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## SCORED SUBMISSION REQUIREMENTS & EVALUATION CRITERIA INSTRUCTIONS

Instructions to Respondents for the Completion of **Exhibit A-5-V3** and the Associated Attachments

All respondents to this solicitation shall utilize **Exhibit A-5-V3** for submission of its response as specified in **Attachment A**, Instructions and Special Conditions, **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item f.**, Submission Requirements and Evaluation Criteria. Respondents shall adhere to the instructions below for each Submission Requirement Component (SRC).

The Agency reserves the right to utilize any or all the respondent’s response materials, documents, and information in negotiations.

Order of Contract Selection

The respondent’s submissions for all Submission Requirements and Evaluation Criteria (SRC) pertaining to prior contract experience will utilize the same three (3) contracts throughout, based on information input by the respondent in **Exhibit A-5-a-V3,** Respondent Information tab. This information will be auto-populated into all other relevant SRC templates included in **Exhibit A-5-a-V3**. The respondent must use these same three (3) contracts in all SRCs pertaining to prior contract experience, unless otherwise specified in an SRC.  The respondent shall select contracts chosen in the order described below. If the respondent (including the respondent’s parent, affiliate(s), or subsidiary(ies)) has multiple contracts within the same numbered category, all contracts in that category, ordered from the greatest to the least number of enrollees, must be chosen before any contracts in the next category can be selected.

1. Florida Medicaid managed care contracts
2. Contracts with another state’s Medicaid managed care program
3. Florida Child Health Insurance Program (CHIP) managed care contracts
4. CHIP managed care contracts with another state
5. Medicare managed care contracts (any state)

Completion of Responses

Respondents shall not include website links, embedded links, and/or cross references between SRCs.

Certain SRCs contain form fields. Population of the form fields with text will allow the form to expand and cross pages. Unless specified in the SRC, there is no character limit. For SRCs with character limits, character counts are inclusive of spaces and exclusive of attachments. Text responses must be formatted for 8-1/2” x 11” paper, single-spaced, and in a size 11 Arial font. Attachments may be formatted for pages larger than 8.5” x 11” but no larger than 11” by 17” paper.

Attachments are acceptable for any SRC response with a form field but must be referenced in the form field for the respective SRC and located behind each respective SRC response. Respondents shall name and label attachments to refer to respective SRCs by SRC identifier number.

The Agency reserves the right to utilize any or all the respondent’s response materials, documents, and information in negotiations.

The SRCs in **Exhibit A-5-V3,** Scored Submission Requirements and Evaluation Criteria, may not be retyped and/or modified and must be submitted in the original format.

The SRCs in **Exhibit A-5-V3, Exhibit A-5-a-V3,** the associated autoscoring procurement intake tools, **Exhibit A-5-b**, MMA SRC# 22 – Provider Network Tool, and **Exhibit A-5-c-V3,** LTC SRC# 22 – Provider Network Tool, may not be retyped and/or modified and must be submitted in the original format.

**Exhibit A-5-a-V3, Exhibit A-5-b**, and **Exhibit A-5-c-V3** are available for respondents to download at:

<https://ahca.myflorida.com/procurements>.

**FAILURE TO SUBMIT EACH REQUIRED FORM IN ITS ORIGINAL FORMAT MAY RESULT IN REJECTION OF THE RESPONSE.**

**FAILURE TO SUBMIT AN SRC MAY RESULT IN REJECTION OF THE RESPONSE.**

**FAILURE TO SUBMIT EACH REQUIRED SRC TEMPLATE IN ITS ORIGINAL FORMAT MAY RESULT IN REJECTION OF THE RESPONSE.**

Scoring of the Responses

Each Evaluator Scored SRC includes a description of the Standard Evaluation Criteria Scale and scoring methodology in the Scoring section of the SRC.

Each Autoscored SRC includes a description of the scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, on the SRC-specific Scoring tab (e.g., Scoring-Managed Care Exp).

**FAILURE TO SUBMIT EACH REQUIRED SRC TEMPLATE IN ITS ORIGINAL FORMAT MAY RESULT IN REJECTION OF THE RESPONSE.**

**FAILURE TO SUBMIT EACH REQUIRED FORM IN ITS ORIGINAL FORMAT MAY RESULT IN REJECTION OF THE RESPONSE.**

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**RESPONDENT NAME:**

# INCENTIVIZING VALUE AND QUALITY

## SRC# 13 – Value-Based Purchasing (VBP): AUTOSCORED

For the three (3) contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall provide its experience in Value-based purchasing (VBP). VBP contracts between health plans and providers are intended to maximize high value care, reduce inappropriate care, and reward best-performing providers. The respondent shall provide the following information:

1. For each VPB contract:
   1. Official Contract Number from the Order of Contract Selection (select from drop-down menu)
   2. State where the VBP contract was executed
   3. Line of Business (e.g., Medicaid, CHIP, Medicare)
   4. Calendar Year when the VBP contract was executed (select from drop-down menu)
   5. Total Enrollee Count in the State Contract
   6. Total Claim-Based Expenditures for all Enrollees in the State Contract
   7. VBP Contract Title (optional)
   8. VBP Model Type (select from drop-down menu)
   9. VBP contract number
   10. LAN Category (chosen from the Alternate Payment Model Framework by the Learning Action Network)
   11. Each Florida Region where the VBP contract took place (select all that apply from drop-down menu)
   12. Description of the VBP contract (maximum 1,000 characters including spaces)
   13. Number of Providers in the VBP contract
   14. Attributed Enrollee Count in the VBP contract (including overlap, LAN 2A+). Total count of enrollees (member months/12) within the calendar year that attribute to the VBP provider(s) and meet the enrollee qualifications under the VBP contract. Enrollees can attribute to more than one contract within the calendar year. For example, in the same year, an enrollee may attribute to one provider in a quality VBP contract and to another provider in an episode-based VBP contract.
   15. Attributed Enrollee Count in the VBP contract (excluding overlap, LAN 2A+). Unique count of enrollees (member months/12) within the calendar year that attribute to the VBP provider(s) and meet the enrollee qualifications under the VBP contract. Enrollees cannot attribute to more than one VBP contract within the calendar year. If an attributed enrollee is in more than one VBP contract, then only include them in the highest LAN Category VBP contract for the calendar year. If the overlapping LAN Categories are the same, then choose any one.
   16. Total VBP Rewards Paid to Providers in the VBP contract defined as non-claim-based payments to a provider that can be classified as VBP LAN 2A+.
   17. Total VBP Penalties Paid by Providers in the VBP contract.
   18. Total VBP Capitation Paid to Providers in the VBP contract. Capitation is defined as when a PMPM payment is made in place of fee-for-service (*i.e.*, claim payments are delegated to the provider).
   19. Measured Claim-Based Expenditures for Attributed Enrollees in the VBP Contract (include overlap, LAN 3A+ only).
   20. Measured Claim-Based Expenditures for Attributed Enrollees in the VBP Contract (excluding overlap, LAN 3A+ only).
   21. Total Claim-Based Expenditures for Attributed Enrollees (including overlap, LAN 3A+ only) defined as all claim-based expenditures of the attributable enrollees whether or not the cost is included in the VBP contract.
   22. Total Claim-Based Expenditures Billed by Providers defined as all claim-based expenditures billed by the provider(s) subject to the VBP contract on both attributed and non-attributed Medicaid enrollees.

**Note:** For purposes of this SRC, LAN 2A+ includes LAN 2A, 2B, 2C, 3A, 3B, 4A, 4B, and 4C, and LAN 3A+ includes LAN 3A, 3B, 4A, 4B, and 4C.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Value Based Purchasing tab, located at <https://ahca.myflorida.com/procurements>, to provide its VBP responses.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent of three (3)-year average percentage of attributed enrollees in a LAN 2A+ VBP agreement.
2. The extent of three (3)-year average percentage of claim-based expenditures in LAN 3A+ VBP agreements.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Value Based Purchasing tab.

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## SRC# 14 – Expanded Benefits – Medical and Long-Term Care: AUTOSCORED

Section 409.966 (3) (a) 6., Florida Statutes (F.S.)

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

6.  Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

Expanded benefits are benefits covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency.

1. The respondent shall identify expanded benefits it proposes to offer its enrollees and submit the per member per month (PMPM) cost of each expanded benefit for the following:
2. Over the Counter (OTC) medications and supplies
3. Adult visual aid services
4. Adult additional primary care services
5. Prenatal services
6. Durable Medical Equipment (DME) services and supplies
7. Physical therapy for adults
8. Newborn circumcision
9. Hearing services for adults
10. Occupational therapy for adults
11. The respondent shall propose additional expanded benefits for the following:
12. Pregnant women.
13. Children and adolescents with a serious mental illness and/or substance use disorder.
14. Enrollees in a home or community-based setting, such as enrollees with developmental disabilities, familial dysautonomia, or residing in long-term care settings.
15. Enrollees living with HIV.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Expanded Benefits tab, and **Exhibit A-5-a-1**, Expanded Benefits – Medical and LTC, located at <https://ahca.myflorida.com/procurements>, to provide information on its proposed Expanded Benefits.

