ensure that the certifying actuary is compliant with guidance in the actuarial standard of practice?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section F. Rate Adjustments Excluded from MMA Cost Proposal See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section F. Rate Adjustments Excluded from LTC Cost Proposal
302	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			24	For the Missing Data Acuity Adjustment, how were the risk scores for excluded plans calculated if the data was deemed to be non-credible in the base period?	The excluded plans' risk scores used in the missing data acuity adjustment were based on a separate encounter data source used for quarterly risk scoring in the MMA program.
303	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			24	For the Missing Data Acuity Adjustment, what methodology was used to determine the credibility of the data for capitated plans and what was the credibility threshold?	The determination of credibility for each capitated plan's data was based on a comparison of the data to financial information as well as supplemental information provided by capitated plans relating to the data. The data was determined to be credible in the sense that it was reliable for use in developing capitation rates (not in the sense of statistical credibility); as such, no explicit credibility threshold was applied.
304	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			27	To help with quantifying the future contracting levels requested in the cost proposal, can the Agency provide an estimate of the magnitude of changes expected by service category for Florida Medicaid FFS reimbursement rates in RY 18/19?	There will be no change to this specification of the ITN.
305	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			39	In order to comply with actuarial and CMS guidelines, in which administrative cost category should taxes and fees be included?	Taxes and fees should be included in Other Management and Administration.
306	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			30	For RY 18/19, what percentage of individuals eligible for the CMS Network are expected to enroll in the CMS Network and what percentage of individuals eligible for the CMS Network are expected to enroll in MMA capitated plans?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
307	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative & Exhibit C-7			29	Page 29 of Attachment C and Exhibit M-11 indicates that data for the nursing facility services for individuals age 18+ is not yet available. Please confirm the Agency will make this available before the submission date.	There will be no change to this specification of the ITN.

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308	Humana			Exhibit C-7			7	Page 7 of the June 16, 2017 MMA data book, Exhibit M-5, and Exhibit M-11 all discuss services added to MMA after the historical data period that are expected to become the financial responsibility of the MMA capitated plans going forward. We observe service categories in the cost proposal named "Various Professional" and "Various Other", with associated base period costs. Please confirm the Agency will provide detailed definitions, descriptions, and procedure codes prior to submission date.	From MDA: See Exhibit C-7 Statewide Medicaid Managed Care Data Book, Florida SMMC MMA Data Book Narrative, Section III, Data Sources and Adjustments, Agency FFS Data, FROM POLICY: See Exhibit C-7, Statewide Medicaid Managed Care Managed Medical Assistance Data Book, Updated June 16, 2017, and Appendix M-1, SMMC Data Book Database, and Exhibits M-5 and M-8
309	Humana			Exhibit C-7			7	Page 7 of the June 16, 2017 MMA data book, Exhibit M-5, and Exhibit M-11 discuss services added to MMA after the historical data period that are expected to become the financial responsibility of the MMA capitated plans going forward. There is an expectation to provide nursing facility services for individuals age 18+ to cover short-term rehab stays, Medicare crossover, and expenditures while an individual is awaiting LTC enrollment. What time period is meant by "short-term"?	See Exhibit B-1. Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits, Item 2.a. See Exhibit B-2. Long-term Care (LTC) Program, Section III. Eligibility and Enrollment, Sub-Section B. Eligibility
310	Humana			Exhibit C-7			7	Page 7 of the June 16, 2017 MMA data book, Exhibit M-5, and Exhibit M-11 discuss services added to MMA after the historical data period that are expected to become the financial responsibility of the MMA capitated plans going forward. There is an expectation to provide nursing facility services for individuals age 18+ to cover short-term rehab stays, Medicare crossover, and expenditures while an individual is awaiting LTC enrollment. Is there a maximum coverage period under MMA for individuals awaiting LTC enrollment?	See Exhibit B-1. Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits, Item 2.a. See Exhibit B-2. Long-term Care (LTC) Program, Section III. Eligibility and Enrollment, Sub-Section B. Eligibility
311	Humana			Exhibit C-7			7	Page 7 of the June 16, 2017 MMA data book, Exhibit M-5, and Exhibit M-11 discuss services added to MMA after the historical data period that are expected to become the financial responsibility of the MMA capitated plans going forward. There is an expectation to provide nursing facility services for individuals age 18+ to cover short-term rehab stays, Medicare crossover, and expenditures while an individual is awaiting LTC enrollment. What is the average length of stay anticipated to be covered by this benefit?	Attachment B. Scope of Service – Core Provisions, Exhibit B-2., Long-term Care (LTC) Program, Section III. Eligibility and Enrollment, Sub-Section B. Eligibility.
312	Humana			Exhibit C-7			28	Appendix M-2, Exhibit M-5: for the Nursing Facility Age 0-17 benefit, we observe statewide cost per unit between rate groups that ranges from approximately $10,000 to $13,000. The typical unit basis for nursing facility costs is per day, and is generally estimated to be a few hundred dollars per day. What unit basis is utilized to calculate the cost per unit in Appendix M-2, Exhibit M-5?	The unit basis is per claim data record, based on AHCA's FFS claims data.
313	Humana			Exhibit C-7			7	Page 7 of the June 16, 2017 MMA data book, Exhibit M-5, and Exhibit M-11 discuss services added to MMA after the historical data period that are expected to become the financial responsibility of the MMA capitated plans going forward. Given that the MMA plans have no historical experience for analysis, would the Agency consider providing historical information that spans more than 2 historical data years to assist us with trend analysis and other adjustments for the cost proposal?	See Exhibit C-7 Statewide Medicaid Managed Care Data Book, Florida SMMC MMA Data Book Narrative, Section III, Data Sources and Adjustments, Agency FFS Data

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314	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			38	Upon review, it appears that the 62,500 unduplicated participant slots that were approved with the 1915(c) LTC Waiver renewal may not be sufficient for an ongoing 3% annual shift from non-HCBS to HCBS along with the approximate 8,000+ participants who will transition from the Traumatic Brain and Spinal Cord Injury Waiver, Adult Cystic Fibrosis Waiver and Project AIDS Care Waiver by January 1, 2018. In order for projections to meet the 3% annual shift, please confirm that for the purposes of this ITN and Cost Proposal, respondents should assume an adequate number of slots are available to receive shifting participants.	Yes
315	Humana								
316	Humana			Attachment C - Cost Proposal Instructions and Rate Methodology Narrative			38	Are available waiver slots and funding for RY 18/19 expected to continue to allow for serving wait listed elders with priority score 4 or higher, as opposed to priority score 5 or higher which was in effect during waiver year 1?	Yes
317	Humana			Exhibit C-1			1	For Nursing Home and Hospice services, please verify that the ITN data book for LTC includes no repricing of nursing facility or hospice claims (i.e., claims incurred during October 1, 2015 through August 31, 2016 reflect the fee schedule effective September 1, 2015 and claims incurred during September 1, 2016 through September 30, 2016 reflect the fee schedule effective September 1, 2016).	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section F. Rate Adjustments Excluded from LTC Cost Proposal, Item 1. Nursing Facility / Hospice Rate Changes
318	Humana			Exhibit C-1			1	If a respondent uses the data book as the base data in the cost proposal template, but includes an additional multiplicative cost proposal adjustment, please verify that the cost proposal should continue to represent nursing facility and hospice fees effective as of the data book time period (i.e., eleven months of September 1, 2015 fee levels and 1 month of September 1, 2016 fee levels)? In other words, will the multiplicative adjustment be understood to apply to the base data contingent upon repricing of nursing facility and hospice claims to September 1, 2018 fee levels?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section III. LTC Cost Proposal Template Instructions, Sub-Section F. Rate Adjustments Excluded from LTC Cost Proposal. Nursing facility and hospice per diem changes should be excluded from cost proposal development. Any adjustments applied in the cost proposal template should not modify the nursing facility and hospice fee levels from those represented in the data book.
319	Humana			Exhibit C-1			1	Please clarify if the Admin and Margin PMPM should be developed as a percentage of premium with rate adjustments ommitting items under exclusion?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section IV. Non-Benefit Expense Cost Proposal Template Instructions, Sub-Paragraph 3. Overview
EXHIBIT A-4-a GENERAL									
320	UnitedHealthcare of Florida, Inc.	9					15	SRC #9 – Expanded Benefits (Regional), states that when electing to offer expanded benefits, the respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2, Expanded Benefits Tool. We have reviewed the Expanded Benefits Tool and are unclear on some of the benefit offerings because some of the expanded benefits provide the same service but have different procedure codes. For example, there are three different codes for bitewings that are each provided one time per year. Another example that we are unclear about is the vision benefit, which states that an enrollee can have both contact lenses and frames in the same year. Could AHCA revise Exhibit A-4-a-2, Expanded Benefits Tool, so that more clarity is provided to the intended amount of benefits per annum?	There will be no change to this specification of the ITN. The Managed Care Plan may apply medical necessity criteria in accordance with Attachment II - Scope of Services - Core Services, Section VI. - Coverage and Authorization of Services, Section G. Authorization of Services.

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321	UnitedHealthcare of Florida, Inc.	14					21	SRC #14 - CAHPS Results, requires that the respondent reports CAHPS results for its adult and child populations for the respondent's three (3) largest Medicaid Contracts (as measured by number of enrollees). However, one of our three largest Medicaid Contracts does not require us to report CAHPS for our adult population. Should we report only the child populations for the third contract? If so, how should we notate this on Exhibit, A-4-a-4, Standard CAHPS Measurement Tool?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
322	Sean Schwinghammer	6					28	If an MCO or delegated authority, authorizes a services and the services is rendered, and then the same MOC or delegated authoirty rejects the claims based on an improper authorization, is that no longer considered a "clean claim" and therefore not subject to the timely payment requirements?	There will be no change to this specification of the ITN
323	Sean Schwinghammer	2					3	Why are points awarded to companies that currently managed Medicare Advantage Plans? This possible points advantage is curious when Advantage Plan populations and their management is exceedingly different than the Medicaid populations. Advantage plans exist for those who are 65 and older and have very set physical needs and monetary capabilities, while Medicaid is for pregnant mothers, children, newborns, exceedingly sick children and adults and the poor elderly. All of whom have a humongous disparity in need and socialization skills.	There will be no change to this specification of the ITN.
324	Community Care Plan	3					4	If the plan's operational function is all conducted by staff in-house in Florida and only after-hours telephonic coverage is conducted outside of Florida, will points be deducted? Would AHCA consider modifying the language such that a plan can qualify for all five points (plus the five "bonus" points") by delineating what is performed outside of Florida and demonstrating the percentage of the overall administrative spending of the health plan these expenditures represent? For example, the fifth point (and eligibility for the five additional points) could be awarded to applicants where more than 98% of administrative expenditures remain in-state.	There will be no change to this specification of the ITN.
325	Community Care Plan	32					48	Can the SIU program be delegated to a subcontracted vendor providing the plan provides oversight or oversees the subcontractor's activities?	See Attachment B, Scope of Service – Core Provisions, Section X., Administration and Management, Sub-section B., Organizational Governance and Staffing, Item 2., Minimum Staffing and Attachment B, Scope of Service – Core Provisions, Section X., Administration and Management, Sub-section F., Fraud and Abuse Prevention, Item 3., Fraud Investigation Unit, Sub-item a.
326	Community Care Plan	14					10	Will the Agency consider requiring the Medicaid plans to select HEDIS scores from the other states with their largest Medicaid enrollment (in addition to Florida, if applicable) rather than allowing applicants to "cherry pick" their most advantageous states?	There will be no change to this specification of the ITN.
327	Community Care Plan	16					10	Will the Agency consider multiplying a Florida-only Medicaid plan's score by three to more fairly compare with the multi-state organizations?	There will be no change to this specification of the ITN.
328	Community Care Plan	14					21	Will the Agency consider requiring the Medicaid plans to select CAHPS scores from the other states with their largest Medicaid enrollment (in addition to Florida, if applicable) rather than allowing applicants to "cherry pick" their most advantageous states?	There will be no change to this specification of the ITN.
329	Community Care Plan	14					21	Will the Agency consider multiplying a Florida-only Medicaid plan's score by three to more fairly compare with the multi-state organizations?	There will be no change to this specification of the ITN.
330	Community Care Plan	16					23	Is the intent of this SRC to summarize the process that the plan has in place for handling provider claims disputes mainly?	There will be no change to this specification of the ITN.

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331	Adventist Health Systems	1					1	This section requires the respondent to provide a list of all current and/or recent (within past 5 years) contracts for managed care services for itself, respondent's parent, affiliates and subsidiaries. If the respondent has in excess 30 affiliates operating ONLY outside of the state of Florida, is AHCA wanting information to be disclosed as to these affiliates?	There will be no change to this specification of the ITN.
332	Adventist Health Systems	1					1	This section requires the respondent to provide a list of all current and/or recent (within past 5 years) contracts for managed care services entered into by its affiliates. If an affiliate was only recently acquired and its past contractual relationships unknown, can the respondent limit its disclosures to the period in which the entity became affiliated with the respondent?	No.
333	Adventist Health Systems	1					1	This paragraph asks for copies of all current and recent contracts for managed care services entered into by respondent and respondent's parent, affiliate(s) and subsidiary(ies). Does this include contracts, such as risk-share contracts, that provider affiliates may have entered into with HMOs or health insurers? Also, is the information sought limited to Florida experience, or may a Respondent detail its experiences in other states?	Only contracts for managed care services as specified in SRC# 1 need be provided. Not limited to Florida.
334	Adventist Health Systems	4					6	Respondents are asked to provide information as to whether the respondent, or a parent, affiliate or subsidiary, have requested enrollment level reductions or voluntarily terminated all or part of a managed care contract, or have withdrawn from a contracted service area. HMOs in Florida may reduce their approved geographic service area from time-to-time by modifying their health care provider certificates, and HMOs and insurers in Florida have reduced the geographic areas in Florida where they are offering coverage on the federal Exchange. Would either or both of these types of reductions be applicable in this section?	There will be no change to this specification of the ITN.
335	Adventist Health Systems	5					8	Paragraph 1. of the evaluation criteria lists certain conditions for which disease management programs are to be provided. Will the Agency also consider disease management programs for conditions that are not listed?	There will be no change to this specification of the ITN.
336	Adventist Health Systems	6					10	Respondent is required to describe its experience in achieving quality standards with populations similar to the target population. If respondent is a newly created entity or otherwise does not have such experience, but respondent's affiliates or subcontractors have such experience, can respondent provide data from its affiliates or subcontractors to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
337	Adventist Health Systems	7					12	If respondent is a newly created entity or otherwise does not have experience with failing to meet HEDIS measurements or quality standards, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
338	Adventist Health Systems	8					13	The timeframe criteria for SRC #8's vignette may be problematic in as much as the disease progression underlying this fact scenario will impact the response. Is the Agency willing to reconsider this?	There will be no change to this specification of the ITN.
339	Adventist Health Systems	9					15	In light of the anticipated release of the State's dental ITN for 2018, is the Agency able to clarify what may be expected from Respondents with respect to the dental benefits for adults?	There will be no change to this specification of the ITN.
340	Adventist Health Systems	16					23	Does the ITN award a respondent a greater number of points if the respondent agrees to incorporate the dispute resolution process of Section 408.7057, Florida Statutes, instead of using another, third-party dispute resolution process?	No.
341	Adventist Health Systems	17					24	What is meant by the phrase "in a manner suitable for the provider community"? In paragraph 1 of the Evaluation criteria, what is meant by "in a format suitable for the public."	The plain meaning of "in a manner suitable for the provider community" should be used is preparing a response.