The respondent shall submit supporting documentation that includes the calculations used to determine each PMPM cost, and the data source(s) used for the calculations (e.g., previous SMMC experience, commercial experience).

**Evaluation Criteria:**

1. The extent of the respondent’s commitment to offer expanded benefits to its enrollees.

**Score:**  See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Expanded Benefits tab, for Items 1 and 2, and **Exhibit A-5-a-1**, Expanded Benefits – Medical and LTC, for Item 2.

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## SRC# 15 – Birth Outcomes: AUTOSCORED

For its **proposed provider network**, the respondent shall provide evidence relative to improving birth outcomes for mothers and infants.

* 1. The respondent shall provide data to support its provider network adequacy and demographics:

1. Number of obstetrician (OB) physicians in network that have specialty certification in Maternal Fetal Medicine (MFM) at the time of application submission.
2. Average rate of Nulliparous, Term, Singleton, Vertex (NTSV) C-Section births in CY2022.
3. Number of OB physicians in network who prescribed Medication Assisted Treatment (MAT) drugs/therapies during CY 2022.
4. Percent of OB physicians in network that are Black women.
5. Percent of OB physicians in network that are Hispanic women.
6. Percent of OB physicians in network who fluently speak English and Spanish
7. Percent of OB physicians in network who submitted at least one Medicaid claim for Screening, Brief Intervention, and Referral to Treatment (SBIRT) (procedure codes H0049 and H0050, 99408, 99409, G0396, and G0397) in CY2022.
8. Percent of OB physicians in network who had a value-based purchasing agreement with a Medicaid health plan in CY2022.
   1. The respondent shall provide data regarding the organizations that the respondent is actively engaged with to improve maternal health outcomes:
9. Number of contracts with Healthy Start Coalitions and Early Steps programs.
10. Percent of in-network hospitals that are participating in the Florida Perinatal Quality Collaborative’s (FPQC) Quality Initiatives below:
    1. Postpartum Access & Continuity of Care (PACC) Initiative
    2. Perinatal Quality Indicators (PQI)
    3. Social Determinants of Health (SDOH) Initiative
    4. PAIRED Initiative – Family Centered Care in the NICU

For the **three contracts** identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall provide evidence relative to improving birth outcomes for mothers and infants.

* 1. The respondent shall provide data regarding the extent to which the respondent has utilized doula services or midwives:

1. Average percent of pregnant women in CY2022 receiving at least two in-person visit by a doula.
2. Average percent of pregnant women in CY2022 receiving at least one in-person visit by a midwife.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Birth Outcomes tab, located at <https://ahca.myflorida.com/procurements>, to provide its Birth Outcomes responses.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent of OB physicians in network with MFM specialty certification.
2. The extent of OB physicians in network with C-section rates below 30%.
3. The extent of OB physicians in network who prescribed MAT drug/therapies during CY 2022.
4. The extent of OB physicians in network who have experience with SBIRT.
5. The extent of OB physicians in network that are Black women.
6. The extent of OB physicians in network that are Hispanic women.
7. The extent of OB physicians in network who fluently speak English and Spanish.
8. The extent of OB physicians in network who had a value-based purchasing agreement in CY 2022 with any Medicaid managed care plan.
9. The extent of Healthy Start Coalitions with which the respondent has a signed agreement for services at the time of response submission.
10. The extent of in-network hospitals that are participating in two or more of Florida Perinatal Quality Collaborative’s (FPQC) Quality Initiatives.
11. The extent of pregnant women in CY2022 receiving at least two in-person visits by a doula.
12. The extent of pregnant women in CY2022 receiving at least one in-person visit by a midwife.

**Score:**  See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Birth Outcomes tab.

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## SRC# 16 – Chronic Disease Management (DM) Program: AUTOSCORED

Section 409.966 (3) (c) 4. & 5., F.S.

(c)  After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

4. Have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings.

The goal of a chronic disease management program is to reduce the physical, mental, and economic burdens of chronic diseases by identifying and treating conditions swiftly and effectively, thereby preventing disease, reducing disease severity, or slowing disease progression. Statewide Medicaid Managed Care (SMMC) plans are required by Florida statute to implement chronic disease management programs for people with cancer or diabetes (Section 409.966, F.S.). The respondent shall detail its experience and proposed approach to implementing chronic disease management for a population of people with low socioeconomic resources.

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall identify whether it implemented a chronic disease management program for the following diseases:

1. Cancer
2. Depression
3. Diabetes (type 1 or type 2)
4. Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS)
5. Anxiety disorders
6. Asthma
7. Attention deficit hyperactivity disorder
8. Bipolar disorder
9. Cardiovascular Disease
10. Chronic Kidney Disease
11. Chronic Obstructive Pulmonary Disease
12. Dementia
13. End Stage Kidney Disease
14. Hypertension
15. Osteoporosis
16. Parkinson’s Disease
17. Sickle Cell Disease
18. Substance use disorders

The respondent shall submit the following supporting documentation about the chronic disease management programs:

1. Cancer
   1. Total number of enrollees with cancer.
   2. Total number of enrollees who participated in a chronic disease management program for cancer.
   3. Percent of enrollees with cancer who participated in a chronic disease management program for cancer.
2. Diabetes
   1. Total number of enrollees with diabetes (type 1 and type 2).
   2. Total number of enrollees who participated in a chronic disease management program for diabetes (choose the program with highest participation).
   3. Percent of enrollees with diabetes (type 1 and type 2) who participated in a chronic disease management program for diabetes (choose the program with highest participation).

The respondent shall submit supporting documentation about each chronic disease management program identified, including at a minimum, the following information:

1. Total number of providers broken down by provider type who participated in the chronic disease management program interventions.
2. Clinical and demographic characteristics of the chronic disease management participants compared to the chronic disease management target population.
3. List of implemented intervention types.
4. Results of the chronic disease management program including quantitative and qualitative data showing trends in quality indicators, comparison of quality indicators to target goal, and comparison of quality indicators to state or national standards or benchmarks.
5. Barriers encountered, such as healthcare team issues, communication issues, non-adherence, technology issues, medication issues, support system issues, transportation issues, financial issues, decline in clinical condition, external factors, and knowledge deficit.
6. Mitigation strategies used to address barriers such as culturally appropriate materials, new provider relationships or communication methods, new information technology solutions, new relationships with community-based organizations, etc.

**Note:** Pursuant to Section 409.966(3)(c)4. and 5., F.S., response to this submission requirement will be considered for negotiations.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, located at <https://ahca.myflorida.com/procurements>, Chr Disease Management tab, to provide information on its proposed Chronic Disease Management Program.

**Evaluation Criteria:**

1. The extent of chronic disease management programs implemented per contract.
2. The extent of enrollees with cancer who participated in a chronic disease management program for cancer.
3. The extent of enrollees with diabetes (type 1 and type 2) who participated in a chronic disease management program for diabetes.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Chr Disease Management tab.

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## SRC# 17 – HEDIS Measures: AUTOSCORED

Section 409.966 (3) (a) 5., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:   
5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

Section 409.967 (2) (f) 2., F.S.

(f) Continuous improvement. —The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.   
2. Each managed care plan must collect and report the Healthcare Effectiveness Data and Information Set (HEDIS) measures, the federal Core Set of Children’s Health Care Quality measures, and the federal Core Set of Adult Health Care Quality Measures, as specified by the agency. Each plan must collect and report the Adult Core Set behavioral health measures beginning with data reports for the 2025 calendar year. Each plan must stratify reported measures by age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income beginning with data reports for the 2026 calendar year. A plan’s performance on these measures must be published on the plan’s website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the measures as a tool to monitor plan performance.

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent (including respondent’s parent, affiliate(s), or subsidiary(ies)) shall provide its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include, in table format, the target population (e.g., TANF, ABD, dual eligible, Medicaid expansion), the geographic area of the Contract (statewide vs. not statewide), the respondent’s results for the HEDIS measures specified below for each of last three (3) years (measurement/calendar year (MY/CY) 2019, MY/CY 2020, and MY/CY 2021) for the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**).

The respondent shall provide the data requested in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, HEDIS Measures tab to provide results for the following HEDIS Health Plan and Long-term Services and Supports (LTSS) measures:

**HEDIS Health Plan Measures**

* Adults’ Access to Preventive/Ambulatory Health Services – Total
* Adherence to Antipsychotic Medications for Individuals with Schizophrenia
* Antidepressant Medication Management – Acute Phase
* Asthma Medication Ratio – Total
* Child and Adolescent Well-Care Visits – Ages 3-11 (2020 and 2021 only)
* Child and Adolescent Well-Care Visits – Ages 12-17 (2020 and 2021 only)
* Child and Adolescent Well-Care Visits – Ages 18-21 (2020 and 2021 only)
* Childhood Immunization Status – Combo 3
* Comprehensive Diabetes Care – HbA1c Control (<8%)
* Controlling High Blood Pressure
* Follow-up after Hospitalization for Mental Illness – Total – 7-day Follow-up
* Immunizations for Adolescents – Combo 1
* Postpartum Care
* Timeliness of Prenatal Care
* Well-Child Visits in the First 30 Months – Ages 0-15 Mos. (2020 and 2021 only)
* Well-Child Visits in the First 30 Months – Ages 15-30 Mos. (2020 and 2021 only)

**Florida Medicaid Statewide mean (LTSS HEDIS Measures)**

* LTSS Comprehensive Assessment and Update – Core Elements
* LTSS Comprehensive Care Plan and Update – Core Elements
* LTSS Shared Care Plan with Primary Care Practitioner
* LTSS Reassessment/Care Plan Update after Inpatient Discharge – Reassessment

**Response:**

The respondent shall provide its experience in HEDIS Measures with populations similar to the target populations for the three contracts identified in the Order of Contract Selection (page 3, **Exhibit A-5-V3**).

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent to which the respondent exceeded the national Medicaid mean for each quality measure indicator reported and showed improvement from the first year to the second year reported and showed improvement from the second year to the third year reported.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-HEDIS tab.

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## SRC# 18 – Organizational Commitment to Quality: AUTOSCORED

Section 409.966 (3) (a) 5., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

5.  Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

From the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall report on three completed quality improvement (QI) projects, one per contract, through which the respondent achieved improved health outcomes. The respondent shall state the key metric for the project, the baseline measure of the key metric before QI project implementation, the reassessment of the key metric after QI project implementation, the absolute value of relative percentage improvement in the key metric between baseline and reassessment, and the percent of enrollees in the contract that were targeted by the QI project.

**Response:**

Respondents shall use in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, located at <https://ahca.myflorida.com/procurements>, Commitment to Quality tab, to provide information on its proposed Organizational Commitment to Quality.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent of improvement in the respondent’s key metric.
2. The extent of enrollees targeted in the respondent’s quality improvement project.
3. The focus of the respondent’s QI project.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Commitment to Quality tab.

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# DELIVERY SYSTEM ENHANCEMENTS AND INTEGRATION

## SRC# 19 – Person-Centered Care and Patient-Centered Medical Homes: AUTOSCORED

Section 409.966(3)(c)2., F.S.

(c)  After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

2. Have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan.

The goal of person-centered care (PCC) is to maximize a person’s choice, direction, and control over their health. For enrollees, PCC means that they receive care from trusted physicians in a patient-centered medical home and other health care providers in a setting and a manner that are responsive to the enrollee’s needs, preferences, goals, and desires. For physicians and other health care providers, PCC requires (a) recognizing and responding to the entirety of the enrollee’s physical, mental, and social needs, (b) actively listening and sharing in decision-making, (c) using technology to work collaboratively as a team of providers across disciplines and facilities, and (d) delivering coordinated care in a medical home with empathy, dignity and respect to enrollees, their families, and other caregivers. For payers, PCC requires careful selection, organization, financing, and integration of services and supports that empower continuity of care relationships in a medical home between enrollees and their trusted physicians.

1. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall report the percentage of the following physician specialties who practiced in a certified patient-centered medical home (PCMH) in the most recent complete contract year. A certified PCMH is a PCMH formally certified by the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC), the Joint Commission (TJC), or the Utilization Review Accreditation Commission (URAC).
   1. **Family Practice**, as defined by Section VII, A, 4. Primary Care Providers in **Attachment B**, **Exhibit B-1**.
   2. **Internal Medicine**, as defined by Section VII, A, 4. Primary Care Providers in **Attachment B**, **Exhibit B-1**.
   3. **Pediatrics** (including Adolescent Medicine), as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   4. **Obstetrics/Gynecology**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   5. **Infectious Diseases**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   6. Board Certified or Board Eligible **Adult Psychiatrists**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   7. Board Certified or Board Eligible **Child Psychiatrists**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
2. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall report the percentage of enrollees, separated by age groups, who had a signed agreement for participant direction option (PDO) services in their enrollee record. PDO services are defined in Section I, Attachment B as adult companion care, attendant care, homemaker services, intermittent and skilled nursing, and personal care services. PDO services are further defined in Attachment B-2.
   1. 21 to 44 years of age
   2. 45 years of age or older
3. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall report the percentage of enrollees that have had outpatient encounters with the same Primary Care Provider at least two times in the last three years, with at least one outpatient visit in CY2019 and one outpatient visit in CY2021. In this SRC, a Primary Care Provider is defined as a physician specializing in any the following specialties:
   1. **Family Practice**, as defined by Section VII, A, 4. Primary Care Providers in **Attachment B**, **Exhibit B-1**.
   2. **Internal Medicine**, as defined by Section VII, A, 4. Primary Care Providers in **Attachment B**, **Exhibit B-1**.
   3. **Pediatrics** (including Adolescent Medicine), as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   4. **Obstetrics/Gynecology**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
4. For its proposed provider network, the respondent shall state the percentage of the following physician specialties who practice in a certified patient-centered medical home (PCMH) at the time of application submission. A certified PCMH is a PCMH formally certified by the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC), the Joint Commission (TJC), or the Utilization Review Accreditation Commission (URAC).
   1. **Family Practice**, as defined by Section VII, A, 4. Primary Care Providers in **Attachment B**, **Exhibit B-1**.
   2. **Internal Medicine**, as defined by Section VII, A, 4. Primary Care Providers in **Attachment B**, **Exhibit B-1**.
   3. **Pediatrics** (including Adolescent Medicine), as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   4. **Obstetrics/Gynecology**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   5. **Infectious Diseases**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   6. Board Certified or Board Eligible **Adult Psychiatrists**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
   7. Board Certified or Board Eligible **Child Psychiatrists**, as defined by the Provider Network Standards Table 4 in Section VII of **Exhibit B-1**.
5. The respondent shall indicate at the time of bid submission with which of the Florida hospitals they have a written contract that includes coordination of care in a multidisciplinary clinic for medically complex children with:
   1. One or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments, or
   2. One life-limiting illness or rare pediatric disease (as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

**Note:** Pursuant to Section 409.966(3)(c)2., F.S., response to this submission requirement will be considered for negotiations.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Person-Centered Care tab, located at <https://ahca.myflorida.com/procurements>, to provide its Person-Centered Care.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent of in-network physician specialists who have practiced in a Person-Centered Medical Home (PCMH).
2. The extent of enrollees who participated in PDO services.
3. The extent of enrollees that have had outpatient encounters with the same PCP.
4. The extent of in-network physician specialists who will practice in a Person-Centered Medical Home (PCMH).
5. The extent of Florida hospitals with contracts for coordinated care of medically complex children.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-PersonCentered Care tab.

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## SRC# 20 – Behavioral Health/Primary Care Integration: AUTOSCORED

Section 409.967(2)(d), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(d) Quality care. —Managed care plans shall provide, or contract for the provision of, care coordination to facilitate the appropriate delivery of behavioral health care services in the least restrictive setting with treatment and recovery capabilities that address the needs of the patient. Services shall be provided in a manner that integrates behavioral health services and primary care. Plans shall be required to achieve specific behavioral health outcome standards, established by the agency in consultation with the department.

Behavioral and mental health are major factors in disease prevention, health promotion, chronic disease management, and quality of life. A large proportion of mental health care is screened and treated in primary care settings with consultative and skills-building support from psychiatrists. Integrating mental health care in primary care settings has led to improved health outcomes, improved patient and physician experiences, and cost-avoidance of high acuity services. In this SRC, the respondent shall demonstrate its past and future support of behavioral health integration.

* + - 1. For its proposed provider network, the respondent shall state the numbers and percentages of the following providers who have a Medicaid-provider-enrolled psychiatrist, psychologist, licensed clinical social worker, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist physically available within the building of their medical practice:

1. All Primary Care Providers in network
2. Pediatricians (including Adolescent Medicine) in network
   * + 1. For its proposed provider network, the respondent shall state the numbers and percentages of the following providers whose practice has earned National Committee for Quality Assurance (NCQA) Distinction in Behavioral Health Integration:
3. All Primary Care Providers in network
4. Pediatricians (including Adolescent Medicine) in network
   * + 1. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall report, the numbers and percentages of providers within their network for the following physician specialties who submitted at least one claim for screening, brief intervention, referral for treatment (SBIRT, H0049 and H0050, G0396 and G0397, and 99408 and 99409) in the most recent available Calendar Year:
5. All Primary Care Providers in network
6. Pediatricians (including Adolescent Medicine) in network
7. Obstetricians/Gynecologists in network
   * + 1. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall report, the numbers and percentages of providers within their network for the following physician specialties who submitted at least one claim for behavioral health integration (BHI) for three consecutive Calendar Years:
8. The number and percentage of All Primary Care Providers in network who submitted at least one claim for BHI CPT code 99484.
9. The number and percentage of Pediatricians (including Adolescent Medicine) in network who submitted at least one claim for BHI CPT code 99484.
10. The number and percentage of Psychiatrists in network who submitted at least one claim for BHI CPT code 99492.
    * + 1. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall report, the numbers and percentages of unutilized, peripheral, standard, and core physicians within their network for the following physician specialties for three consecutive Calendar Years:
11. All Providers in network
12. All Primary Care Providers in network
13. Pediatricians (including Adolescent Medicine) in network
14. Obstetricians/Gynecologists in network
15. Cardiologists in network
16. Psychiatrists in network
    * + 1. The respondent shall indicate at the time of bid submission with which of the Florida Pediatric Mental Health Collaborative (FPMHC) Behavioral Health Hubs they have a written contract that includes, but is not limited to, interprofessional consultation between providers and psychiatrists, technical assistance in coordination of mental and medical health care, case management support for referring people to community-based services, and skills-building training of providers in mental health care. The contract may include enhanced payment for behavioral health integration services, interprofessional consultation, case management services, incentive payments for achieving high quality performance, removal of utilization management controls, or other enablement of integrating high quality mental, emotional, and behavioral health care for people and their families in medical offices and the managed health care environment.