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342	Adventist Health Systems	20					30	What is meant by the phrase "in a manner suitable for the provider community"? In paragraph 1 of the Evaluation criteria, what is meant by "in a format suitable for the public."	The plain meaning of "in a manner suitable for the provider community" should be used is preparing a response.
343	Adventist Health Systems	34					51	What is meant by the term “Housing Stability”?	The plain meaning of "housing stability" should be used is preparing a response.
344	Adventist Health Systems	35					52	If respondent is a newly created entity or otherwise does not have completed, quality improvement projects, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
345	Adventist Health Systems	36					52	Are the three accreditation agencies that are listed the only acceptable ones, or will any other accreditation agencies be considered? If so, which ones?	There will be no change to this specification of the ITN.
346	Adventist Health Systems	14					21	If respondent is a newly created entity or otherwise does not have experience with CAHPs, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
347	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	8					13	Because the repsondent is proposing a Specialty Care Plan for Chronically-Ill children, should the Respondent substitute the case vignette with a pediatric patient with an asthma diagnosis? Would the answer be acceptable and points awarded at the same level for a pediatric scenario?	There will be no change to this specification of the ITN.
348	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	8					13	Evaluation Criteria 2 requests timeframes for completion of each step in the care planning process. Will AHCA reviewers consider a narrative of the description of the timeframe adequate or will reviewers prefer a graph representation of the timeframes?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
349	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	25					39	Because the repsondent is proposing a Specialty Care Plan for Chronically-Ill children, should the Respondent substitute the case vignette with a pediatric patient? Would the answer be acceptable and points awarded at the same level for a pediatric scenario?	There will be no change to this specification of the ITN.
350	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	5					8	Please confirm the diagnoses AHCA wants included in the Specialty Plan for Chronically Ill Children, as a minimum.	There will be no change to this specification of the ITN.
351	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	5					8	As a Specialty Plan for Chronically Ill Children, may we add additional diagnoses to the minimum required by AHCA?	There will be no change to this specification of the ITN.
352	Magellan Complete Care of Florida	17					24	Please clarify what is meant by "in a format suitable for the provider community" in the question itself and "in a format suitable for the public" in the evaluation criteria.	The plain meaning of "in a manner suitable for the provider community" should be used is preparing a response.
353	Magellan Complete Care of Florida	31					47	Is the definition of "subcontractor" for the purposes of identifying fraud and abuse the same as the definition outlined in SRCs #26 and 27?	See Attachment B - Scope of Service - Core Provisions, Section 1. Definitions and Acronyms, Sub-Section A. Definitions, Page 22.
354	Florida Community Care	5					73	SRC #5 asks the respondent to describe its approach to implementation of specific disease management programs and how they will be used to advance the Agency's goals. Please confirm that the programs to be included/described by the respondent are not limited to those listed in Evaluation Criteria #1. a-f. For example, would descriptions of integrated care models/interventions that manage diseases across the continuum be recognized/scored?	There will be no change to this specification of the ITN.
355	Simply Healthcare	10					16	In responding to SRC# 10, can an entity offer an expansion upon the benefits identified in SRC# 9? For example, could an entity offer an additional 6 months of coverage for contact lenses, above and beyond the limits articulated in Exhibit A-4-a-2?	No. See Attachment A - Instructions and Special Conditions, Exhibit A-4-a General Submission Requirements and Evaluation Criteria, Section C. Recipient Experience, SRC# 10
356	Simply Healthcare	26					40	Regarding SRC# 26, for the purpose of this ITN response, is a respondent’s parent company considered to be a subcontractor?	Yes, if respondent proposes to delegate the management of any of the items in SRC# 26 to its parent company.

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357	Simply Healthcare	6					10	Regarding SRC# 6, please confirm that in order to ensure an accurate evaluation of a respondent's experience in achieving quality standards most applicable to this ITN, that the respondent should include its results for its, or its organization's, Medicaid operations in its three largest States (by number of Medicaid enrollees) where it reports on all the listed HEDIS measures.	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
358	Simply Healthcare	6					10	In the context of a Specialty Plan, HEDIS results may be available for some, but not all, of the measures requested for SRC# 6 and MMA SRC# 14 due to small denominators. Please confirm that submission of a Respondent's Specialty Plan's HEDIS results is not required if the Respondent has other Medicaid HEDIS results that meet the requirements of SRC# 6 and SRC# 14.	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC. [Should stock language re: respondents being able to include parent and/or affiliate data and experience in their responses be added as well?]
359	Simply Healthcare	6					10	For Measurement Year (Calendar Year) 2016, AHCA required separate HEDIS submissions for Medicaid and Florida Healthy Kids. Please confirm that the Florida Medicaid results are requested for SRC# 6 and MMA SRC# 14, not scores for Florida Healthy Kids.	The respondent should respond in the manner that it believes best responds to the requirements of the ITN. [could just refer back to SRC #6 and MMA SRC #14--they specifically state Medicaid results or Commercial if plans do not have enough Medicaid states]
360	Simply Healthcare	9					14	Regarding Exhibit A-4-a SRC# 9, please confirm that respondents do not need to identify proposed expanded benefits "by eligible population" because the response template (Exhibit A-4-a) does not allow opportunity to identify this information. If it is the State's intent to have it broken out by eligible population, please advise on how you would like bidders to provide this information (i.e. attachment).	Please see Addendum, Item #8
361	Simply Healthcare	10					16	Regarding Exhibit A-4-a SRC# 10, if a proposed expanded benefit does not have a related procedure code, can we mark "N/A" in the Procedure Code Description and Procedure Code columns of Exhibit A-4-a-3? Should respondents submit the required calculation documentation as an attachment to SRC #10, or should it be included in the response box?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
362	Simply Healthcare	10					16	Does the expanded vision services referencing the provision of contact lenses (e.g. V25xx codes) apply to adults, contingent on medical necessity only, or as an elective/optional optical benefit for all adults?	There will be no change to this specification of the ITN. The Managed Care Plan may apply medical necessity criteria in accordance with Attachment II - Scope of Services - Core Services, Section VI. - Coverage and Authorization of Services, Section G. Authorization of Services.
363	Simply Healthcare	10					1	The expanded benefit tool for adult dental lists a number of evaluation codes (D0120, D0190, D0191). For each code it has a limitation of once per 2 years. Is this limitation once per 2 years per code or once per 2 years for any evaluation code? If you allow once per 2 years per code, then there could be abuse in the system as members could receive 6 evaluations a year when the standard of care is 2 per year.	There will be no change to this specification of the ITN. The Managed Care Plan may apply medical necessity criteria in accordance with Attachment II - Scope of Services - Core Services, Section VI. - Coverage and Authorization of Services, Section G. Authorization of Services.
364	Simply Healthcare	10					2	The expanded benefit tool for adult dental includes two fluoride treatment codes – D1206 and D1208. The imitation for each is twice per year. Is this limitation twice per year per code or twice per year for any of the fluoride codes? If you allow twice per year per code, then there could be abuse in the system as members could receive 4 fluoride treatments a year when the standard of care is twice per year.	There will be no change to this specification of the ITN. The Managed Care Plan may apply medical necessity criteria in accordance with Attachment II - Scope of Services - Core Services, Section VI. - Coverage and Authorization of Services, Section G. Authorization of Services.

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365	Simply Healthcare	10					2	The expanded benefit tool for adult dental includes D1351 Dental Sealants. Can you explain why you included this dental benefit as this procedure is a preventive procedure that is traditionally limited to children? There is no evidence that dental sealants are beneficial for adults. Moreover, the national guidance indicates dental sealants should be placed soon after the adult tooth erupts. First molars erupt at age 6 and second molars erupt at age 12. Thus adults with molars that have not been sealed will have had those teeth present in their mouths for years. If those teeth are caries free that is an indication that there is little risk of caries development and thus sealants are not indicated. Additionally, if this procedure remains in the benefits package is it limited to molars – the limitation says one per tooth per 3 years. The child benefit for sealants limits sealants to permanent molars only.	There will be no change to this specification of the ITN. The Managed Care Plan may apply medical necessity criteria in accordance with Attachment II - Scope of Services - Core Services, Section VI. - Coverage and Authorization of Services, Section G. Authorization of Services.
366	Simply Healthcare	10					4	The expanded benefit tool for adult dental includes D4346 – Scaling in the presence of moderate or severe inflammation. The limitation is set at 2 times per year. The benefit package also allows for 2 adult prophys a year (D1110). The national guidance on these codes 2 is cleanings of any sort a year. Thus are the limitations for the two codes able to edit against each other? Otherwise some members could receive 4 cleanings a year.	There will be no change to this specification of the ITN. The Managed Care Plan may apply medical necessity criteria in accordance with Attachment II - Scope of Services - Core Services, Section VI. - Coverage and Authorization of Services, Section G. Authorization of Services.
367	Simply Healthcare	10					4	The expanded benefit tool for adult dental includes D9110 – Treatment of dental pain minor procedure. The limitation says “none”. What does AHCA mean by “none”?	There will be no change to this specification of the ITN. The Managed Care Plan may apply medical necessity criteria in accordance with Attachment II - Scope of Services - Core Services, Section VI. - Coverage and Authorization of Services, Section G. Authorization of Services.
368	Simply Healthcare	10					5	For the Over the Counter Expanded Benefits, the tool says the plan must provide over the counter benefits in the following categories up to $25 per member per month. Is the $25 limitation per category or for all categories combined?	Please see Addendum, Item #9
369	Staywell (WellCare)	1					1	SRC #1 asks the respondent to list all current or recent contracts for managed care services but item a. asks the respondent to indicate the Medicaid population served. Could the Agency clarify if respondent should exclude from its list of contracts in SRC #1 any contracts that are not for Medicaid services?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
370	Staywell (WellCare)	2					3	Exhibit A-4-a, SRC #2 instructs the respondent to provide documentation of any Medicare Advantage Plan contracts for counties in the State of Florida. What type of documentation is contemplated? Would a copy of the Medicare Advantage contract itself satisfy this requirement?	Yes.
371	Staywell (WellCare)	4					6	Please confirm that SRC #4 relates only to contracts for Medicaid managed care services.	No. This is not limited to Medicaid managed care services.
372	Staywell (WellCare)	4					6	As a follow up to the previous question, if SRC #4 relates to managed care contracts other than Medicaid, would voluntary termination of a contract include a situation where a managed care plan elected not to renew a Medicare Advantage contract since July 14, 2012?	No. Declining to exercise an option to renew is not the same as terminating.
373	Staywell (WellCare)	6					10	Will the HEDIS scores and benchmarks be rounded to whole numbers or evaluated to the second decimal place?	The ITN requires that plans report their HEDIS scores to the second decimal place and this is how they will be compared to the benchmarks.
374	Staywell (WellCare)	14					21	Will the CAHPS scores and benchmarks be rounded to whole numbers or evaluated to the second decimal place?	The ITN requires that plans report their CAHPS scores to the second decimal place and this is how they will be compared to the benchmarks.

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375	Wellmerica, A Provider Led Plan	6					32	What can AHCA do to encourage or facilitate a contractual relationship between a prospective managed care plan and a statutory teaching hospital which is deemed an essential Medicaid provider in the SMMC program pursuant to s. 409.975(a), Florida Statutes, where such hospital refuses to enter into such contract on the basis that they too may be submitting a proposal to the agency to participate in the SMMC program and thus views the prospective plan as a competitor?	There will be no change to this specification of the ITN.
376	Wellmerica, A Provider Led Plan	6					32	For the Essential Providers listed some of them represent health system names and not any particular hospitals(e.g. Lee Memorial, Jackson Health, etc.), does this represent that all the hospitals are considered Essential Providers or are they specific hospitals within the health system that are considered Essential Providers?	This SRC is specific to Statewide Essential Providers, see Section 409.757 (1)(b), Florida Statutes.
377	Quintairos, Prieto, Wood & Boyer	22					34	Given that dental services will be a carve out, will MCOs be held accountable for reporting and performance on EPSDT dental measures, such as PDENT (preventive dental), TDENT (dental treatment), and SEA (dental sealants)? Should we describe in our response the strategies we would put in place to coordinate dental care for our EPSDT eligible members with AHCA's selected dental vendor?	No. See Attachment B, Scope of Service - Core Provisions, Exhibit B-1, Managed Medical Assistance (MMA) Program, Section IX.B.1.a. (pages 59-61) and Attachment A, Instructions and Special Conditions, Exhibit A-4-b, MMA Submission Requirements and Evaluation Criteria, MMA SRC#17. The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
378	Quintairos, Prieto, Wood & Boyer	6					10	How will the ITN responses for this SRC be scored for Specialty Plan or PSN Respondents that do not have Medicaid Contracts or Commercial HEDIS scores identified in this SRC? According to the scoring matrix it appears a respondent proposing a Florida only Specialty Plan or PSN could be at a significant disadvantage.	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
379	Quintairos, Prieto, Wood & Boyer	6					10	For PSN or Specialty Plan who do not manage certain populations, where HEDIS measures are being asked, will the total point value be adjusted for measures that were not reportable?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
380	Quintairos, Prieto, Wood & Boyer	6					10	Will Medicare rates be considered commercial rates and thus be acceptable contracts for providing HEDIS measures?	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
381	Quintairos, Prieto, Wood & Boyer	32					48	Does the agency have any specific plans, which include specific biometric programs that the proposed respondent should be aware of?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
382	Quintairos, Prieto, Wood & Boyer	14					21	How will the ITN responses for this SRC be scored for Specialty Plan or PSN Respondents that do not have Medicaid Contracts or Commercial CAHPS scores identified in this SRC? According to the scoring matrix it appears a respondent proposing a Florida only Specialty Plan or PSN could be at a significant disadvantage.	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
383	Quintairos, Prieto, Wood & Boyer	14					21	For PSN or Specialty Plan who do not manage certain populations, where CAHPS measures are being asked, will the total point value be adjusted for measures that were not reportable?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
384	Sunshine State Health Plan	1					1	Please confirm that by managed care services you mean 1) public sector health care services similar to the scope of services provided in this ITN; and 2) services provided by a managed care entity holding a direct contract with a state or federal agency.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