* University of South Florida’s Florida Center for Behavioral Health Improvements and Solutions
* Florida State University’s College of Medicine Center for Behavioral Health Integration and their partner the Tallahassee Pediatric Behavioral Health Center
* University of Florida’s Department of Psychiatry, Division of Child & Adolescent Psychiatry
* University of Miami’s Miller School of Medicine Department of Psychiatry and Behavioral Sciences
* Florida International University’s Herbert Wertheim College of Medicine Department of Psychiatry and Behavioral Health
* Nemours Children’s Hospital, Division of Developmental and Behavioral Pediatrics, Orlando Florida

**Definitions of Terms Specific to this SRC:**

**All Providers in network** are defined in Florida Statute 409.975(1) and 409.967(2)(c).

**All Primary Care Providers in network** are defined as Primary Care Providers in **Attachment B**, **Exhibit B-1**, Section VIII. Provider Services, A. Network Adequacy Standards.

**Pediatricians (including Adolescent Medicine) in network** are defined as Pediatrics (including Adolescent Medicine) in **Attachment** **B**, **Exhibit B-1**, Section VIII. Provider Services, A. Network Adequacy Standards.

**Obstetricians/Gynecologists in network** are defined as Obstetrics/ Gynecology in **Attachment B**, **Exhibit B-1**, Section VIII. Provider Services, A. Network Adequacy Standards.

**Cardiologists in network** are defined as Cardiology in **Attachment B**, **Exhibit B-1**, Section VIII. Provider Services, A. Network Adequacy Standards.

**Psychiatrists in network** are defined as Board Certified or Board Eligible Adult Psychiatrists and Board Certified or Board Eligible Child Psychiatrists in **Attachment B**, **Exhibit B-1**, Section VIII. Provider Services, A. Network Adequacy Standards.

**Physically available within the building of their medical practice** is defined as a provider physically present in a structure under one roof, connected by the same or contiguous indoor hallway, and available to provide immediate evaluation and therapy to a Medicaid enrollee. A telemedicine connection does not meet this definition.

**Fiscal Year (FY)** as defined in **Attachment B**.

**Cared for** is defined as at least one professional service provided to a Medicaid enrollee in the designated timeframe.

**Unutilized** is defined as physicians who cared for zero (0) Medicaid enrollees within the calendar year.

**Peripheral** is defined as physicians who cared for one to ten (1-10) Medicaid enrollees within the calendar year.

**Standard** is defined as physicians who cared for eleven to one-hundred fifty (11-150) Medicaid enrollees within the calendar year.

**Core** is defined as physicians who cared for more than one-hundred fifty (150) Medicaid enrollees within the calendar year.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Behav Health-Prim Care Integ tab, located at <https://ahca.myflorida.com/procurements>, to provide its Behavioral Health/Primary Care Integration response.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent of providers who have a Medicaid-provider enrolled behavioral health practitioner (i.e., psychiatrist, psychologist, licensed clinical social workers, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist).
2. The extent of providers whose practice has earned National Committee for Quality Assurance (NCQA) Distinction in Behavioral Health Integration.
3. The extent of providers who submitted at least one (1) claim for Screening, Brief Intervention, Referral for Treatment (SBIRT) in most recent available CY.
4. The extent of providers who submitted at least one (1) claim for behavioral health integration (BHI).
5. The extent to which core, standard physicians, peripheral, and unutilized physicians were in-network.
6. The extent to which hubs within the Florida Pediatric Mental Health Collaborative (FPMHC) are engaged in contracts.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Behav Health-Prim Care tab.

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## SRC# 21 – Vignette – Coordination of Benefits: EVALUATOR SCORED

The respondent shall review the following case vignette, which describes a potential Florida Medicaid recipient. Note: The following clinical vignette is fictional and created for evaluation purposes only. Any similarity with real person or people is coincidental.

*Gabriel is a sixty-three (63)-year-old man who has been homeless for the past two (2) years. He survives by staying with relatives and friends but lacks any permanent sustainable housing. His car needs a new timing belt and does not run. Gabriel is currently unemployed and not looking for work, although he worked as a plumber in the past. Currently, he receives supplemental security income (SSI). His pertinent medical history includes congestive heart failure (CHF) and type 2 diabetes, which are both managed poorly. His pertinent mental health history includes depression with suicidal ideation and alcohol misuse. In the past six (6) months he was treated in an emergency department (ED) two (2) times for congestive heart failure, which resulted in two (2) hospital admissions. After one of the hospital discharges Gabriel was re-admitted within 21 days because of problems with medication availability and apathy stemming from his depression. A relative called a local homeless shelter for him, but Gabriel never followed up because he wasn’t sure he would qualify and the last time he waited for a ride-sharing driver, he wasn’t picked up. Gabriel has been a Florida Medicaid recipient since 2019 and a member of the long-term care plan since December 2021.*

The respondent shall describe its approach to coordinating care for an enrollee with Gabriel’s profile, including a detailed description and workflow demonstrating notable points in the system where the respondent’s processes are implemented:

* Health Risk Assessment
* Care Coordination/Case Management
* Disease Management
* Service Planning
* Discharge/Transition Planning
* Utilization Management
* Grievance and Appeals
* Connections to Pathways to Purpose

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

**Response:**

Limit your written response to a maximum of 10,000 characters, including spaces.

**Evaluation Criteria:**

1. The extent to which the respondent:
2. Identifies processes for enrollees with complex health conditions who require care coordination (5 pts.)
3. Describes the sources of data/information that would be utilized in the assessment process, including timeframes for completion (5 pts.)
4. Identifies service needs (covered and non-covered) and a description for service referral processes (5 pts.)
5. Describes case management strategies that connect enrollee to available social services (e.g., services offered by other state agencies) and medically necessary health services (5 pts.)
6. Identifies strategies that promote enrollee self-management and continuous medical availability (5 pts.)
7. Describes the timeframes by which the respondent identifies the special needs of the enrollee to getting him on a continuous plan of care (5 pts.)
8. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.) (5 pts.)
9. Description of how the respondent will direct the enrollee towards Pathways to Purpose (5 pts.) (i.e., opportunities for linking seniors with Hope Heroes), including the use of incentives (5 pts.)
   * + 1. Connecting the enrollee with a Hope navigator
       2. Assisting with linking the enrollee to community activities and organizations
10. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions (5 pts.)
11. Identification of the processes for maintaining current information (e.g., address) for enrollees (5 pts.)
12. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc. (5 pts.)
13. The extent to which the respondent’s workflows/narrative descriptions include timeframes for completion of each step in the care coordination/case management process, which include the following:
14. Process describing a new enrollee’s care coordination beginning with the enrollee’s enrollment in the plan through the enrollee’s first ninety (90) days in the plan (5 pts.)
15. Timeframes for the following care coordination/case management activities:
    1. Completing a health risk assessment (5 pts.)
    2. Connecting enrollee with providers for medically necessary Medicaid services (5 pts.)
    3. Following up with enrollee on contacting providers and making appointments (5 pts.)
    4. Determining whether the enrollee is eligible for enhanced care coordination/case management (5 pts.)
16. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions). (5 pts.)
17. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary inpatient or emergency department use. (5 pts.)
18. The extent to which the respondent demonstrates experience in providing services to enrollees with complex social and medical needs and provides evidence of strategies utilized that resulted in improved health outcomes. (5 pts.)
19. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows. (5 pts.)
20. The extent to which the respondent describes utilizing strategies that improve enrollee health and socio-economic outcomes. (5 pts.)
21. The extent to which the respondent demonstrates a system of coordinated health care that results in timely enrollee access to high-quality mental health/substance abuse services. (5 pts.)

**Score:** This section is worth a maximum of **200** points. Each of the above components is worth a maximum of 5 points each using the Standard Evaluation Criteria Scale for a maximum of 115 points. The final score is determined by multiplying the raw score by a factor of 1.73913043.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below.

|  |  |
| --- | --- |
| **STANDARD EVALUATION CRITERIA SCALE** | |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed anywhere in the response submission. |
| 1 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 4 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 5 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 22 – Provider Network Agreements/Contracts: AUTOSCORED

Section 409.966(3)(a)7., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

7.  Evidence that an eligible plan has obtained signed contracts or written agreements or has made substantial progress in establishing relationships with providers before the plan submits a response.

Section 409.966(3)(c)1., F.S.

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

1. Have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to Section 409.967(2)(c).

The Agency has identified key network service provider types that will be critical in order for the respondent to promote the Agency’s goal of ensuring the availability of comprehensive, quality-driven provider networks that will provide all medically necessary services in a timely manner to Medicaid enrollees.

MMA Providers

|  |  |
| --- | --- |
| Allergy | Optometry |
| Cardiology | Orthopedic Surgery |
| Cardiology (Pediatric) | Otolaryngology |
| Cardiovascular Surgery | Pediatrics (Including Adolescent Medicine) |
| Chiropractic | Pharmacy |
| Dermatology | Podiatry |
| Endocrinology | Pulmonology |
| Endocrinology (Pediatric) | Rheumatology |
| Gastroenterology | Therapist (Occupational) |
| General Surgery | Therapist, Pediatric (Occupational) |
| Infectious Disease | Therapist (Speech) |
| Internal Medicine Specialist | Therapist, Pediatric (Speech) |
| Midwife | Therapist (Physical) |
| Nephrology | Therapist, Pediatric (Physical) |
| Nephrology (Pediatric) | Therapist (Respiratory) |
| Neurology | Therapist, Pediatric (Respiratory) |
| Neurology (Pediatric) | Urology |
| Neurosurgery | Board Certified/Eligible Psychiatrist (Adult) |
| Obstetrics/Gynecology | Board Certified/Eligible Psychiatrist (Child) |
| Oncology | Licensed Practitioners of the Healing Arts |
| Ophthalmology |  |

LTC Providers

Adult Day Care

Assisted Living Facilities

Home Health Agency

Nurse Registry

**Response:**

Respondents shall use **Exhibit A-5-b,** MMA SRC# 22 –Provider Network Tool and **Exhibit A-5-c-V3,** LTC SRC# 22 – Provider Network Toollocated at <https://ahca.myflorida.com/procurements>, to provide its Provider Network information.

**Evaluation Criteria:**

* + - 1. The extent of the respondent’s progress with executing provider agreements or contracts in numbers adequate for each of the regions in which it is bidding.

**Score:**  See scoring methodology in **Exhibit A-5-b,** MMA SRC# 22 –Provider Network Tool – MMA Scoring tab, and **Exhibit A-5-c-V3, LTC SRC# 22** –Provider Network Tool – LTC Scoring tab. The respondent may receive up to 100 points for MMA provider networks and up to 50 points for LTC provider networks, for a combined total of 150 points.

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## SRC# 23 – Telemedicine: AUTOSCORED

The ability for physicians to monitor aspects of acute and chronic conditions has increased access to care, reduced costs, and mitigated infection risks. The respondent shall detail its experience and proposed plans for the use of telemedicine.

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3,**and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall report the percentage of the following physician specialties who made claim for at least one telemedicine encounter in the most recent complete contract year (Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Infectious Disease, Adult Psychiatrists, Child Psychiatrists, Emergency Medicine Physicians, and Mental Health Therapists) . A telemedicine encounter is defined as a two-way, synchronous audio and visual connection between patient and provider.

For its proposed provider network as provided by the respondent in **Exhibit A-5-b**, MMA SRC# 22 – Provider Network Tool, the respondent shall state the percentage of physician specialties who will offer telemedicine visits. A telemedicine encounter is defined as a two-way, synchronous audio and visual connection between patient and provider.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Telemedicine tab, located at <https://ahca.myflorida.com/procurements>, to provide its Telemedicine information.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

* + 1. The extent of each of the physician specialties who submitted a claim for at least one telemedicine encounter in the most recent complete contract year.
    2. The extent of each of the physician specialties in the respondent’s proposed provider network who will offer telemedicine visits.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Telemedicine tab.

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## SRC# 24 – Evidence-Based Programs for Children with Intense Behaviors: AUTOSCORED

Evidence-Based Programs for Children with Intense Behaviors are intended to strengthen family relationships, build resiliency in children and parents, and prevent child abuse and neglect.

1. The respondent shall identify Evidence-Based Programs for Children with Intense Behaviors it proposes to offer its enrollees, and the proposed billing services codes, from the following:
2. **Homebuilders**: This program is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning and by enlisting them as partners in assessment, goal setting and treatment planning (Target population is families with children under eighteen (18) years of age).
3. **Motivational Interviewing**: This program is a person-centered, directive method designed to enhance a person's internal motivation for behavior change, to reinforce this motivation and develop a plan to achieve change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. Motivational Interviewing can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate individuals for other treatment modalities. Motivational Interviewing can be used to promote behavior change with a range of target populations and for a variety of problem areas (Target population is all age groups and individuals).
4. **Multisystemic Therapy**: This program is an intensive treatment for troubled youth. The program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, substance use and out-of-home placements. Multisystemic Therapy addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, school, and community. The intervention strategies are personalized to address the identified drivers (Target population is families with children ages two (2) to seven (7) years of age).
5. **Parent-Child Interaction Therapy**: This program is a dyadic behavioral intervention for children and their parent or caregivers. Parent-Child Interaction Therapy focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcement of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skill and master them rapidly (Target population is families with children ages two (2) to seven (7) years of age).
6. **Functional Family Therapy**: This program is a family intervention program for at-risk youth and their families. The programming is delivered by master's level therapists, meeting weekly with families. (Target population is children eleven (11) to eighteen (18) years of age with behavioral or emotional challenges).
7. **Parents as Teachers**: This program is an early childhood parent education, family support, family well-being, and school readiness home visiting model. It teaches parents skills intended to promote positive child development and prevent child maltreatment. The Parents as Teachers model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings and community resource networks (Target population is expectant parents and parents with children up to five (5) years of age that in high-risk environments such as teen parents, low income, parental low educational attainment, history of substance use in the family, and chronic health conditions).
8. **Brief Strategic Family Therapy**: This program is a brief intervention used to treat adolescent drug use, conduct problems, oppositional behavior, delinquency, aggressive and violent behavior, and risky sexual behavior. Brief Strategic Family Therapy is a family systems approach which recognizes that patterns of interaction in the family influence the behavior of each family member. Brief Strategic Family Therapy directly provides services to parents/caregivers and addresses lack of parental leadership, unhealthy parental collaboration, lack of guidance and nurturance to adolescents in their care (Target population is families with children under eighteen (18) years of age who display or are at risk for developing problem behaviors including: drug use and dependency, antisocial peer associations, bullying, or truancy).
9. **Healthy Families**: This program is a multi-year, intensive, home visiting. The program best serves families who are high-risk, including those families who may have histories of trauma, intimate partner violence, mental health issues and/or substance use issues. Services focus on promoting healthy parent-child interaction and attachment, increasing knowledge of child development, improving access to and use of services, and reducing social isolation (Target population is parents of children under five (5) years of age).
10. **Nurse Family Partnership**: This program provides home visits by registered nurses to first-time, low -income mothers beginning. The program promotes women's health, pregnancy outcomes, early childhood development, and parenting capacity. It also enhances relationships and economic well-being of mothers and their children. Nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning (Target population is first-time mothers who are pregnant or have a child under two (2) years of age).

**Response:**

Respondents shall use the Evidence-Based Programs tab in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, EBP tab, located at <https://ahca.myflorida.com/procurements>, to provide information on its proposed Evidence-Based Programs for Children with Intense Behaviors.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent of the respondent’s commitment to offering Evidence-Based Programs for Children with Intense Behaviors.

**Score:**  See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-EBP tab.

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## SRC# 25 – Essential Provider Networks: AUTOSCORED

Section 409.974(2), F.S.

(2) QUALITY SELECTION CRITERIA. —In addition to the criteria established in Section 409.966, the agency shall consider evidence that an eligible plan has obtained signed contracts or written agreements or has made substantial progress in establishing relationships with providers before the plan submits a response. The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to Section 409.975(1). When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

The respondent shall demonstrate its progress with executing agreements or contracts with Statewide Essential Providers by providing a response on **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Statewide Essential Providers tab:

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Statewide Essential Providers tab, located at <https://ahca.myflorida.com/procurements>, to provide its Statewide Essential Providers. Respondents shall only include those Statewide Essential Providers with which it has a fully executed agreement/contract.

**Evaluation Criteria:**

* + - * 1. The extent to which the respondent has executed agreements or contracts with Statewide Essential Providers

**Score:**  See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-SW Essential Providers tab.

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# PATHWAYS TO PROSPERITY

## SRC# 26 – Community Partnerships: AUTOSCORED

Section 409.966(3)(a)4., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

4.  Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

The respondent shall describe the extent to which it has established community partnerships with providers that create opportunities for reinvestment in community-based services. In this SRC, providers are public or private, nonprofit community-based organizations (CBOs) of demonstrated effectiveness that have principal address of operations in Florida, are representative of a Florida community or significant segments of a Florida community and provide services to individuals in the community.