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385	Sunshine State Health Plan	6					10	Please confirm that respondents submitting commercial HEDIS rates will be compared to commercial HEDIS national and regional means rather than the Medicaid mean for scoring.	National and Regional Medicaid means will be used for comparison, as stated in the SRC.
386	Sunshine State Health Plan	6					10	Would AHCA consider removing dually eligible enrollees from the HEDIS calculations, given that a plan that does not also supply Medicare coverage for a particular individual does not have access to primary care HEDIS data and any measure including this group will deflate their HEDIS scores. This is particularly important because some plans have a higher percentage of dually eligible enrollees and it is possible to show HEDIS values with and without these individuals included.	Plans should follow NCQA's Technical Specifications and General Guidelines for Data Collection and Reporting to generate the HEDIS calculations.
387	Sunshine State Health Plan	6					11	If a rate was not reportable for either 2016 or 2017, please clarify how AHCA will score that measure since no comparison can be made from the reported rate to the national or regional means, nor is it possible to measure any improvement. Evaluation Criteria - 2 points for each year the rate met or exceeded national and regional mean; 2 points for improvement in rate from 2016 – 2017"	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
388	Sunshine State Health Plan	18					26	Subpart d of the question asks for "A description of the approach used to determine whether a service will be needed short term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the respondent's service authorization approach (if any exists) based on the length of time that the service will be needed. " Please confirm that this question is only asking about non-LTC services.	There will be no changes to this specification of the ITN. See Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, Section E. Delivery System Coordination, SRC#18 Utilization Management (Statewide)
389	Sunshine State Health Plan	18					26	Subpart e of the question asks "To the extent that a service is needed long-term, a description of the strategies that the respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization. " Please confirm whether this question applies to LTC services	There will be no changes to this specification of the ITN. See Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, Section E. Delivery System Coordination, SRC#18 Utilization Management (Statewide)
390	Sunshine State Health Plan	20					30	The four types of needs presented in the question appear to have significant overlap, and it is not completely clear how AHCA may be distinguishing each. Please clarify the difference between 'complex medical and BH needs' and 'intensive health care needs'. Also please clarify the difference between 'high service utilization' and 'consistently accessing services at the highest levels of care.'	See Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, SRC# 5 - Disease Management (DM) Program (Statewide), Evaluation Criteria.
391	Sunshine State Health Plan	17					24	Regarding SRC# 17 of Exhibit A-4-a, please confirm that when AHCA uses the phrase: "access to real-time and trend data regarding claims processing and payment," AHCA is referring to the ability for a provider to securely obtain timely claims processing and payment information online. Is that assumption correct? If not, please clarify.	Yes
392	Sunshine State Health Plan	30					46	Regarding SRC# 30 of Exhibit A-4-a, we assume that when AHCA uses the phrase: "Non-Pay" in the title of SRC 30, this is referring to encounter submission for non-participating providers." If this is correct, please revise the language accordingly. In other words: we assume that "Non-Pay" should be edited to say: "Non-Par" in the title of SRC #30. If our assumption is incorrect, please clarify.	Please see Addendum, Item #10

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393	Sunshine State Health Plan	30					46	Regarding SRC# 30 of Exhibit A-4-a, and the use of the word "Atypical." The term "Atypical" is not defined in the ITN. We assume that AHCA's definition of "Atypical provider" matches CMS' definition, which is: "Atypical providers are providers that do not provide health care, as defined under HIPAA in Federal regulations at 45 CFR section 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of health care and therefore cannot receive an NPI." (see: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD091906b.pdf). Please confirm whether the CMS definition is accurate. If not, please define Atypical Provider.	Confirmed.
394	Sunshine State Health Plan	11					17	Evaluation Criteria #5 reads: "The extent to which the respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency's information." We assume that respondents should communicate provider directory updates to AHCA via the weekly submission of the respondent's Provider Network Validation (PNV) file. Are we correct in our assumption? If we are not correct, please clarify if there is another method that AHCA requires the respondent to communicate online provider directory updates to AHCA.	See Attachment B- Scope of Services, Core Provisions, Section VIII - Provider Services, Sub-Section A - General, paragraph 3
395	Sunshine State Health Plan	17					24	Regarding the phrase "In a manner suitable for the provider community…", we are unclear what this phrase means. Please clarify. Our assumption is that AHCA wishes the respondent to address SRC 17 using descriptions of "key components of claims processing and payment" from the perspective of "the lay public" (based on Evaluation Criteria #1 in SRC 17) and not from the perspective of the billing personnel/staff at provider organizations. Thus we assume any claim processing specific terminology, diagrams and attachments, and/or references to AHCA, Florida, or Federal requirements must be defined in the response to SRC 17 in a format suitable for laypersons. Are we correct in our assumption? if not please correct our assumption.	The plain meaning of "in a manner suitable for the provider community" should be used is preparing a response.
396	Sunshine State Health Plan	24					37	In subpart c.5 please confirm that the definition of "complaints" includes complaints regarding transportation received from any source, including state-referred complaints.	Yes
397	Sunshine State Health Plan	5					8	SRC 5 asks respondents to describe "each proposed DM program." SRC 5 evaluation criteria #1 will judge the respondent on its "innovative and evidence-based" DM approach for 6 types of conditions (cancer, diabetes, asthma, hypertension, mental health and substance abuse). How will any additional DM programs, if proposed, be evaluated and scored?	See Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, SRC# 5 - Disease Management (DM) Program (Statewide), Evaluation Criteria.

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398	Sunshine State Health Plan	5					8	SRC 5 asks respondents to describe "each proposed DM program." SRC 5 evaluation criteria #1 will judge the respondent on its "innovative and evidence-based" DM approach for 6 types of conditions (cancer, diabetes, asthma, hypertension, mental health and substance abuse). SRC 5 evaluation criteria #5 will judge the respondent on the extent to which the respondent's DM programs address 5 specified components. Please clarify whether Respondents should only provide descriptions of the 6 DM programs listed in the evaluation criteria #1. If this is the case, please clarify how any additional DM programs, if proposed, will be evaluated and scored? For example, will the state apply evaluation criteria #2-6 to all DM program descriptions, including DM programs proposed in addition to those listed in evaluation criteria #1?	See Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, SRC# 5 - Disease Management (DM) Program (Statewide), Evaluation Criteria.
399	Sunshine State Health Plan	5					8	SRC 5 asks Respondents to provide “a description of performance metrics used to evaluate the efficacy of the disease management program, ...including relevant experience to provide support for the use of the specific performance metrics. Please clarify whether AHCA is seeking the Respondent’s justification for using the performance metrics, based on relevant experience.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
400	Sunshine State Health Plan	9					5	The OTC benefit in Exhibit A-4-a-2 Expanded Benefits Tool, Expanded Benefits Coverage is now showing a per member unit coverage vs. a per household unit coverage. Please confirm this was AHCA's intent.	Please see Addendum, Item #9
401	Sunshine State Health Plan	1					1	General SRC #1 asks for Managed Care Experience to include the respondent's parent, affiliate(s) and subsidiary(ies). The information requested will require a significant number of pages for those health plans with a local presence in Florida but with a parent organization and affiliates in other states. This then limits the pages a health plan with signficant managed care experience can dedicate to responding to SRCs that align with the agency's goals and those that are a higher point value. Would AHCA consider allowing the following components of the response to be provided in a separate binder outside of the three (3), three-inch binders: the Transmittal Letter, Exhibit A-2-a - Exhibit A-3-b and Exhibit A-4-a Section A. Respondent Background/Experience? This solution would allow all Respondents an equal opportunity in relation to page limits.	No.
402	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	2					2	Please confirm what type of "documentation" is sufficient to show evidence of a respondent's experience operating as a Florida Medicaid health plan.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
403	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	2					3	Please confirm what type of "documentation" is sufficient to show evidence of a respondent's experience operating as a Florida Medicare Advantage Plan.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
404	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	1					1	Please clarify whether the "brief narrative describing the...scope of the work performed" refers to broad categories (behavioral health, LTSS, pharmacy, etc.) or should the respondent include more detail regarding the actual services covered? If the latter, please specify the type of information requested.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
405	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	29					44	Please confirm the type of "documentation" sufficient to describe the tools and methodologies used to determine compliance with encounter data submission requirements as required by SCR #29 of Exhibit A-4-a.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

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406	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	1					1	SRC #1 seeks large amounts of detailed information regarding "all current and/or recent...contracts for managed care services" from "respondent, including respondent's parent, affiliate(s) and subsidiary(ies)." Most large health insurance companies have various parent and/or subsidiary organizations that conduct multiple lines of business beyond the Medicaid managed care business that is the subject of this procurement, with each line of business holding numerous contracts for managed care services. To avoid receiving voluminous amounts of information that is irrelevant to the Medicaid managed care business that is the subject of this procurement, please confirm our understanding that the first sentence of SRC #1, which asks respondents to include contracts held by its parents, affiliates and subsidiaries, is limited to Medicaid managed care contracts managed by respondents' parents, affiliates, and/or subsidiaries and that respondents are not required to provide the information requested in SRC #1 for Commercial and Medicare managed care contracts.	This understanding is correct. Only contracts for managed care services as specified in SRC# 1 need be provided.
407	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	1					1	Please confirm that subpart k of SRC #1 seeks the total number of enrollees in commercial and Medicare managed care contracts across respondents' enterprise (including the respondent and respondent's parent, affiliate(s) and subsidiary(ies)) and that it is not asking for the number of enrollees to be broken down and provided for each Medicare and/or commercial managed care contract held by respondent and/or respondent's parent, affiliate(s) and subsidiary(ies).	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC. Information submitted for SRC #1 shall be by contract.
408	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	1					1	Are respondents to limit their discussion of subcontractor experience to subcontractors' experience supporting Medicaid managed care contracts held by respondents only or may respondents include subcontractors' experience supporting Medicaid managed care contracts held by competitor managed care companies?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
409	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	1					1	Are respondents to limit their discussion of subcontractor experience to subcontractors' experience supporting Medicaid managed care contracts held by respondents only or may respondents include subcontractors' experience with Medicaid managed care contracts held or managed by respondents' affiliates, as long as those subcontractors also will be used for the SMMC program?	For this SRC, the respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program. The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
410	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	SRC #4 seeks information about terminations of managed care contracts under which "respondent as well as the respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries" provided health care services as the insurer. Most large health insurance companies have various parent and/or subsidiary organizations that conduct multiple lines of business beyond the Medicaid managed care business that is the subject of this procurement, with each line of business holding numerous contracts for managed care services. To avoid receiving voluminous amounts of information that is irrelevant to the Medicaid managed care business that is the subject of this procurement, please confirm our understanding that this question is limited to Medicaid managed care contracts held by the respondent and respondents' affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries.	This understanding is correct. Only contracts for managed care services as specified in SRC# 1 need be provided.

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411	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	Please confirm that the types of terminations required to be disclosed in SRC #4 are limited to terminations of Medicaid managed care contracts under which the respondent (as well as the respondent's affiliates and subsidiaries and its parent organization and that organization's affiliates and subsidiaries) is the insurer holding a direct contract with a State agency for Medicaid managed care services. In other words, please confirm that SRC #4 does not include terminations of Medicaid managed care contracts between an unaffiliated entity and a State agency, for which respondent's affiliate provides plan management services but is not itself a licensed insurer and does not hold a direct contract with the State agency.	No. SRC 4 relates to all Medicaid managed care contracts held by the respondent, as well as the respondent's affiliates and subsidiaries and its parent organization and that organization's affiliates and subsidiaries, at any tier.
412	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	1					1	The information requested in SRC #1 may be best presented in table format for clarity. Please confirm that respondent may present this information in an attachment in the form of tables, as long as reference is made in the form field and the attachment is located behind the response and labeled appropriately.	Confirmed. The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
413	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	Please confirm that this question does not include situations where covered services and/or populations under an original state contract were assumed under a different contract for a new or redesigned State program, even where the State may have terminated or sun-setted an original contract before its natural termination date to accommodate the start-date of the new State contract. In other words, please confirm, for example, that this question would not include FL contracts that ended when the new Statewide Medicaid Managed Care Program contract covering those same populations was implemented.	Contracts that were terminated by a mandate from the public entity are not considered to have been terminated by the respondent, or the respondent's affiliates or subsidiaries or parent organization and that organization's affiliates and subsidiaries.
414	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	3					4	Section 409.966(3)(c)(3) is focused on whether certain “operational functions” are performed in Florida, including the location of respondents' "corporate headquarters." Both the statute and the evaluation criteria indicate that “corporate headquarters” would not include a Florida-based subsidiary of another entity located outside of Florida. Some respondents, however, may be subsidiaries of parent entities, which are located outside of Florida but which perform no operational functions for their subsidiary health plans located in Florida. Given Section 499.966(3)(c)(3)’s clear intent to award “the highest number of points…to a plan that has all or substantially all of its operational functions performed in [Florida],” please confirm that respondent health plans located in Florida and which have all or substantially all of their operational functions performed in Florida will earn the full five points in connection with Evaluation Criteria 1, notwithstanding a parent company located outside of Florida which performs no operational functions for the health plan, such that the parent company’s location is irrelevant to the inquiry about where the operational functions are performed.	The scoring criteria for SRC# 3 are clearly stated in the ITN
415	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	1					1	In response to the last paragraph of SRC #1, asking about "experience provided by subcontractors for which respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program," should respondents list specific Medicaid managed care contracts with which its subcontractors have experience and provide all of the information requested in SRC #1, including subparts a-l, for each such contract; or, is this paragraph seeking the same information as subpart f, which asks for a description of "[t]he use of administrative and/or delegated subcontractor(s) and their scope of work." If neither option is correct, please elaborate on what information the Agency is seeking in response to the last paragraph of SRC #1.	For this SRC, the respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program. The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

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416	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	17					24	Please clarify the terms "in a manner suitable for the provider community" and "in a format suitable for the public."	The plain meaning of "in a manner suitable for the provider community" and "in a format suitable for the public" should be used is preparing a response.
417	AHF MCO Florida	5					73	There is currently no accommodation included to score HIV. The list of sc	There will be no change to this specification of the ITN. See Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, SRC# 5 - Disease Management (DM) Program (Statewide).
418	AHF MCO Florida	6					75	Would it be possible for any socio-demographic barriers to be considered in the scoring of CAHPS or HEDIS results such as substance abuse and/or mental illness? The plan would like to request the inclusion of mental illness and substance abuse as potential modifiers for quality reporting and tracking of improvements made year over year.	There will be no change to this specification of the ITN.
419	AHF MCO Florida	14					86	For CAHPS and HEDIS, data for three states is required to be submitted. However, we only have plans in two states and therefore data for two states. Will a submission with data for two states be acceptable?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
420	AHF MCO Florida	24					102	The proposal current requires all plans take responsibility of obtaining EQRO contracting. Since the EQRO's are already contracted with CMS for each State and have deliverables they have to meet for CMS, would it be possible for the plans to use the same EQRO that has already been vetted with CMS?	SRC #24 is regarding transportation--External Quality Review Organizations are not mentioned. It is unclear what the source of this question is.
421	AHF MCO Florida	6					119	If a specialty health plan, due to the nature of the specialty, does not have a credibly sized population to report a HEDIS measure or a "parent" organization with a large population for HEDIS, how will this be evaluated?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
422	AHF MCO Florida	14					138	When a specialty plan has minimal to no children who qualify for CAHPS, how does the plan respond given no ratings in this category? How will scoring be handled when a specialty plan, by nature of its population does not have a credible population or large enough sample for women and/or children/adolescents for related measures in its Florida Medicaid Plan or in its other state Medicaid or other commerical plan? Will parent company HEDIS results be excluded from Specialty Plan response to this SRC and only consider the specialty plan HEDIS data form Florida or other states?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
423	Molina Healthcare of Florida	6					10	SRC #6 and SRC #7 refer to "Follow Up after Hospitalization for Mental Illness – 7 day". Could the Agency please confirm if this is referring to the AHCA "Follow Up after Hospitalization for Mental Illness - 7 day" (FHM) measure or the NCQA HEDIS measure "Follow Up after Hospitalization for Mental Illness - 7 day" (FUH)? The definitions for these measures differ. We realize that the ITN refers to FHM, but our other state health plans have FUH as a measure, please clarify whether we are to report on FHM or FUH?	Plans should follow NCQA's Technical Specifications and General Guidelines for Data Collection and Reporting to generate the HEDIS calculations.
424	Molina Healthcare of Florida	7					12	See Question above	Plans should follow NCQA's Technical Specifications and General Guidelines for Data Collection and Reporting to generate the HEDIS calculations.