The respondent shall provide a list of CBOs with which the respondent has executed a formal contract for health-related services and supports in the upcoming contract period. In **Exhibit A-5-a-V3,** the respondent shall list the CBO name, the CBO’s federal employer identification number (FEIN), the CBO’s Florida Division of Corporations (FDOC) document number, the CBO principal address, the CBO mailing address, the respondent’s contract identification number with the CBO, the contract execution date, a description of the enrollee population(s) being served, a description of the health-related services and supports for said enrollees, whether the CBO contract was designed to directly improve birth outcomes of enrollees, whether the CBO contract was designed to directly improve mental health of child or adolescent enrollees, whether the CBO contract was designed to directly increase home and community based services for senior enrollees, regions where the CBO will provide services and supports, counties where the CBO will provide services and supports, whether there will be a closed-loop software system of referrals and service verification between the respondent and CBO, annualized financial investment into the CBO, annualized in-kind investment into the CBO, and whether the CBO has a representative on the respondent’s committees or advisory boards.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Statutory Community Partnerships tab, located at <https://ahca.myflorida.com/procurements>, to provide information on Statutory Community Partnerships.

**Evaluation Criteria:**

* + - 1. The extent of unique, contracted CBOs with principal address in Florida for the upcoming contract period.
      2. The extent to which each CBO provides services or supports in at least one of the following areas: improving birth outcomes, improving mental health of children or adolescents, or increasing home and community-based services and supports.
      3. The extent to which at least one CBO provides services or supports in each AHCA region.
      4. The extent of Florida counties with at least one CBO providing services and supports to enrollees.
      5. The extent to which each CBO uses a closed-loop software system to receive enrollee referrals from health care providers and verify with the respondent that services or supports were provided to enrollees.
      6. The extent to which each CBO receives a financial investment from the respondent.
      7. The extent to which each CBO receives in-kind support from the respondent.
      8. The extent to which each CBO has a representative who serves on a respondent committee or advisory board.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Community Partnerships tab.

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## SRC# 27 – Expanded Benefits – Pathways to Prosperity: AUTOSCORED

Section 409.966(3)(a)6., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

6.  Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

Expanded benefits are benefits covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency.

1. The respondent shall identify and describe the Pathway to Prosperity expanded benefits it proposes to offer its enrollees from the following categories:
2. Pathway to Prosperity: Housing assistance
3. Pathway to Prosperity: Food assistance
4. Pathway to Prosperity: Non-medical transportation
5. Pathway to Prosperity: Tutoring, vocational training, and job readiness
6. The respondent shall provide all of the following information for each of the Pathway to Prosperity expanded benefit it proposes to offer its enrollees:
   * + - 1. Pathway to Prosperity Category (pre-populated)
         2. Procedure Code Description
         3. Procedure Code (Current Procedural Technology (CPT) or Healthcare Common Procedure Coding System (HCPCS))
         4. Minimum Age of Enrollee (include whether days (D), months (M), or years (Y))
         5. Maximum Age of Enrollee (include whether days (D), months (M), or years (Y))
         6. Current Florida Medicaid Coverage (enter n/a if not applicable)
         7. Proposed Expanded Benefit Coverage (Units, amount, and frequency)
         8. Per member per month (PMPM)

**Response:**

The respondent shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Expanded Benefits-Pathways tab, located at <https://ahca.myflorida.com/procurements>, to provide information on its proposed Expanded Benefits for Pathways to Prosperity.

**Evaluation Criteria:**

1. The extent of the respondent’s commitment to offering expanded benefits that advance the Agency’s goals for Pathways to Prosperity

**Score:**

See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Exp. Benefits-Pathways tab.

The respondent shall submit supporting documentation that includes the calculations used to determine each PMPM cost, and the data source(s) used for the calculations (e.g., previous SMMC experience, commercial experience).

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## SRC# 28 – Vignette – Pathways to Prosperity #1: EVALUATOR SCORED

The respondent shall review the following case vignette, which describes a potential Florida Medicaid recipient. Note: The following clinical vignette is fictional and created for evaluation purposes only. Any similarity with a real person or people is coincidental.

*Rebecca is a twenty-seven (27)-year-old woman who just moved to Florida and is six (6)-months pregnant. Her application for Medicaid was approved in October 2022 and she was auto-enrolled in a health plan at that time. Rebecca never completed high school and reads at a fourth (4th) grade level. She is unemployed and not actively looking for work. In addition, she has a five (5)-year-old daughter, who is also enrolled in the same health plan, and whose father lives out-of-state and does not pay child support. Rebecca currently lives with her boyfriend and has limited access to her boyfriend’s car. At her first prenatal care visit in Florida, Rebecca was a poor historian but did describe a history of being admitted to a psychiatric hospital when she was a teenager for suicidal attempt. She couldn’t recall the total number of times she has been pregnant. Her last pregnancy was a spontaneous vaginal delivery without complication. She couldn’t remember much about her last postpartum period other than to say it was a bad time for her. At the prenatal visit, the OB/Gyn physician administered a PHQ-9 questionnaire and Rebecca indicated that she felt depressed almost every day. Since enrolling in the health plan, Rebecca took her child to an emergency department (ED) for an asthma exacerbation. The ED physician administered a nebulizer treatment and discharged the child on prescription steroidal and bronchodilator inhalers. The after-visit summary to Rebecca and her child recommended that the patient call the health plan to schedule a follow-up visit.*

The respondent shall describe its approach to coordinating care for an enrollee with Rebecca’s profile, including a detailed description and workflow demonstrating notable points in the system where the respondent’s processes are implemented:

* Health Risk Assessment
* Care Coordination/Case Management
* Disease Management
* Service Planning
* Discharge/Transition Planning
* Utilization Management
* Grievance and Appeals
* Connections to Pathways to Prosperity

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

**Response:**

Limit your written response to a maximum 10,000 characters, including spaces.

**Evaluation Criteria:**

1. The adequacy of the respondent’s approach in addressing the following:
2. Identification processes for enrollees with complex health conditions who require care coordination (5 pts.)
3. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion (5 pts.)
4. Identification of service needs (covered and non-covered) and a description for service referral processes (5 pts.)
5. Description of case management strategies that connect enrollee to available social services (e.g., services offered by other state agencies) and medically necessary health services (5 pts.)
6. Identification of strategies that promote enrollee self-management and treatment adherence (5 pts.)
7. Description of the timeframes by which the respondent identifies the special needs of the enrollee to getting her on a continuous plan of care (5 pts.)
8. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.) (5 pts.)
9. Description of how the respondent will direct the enrollee towards Pathways to Prosperity (i.e., opportunities for self-improvement such as education or job readiness) (5 pts.), including the use of incentives (5 pts.)
10. Connecting the enrollee to community partners
11. Assisting with linking the enrollee to vocational training or educational opportunities
12. Providing the enrollee with training for managing personal finances
13. Assisting with linking the enrollee’s child with school readiness, tutoring, or pre-kindergarten services
14. Providing the enrollee with housing stability support
15. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions (5 pts.)
16. Identification of the processes for maintaining current information (e.g., address) for enrollees (5 pts.)
17. Application of strategies to promote healthy birth outcomes for pregnant enrollees and their infants (5 pts.)
18. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc. (5 pts.)
19. The extent to which the respondent’s workflows/narrative descriptions include timeframes for completion of each step in the care coordination/case management process, which address the following:
20. Process describing a new enrollee’s care coordination beginning with the enrollee’s enrollment in the plan through the enrollee’s first ninety (90) days in the plan (5 pts.)
21. Timeframes for the following care coordination/case management activities (5 pts.):
    1. Completing a health risk assessment.
    2. Connecting enrollee with providers for medically necessary Medicaid services.
    3. Following up with enrollee on contacting providers and making appointments.
    4. Determining whether the enrollee is eligible for enhanced care coordination/case management.
22. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions). (5 pts.)
23. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary inpatient or emergency department use. (5 pts.)
24. The extent to which the respondent demonstrates experience in providing services to enrollees with complex social and medical needs (both physical and behavioral) and provides evidence of strategies utilized that resulted in improved health outcomes. (5 pts.)
25. The extent to which the respondent describes its chronic disease management strategies for enrollees with multiple chronic conditions, including behavioral and physical issues. (5 pts.)
26. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows. (5 pts.)
27. The extent to which the respondent describes utilizing strategies that improve enrollee health and socio-economic outcomes. (5 pts.)
28. The extent to which the respondent demonstrates a system of coordinated health care that results in timely enrollee access to high-quality mental health/substance abuse services. (5 pts.)
29. The extent to which the respondent describes its processes and strategies for connecting enrollees to Pathways to Prosperity that include the following (5 pts.):
30. Job readiness
31. GED preparation
32. Vocational education (includes access to certification/licensure)
33. College enrollment
34. The extent to which the respondent describes its strategies for promoting the health and socio-economic conditions for pregnant enrollees and enrollees raising infants and toddlers (i.e., children under two (2) years old). (5 pts.)
35. The extent to which the respondent identifies Pathways to Prosperity for pregnant enrollees and enrollees raising infants and toddlers (i.e., children under two (2) years old). (5 pts.)

**Score:** This section is worth a maximum of 175 points with each of the above components being worth a maximum of 5 points each using the Standard Evaluation Criteria Scale for a maximum of 125 points. The final score is determined by multiplying the raw score by a factor of 1.40.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below.

|  |  |
| --- | --- |
| **STANDARD EVALUATION CRITERIA SCALE** | |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed anywhere in the response submission. |
| 1 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 4 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 5 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 29 – Vignette – Pathways to Prosperity #2: EVALUATOR SCORED

The respondent shall review the following case vignette, which describes a potential Florida Medicaid recipient. Note: The following clinical vignette is fictional and created for evaluation purposes only. Any similarity with a real person or people is coincidental.