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425	Molina Healthcare of Florida	10					16	The template includes minimum and maximum age and eligible population. Can Plans also establish additional criteria that members must meet in order to qualify for the additional expanded benefit?	The Respondent should use the form of response that it believes best responds to the requirements of the ITN.
426	Molina Healthcare of Florida	31					47	Could the agency please define the scope and extent of fraud and abuse under SRC 31 vs 32? Both SRCs make reference to fraud and abuse. Is the intent that the reference to fraud and abuse on SRC 31 is only related to internal performance of the HMOs and subcontractors activities and processes in connection with the Medicaid contract. In turn, is the reference to fraud and abuse on SRC 32 considered potential fraud and abuse committed by providers in rendering and billing of Medicaid benefits, including overpayments.	The terms “fraud” and “abuse” are as defined in Florida Statutes. SRC 31 relates to experience in identifying fraud and abuse by subcontractors and fraud and abuse internally within the managed care organization which are considered functions that are typically under the compliance officer. SRC 32 relates to the activities of the SIU, and the experience in identifying fraud and abuse in the capacity that the SIU will function, which would minimally include network provider fraud and abuse.
427	Molina Healthcare of Florida	32					48	See Question above	The terms “fraud” and “abuse” are as defined in Florida Statutes. SRC 31 relates to experience in identifying fraud and abuse by subcontractors and fraud and abuse internally within the managed care organization which are considered functions that are typically under the compliance officer. SRC 32 relates to the activities of the SIU, and the experience in identifying fraud and abuse in the capacity that the SIU will function, which would minimally include network provider fraud and abuse.
428	Molina Healthcare of Florida	1					1	SRC #1 requests contract information for a period of years. Would the Agency allow respondents to provide their answers in an attachment rather than the form field format? This would allow us to format the contract information for ease of reviewer evaluation. In addition, would the Agency confirm that answers to SRCs provided in attachments will be considered as part of the response and scored accordingly?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
429	Humana	6					10	There is no space within Exhibit A-4-a-1 to note the target population of the contracts included in the reponse. Please confirm the respondent should attach an additional table, which includes the target population of the contracts.	The respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
430	Humana	6					10	Regarding "Follow Up after Hospitalization for Mental Illness – 7 day" within Exhibit A-4-a-1, please confirm that the health plan should use the Agency-defined measure results where applicable (i.e., Florida Medicaid contracts), and NCQA where not applicable, given that AHCA has defined its own criteria for this performance measure.	Plans should follow NCQA's Technical Specifications and General Guidelines for Data Collection and Reporting to generate the HEDIS calculations.
431	Humana	4					6	In Exhibit A-2-c, the language within paragraph 15 regarding terminated contracts refers specifically to a State or Federal government contract. Per the direction in Exhibit A-2-c to respond based on a State or Federal government contract only, please confirm for SRC# 4 - Contract Performance that the respondent should only provide contract information related to a State or Federal government contract.	Exhibit A-4-a, General Submission Requirements and Evaluation Criteria, SRC #4, Contract Performance, is not limited to State or Federal government contracts.
432	Humana	6					10	Regarding the General Performance Measurement Tool (Exhibit A-4-a-1), the "Performance Measure Group A" tab appears to have maximum points calculated at 288, instead of the maximum of 360 points as the ITN indicates. It appears that the underlying data utilized to calculate these points may be incomplete. Can the Agency please provide clarification and update Exhibit A-4-a-1 as needed?	Please see Addendum, Item #7

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433	Humana	2					3	The scoring states that "this section is worth a maximum of 30 raw points as outlined below"; however, the sum of points from Items 1 through 5 appears to be 40, not 30. Additionally, we interpret the use of the term "additional points" in Items 3 and 4 to indicate that these points are included in the raw point total prior to the application of the weight factor (consistent with the treatment of "additional points" outlined in SRC #3). If our interpretation is correct, the maximum raw score possible in the "General Criteria" section of Attachment A (page 29) should be 100 and not 90. Can the Agency please confirm that the maximum points should be 360 points?	Initially, the respondent may earn up to 20 points (Items 1. and 2.). Then there is an opportunity for the respondent to earn an additional 10 points (Items 3. and 4.) for a maximum of 30 raw points.
434	Humana	6					10	Please confirm Medicaid contracts that exclude the under 19 population should not be considered when determining the three largest Medicaid contracts to submit.	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
435	Humana	6					10	Plan measures may have missing values (i.e. Not Reported, Not Applicable) for Medicaid contracts that exclude under 19 population. How does the Agency plan to evaluate such measures?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
436	Florida True Health, Inc. d/b/a Prestige Health Choice	9					5	For the OTC benefit, some MCOs have historically administered the benefit on a per household basis and/or with an annual limit that is less than the accumulation of 12 months of the monthly benefit amount. The new ITN per enrollee requirement will materially increase the annual cost of this benefit. What is the annual cost limit for the OTC benefit?	Please see Addendum, Item #9
437	Florida True Health, Inc. d/b/a Prestige Health Choice	9					5	The OTC benefit categories are fairly broad (e.g. skin care). 1 Will there be a standardized product listing provided to the MCOs to administer the benefit? 2 Will the MCOs have opportunity to provide specific feedback on the product listing and/or limit products to generic equivalents where available?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN. See also Attachment A, Instructions and Special Conditions, Section D. Sub-Section 6. Selection Criteria for Determining Best Value
438	Florida True Health, Inc. d/b/a Prestige Health Choice	9					15	For Newborn circumcisions the ITN lists CPT 54160 (surgical) only and excludes CPT 54150 (clamp). Please clarify whether the omission of CPT 54150 was an oversight and if CPT 54160 is the CPT preferred by AHCA?	No, this was not an oversight. There will be no change to this specification of the ITN.
439	Florida True Health, Inc. d/b/a Prestige Health Choice	9					15	For all Adult Therapy Services (PT, OT, ST and RT) specified on SRC #9, is the covered place of service location limited to Office, Home, or OP or does it include all locations?	See Attachment B - Scope of Service - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section B. Expanded Benefits, Item 1. General Provisions, Sub-item c.
440	Florida True Health, Inc. d/b/a Prestige Health Choice	9					9	Please clarify hearing aid and dispensing fee coverage limitations by confirming that members would be eligible for a hearing evaluation, an assessment and a hearing aid fitting/checking once every two years. Also, one hearing aid (monaural/cros) or one hearing aid set (binaural/bicros) every two years with associated dispensing fee (with exception of hearing aid monaural which is once per year).	See Exhibit A-4-a-2, SRC# 9, Expanded Benefits Tool (Regional).
441	Florida True Health, Inc. d/b/a Prestige Health Choice	9					15	Can the OTC benefit be administered by the Health Plan through a mail order vendor exclusively?	Yes. See Attachment B, Scope of Service - Core Provisions, Section VIII Provider Services, Sub-Section A. Network Adequacy Standards, Item 6. Facilities and Ancillary Providers, Sub-Item e.
442	Florida True Health, Inc. d/b/a Prestige Health Choice	30					46	Is the part of the question that says “Non-Pay” intended to be “Non-Par”?	Please see Addendum, Item #10
443	Florida True Health, Inc. d/b/a Prestige Health Choice	31					47	In regards to the portion of SRC #31 that states “The respondent shall also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority,” What is meant by level of authority?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.

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EXHIBIT A-4-b MMA									
444	UnitedHealthcare of Florida, Inc.	6					9	Can you please provide a listing of eligible FQHCs and RHCs in the State of Florida that correspond to the numbers listed on Exhibit A-4-b-1, Provider Network Agreements/Contracts, in cells E17 and E18 for each of the regional tabs?	Please see Addendum, Item #12
445	Best Care Assurance	6					9	Will AHCA specify the formula it will use to count the number of providers. For instance, will providers be counted on the basis of unique National Provider Identifiers (NPI), unique service locations or other categories?	Please see Addendum, Item #12
446	Best Care Assurance	6					9	Is the respondent permitted to count contracted providers who have not yet applied to enroll in Florida Medicaid but will enroll in Florida Medicaid prior to Readiness Review? If not, is the respondent permitted to count contracted providers who have applied to enroll in Florida Medicaid but are currently in a Pending status?	Yes
447	Community Care Plan	6						Exhibit A4b1: How will the current network waivers be addressed by this exhibit?	Existing network waivers are not factored into the exhibit.
448	Community Care Plan	6						Exhibit A4b1: Region 11 requires 104 rural clinics; Can the Agency confirm that there are 104 rural clinics in Region 11?	Please see Addendum, Item #12
449	Community Care Plan	21						Exhibit A4b3: How will the Plan demonstrate "Best Efforts" in recruitment of essential providers?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
450	Community Care Plan	21						Exhibit A4b3: Will the Agency accept "Letters of Agreements" or "Letters of Intent" from Essential Providers as responsive or must the Plan have formal executed agreements?	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.
451	Adventist Health Systems	17					23	The respondent is to describe their approach to coordinating services that are not covered by the respondent, but are covered by Florida Medicaid FFS. Are the state HCBS waiver programs part of the FFS delivery system mentioned in SRC#17? What additional obligations would the respondent have since these programs have a cap on the number of people they can serve?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
452	Adventist Health Systems	3					5	If respondent is a newly created entity or otherwise does not have experience with patient centered medical homes, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
453	Adventist Health Systems	4					6	How will the Agency reconcile telemedicine usage with other requirements of this ITN that favor in-state service?	See Attachment B - Scope of Services - Core Provisions, Section VIII. Provider Services, Sub-Section B. Network Management, Item 2. Annual Network Development Plan, Sub-Item c.
454	Adventist Health Systems	7					10	The Agency's instructions in A.17.a.2)a. seem to run counter to Fee-for-Service PSN's making incentive payments to providers. Is SRC #7 to be interpreted as an exception to the earlier guidance?	SRC 7 is designed to provide incentive for a PSN to submit a proposal as a capitated plan.
455	Adventist Health Systems	12					16	Number 5 of the Evaluation Criteria refers to the Agency's streamlined credentialing capability for use with the respondent's credentialing and recredentialing processes. Please explain what this is.	Information about the streamlined credentialing process can be found on the agency's website at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Public%20Misc%20Files/Streamlined%20Credentialing%20Overview.pdf and http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Training/Streamlined%20Credentialing%20(Limited%20Enrollment).pdf
456	Adventist Health Systems	14					19	If respondent is a newly created entity or otherwise does not have experience with achieving quality standards or HEDIS measurements, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section? Also, if Medicaid information is not available, will the Agency accept similar information regarding commercial or Medicare coverage?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC. There will be no change to this specification of the ITN.

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457	Adventist Health Systems	15					21	If respondent is a newly created entity or otherwise does not have experience with failing to meet HEDIS measurements or quality standards, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
458	Adventist Health Systems	16					22	If respondent is a newly created entity or otherwise does not have experience with achieving HEDIS or standard supplemental data sources for its HEDIS and other performance measures, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
459	Adventist Health Systems	20					29	In this SRC, the Agency asks for the "specific experiences the respondent has had in addressing the needs in Florida or other states." If respondent is a newly created entity or otherwise does not have experience such specific experiences, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
460	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	6					9	Will an executed memorandum of understanding between the Vendor and its subcontractor qualify as having an agreement or a contract in place?	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.
461	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	9					12	Are there specific standards in place for Specialty Plans for Chronically Ill Children?	See Attachment A, Exhibit A-4-d, Specialty Submission Requirements and Evaluation Criteria, Section C. Recipient Experience, Specialty SRC #4: Eligibility and Enrollment.
462	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	19					27	Because the respondent is proposing a Specialty Care Plan for Chronically-Ill children, should the Respondent substitute the case vignette with a pediatric patient with Type 1 diabetes rather than a 57-year old patient as described? Would the answer be acceptable and points awarded at the same level for a pediatric scenario?	There will be no change to this specification of the ITN.
463	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	21					32	Nicklaus Children's Hospital is an Essential Provider and also proposing the Specialty Plan for Chronically Ill Children. Does it receive additional points for its PSN contracting with itself since the vendor is the Essential Provider?	There will be no change to this specification of the ITN.
464	Magellan Complete Care of Florida	12					16	Is the definition of "subcontractors" for purposes of credentialing the same as the definition outlined in SRCs #26 and 27?	Yes
465	Florida Council for Community Mental Health	21					32	Currently, AHCA requires MMA plans and specialty MMA plans to be contracted with every Statewide Inpatient Psychiatric Program (SIPP) in Florida. Given that the ITN identifies SIPPs as essential Medicaid providers, will the requirement to contract with every SIPP in the state continue into the new procurement period? Can the MMA plan or specialty MMA plan contract with SIPPs that are outside of the Region(s) they serve? Please clarify if contracts with these providers (SIPP) are required to be submitted in the response or will be confirmed during the plan readiness phase after the award is made, or at some other time.	There will be no change to this specification of the ITN. See also Attachment B- Exhibit B-1- Managed Medical Assistance Program, Section VIII. Provider Services, Sub-Section A. Network Adequacy Standards 7. f.
466	Florida Council for Community Mental Health							Please reference : Exhibit A 4-b-3 MMA SRC#21 (Essential Providers - The statewide essential providers) and ACHA ITN 011-17/18 Attachment B, Exhibit B-1 Page 47 of 86, (Section VIII. Provider Services, 7. Essential Providers c. f ..the Managed Care Plan shall include all providers in the region that are classified by the Agency as essential Medicaid providers…(1)-(3))	This question is too unclear for the Agency to respond to.