*Evan is a nineteen (19)-year-old male who has been homeless since the age of sixteen (16). He does not have any contact or support from family members and survives by sleeping and eating at the homes of friends. He does not own a car or have access to reliable transportation. In addition, Evan is currently unemployed and not looking for work. He is also not enrolled in any kind of educational programs such as vocational school or community college, despite having received his GED during the previous year. Although Evan has no significant physical health issues, he was diagnosed with bipolar disorder when he was fifteen (15) years old and has problems accessing medications needed to stabilize his condition due to his financial situation. Evan’s bipolar disorder has also caused him to lose employment on three occasions. Other issues he faces include a history of abusing alcohol and cannabis in addition to a recent nonviolent felony conviction. As a result, Evan is currently on probation. He cannot recall the last time he saw a mental health provider and has not seen a physician since before his arrest two (2) years previously. Evan has been a Florida Medicaid recipient since birth and a member of the plan since December 2021.*

The respondent shall describe its approach to coordinating care for an enrollee with Evan’s profile, including a detailed description and workflow demonstrating notable points in the system where the respondent’s processes are implemented:

* Health Risk Assessment
* Care Coordination/Case Management
* Disease Management
* Service Planning
* Discharge/Transition Planning
* Utilization Management
* Grievance and Appeals
* Connections to Pathways to Prosperity

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

**Response:**

Limit your written response to a maximum of 10,000 characters, including spaces.

**Evaluation Criteria**

1. The adequacy of the respondent’s approach in addressing the following:
2. Identification processes for enrollees with complex health conditions who require care coordination (5 pts.)
3. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion (5 pts.)
4. Identification of service needs (covered and non-covered) and a description for service referral processes (5 pts.)
5. Description of case management strategies that connect enrollee to available social services (e.g., services offered by other state agencies) and medically necessary health services (5 pts.)
6. Identification of strategies that promote enrollee self-management and treatment adherence (5 pts.)
7. Description of the timeframes by which the respondent identifies the special needs of the enrollee to getting him on a continuous plan of care (5 pts.)
8. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.) (5 pts.)
9. Description of how the respondent will direct the enrollee towards Pathways to Prosperity (e.g., opportunities for self-improvement such as education or job readiness), including the use of incentives (5 pts.)
   * 1. Connecting the enrollee to community partners
     2. Assisting with linking the enrollee to vocational training or educational opportunities
     3. Providing the enrollee with training for managing personal finances
     4. Providing the enrollee with housing stability support
10. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions (5 pts.)
11. Identification of the processes for maintaining current information (e.g., address) for enrollees (5 pts.)
12. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc. (5 pts.)
13. The extent to which the respondent’s workflows/narrative descriptions include timeframes for completion of each step in the care coordination/case management process, which address the following:
14. Process describing a new enrollee’s care coordination beginning with the enrollee’s enrollment in the plan through the enrollee’s first ninety (90) days in the plan (5 pts.)
15. Timeframes for the following care coordination/case management activities:
    1. Completing a health risk assessment (5 pts.)
    2. Connecting enrollee with providers for medically necessary Medicaid services (5 pts.)
    3. Following up with enrollee on contacting providers and making appointments (5 pts.)
    4. Determining whether the enrollee is eligible for enhanced care coordination/case management (5 pts.)
16. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions). (5 pts.)
17. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary inpatient or emergency department use. (5 pts.)
18. The extent to which the respondent demonstrates experience in providing services to enrollees with complex social and medical needs and provides evidence of strategies utilized that resulted in improved health outcomes. (5 pts.)
19. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows. (5 pts.)
20. The extent to which the respondent describes utilizing strategies that improve enrollee health and socio-economic outcomes. (5 pts.)
21. The extent to which the respondent demonstrates a system of coordinated health care that results in timely enrollee access to high-quality mental health/substance abuse services. (5 pts.)
22. The extent to which the respondent describes its processes and strategies for connecting enrollees to Pathways to Prosperity that include the following (5 pts.):
23. Job readiness
24. GED preparation
25. Vocational education (includes access to certification/licensure)
26. College enrollment
27. The extent to which the respondent describes its strategies for transitioning enrollees from Medicaid to other insurers or payors following termination of eligibility, which include the following (5 pts.):
28. Providing care coordination/case management during the transition to ensure continuity of care
29. Providing access to a Hope navigator during the transition process
30. The extent to which the respondent demonstrates experience and describes processes regarding Early and Periodic Screening, Diagnosis, and Testing guidelines. (5 pts.)

**Score:**

This section is worth a maximum of 175 points. Each of the above components is worth a maximum of 5 points each using the Standard Evaluation Criteria Scale for a maximum raw score of 125 points. The final score is determined by multiplying the raw score by a factor of 1.40.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below.

|  |  |
| --- | --- |
| **STANDARD EVALUATION CRITERIA SCALE** | |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed anywhere in the response submission. |
| 1 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 4 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 5 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 30 – Commercial Insurance Premium Assistance Program: EVALUATOR SCORED

The respondent shall describe its proposed approach to the creation and implementation of a Commercial Insurance Premium Assistance program and how it will be used to advance the Agency’s goal for Pathways to Prosperity. The respondent’s description shall include a description of proposed premium assistance program where it will reimburse for private full coverage health insurance. Options include, but are not limited to, offering premium payments for employer sponsored insurances, assisting in Medicaid pregnant women transitioning out of Medicaid, assisting in any potential gap coverage, assistance with maintaining Consolidated Omnibus Budget Reconciliation Act (COBRA) insurance, offering commercial insurance products to enrollees who may qualify, and assisting recipients who may already have a commercial insurance plan. This program will be a bridge for a seamless transition from Florida Medicaid coverage to private insurance product(s) or to assist an enrollee in maintaining commercial insurance in place at the time of gaining Medicaid eligibility.

**Response:**

Limit your written response to a maximum of 10,000 characters, including spaces.

**Evaluation Criteria:**

1. The extent with which the respondent thoroughly describes its approach to the creation and implementation of a Commercial Insurance Premium Assistance program. (5 pts.)
2. The method to identify current members who may be eligible to receive employee sponsored health insurance. (5 pts.)
3. A description of outreach and communication strategies that will be used to inform members of your commercial insurance premium assistance program. (5 pts.)
4. The method to notify the Agency of the members enrolled in the plan’s commercial insurance premium assistance program. (5 pts.)

**Score:** This section is worth a maximum of 50 points. Each of the above components is worth 5 points each, based on the Standard Evaluation Criteria Scale, for a maximum raw score of 20. The raw score is then multiplied by a factor of 2.5.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below.

|  |  |
| --- | --- |
| **STANDARD EVALUATION CRITERIA SCALE** | |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed anywhere in the response submission. |
| 1 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 4 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 5 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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# RESPONDENT BACKGROUND AND EXPERIENCE

## SRC# 31 – Managed Care Experience: AUTOSCORED

Section 409.966(3)(a)2., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

2. Experience serving similar populations, including the organization’s record in achieving specific quality standards with similar populations.

The respondent, including respondent’s parent, affiliate(s), and subsidiary(ies), shall provide a list of up to twenty (20) of its current and/or recent (within five (5) years of the issue date of this solicitation (since February 1, 2018)) capitated contracts for managed care services (e.g., medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support). For purposes of identifying the respondent’s parent, affiliate(s), and subsidiary(ies), see “business relationship” as defined in Section 409.966(3)(b), F.S.

The respondent shall provide the following information for each identified contract:

* 1. The line of business (Medicaid, CHIP, or Medicare).
  2. The state in which the contract is held.
  3. The specific contract implementation date (first date of services provided) and end date of the contract. Note: The respondent will enter the contract end date as it appears in the applicable contract. However, dates after August 15, 2023, will not be counted toward the actual length of contract in years.
  4. Whether the contract is statewide or not statewide.
  5. Whether the respondent provided Home and Community-Based Services (HCBS) to its enrollees under the contract.
  6. Total unduplicated population served under the contract.
  7. Premium revenue for latest contract year.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Managed Care Experience table, located at <https://ahca.myflorida.com/procurements>, to provide its managed care experience.

**Evaluation Criteria:**

1. The relevance of the line of business to this Solicitation.
2. The extent of the respondent’s ability to maintain contracts. Note: Dates after August 15, 2023, will not be counted toward the actual length of contract in years.
3. The extent of the respondent’s experience with statewide versus not statewide contracts.
4. The extent to which the respondent’s contract provided HCBS to its enrollees.
5. The extent of the respondent’s experience with population.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Managed Care Exp tab.

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## SRC# 32 – Compliance History: AUTOSCORED

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3,** and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall report imposed actions (liquidated damages, fines, penalties, sanctions, and Corrective Action Plans (CAPs)) and contract terminations as directed below. Do not include imposed actions for an acquired or merged entity prior to the respondent’s ownership.