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467	Florida Council for Community Mental Health	6					9	Are specialty plans required to submit networks that meet the ratio results for the general population of a region or networks that meet the ratio results requirements just for the specialty population of a region? If solely the specialty population, will the recipient count and results data be provided in the procurement documents? Please reference: Exhibit A-4-b-1 MMA SRC#6 (total population by region), Page 40 of 41 ACHA ITN 011-17/18 Attachment A (enrollment in specialty plan), Page 36 of 41 AHCA ITN 011-17/18, Attachment A (aggregate enrollment in specialty plan not exceed 10% of total enrollees in a region), Page 11 of 22 ACHA ITN 011-17/18 Attachment B, Exhibit B-3 (The Agency shall determine regional provider ratios based upon one hundred and twenty percent (120%) of the Specialty Plan's actual monthly enrollment)	There will be no change to this specification of the ITN.
468	Our Children PSN of Florida, LLC	6						Exhibit A-4-b-1 MMA SRC# 6 - Provider Network AgreementsContracts (Regional) has no field for the respondent's name. Please provide an updated form with a respondent name field as needed.	Please see Addendum, Item #12
469	Our Children PSN of Florida, LLC	21						Exhibit A-4-b-3 MMA SRC# 21 - Provider Network AgreementsContracts Statewide Essential Providers has no field for the respondent's name. Please provide an updated form with a respondent name field as needed.	Please see Addendum, Item #26
470	Simply Healthcare	4					6	Can the physician providing care via telemedicine be an out of state provider? Must they hold a FL physician license?	Telemedicine services must comply with Florida Law. See, e.g., Rule 59G-1057 and Rule 64B8-9.0141 (1), F.A.C.
471	Simply Healthcare	4					6	Given the historically low utilization of telemedicine in Florida, can the plan use affiliate information from other neighboring states, such as Georgia, as evidence of significant achievements in the deployment of telemedicine?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
472	Simply Healthcare	6					9	Please confirm that the number of agreements/contracts should reflect the number of physicians covered by contracts/agreements not the number of contracts as noted in the score card exhibit A-4-b-1.	Please see Addendum, Item #12
473	Simply Healthcare	6					9	Is this SRC evaluation only related to the specialty types on the Score card Exhibit A-4-b-1 provided or all provider service types?	This SRC is only related to the Specialty Types listed on Exhibit A-4-b-1.
474	Simply Healthcare	6					9	Will the Agency post a list of FQHCs that matches the number of FQHCs listed in the score card provided?	Please see Addendum, Item #12
475	Simply Healthcare	6					9	Will the Agency post a list of RHCs in order to match the number of RHCs listed in the score card provided? RHCs are located in the AHCA facility finder however the locations listed in this resource by region do not match the region count prefilled in the Exhibit A-4-b-1 score card. For example, region 10 score card states there is one RHC in the region however, when pulling the AHCA facility finder the results show zero facilities.	Please see Addendum, Item #12
476	Staywell (WellCare)	6					9	In Exhibit A4b1, for Regions 5 and 11, the Rural Health Clinic (RHC) line item on row 18 is not included in the spreadsheet. There are no RHCs in those two regions. Can you confirm how the total score for MMA SRC# 6 will be counted for those two regions? For example, will the RHC line item score default to 0 or to 20 for all of the Respondents, or will the maximum score be 220 raw points rather than 240 for those two regions?	Please see Addendum, Item #12
477	Staywell (WellCare)	6					9	Can you confirm that a non-binding Letter of Intent is not considered a contract/agreement?	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.
478	Staywell (WellCare)	7					10	In the cost proposal, should respondents adjust the physician unit costs to the Medicare fee schedule to correspond to section SRC#7 or will this be an adjustment applied at a later date by the state actuary?	See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-section F, Rate Adjustments Excluded from MMA Cost Proposal

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479	Staywell (WellCare)	13					17	The second evaluation criterion for this SRC states that respondents will be evaluated on the "specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement." This seems to indicate that the NUMBER of provider contracts in each category should be used to calculate the percentage of respondent's value-based purchasing. May respondents instead calculate the VBP percentage based on anticipated amount of medical spend or anticipated number of members cared for by providers contracted through a VBP arrangement? We have found these metrics to be much more impactful to members and to state clients than the number of VBP contracts. Using the number of contracts assumes a VBP contract with a solo practitioner seeing a single member has the same impact as a VBP contract with a large independent practice association whose providers see hundreds of members.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
480	Staywell (WellCare)	14					19	Will the HEDIS scores and benchmarks be rounded to whole numbers or evaluated to the second decimal place?	The ITN requires that plans report their CAHPS scores to the second decimal place and this is how they will be compared to the benchmarks.
481	Staywell (WellCare)	14					20	Both the narrative in SRC 14 and the MMA Performance Measurement Tool in Exhibit A-4-b-2 list seven HEDIS measures on which the respondent will be scored, but the detailed explanation of the scoring refers to eight HEDIS measures. The mathematical calculation of the 120 available points also is consistent with eight HEDIS measures. Was a measure omitted?"	Please see Addendum, Item #13
482	Staywell (WellCare)	21					32	Can you confirm that a non-binding Letter of Intent is not considered a contract/agreement?	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.
483	Quintairos, Prieto, Wood & Boyer	14					19	For PSN or Specialty Plan who do not manage certain populations, where HEDIS measures are being asked, will the total point value be adjusted for measures that were not reportable?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
484	Quintairos, Prieto, Wood & Boyer	14					19	How will the ITN responses for this SRC be scored for Specialty Plan or PSN Respondents that do not have Medicaid Contracts or Commercial HEDIS scores identified in this SRC? According to the scoring matrix it appears a respondent proposing a Florida only Specialty Plan or PSN could be at a significant disadvantage.	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
485	Quintairos, Prieto, Wood & Boyer	14					19	Will Medicare rates be considered commercial rates and thus be acceptable contracts for providing HEDIS measures?	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
486	Sunshine State Health Plan	6					9	The same general instructions are used for Exhibit A.4.b.1 and Exhibit A.4.b.3. Is this correct? Please provide the correct instructions for Exhibit A.4.b.1.	Please see Addendum, Item #12
487	Sunshine State Health Plan	21					32	The same general instructions are used for Exhibit A.4.b.1 and Exhibit A.4.b.3. Is this correct? Please provide the correct instructions for Exhibit A.4.b.1.	Please see Addendum, Item #12
488	Sunshine State Health Plan	4					6	MMA SRC# 4 is currently asking for a Regional response. Given that telemedicine is no longer bound by geographic areas and can be accessible to members across multiple Regions, would AHCA consider changing this question from Regional to Statewide to allow a more accurate representation of the telemedicine services available to members?	See Attachment B - Scope of Services - Core Provisions, Section VIII. Provider Services, Sub-Section B. Network Management, Item 2. Annual Network Development Plan, Sub-Item c.

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489	Sunshine State Health Plan	4					6	Can AHCA please clarify how it will account for Regional incumbents vs. non-incumbents in the evaluation criteria outlined in MMA SRC# 4 - Telemedicine (Regional), Evaluation Criteria 3(b), "the percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year"?	See Attachment B - Scope of Services - Core Provisions, Section VIII. Provider Services, Sub-Section B. Network Management, Item 2. Annual Network Development Plan, Sub-Item c.
490	Sunshine State Health Plan	14					19	Please confirm that respondents submitting commercial HEDIS rates will be compared to commercial HEDIS national and regional means rather than the Medicaid mean for scoring.	National and Regional Medicaid means will be used for comparison, as stated in the SRC.
491	Sunshine State Health Plan	14					20	If a rate was not reportable for either 2016 or 2017, please clarify how AHCA will score that measure since no comparison can be made from the reported rate to the national or regional mean, nor is it possible to measure any improvement? Evaluation Criteria - 1 point for each year the rate met or exceeded national and regional mean; 1 point for improvement in rate from 2016 – 2017"	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
492	Sunshine State Health Plan	14					20	The scoring methodology for this SRC references 8 measures but there are only 7 measures listed for data submission. Please adjust the scoring to reflect the correct number of measures.	Please see Addendum, Item #13
493	Sunshine State Health Plan	10					13	Please confirm that "nursing facility rehabilitation" in this question refers to an acute stay, not a custodial/long term stay.	Confirmed. See Exhibit B-1. Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits, Item 2.a. See Exhibit B-2. Long-term Care (LTC) Program, Section III. Eligibility and Enrollment, Sub-Section B. Eligibility
494	Sunshine State Health Plan	11					14	Please clarify whether AHCA prefers Respondents to "Attach" a draft network development plan, or summarize such plan in the narrative.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
495	Sunshine State Health Plan	11					14	Please identify where the network access standards are provided for: · Early intervention services; · Compounding pharmacies; and · Specialized therapeutic foster care. Are the access standards described or listed somewhere in the ITN? In order to report if we are deficient / have network gaps, or if we meet / exceed the requirements for these services, we need to have the network access standards for each service or provider type for this population.	See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section A. Network Adequacy Standards, Item 2. Network Capacity and Geographic Access Standards. See Attachment B - Scope of Service - Core Provisions, Exhibit B-1 - Managed Medical Assistance (MMA) Program, Section VIII. Provider Services, Sub-Section A. Network Adequacy Standards, Item 8. Timely Access Standards.
496	Sunshine State Health Plan	5					7	Please clarify whether AHCA prefers Respondents to "Attach" a draft network development plan, or summarize such plan in the narrative.	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
497	Sunshine State Health Plan	2					3	When long acting reversible contraceptives are mentioned in SRC #2, are they referring to the strict ACOG definition, which would include only IUDs and implants, or are they also allowing for injectables, such as Depo-Provera?	See Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required MMA Benefits, Item 1. Specific MMA Services to Be Provided, Sub-Item a. incorporating Rules 59G-4.002,59G-4.030, 59G-4.150, and 59G-4.250, Florida Administrative Code.
498	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	6					9	SRC 6 and SRC 21, pages 9 and page 32 Will Letters of Intent (LOIs) be accepted as evidence of respondents' progress with executing agreements or contracts it has with providers for purposes of MMA SRC #6 and #21?	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.
499	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	6					9	SRC 6 and SRC 21, pages 9 and page 32 Please confirm that Letters of Agreement (LOAs) will be accepted as evidence of "agreements" respondents have with providers for purposes of MMA SRC # 6 and #21.	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.

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500	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	17					23	Please provide the State's definition of "reciprocal referral" as used in MMA SRC# 17.	The plain meanings of "reciprocal" and "referral" should be used in preparing a response. The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
501	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	6					9	In the scenario where you have a group of 3 physicians under one paper contract/agreement, should the group be counted as one or should the physicians be counted as 3?	Please see Addendum, Item #12
502	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	Are telemedicine services considered an in-state or out-of-state service. Does it depend where the telemedicine provider is physically located?	Telemedicine services must comply with Florida Law. See, e.g., Rule 59G-1057 and Rule 64B8-9.0141 (1), F.A.C.
503	Humana	6					9	Please confirm that plans are permitted to enter the number of unique practitioners, based on NPI, in column B of Exhibit A-4-b-1 as covered by the plan's Provider Network Agreements/Contracts for the physician Service Provider Types listed in column A of the Exhibit.	Please see Addendum, Item #12
504	Humana	6					9	Please confirm that plans are permitted to enter the number of unique service locations in column B of Exhibit A-4-b-1 as covered by the plan's Provider Network Agreements/Contracts for the FQHC and RHC Service Provider Types listed.	Please see Addendum, Item #12
505	Humana	6					9	Please confirm that plans may include providers that have signed Letters of Intent and/or Letters of Agreements in column B of Exhibit A-4-b-1.	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.
506	Humana	6					9	Does the Agency plan to validate the accuracy/authenticity of respondents' submissions for Exhibit A-4-b-1 ahead of selections for negotiations?	Misrepresentation of bid information is found in PUR 1001, Section 9, which provides that misrepresentation will be treated as fraudulent concealment. That would constitute grounds for termination for cause, which not only would result in termination of the contract, but would also provide cause to forfeit the performance bond.
507	Humana	6					9	Can the Agency confirm the FQHC and RHC Region Counts for all regions in Exhibit A-4-b-1? Additionally, can the Agency please confirm that it has not included Walton County Health Department or any other non-valid FQHCs and RHCs in column E? For example, in Region 1, the Region count in column E for FQHC is 26. We are only aware of 3 FQHCs operating in Region 1 that represent 15 service locations (North Florida Medical Center, Inc., Escambia Community Clinics, and PanCare of Florida).	Please see Addendum, Item #12
508	Humana	14					19	Please confirm Medicaid contracts that exclude the under 19 population should not be considered when determining the three largest Medicaid contracts to submit.	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
509	Humana	14					19	Plan measures may have missing values (i.e. Not Reported, Not Applicable) for Medicaid contracts that exclude under 19 population. How does the Agency plan to evaluate such measures?	If respondents do not have HEDIS or CAHPS results to submit for particular measures, for three contracts, for both of the years or populations (Adult and Child) requested, they should report the applicable results they do have. Points will be given according to the scoring methodology given in the applicable SRC.
EXHIBIT A-4-c LTC									
510	Adventist Health Systems	1					1	If respondent is a newly created entity or otherwise does not have experience with participant direction of services, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
511	Sunshine State Health Plan	1					1	Please confirm that an incumbent Respondent need only provide a flowchart representing its PDS process in Florida.	If the Respondent references Participant Direction of Services models that are currently or previously utilized, then a flowchart(s) representing those models should be included.

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512	Adventist Health Systems	2					3	If respondent is a newly created entity or otherwise does not have experience with measuring performance and achieving quality standards with populations similar to the target population, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section?	The respondent should respond in the manner that it believes best responds to the requirements of the ITN. Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC.
513	Simply Healthcare	2					3	Regarding LTC SRC# 2, please provide clarification about how best to demonstrate experience with measures a.4 through a.7 given that plans in Florida have not previously reported on these measures.	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
514	Sunshine State Health Plan	2					3	Does the term "Institutional Stay" in performance measures (6) and (7) refer to nursing facility stay?	"Institution" is described in performance measure (5). [could refer the respondent to the language in the performance measure SRC]
515	Sunshine State Health Plan	2					3	Confirming that in performance measures (6) and (7), successful transition is defined as community residence for 30 or more days.	There will be no change to this specification of the ITN. See Exhibit A-4-c, LTC Submission Requirements and Evaluation Criteria, LTC SRC #2.
516	Sunshine State Health Plan	2					3	Since I/DD population is carved out of LTC and ICF facilities are not contracted for LTC services, should this PM be modified?	There will be no change to this specification of the ITN.
517	Sunshine State Health Plan	3					5	Please confirm that "nursing facility rehabilitation" in this question refers to an acute stay, not a custodial/long term stay.	Confirmed. See Exhibit B-1. Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits, Item 2.a. See Exhibit B-2. Long-term Care (LTC) Program, Section III. Eligibility and Enrollment, Sub-Section B. Eligibility
518	Simply Healthcare	4					1	Exhibit A-4-c-1 includes the following network to submit for Service Type: Adult Day Care, Attendant Care, Home Delivered Meals, Intermittent and Skilled Nursing, Medication Administration, Medication Management, Medical Equipment and Supplies, Personal Care, Occupational Therapy, Physical Therapy, Respiratory Therapy and Speech Therapy. Can the State confirm the following Long Term Care network service types are NOT to be included in the ITN submission? • Assisted Living (non certified Adult Day Care) • Adult Family Care Homes • Behavioral Management • Home Accessibility • Hospice • Nursing Facilities • Personal Emergency Response	See Attachment B - Exhibit B-2, Long-Term Care Program, Section VI. Coverage and Authorization of Services, Sub-Section 2, Specific LTC Services to be Provided
519	Simply Healthcare	4					1	Exhibit A-4-c-1 requires Adult Day Care to include provider types Assisted Living Facilities with the referenced Available Service Provider Types. Using Region 1 as an example, Exhibit A-4-c-1 shows 50 available providers. In using the same source document (FloridaHealthFinder.gov) and applying the following criteria: Certified Adult Day Care and Medicaid, the results show 8 providers, not 50 available providers. This differential will impact the evaluation criteria and points will not represent eligible providers. Please provide the Agency source used to identify Medicaid eligible and certified Adult Day Cares. We are concerned that the requirement is overstated in Exhibit A-4-c-1 and this inaccuracy will make it impossible for plans to contract the required number of providers in all areas. Will AHCA be updating the available providers' number to match the information found on AHCA's website which is to represent based on credentialing requirements, including required certification and Medicaid registration?	Please see Addendum, Item #15 & #16

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520	Simply Healthcare	4					1	Regarding Exhibit A-4-c-1, using Region 11 as an example, the number of available providers to service Medicaid population does not match the AHCA site and appears to be inaccurate. • Example: Home Health Agency under Personal Care shows 329. When using the AHCA site (FloridaHealthFinder.gov) and sorting to only include Home Health providers who are Medicaid certified, the results show 135 providers, not 329. Please provide the Agency source used to identify certified providers. We are concerned that the requirement is overstated in Exhibit A-4-c-1 and this inaccuracy will make it impossible for plans to contract the required number of providers in all areas. Will AHCA be updating the available providers to match the information found on ACHA's website?	Please see Addendum, Item #15 & #16
521	Simply Healthcare	4					1	Regarding Exhibit A-4-c-1, Service Type Medication Administration and Medication Management is showing Service Provider Type RN/LPN only, however per the 2017 SMMC Long Term Care Program Coverage Policy, there are other qualified providers such as Home Health Agencies and Nurse Registries. 1) Is the expectation from AHCA to contract directly with RN/LPN or to contract at the Home Health/Nurse Registry agency level and report how many RN/LPN are on staff? 2) If the expectation is to contract only directly with the RN/LPN, will the available service provider type be updated to show actual number of RN/LPN that have individual Medicaid ID #? 3) Region 1 is showing 12,409 available RN/LPN . However it is important to note that this included providers without a Medicaid ID#, but provide service under a qualified provider. Will AHCA update the available providers to accurate available providers, including a list of providers who have Medicaid numbers? We are concerned that the requirement is overstated and that the number of required certified providers does not exist in the area, making it impossible for plans to contract the required providers in all areas.	Please see Addendum, Item #15 & #16
522	Simply Healthcare	4					1	Regarding Exhibit A-4-c-1, for each region, the Available Service Provider Type numbers are based on a provider's primary registered office location in that region. However, many providers, such as Home Medical Equipment & Supplies, are licensed and able to provide service regionally and/or statewide. Example is Provider SurfMed DME shows only in Broward County on the HQA report but can service members statewide. Can we use the same Home Medical Equipment provider in our count for multiple regions if they have the ability to cover multiple regions or statewide?	Please see Addendum, Item #15 & #16

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523	Simply Healthcare	4					1	Regarding Exhibit A-4-c-1, Service Type, Medical Equipment & Supplies, even though Home Health providers are qualified to provide Medical Equipment & Supplies, very few actually take advantage of this option to provide this to members. Does the agency provide an accurate list of those Home Health agencies that provide Medical Equipment & Supplies? Can the agency provide the listing to us?	Please see Addendum, Item #15 & #16
524	Simply Healthcare	4					1	Regarding Exhibit A-4-c-1, Occupational Therapy, Physical Therapy, Respiratory Therapy, Speech Language Pathologist, many therapy providers that are licensed do not have Medicaid ID individually, but they work under a Home Health agency. Can we get the Home Health Agency roster showing how many therapists are staffed by the agency and use that as part of the provider count?	Please see Addendum, Item #15 & #16
525	Simply Healthcare	4					1	Regarding Exhibit A-4-c-1, Personal Care, the providers under CCE are the downstream network for CCE which are the same providers listed as Home Health Agencies. Is the expectation for the Agency for us to report the same unique provider (i.e. R 11 NEIGHBORHOOD HOME HEALTH SERVICES INC) 2 times, once (1) under Personal Care Home Health Agency and again (2) under Personal Care CCE Provider?	Please see Addendum, Item #15 & #16
526	UnitedHealthcare of Florida, Inc.	4					6	Exhibit A-4-c-1, Provider Network Agreements/Contracts includes over 370,000 individual nurses (RN/LPN) as a service provider type for medication management and medication administration. Do these individual nurses include hospital, physician, and specialist-based employees? We only report nurses for long-term care home-based services that provide medication management and administration. Will AHCA revise Exhibit A-4-c-1 to include only the long-term care home-based nurses (as employed by Home Health Agencies and Nurse Registries) for medication administration and medication management?	Please see Addendum, Item #15 & #16
527	UnitedHealthcare of Florida, Inc.	4					6	For the counties within Region 7, there are duplicate data entries in the "Health Quality Assurance (HQA)" tab in Exhibit A-4-c-1, Provider Network Agreement/Contracts. Therefore, on the "Scoring" tab for Region 7, the number of Available Service Provider Types listed seems to be double what it should be. Is it AHCA's intention to have duplicate entries?	Please see Addendum, Item #15 & #16
528	Florida Community Care	4					6	The scoring criteria include individual/unique provider types with highest points related to the percentage of participation. Please confirm how the agency will credit related provider types that are consistent with typical care delivery scenarios. As one example, Medication Administration scoring requires contracting with individual providers (RNs), however, these services are provided within the scope of the home care agency contracts.	Please see Addendum, Item #15 & #16
529	Staywell (WellCare)	4					6	Can you confirm that a non-binding Letter of Intent is not considered a contract/agreement?	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.

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530	Staywell (WellCare)	4					6	The "Medication Administration" and "Medication Management" scoring is based on a list of all Florida RNs/LPNs, many of which do not provide LTC services. Most RNs / LPNs are generally not credentialed by, nor directly contracted with, LTC plans (e.g. employed by hospitals or physician groups). As an example, there are 38,636 RNs/LPNs listed for Region 7 in Exhibit A-4-c-1. Should the Respondent assume it must have executed contracts or agreements with nearly 29,000 RNs/LPNs or their employers (75.1% or greater) to obtain the full 20 points for this service category?	Please see Addendum, Item #15 & #16
531	Staywell (WellCare)	4					6	Should the Respondent assume that the specific providers enumerated in Exhibit A-4-c-1 are the only / exact providers for which points may be earned for executed agreements or contracts as per the evaluation criteria in LTC SRC# 4?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
532	Staywell (WellCare)	4					6	Are the Available Service Provider Types for Pharmacies in Exhibit A-4-c-1 aligned to Regions based on "Mailing Address" or "Practice Location Address". For example, all Publix Pharmacies appear to be aligned with Region 6 (given the Lakeland mailing address), even though practice locations appear to be in other parts of the State (e.g. Store #0835 in Miami).	Please see Addendum, Item #15 & #16
533	Staywell (WellCare)	4					6	The Health Quality Assurance (HQA), Medical Quality Assurance (MQA), and Department of Elder Affairs (DOEA) tabs within Exhibit A4c1 appear to be lists of all of Florida licensed providers for each of the categories of Provider Serves Types listed on the network scoring template. There may be applicable network providers that are not listed (e.g. out-of-state providers in contiguous Georgia or Alabama border counties), or not yet listed in the HQA, MQA, and DOEA tabs within Exhibit A4c1. The question is the following: Within the A4c1 network scoring template, can Respondents include network providers within their Column C network counts per Service Provider Types that are not listed in the HQA, MQA, or DOEA listings?	Please see Addendum, Item #15 & #16
534	Staywell (WellCare)	4					6	In Exhibit A-4-c-1, the Service Provider type category "CCE Leads" for the Service Types "Home Delivered Meals" and "Personal Care" refer to listings of some CCEs that do not provide those covered network benefits. If a Respondent has an Agreement with a listed CCE but the CCE states they do not actually provide that particular Service Type, should the Respondent include or exclude that CCE within the count for that line item? Related to that question, if a listed CCE is not a provider that particular Service Type, will the count of "Available Provider Service Types" be revised by AHCA to reflect the count of only available CCEs that actually provide that Service Type?	Please see Addendum, Item #15 & #16
535	Staywell (WellCare)	4					6	Will the Health Quality Assurance (HQA), Medical Quality Assurance (MQA), and Department of Elder Affairs (DOEA), tabs within the Exhibit A4c1 be updated on or near 11-1-17, at the time of the ITN submission date, in order to reflect provider additions or deletions to the provider databases as a result of provider change in status (e.g. new providers in Florida or those that have retired or closed down) since the ITN release on 7-14-17?	Please see Addendum, Item #15 & #16

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536	Staywell (WellCare)	4					6	Most non-physician individual providers (e.g. RNs, LPNs, PTs, OTs, STs and RTs) are within our network through our contracts with the hospitals or other facilities that employ them. We have found that that many of these facilities are concerned about the privacy of their employees and will provide to us only the number of these licensedprofessionals they employ rather than a detailed list that includes their names. Can the respondent include these counts provided by the facilities in its total contracted providers (to be reported on the Scoring tab of Exhibit A-4-c-1)?	Please see Addendum, Item #15 & #16
537	Wellmerica, A Provider Led Plan	4					6	Under Medication Management and Medication Administration for Region 8, for example, there are over 26,000 individual providers listed. Is the expectation to contract with 75.1% of over 26,000 individuals to receive the full 20 points?	Please see Addendum, Item #15 & #16
538	Sunshine State Health Plan	4					6	Exhibit A-4-c-1 for LTC SRC#4 requests a count of the number of Agreements/Contracts but the scoring tool for Available Service Provider Types addresses individual RN/LPN providers. Please address the inconsistency between the information requested and the Scoring Tool. Currently, home health agencies and nurse registries are the provider types with which we contract and RNs/LPNs contract with or are employees of these agencies. Please consider allowing Agreements/Contracts to count for network adequacy vs individual provider counts.	Please see Addendum, Item #15 & #16
539	Sunshine State Health Plan	4					6	Only OAA and CCE providers are listed for network adequacy in the Home Delivered Meals category. What about Food Establishment Older American's Act Permitted under 500.12,F.S. and Food Service Establishments Licensed per S.509.241, F.S? Will AHCA allow these additional provider types to count toward network adequacy and adjust the scoring accordingly?	Please see Addendum, Item #15 & #16
540	Sunshine State Health Plan	4					6	In the Exhibit A-4-c-1, 12.6% of the RNs and LPNs listed indicate under Practice Location that they are "Not Practicing." We have identified the same issue for OT,PT, ST, & RT providers. Would AHCA consider removing all providers indicating "Not Practicing" from the Summary Counts on Scoring Tool. If not, please clarify how network adequacy can/will be determined for this provider type when so many providers are not practicing, yet keep their license active.	Please see Addendum, Item #15 & #16
541	Sunshine State Health Plan	4					6	Currently, Home Health Agencies and Nurse Registries are utilized for Medication Administration and Medication Management, yet they are not being considered for network adequacy in this category. Rather, it appears that individual employee counts are being requested (e.g. RNs/LPNs, and OT,PT,ST, & RT Providers). We recommend that only contracts with the Agencies and Registries be considered for network adequacy vs the individual employees and subcontractors to these agencies. Please provide guidance.	Please see Addendum, Item #15 & #16
542	Sunshine State Health Plan	4					6	In the Exhibit A-4-c-1, all licensed RNs and LPNs appear to be included. Does AHCA expect Respondents to count RNs/LPNs who work in hospitals and physicians' offices (and provide services under the MMA benefit), even though these providers may not work directly in the LTC field. The same issue exists for OT,PT, ST, & RT providers. If not, will AHCA provide a listing and rescoring tool that only includes RNs/LPNs who do work in the LTC line of business? Please provide guidance.	Please see Addendum, Item #15 & #16
543	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	Will Letters of Intent (LOIs) be accepted as evidence of respondents' progress with executing agreements or contracts it has with providers for purposes of LTC SRC #4?	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.

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544	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	Please confirm that Letters of Agreement (LOAs) will be accepted as evidence of "agreements" respondents have with providers for purposes of LTC SRC #4.	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.
545	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	It appears that the State, when calculating the total number of available professionals for the following provider types in the region included all licensed individuals in the region as the total available population, including those that are employed by hospitals, schools facilities, physician practices, and even health plans: - Medication Administration (RNs/LPNs) - Medication Management (RNs/LPNs) - Occupational Therapists - Physical Therapists - Speech-Language Therapists Please clarify the Agency's intent and confirm that the Agency is only requiring MCOs to contract with providers that serve the LTC population in their homes or place of residency. If the above is the Agency's intent, will the Agency be providing bidders with revised Exhibits A-4-c-1 reflecting only providers that serve the LTC population?	Please see Addendum, Item #15 & #16
546	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	It appears that the State, when calculating the total number of available professionals for the following provider types in the region included all licensed individuals in the region as the total available population, including those that are employed by hospitals, schools facilities, physician practices, and even health plans: - Medication Administration (RNs/LPNs) - Medication Management (RNs/LPNs) - Occupational Therapists - Physical Therapists - Speech-Language Therapists Please provide additional data elements such as the employer identification (tax) identification number (EIN), as these home and community based services are normally provided by professionals employed home health agencies. By providing the EIN, we can verify that they are contracted through the employers that typically supply these services such as skilled nursing facilities, home health agencies and other contracted organizations.	Please see Addendum, Item #15 & #16
547	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	4					6	MCOs serving the LTC population generally contract with a small number of DME providers that have a presence in multiple regions or statewide to fulfill the contract DME requirements for LTC. In exhibit A-4-c-1 the state appears to have listed all pharmacies as well as DME providers in the Region. Is it the state's intent that LTC plans contract with all or a majority of DME and pharmacy providers in the Region to meet the DME access requirements, even pharmacies who may not have the requisite DME supplies for the LTC population? If the above is the Agency's intent, will the Agency be providing bidders with revised Exhibits A-4-c-1 reflecting only providers that serve the LTC population?	Please see Addendum, Item #15 & #16

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548	Molina Healthcare of Florida	4					6	Can the Agency provide additional guidance on the completion of this Exhibit? For instance, numerous plan employees, who are licensed professionals are included in the listing of "eligible providers". Should the health plan count their case managers /employees when completing?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
549	Humana	4					6	Please confirm that plans may include providers that have signed Letters of Intent and/or Letters of Agreements in column C of Exhibit A-4-c-1.	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.
550	Humana	4					6	Exhibit A-4-c-1 scoring appears to be driven by volume of Agreement/Contracts against an Available Service Provider Type denominator without regard for network management strategy. Please confirm that the Agency will not disadvantage respondents for configuring networks aimed at meeting AHCA's goals of timely access to services, appropriate care setting and achieving best quality outcomes while striving to manage overall costs.	Please see Addendum, Item #15 & #16
551	Humana	4					6	Please note that during our review of the "Available Service Provider Type" data included in the Exhibit tabs, we noticed a significant volume of providers that, based on our experience, are not best suited to provide services to LTC enrollees. We also identified 1,364 duplicate rows (all except 2 rows are in region 7) where the County, Service Provider Type, License number, last name, mailing address, and AHCA number are exactly the same for 2 rows, impacting Service Provider Types of Assisted Living Facility (700), Home Health Agency (342), Home Medical Equipment Provider (214), Nurse Registry (74), Adult Day Care Center (34). Can you confirm that these data points (provider listings and duplicate entries) were included as intended or if there is a mistake in the data shared?	Please see Addendum, Item #15 & #16
552	Humana	4					6	Please note that in reviewing the "Available Service Provider Type" data in the Exhibit tabs, we discovered a significant volume of providers that, based on our experience, do not appear to be appropriate to provide services to LTC enrollees. -- We identified 1,878 ALFs (across all regions) contributing to column D, Avaialble Service Provider Type, by utilizing FL Health Finder – http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx), that appear not to be approved to provide adult day care at this time. -- We noticed 6 rows where different entities appear to be sharing the same license number. Listed below are those rows including provider name and AHCA number: - KIVA AT CANTERBURY LLC: AHCA#:11910496; LIC#7622 - TANGERINE COVE OF BROOKSVILLE: ACHA#:11910431; LIC#7622 - TAMPA LIVING CARE: AHCA#:11942892; LIC#5898 - T L C HOME INC.: ACHA#:11911389; LIC#5898 - DIVINE GALLO HOUSE ALF: ACHA#:11932639;LIC#6665 - ANGEL'S TOUCH: ACHA#:11943052;LIC#6665 Can you confirm that these data points were included as intended or if there is a mistake in the data shared?	Please see Addendum, Item #15 & #16

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553	Humana	4					6	Please note that in reviewing the "Available Service Provider Type" data in the Exhibit tabs, we discovered service provider types that appear to be missing from the Exhibit A-4-c-1 denominator for scoring. For example, we did not see GA Foods, Cuban Buffet under the Food Establishment/Food Service Establishment category. Additionally we did not see “Home Delivered Meals – Frozen” and “Home Delivered Meals – Hot”. Can you confirm that these data points were included as intended or if there is a mistake in the data shared?	Please see Addendum, Item #15 & #16
554	Humana	4					6	Please note that in reviewing the "Available Service Provider Type" data in the Exhibit tabs, we discovered a significant volume of providers that, based on our experience, appear not to be appropriate to provide services to LTC enrollees. For example, we noticed: - Providers contributing to column D Available Service Provider Type appear to be full list of licensed RN/LPNs and may not be represntative of the RN/LPNs performing Medication Administration and Medication Management services - We identified 65 RNs and 50 LPNs (across all regions) that are listed in the accompanying Exhibit tabs that appear to have a license on probation (License-Status-Description = Probation) in service provider types contributing to the denominator supporting column D, Available Service Provider Type. Can you confirm that these data points were included as intended or if there is a mistake in the data shared?	Please see Addendum, Item #15 & #16
555	Humana	4					6	Please note that in reviewing the "Available Service Provider Type" data in the Exhibit tabs, we discovered a significant volume of providers that, based on our experience, appear not to be appropriate to provide services to LTC enrollees. - We found the following entities in the accompanying Exhibit tabs who are not appropriate to provide Medical Equipment and Supplies to the LTC population: o Hospital Pharmacy – 522 o Surgery Center - 284 o Health System – 273 o Medical Center – 183 o Renal Center - 83 o Hospice - 71 o Animal Center – 68 o Jail – 55 o Rehab - 54 o Endoscopy – 43 o Mental Health Center – 26 o Retirement Home - 23 o HUD – 12 o Student Health Center - 9 o Assisted Living Facility – 5 o Police Dept - 2 - We identified six pharmacies that appear to have a license on probation in the accompanying Exhibit tabs contributing towards the denominator in column D, Available Service Provider Type. Can you confirm that these data points were included as intended or if there is a mistake in the data shared?	Please see Addendum, Item #15 & #16

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556	Humana	4					6	Please note that in reviewing the "Available Service Provider Type" data in the Exhibit tabs, we discovered a significant volume of providers that, based on our experience, appear not to be appropriate to provide services to LTC enrollees. We identified 2 Occupational Therapists, 2 Physical Therapist, 1 Respiratory Therapist and 3 Speech Therapists (across all regions) that appear to have a license on probation in service provider types contributing to the denominator in column D, Available Service Provider Types. Can you confirm that these data points were included as intended or if there is a mistake in the data shared?	Please see Addendum, Item #15 & #16
557	Humana	4					6	Please note that in reviewing the "Available Service Provider Type" data in the Exhibit tabs, we discovered a significant volume of providers that, based on our experience, appear not to be appropriate to provide services to LTC enrollees. It is our understanding that Occupation Therapy Aides cannot see patients without the supervision of a licensed Occupational Therapist. Including the aides in the SRC score appears to artificially inflate the number of occupational therapists available to serve the enrollee population. Can you confirm that these data points were included as intended or if there is a mistake in the data shared?	Please see Addendum, Item #15 & #16
558	Humana	4					6	Does the Agency plan to validate the accuracy/authenticity of respondents' submissions for Exhibit A-4-c-1 ahead of selections for negotiations?	Misrepresentation of bid information is found in PUR 1001, Section 9, which provides that misrepresentation will be treated as fraudulent concealment. That would constitute grounds for termination for cause, which not only would result in termination of the contract, but would also provide cause to forfeit the performance bond.
559	Adventist Health Systems	5					7	If respondent is a newly created entity or otherwise does not have experience with transitioning individuals from institutional to community settings, can respondent provide experience from affiliated or subcontracted entities to meet the requirements of this section	Experience or information relating to affiliated or subcontracted entities can only be used when specifically provided for in the SRC. There will be no change to this specification of the ITN.
560	Sunshine State Health Plan	5					7	Subpart a of the question asks for "Experience and strategies pertaining to deploying transition care teams and using evidence-based practices with support from other clinical resources and community based organizations." Please confirm that "other clinical resources" pertains to those clinical resources available within the MCO.	The plain meaning of other clinical resources should be used is preparing a response.
561	Sunshine State Health Plan	7					9	The question asks for a description of safeguards that will be in place "during implementation of the re-procurement of the SMMC program to ensure enrollees do not have to move out of their current residence." Please confirm that 'implementation of the reprocurement' refers to implementation of the new contract and continuity of setting for enrollees who must, or choose to, change health plans due to a change in contracted health plans in their Region.	Yes
562	Sean Schwinghammer	10					1	If a MCO or delegated authority authorizes a service and the service is rendered and then the same MOC or delegated authoirty rejects the claims based on an improper authorization, is that no longer considered a "clean claim" and therefore not subject to the timely payment requirements?	See Attachment B - Scope of Service - Core Provisions, Section I. Definitions and Acronyms, Sub-Section A. Definitions, Page 7

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563	Sean Schwinghammer	10					1	Are the payment timeframes to begin when a claim is received or after an MCO decided to pay the claim? Much of the claims data compiled by the Agency is inaccurate, as health plans' configuration systems reroute claims from pending to denial, recoupment, provider error, requiring more information, etc. As a results claims are not paid and providers suffer. Now the Agency has laid out very clear payment timlines, unfortunately what happens if a plan's configuration system fails to properly assign a claim as pending payment. Does the tiemframe still stay in effect and will penalties be charged to the plan based on the date the claim was initially received or after MCO discover the claims were misaligned in their system?	See Attachment B, Scope of Services, Core Provisions, Section VIII Provider Services, Sub-section E Claims and Provider Payment, Item 2. Timely Claims Payment; Attachment B, Scope of Services, Core Provisions, Section XIII Sanctions, Sub-section A Contract Violation and Noncompliance and Attachment B, Scope of Services and Section XIV Liquidated Damages, Sub-section B, Issues and Amounts, Item 70 Failure to Comply with Claims
564	Staywell (WellCare)	13					17	The Evaluation Criteria for Exhibit A-4-c, SRC #13, indicate that 5 points are available based on evidence presented "by contract, for the respondent's two (2) most recent contracts". How should a respondent who has several current contracts decide which is the "most recent"?	Recent should be based on the date of completion or, if ongoing, based on the due date of the ITN as long as there has been two years of performance.
565	Sunshine State Health Plan	13					17	LTC SRC #13 evaluation criteria # 3 states: "The degree to which the respondent provides evidence, data, or metrics to demonstrate the effectiveness of its approaches to staff retention, including staff tenure, by contract, for the respondents two (2) most recent contracts." Please confirm that "two (2) most recent contracts" relates only to the Respondent's contracts.	Correct.
EXHIBIT A-4-d SPECIALTY									
566	Community Care Plan	4					5	Is the intent of this SRC for the Plan to develop the criteria for enrollment for a specialty plan or for the Plan to validate the criteria the Agency has in place?	There will be no change to this specification of the ITN.
567	Community Care Plan							If a plan is submitting a response to service mulitple specialty populations, is it required to submit separate copies of exhibit A-4-b, and A-4-d for each specialty population?	Yes, Respondents must submit separate proposals for each plan type, including all certifications and statements, exhibits and attachments.
568	Community Care Plan	4					5	Can a specialty plan propose to use the existing criteria in place for identification of populations as reflected in the Data Book?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
569	Community Care Plan	4					5	Can AHCA proviide all algorithms or other identification processes for existing specialty populations covered under SMMC in the Procurement Library (ie Data Book)?	See Exhibit C-7 Statewide Medicaid Managed Care Data Book, MMA Appendix M-4, SMI Identification Memorandum See the current HIV/AIDS algorithm at http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Report_Guides/April_2017/HIV-AIDS_DM_Algorithm_10012017.xlsx
570	Variety Children's Hospital d/b/a Nicklaus Children's Hospital	1					1	Nicklaus Children's Hospital is an Essential Provider and also proposing the Specialty Plan for Chronically Ill Children. Does it receive additional points for its PSN contracting with itself since the vendor is the Essential Provider?	Points will be assigned as prescribed in Exhibit A-4-b-1 MMA SRC# 6 - Provider Network Agreements/Contracts (Regional)
571	Sunshine State Health Plan	2					3	This question asks about Care Coordination and Case Management for the proposed specialty population. Please confirm whether our response to other care coordination/management-related questions in Exhibits A-4-a and A-4-b (as applicable) should also include activities for the proposed specialty population or whether AHCA prefers all specialty population-specific information to be provided in the response to this question.	The Evaluation Criteria for these SRCs are clear.

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572	Sunshine State Health Plan	4					5	Evaluation Criteria Score for Item 2 (a) states: "20 points if the estimated size of the specialty population does not exceed ten percent (10%) of the estimated total population of MMA receipients" Please provide estimated total population of MMA recipients for the MCO's calculation.	For the current estimate, See Attachment A - Instructions and Special Conditions, Section A Overview, Sub-Section 14 Program Overview
					GENERAL QUESTIONS				
573	Sean Schwinghammer							Are Authorizations a guarantee of payment? MCOs decide to render services, MCOs authorize providers, MCO receive claims and MCO are supposed to pay claims, yet MCO often deny payments because they are 'improperly authorized', which is no fault of the provider. This is odd considering the MCO controls all aspects of the authorization. Is the Agency requiring that MCO and related companies that authorize services must pay for said services?	See Attachment B, Scope of Services, Core Provisions, Section VIII Provider Services, Sub-section E Claims and Provider Payment
574	Sean Schwinghammer							Are the payment timeframes to begin when a claim is received or after an MCO decided to pay the claim? Much of the claims data compiled by the Agency is inaccurate, as health plans' configuration systems reroute claims from pending to denial, recoupment, provider error, requiring more information, etc. As a result, claims are not paid and providers suffer. Now, the agency has laid out very clear payment timelines, unfortunately what happens if a plan's configuration system fails to properly assign a claim as pending payment. Does the timeframe still stay in effect and will penalties be charged to the plan based on the date the claim was initially received or after MCO discover the claims were misaligned in their system?	See Attachment B, Scope of Services, Core Provisions, Section VIII Provider Services, Sub-section E Claims and Provider Payment, Item 2. Timely Claims Payment
575	Sean Schwinghammer							What is the roll out schedule?	The Agency will determine the regional rollout schedule, including enrollee notification, at a later date.
576	Sean Schwinghammer							When MCO recoup payments without cause from other payments, what consequences will befall MCOs or their delegated payment authorities?	See Attachment B, Scope of Services, Core Provisions, Section XIII Sanctions, Sub-section A Contract Violation and Noncompliance and Attachment B, Scope of Services, Section XIV Liquidated Damages, Sub-section B, Issues and Amounts, Item 70 Failure to Comply
577	Sean Schwinghammer							Can Nurse Registries be used to render personal care in the Comprehensive program? Nurse Registries are licensed entities that provide personal care services in Florida. Due to its licensing structure and the flexibility of workers, Nurse Registries normally provide less expensive personal care services, therefore the question was asked above.	For MMA enrollees, no. See Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required MMA Benefits, Item 1. Specific MMA Services to Be Provided, Sub-Item a. For LTC enrollees, yes. See Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required LTC Benefits, Item 2. Specific LTC Services to Be Provided, Sub-Item a.
578	Sean Schwinghammer							How can a reliable company be it a MCO or delegated authority, offer a single percentage off of the Medicaid fee Schedule as a set price for all providers? Networks and MCOs alike are offering single rate pricing for all items on the DME fee schedule, with no acknowledgement that the differential in pricing among items is vast. For example, the manufacture's cost of an ostomy item is above the price listed on the current DME fee schedule while a provider can make a profit on certain oxygen related items at 55% of the current fee schedule. The pricing is variable and without volume certainty, reliable companies cannot accept such pricing.	The terms of the solicitation regarding payments remain unchanged.

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579	Sean Schwinghammer							What has the Agency done to assure that the data regarding Durable Medical Equipment Services is accurate, as we question the costs listed for being far too low compared to the actual cost of services? The data regarding Durable Medical Equipment, like all data is based upon claims data. As primary providers of DME services in LTC and MMA, currently, we are aware that many MCOs have not paid their providers timely, have not collected proper data regarding codes and payments, have erroneously issued recoupments due to their own system errors, and are holding millions of dollars in provider owed funds not reflected in their claims data. This issue was raised at preliminary ITN meetings. Now we see that the data used to craft the ITN reflects overall pricing well below the actual cost of services performed daily by DME providers. The result of this is that MCO's, PSNs and other groups not currently involved with the SMMC program will budget far below the cost of actual DME, driving down pricing unfairly. This is an untenable situation for legitimate providers.	There will be no change to this specification of the ITN.
580	Adventist Health Systems							Can the State provide any guidance on the preferred way to reflect investment and start-up costs in the administrative cost portion of the cost application? In addition, what allowances are there for differences between the pro forma projections submitted with the ITN and the administrative costs identified in the cost application? (e.g., inclusion and exclusion of the HIT, amortization of start-up costs past year 3 of the point of profitability)?	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
581	Adventist Health Systems							Can the State provide any guidance on the rate that the population is transitioning to SMI status? For example, as more enrollees have attained SMI status has the percentage of the population identified as SMI stabilized?	The respondent should respond in the manner that it believes best responds to the requirements of the ITN.
582	Adventist Health Systems							S. 409.966(3)(d) requires that rates produce savings of 5% compared to Medicaid rates for the same population in the same area in the prior period. This requirement would seem to require savings at 5% regardless of influence of trend. Does the 5% savings target take into consideration secular trend? Does this savings guarantee in the statute serve as a maximum allowable capitation rate for organizations responding to the ITN? Please confirm that this 5% savings does not extend past the first year of the new five year negotiation period.	The Initial 5% savings anticipated in s. 409.966(3)(d), F.S., only applied to the first issuance of the MMC contracts. The ITN contains the only criteria that will be subject to negotiation related to savings.
583	Adventist Health Systems							If a bidder is not expecting to provide a separate bid on the dental managed care contract, will it be scored lower if it does not offer expanded dental benefits (relative to other bidders that might bid on both contracts)? If so, it would seem that there is a strong incentive for MMA bidders to offer coverage of the expanded dental benefits even if some other entity takes risk for the core dental services for their covered services. This would also seem to create administrative challenges with claims processing as members seek core and expanded services with a provider. Please confirm that we have understood this provision and its subsequent challenges correctly.	Respondents should submit their best terms and conditions in order to maximize chances of receiving the highest possible number of points and best value.
584	Variety Children's Hospital d/b/a Nicklaus Children's Hospital							Can a party which submitted an LOI in February form a new entity which is controlled by the LOI sponsor to respond to the ITN?	Yes
585	Variety Children's Hospital d/b/a Nicklaus Children's Hospital							Can a party which did not submit a non-binding LOI in February be considered for contract award?	Yes
586	Variety Children's Hospital d/b/a Nicklaus Children's Hospital							Is an entity related to the LOI respondent allowed to submit the ITN response in place of the LOI sponsor and still be considered?	Yes
587	Variety Children's Hospital d/b/a Nicklaus Children's Hospital							Are there any points awarded for submitting the LOI in February?	No

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588	Variety Children's Hospital d/b/a Nicklaus Children's Hospital							Can a party which did not submit a non-binding LOI in February be favorably ranked against a party which did submit an LOI?	Yes
589	Variety Children's Hospital d/b/a Nicklaus Children's Hospital							Please confirm the diagnoses AHCA wants included in the Specialty Plan for Chronically Ill Children, as a minimum.	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
590	Variety Children's Hospital d/b/a Nicklaus Children's Hospital							As a Specialty Plan for Chronically Ill Children, may we add additional diagnoses to the minimum required by AHCA?	See Attachment A, Exhibit A-4-d, Specialty Submission Requirements and Evaluation Criteria, Section C. Recipient Experience, Specialty SRC #4: Eligibility and Enrollment.
591	Variety Children's Hospital d/b/a Nicklaus Children's Hospital							Is there a maximum limit as to the length of any individual SRC response?	No. However, respondents shall comply with Attachment A - Instructions and Special Conditions, Section C. Response Submission Requirements, Sub-Section 1. Hardcopy and Electronic Submission Requirements, Item b.3).
592	Florida Council for Community Mental Health							Will the Agency-approved algorithm to identify the population eligible for enrollment in a Serious Mental Illness (SMI) specialty plan continue to use the current SMI diagnosis codes and list of medications used to treat SMI? (Statewide Medicaid Managed Care Data Book, Attachment M4)	There will be no change to this specification of the ITN.
593	Florida Council for Community Mental Health							Will minors who meet SMI diagnosis/medication criteria be assigned to an SMI specialty MMA plan? The SMI algorithm does not include age specific criteria (SMMC databook attachment M4), however, there does not appear to be a rate cell for TANF and SSI - SMI younger than 5-14yrs (SMMC data book, page 13) What ages will be assigned to an SMI Specialty Plan? (SMMC databook attachment M4) (SMMC databook, page 13)	Respondents submitting a bid as Specialty plans will propose the populations they wish to serve. See Exhibit A-4-d, Specialty SRC# 4. In accordance with Section 409.977(1), Florida Statutes, the Agency will assign enrollees into a Specialty Plan in a region, if there is Specialty Plan available for which the enrollee meets all eligibility criteria (based upon age, diagnosis, and/or condition).
594	Simply Healthcare							While the ITN does not ask for it, would the state allow bidders to submit an Executive Summary?	No.
595	Simply Healthcare							Please confirm that the Agency intends to once again honor prior plan affiliation of the member and that members currently or historically being served by a plan will be assigned back to that plan in the new SMMC roll out? Additionally, for existing managed care plans that have legally consolidated/merged with another existing plan during the SMMC 2014-2019 contract period, please confirm that for those MMA enrollees that do not make an active plan choice into an existing plan, the Agency will recognize the merger of one existing plan ("Merging Exiting Plan") into another existing plan ("Surviving Existing Plan") and assign the enrollees to that Surviving Existing Plan that was awarded a contract in the same region where the Merging Existing Plan operated.	See Attachment A, Instructions and Special Condition, Section E. Contract Implementation, Sub-section 4. Transition Enrollment.
596	Simply Healthcare							Regarding Exhibit A-8, Standard Contract, Section I, Subsection K Background Screening, the contract requires that all plan employees, including managing employees that have access to member PHI, PII, or financial information, undergo a county, State and Federal Background screening comparable to a level 2 Background screening; prior to being employed; and every 5 years. Please confirm that this language is not limited to managing employees, as in previous contracts.	See Attachment B - Scope of Services - Core Provisions, Section XV Special Terms and Conditions, Sub-Section C. Ownership and Management Disclosure.
597	Simply Healthcare							Current MMA contracts are valid through January of 2019. How will the Agency handle the overlap effective dates if execution of new contracts occur before January 2019?	The contracts for current health plan contracts would be amended to reflect an end date that would coincide with the effective end of their operations and the effective date of the new contracts.
598	Simply Healthcare							Many providers are not willing to sign a contract until the award, what documentation can support efforts (i.e. LOA, LOI, etc.)?	For the purpose of evaluating this SRC we will count Contract Agreements, LOA & LOI.

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599	Quintairos, Prieto, Wood & Boyer							In general, for the vignettes, what is AHCA's preferred response format?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
600	Quintairos, Prieto, Wood & Boyer							What additional licenses or permits are required if a Respondent to the ITN is currently under contract with AHCA for the Medicaid Managed Care Program and would like to submit an ITN response for an additional Region in which the Respondent is not currently contracted?	Awardees are expected to have all licenses or permits required by law. Moreover, in Florida those who contract with the government are presumed to know the law.
601	Quintairos, Prieto, Wood & Boyer							When should a Medicaid Provider Expansion Application be submitted for a Respondent to the ITN that is currently under contract with AHCA for the Medicaid Managed Care Program and would like to be eligible to submit ITN responses in Regions in which the Respondent is not currently contracted	See Exhibit A-2-a - Qualification of Plan Eligibility, Section 2 Qualification of Plan Eligibility. A current HMO is only required to be qualified in one county in order to submit a response.
602	Quintairos, Prieto, Wood & Boyer							Currently, the General Performance Measurement Tool and Standard CAHPS Measurement Tool spreadsheets provide point values for non-numeric responses. Is this an accurate understanding of the scoring methodology in these spreadsheets?	Both the General Performance Measurement Tool and the Standard CAHPS Measurement Tool are spreadsheets where respondents will input their performance measure and CAHPS survey data as decimal values in XX.XX format
603	Sunshine State Health Plan							If a respondent is bidding as a specialty plan, it is our understanding that we respond to the General SRCs, MMA SRCs and Specialty SRCs. However, some of the SRCs in the General and MMA would not apply to a pediatric population such as for Child Welfare. If a Respondent is bidding as a Specialty Plan for a child population, please confirm that we do not need to respond to questions that clearly pertain to adult populations. Examples include, General SRC #8, General SRC #25, MMA SRC #19. If the Respondent is not required to respond to certain SRCs as indicated above, please confirm the Respondents score would be adjusted to reflect these changes.	There will be no change to this specification of the ITN.
604	Sunshine State Health Plan							Can AHCA please confirm when a Respondent is submitting a ITN proposal as a Comprehensive Plan (completing Exhibits A-4-a, A-4-b and A-4-c) and as a Specialty Plan (completing exhibits A-4-a, A-4-b and A-4-d) that for the Specialty Plan proposal, the Respondent can submit an identical response for Exhibits A-4-a and A-4-b as the Respondent provided for the Comprehensive Plan proposal.	Yes. However, the Respondent should utilize the form of response that it believes best responds to the requirements of the ITN.
605	Sunshine State Health Plan							Will AHCA consider adjusting the 11/1 moritorium on subcontractor changes so as to allow the inclusion of expanded benefits proposed to be managed through a subcontractor. For example, adult dental benefits.	The moratorium on subcontractor changes is applicable to the current SMMC program, not this ITN.
606	Sunshine State Health Plan							How will the program handle retroactive eligibility (either new members, or members changing aid categories)? Who is at risk for retroactive costs and if the MCOs are at risk, how will they be compensated in the case of high-cost retroactive claims?	The Agency intends to negotiate actuarially sound capitation rates.
607	Sunshine State Health Plan							When does AHCA intend to rebase rates for rate periods after the first year of the contract? How often will rates be rebased?	There will be no change to this specification of the ITN.
608	Sunshine State Health Plan							Given the volume of data and material that must be understood and the very complex bidding requirements, will AHCA please consider another round of Q&A? Even if in a conference call or meeting format (rather than written) we believe it would be helpful and appreciated by the bidding health plans.	See Attachment A - Instructions and Special Conditions, Section A. Overview, Sub-Section 10. Respondent Questions, Item e.
609	Sunshine State Health Plan							Does the pricing of expanded benefits require actuarial certification?	"Respondents should exclude expanded benefits from the MMA Claim Cost or LTC Service Cost. See Attachment C - Cost Proposal Instructions and Rate Methodology Narrative, Section II. MMA Cost Proposal Template Instructions, Sub-Section D. MMA Base Data Adjustments, Item 1. Expanded Benefit Adjustment."

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610	Sunshine State Health Plan							If a health plan is responding as a comprehensive plan, which requires responding to SRCs in Exhibit A-4-a, A-4-b and A-4c, they are held to the same packaging standards (hard copy responses shall be bound individually and submitted in up to three (3), three-inch binders) as a health plan bidding as a Long-Term Care Plus Plan or a MMA health plan even though Comprehensive Plans are required to respond to three of the A-4 exhibits whereas the others are only required to respond to two of the A-4 exhibits. Would AHCA consider either increasing the binder size or allowing an additional binder for health plans bidding as a comprehensive plan?	No.
611	Interested Party Florida Health 2017							There are only a few items that require prior auth on the Durable Medical Equipment and Medical Supply Services Fee Schedule. Can a respondent require prior authorization on more items than those reflected on the current fee schedule? If so, are there any limitations to the number of items that a respondent can require a prior auth?	Yes. See Attachment B - Scope of Service - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits, Item 1. General Provisions, Sub-Item d. and Sub-item .e.(1).
612	Interested Party Florida Health 2017							Are respondents required to give providers retroactive authorizations to cover new service requests provided afterhours and on weekends?	See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section D. Provider Services, Item 4. Toll-Free Provider Helpline See Section VI. Coverage and Authorization of Services, Sub-Section G.Authorization of Services, Item 2. Utilization Management Program Description and Item 3. Service Authorization System.
613	Interested Party Florida Health 2017							Can a respondent deny payment for no prior authorization for a service when the Medicaid fee schedule does not require a prior authorization for said service?	See Attachment B - Scope of Service - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits, Item 1.General Provisions, Sub-Item d. and Sub-Item e.(1).
614	Interested Party Florida Health 2017							Under what circumstances can AHCA change a beneficiary from another plan to the respondents plan, or vice versa, within the same month?	See Attachment B - Scope of Service - Core Provisions , Section III. Eligibility and Enrollment, Sub-Section D. Disenrollment. See Exhibit B-2. Long-term Care (LTC) Program, Section III. Eligibility and Enrollment, Sub-Section D. Disenrollment.
615	Interested Party Florida Health 2017							The beneficiary's plan changed after the first of the month. If the beneficiary's effective date is retroactive back to the first of the month, are respondents required to give a retroactive authorization back to the beneficiary's new effective date? If the beneficiary's effective date is not retro'd back to the first of the month, are respondents required to give authorization as of the beneficiary's new effective date?	See Attachment B - Scope of Service - Core Provisions, Section IX. Quality, Sub-Section H. Continuity of Care in Enrollment. See Exhibit B-1. Managed Medical Assistance (MMA) Program, Section IX. Quality, Sub-Section H. Continuity of Care in Enrollment. See Exhibit B-2. Long-Term Care (LTC) Program, Section IX. Quality, Sub-Section H. Continuity of Care in Enrollment.
616	Interested Party Florida Health 2017							Can the respondent's claim timely filing deadline be less than the 1 year as permitted by Medicaid?	For non-Medicare claims, yes. See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section E. Claims and Provider Payment, Item 1. General Provisions, Sub-Item h.

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617	Interested Party Florida Health 2017							Can the respondent require billing modifiers that are not required by the Medicaid fee schedule?	Yes. See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section C. Provider Credentialing and Contracting, Item 5. Provider Agreement Requirements, Sub-Item c.(5). See Attachment B - Scope of Services - Core Provisions, Section XV. Special Terms and Conditions, Sub-Section H. Agency Contract Management, Item 2.
618	Interested Party Florida Health 2017							Can the respondent cap certain DME rental items that are not capped by the Medicaid fee schedule?	No. See Attachment B - Scope of Services - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits, Item 1. General Provisions, Sub-Item d. and Sub-Item e.(1).
619	Interested Party Florida Health 2017							Does the respondent have to pay providers for "By Report" items and other items that have a $0 reimbursement listed on the Durable Medical Equipment fee schedule?	See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section C. Provider Credentialing and Contracting, Item 5. Provider Agreement Requirements; Exhibit B-1. Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required MMA Benefits, Item 1. Specific MMA Services to Be Provided, Sub-Item a.; and Exhibit B-2. Long-term Care (LTC) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required LTC Benefits, Item 2. Specific LTC Services to Be Provided, Sub-Item a., incorporating Rules 59G-4.070 and 59G-4.002 by reference.
620	Interested Party Florida Health 2017							If Medicaid pays "Cost Plus" for some $0 reimbursement items listed on the Durable Medical Equipment fee schedule, what reimbursement methodology is the respondent required to follow?	See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section C. Provider Credentialing and Contracting, Item 5. Provider Agreement Requirements; Exhibit B-1. Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required MMA Benefits, Item 1. Specific MMA Services to Be Provided, Sub-Item a.; and Exhibit B-2. Long-term Care (LTC) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required LTC Benefits, Item 2. Specific LTC Services to Be Provided, Sub-Item a., incorporating Rules 59G-4.070 and 59G-4.002 by reference.
621	Interested Party Florida Health 2017							Please clarify for respondent if the rate listed in the DME Medicaid Fee Schedule is a daily rate or a monthly rate for E0619 and E0202?	See Exhibit B-1. Managed Medical Assistance (MMA) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required MMA Benefits, Item 1. Specific MMA Services to Be Provided, Sub-Item a. and Exhibit B-2. Long-term Care (LTC) Program, Section VI. Coverage and Authorization of Services, Sub-Section A. Required LTC Benefits, Item 2. Specific LTC Services to Be Provided, Sub-Item a., incorporating Rules 59G-4.070 and 59G-4.002 by reference.

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622	Interested Party Florida Health 2017							How frequently can a respondent change their prior authorization, documentation, billing, and process requirements?	See Attachment B - Scope of Service - Core Provisions, Section VIII. Provider Services, Sub-Section C. Provider Credentialing and Contracting, Item 5. Provider Agreement Requirements, Sub-item c(5) See Attachment B - Scope of Service - Core Provisions, Section XV. Special Terms and Conditions, Sub-Section H. Agency Contract Management, Item 2.
623	Interested Party Florida Health 2017							Can respondent require a prior authorization for a therapy evaluation or re-evaluation when a prior authorization is not required by Medicaid for said services?	Yes. See Attachment B - Scope of Service - Core Provisions, Section VI. Coverage and Authorization of Services, Sub-Section A. Required Benefits, Item 1. General Provisions, Sub-Item d. and Sub-Item e.(1).
624	AHF Florida MCO							May a standard plan also apply as a Specialty Plan by contracting with a Specialty Plan as a vendor to fulfill the Specialty Plan requirements?	The Respondent should utilize the form of response that it believes best responds to the requirements of the ITN. Respondents must submit separate proposals for each plan type, including all certifications and statements, exhibits and attachments.
625	Molina Healthcare of Florida							Would the Agency consider allowing respondents to use regular Word templates for responding to Exhibit A-4 (the Statewide and Regional SRCs) rather that the Agency issued templates with the form fields? If we are allowed to use our own templates, we would be able to format the text for the convenience of the reviewers.	No.
626	Humana							Please confirm the county compositions of all 11 SMMC Regions referenced in the ITNs are the same as the 11 SMMC Regions defined in Florida Statute 409.966.	Confirmed.
627	Florida True Health, Inc. d/b/a Prestige Health Choice							Will the Insolvency Protection Account from 2014 - 2018 contract be held until all the run out is complete?	See Attachment B - Scope of Services, Section XII. Financial Requirements Sub-section A. Insolvency Protection 1. Insolvency Protection Requirements Item d.
628	Florida True Health, Inc. d/b/a Prestige Health Choice							Will ACHA require new Insolvency Protection Accounts and separate funding for the 2018-2023 contract for plans that already have existing insolvency accounts in place?	Plans currently contracted with the Agency and selected for participation in the next contract period will be allowed to transition their insolvency protection accounts with Agency approval. The insolvency protection account will be required to be funded in accordance with Attachment B - Scope of Services, Section XII. Financial Requirements Sub-section A. Insolvency Protection 1. Insolvency Protection Requirements.