The respondent shall provide all of the following information:

* **Liquidated damages, fines, and penalties** - The respondent shall disclose whether any monetary amounts were charged to it due to non-compliance for the previous three (3) full calendar years.
* **Sanctions** - The respondent shall disclose whether any monetary or non-monetary penalty was imposed upon it for the previous three (3) full calendar years.
* **Corrective Action Plans (CAPs)** -The respondent shall disclose whether it developed any written plan of action to correct cited deficiencies in compliance with federal or state regulations, rules, or policies for the previous three (3) full calendar years.
* **Contract Terminations** -The respondent shall disclose, for the past five (5) years (since March 1, 2018), whether it:
  + Voluntarily terminated a managed care contract, in whole or in part, under which health care services were provided as the insurer.
  + Had a managed care contract partially or fully terminated before the contract end date (with or without cause).
  + Withdrew from a contracted service area of a managed care contract.
  + Requested a reduction of enrollment levels of a managed care contract.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Compliance tab and Compliance-Terminations tab, located at <https://ahca.myflorida.com/procurements>, to provide its Compliance History response.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.
2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.
3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).
4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Compliance tab.

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## SRC# 33 – Florida Presence: AUTOSCORED

Section 409.966(3)(c)3., F.S.

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

3. Are organizations that are based in and perform operational functions in this state, in-house or through contractual arrangements, by staff located in this state. Using a tiered approach, the highest number of points shall be awarded to a plan that has all or substantially all of its operational functions performed in the state. The second highest number of points shall be awarded to a plan that has a majority of its operational functions performed in the state. The agency may establish a third tier; however, preference points may not be awarded to plans that perform only community outreach, medical director functions, and state administrative functions in the state. For purposes of this subparagraph, operational functions include corporate headquarters, claims processing, member services, provider relations, utilization and prior authorization, case management, disease and quality functions, and finance and administration. For purposes of this subparagraph, the term “corporate headquarters” means the principal office of the organization, which may not be a subsidiary, directly or indirectly through one or more subsidiaries of, or a joint venture with, any other entity whose principal office is not located in the state.

The respondent shall provide information regarding whether each operational function, as defined in Section 409.966(3)(c)3, F.S., will be based in the State of Florida.

**Note:** Pursuant to Section 409.966(3)(c)3., F.S., response to this submission requirement will be considered for negotiations.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Florida Presence tab, located at <https://ahca.myflorida.com/procurements>, to provide its Florida Presence information.

**Evaluation Criteria:**

The extent of the respondent’s commitment to providing operational functions in Florida, including Corporate Headquarters, etc.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Florida Presence tab.

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## SRC# 34 – Managed Care Plan Accreditation: AUTOSCORED

Section 409.966(3)(a)1., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

The respondent shall provide information regarding its current accreditation status by a nationally recognized accrediting body as defined in Section 409.966(3)(a)1., F.S. This shall include the name of the accrediting body, the most recent date of certification, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (e.g., provisional, and conditional).

The respondent may receive additional points for achieving additive accreditations for increasing the respondent’s capacity to improve quality.

**Response:**

The respondent shall attach documentation that provides evidence of each accreditation it has obtained and that accreditation’s status.

**Evaluation Criteria:**

1. Evidence that the respondent has:
2. Full Managed Care Plan accreditation by a nationally recognized accrediting body (e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)); or
3. Partial/conditional Managed Care Plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or
4. No Managed Care Plan accreditation or denied accreditation.
5. Evidence that the respondent has additive accreditations from one or more of the following programs:
6. NCQA Electronic Clinical Quality Measures (eCQM) Certification.
7. NCQA Long-Term Supports and Services Distinction.
8. NCQA Population Health Program Accreditation.
9. URAC Integrated Behavioral Health Designation.
10. URAC Medicaid with Long-Term Services and Supports.
11. URAC Opioid Stewardship Designation.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Accreditation tab.

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# RECIPIENT AND PROVIDER EXPERIENCE

## SRC# 35 –Grievances: AUTOSCORED

Section 409.967(2)(h), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(h) Grievance resolution. —Consistent with federal law, each managed care plan shall establish and the agency shall approve an internal process for reviewing and responding to grievances from enrollees. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees.

The respondent shall provide data and information relevant to its top-ranking contract identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**) on the performance of its enrollee grievance and appeal system, including providing sufficient staffing to support the grievance and appeal system, and identifying, tracking, trending, and resolving enrollee grievances, appeals, and Medicaid fair hearings for calendar year 2022.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Grievances tab, located at <https://ahca.myflorida.com/procurements>, to provide performance metrics for its Grievances.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

The percentage of grievances not resolved within ninety (90) days.

The percentage of grievances per total population.

The percentage of appeals not resolved within thirty (30) days.

The percentage of appeals per total population.

The percentage of Medicaid Fair Hearings overturned.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Grievances tab.

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## SRC# 36 – Claims Processing and Payment: AUTOSCORED

Section 409.966(3)(c)6., F.S.

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

6. Have a claims payment process that ensures that claims that are not contested or denied will be promptly paid pursuant to s. 641.3155.

The respondent shall provide data and information relevant to its top-ranking contract identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**) for the time period of the most recent calendar year.

The respondent shall demonstrate performance of timely claim processing by providing data needed to complete the spreadsheet. Timeliness is defined by the timeframes associated with each of the measures outlined in the scoring criteria.

The respondent shall demonstrate performance related to claim processing accuracy by providing data needed to complete the spreadsheet. Accuracy is defined as the number/percent of claims processed correctly resulting in accurate payment.

The respondent shall demonstrate the ability to make accurate initial grievance and appeal determinations by providing data needed to complete the spreadsheet. Accuracy of initial grievance and appeal determinations is defined by the measures outlined in the scoring criteria associated with this SRC.

**Note:** Pursuant to Section 409.966(3)(c)6., F.S., response to this submission requirement will be considered for negotiations.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Processing and Payment tab, located at <https://ahca.myflorida.com/procurements>, to provide its Claims Processing and Payment Process responses.

The respondent shall submit internal reports used to monitor/measure accuracy, timeliness of claims processing and grievance/appeal processing in order to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

* + - 1. The extent to which the respondent’s electronically submitted claims are paid or denied within seven (7) calendar days.
      2. The extent to which the respondent’s electronically submitted nursing facility claims are paid or denied within ten (10) calendar days.
      3. The extent to which the respondent’s electronically submitted hospice claims are paid or denied within ten (10) calendar days.
      4. The extent to which the respondent’s electronically submitted hospital claims are paid or denied within fifteen (15) calendar days.
      5. The extent to which the respondent’s electronically submitted Durable Medical Equipment (DME) claims are paid or denied within fifteen (15) calendar days.
      6. The extent to which the respondent’s electronically submitted County Health Department claims are paid or denied within fifteen (15) calendar days.
      7. The extent to which the respondent’s electronically submitted total claims for all other providers are paid or denied within fifteen (15) calendar days.
      8. The extent to which the respondent’s non-electronically submitted claims are paid or denied within ten (10) calendar days.
      9. The extent to which the respondent’s non-electronically submitted claims are paid or denied within fifteen (15) calendar days.
      10. The extent to which the respondent’s non-electronically submitted claims are paid or denied within twenty (20) calendar days.
      11. The extent to which the respondent’s electronically submitted claims are accurately processed.
      12. The extent to which the respondent’s non-electronically submitted claims are accurately processed.
      13. The extent to which the respondent’s overturned claim disputes without the need for medical review.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Processing and Payment tab.

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## SRC# 37 – Provider Engagement Model: AUTOSCORED

The respondent shall provide data and information detailing its experience implementing its provider engagement model with a contract. The respondent must use data relevant only to the first contract identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**) and provide three (3) years’ worth of data. The respondent shall include the following elements in its response:

1. The respondent’s responsiveness to provider-initiated interactions.
2. The frequency with which the respondent reviews provider complaint reasons to determine the greatest areas of need for provider communication and training.
3. The type and frequency with which the respondent reviews claim denial reason codes to determine greatest areas of need for provider training.
4. The respondent’s extent of engagement with provider organizations, including regularity, frequency, and number of associations.
5. The respondent’s coverage of provider training topics, including at a minimum, service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, dispute resolution process and timeframes, and Agency contract requirements.
6. The respondent’s program of training, including methods of presentation and frequency of training.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Provider Engagement tab, located at <https://ahca.myflorida.com/procurements>, to provide the data and details concerning its prior experience operating a provider engagement model.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent of the respondent’s responsiveness to provider-initiated interactions.
2. The extent to which the respondent reviews provider complaint reasons to determine the greatest areas of need for provider communication and training.
3. The extent to which the respondent reviews claim denial reason codes to determine greatest areas of need for provider training.
4. The extent to which the respondent regularly engages with provider organizations.
5. The frequency with which the respondent engages with provider organizations.
6. The extent of providers associations with which the respondent has engaged.
7. The extent of the respondent’s coverage of provider training topics, including at a minimum. service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, dispute resolution process and timeframes, agency contract requirements.
8. The extent of the respondent’s program of training, including methods of presentation and frequency of training. (unscored)

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring Provider Engagement tab.

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## SRC# 38 – Non-Emergency Transportation Performance: AUTOSCORED

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall provide data reporting its non-emergency transportation (NET) services delivered between January 2022 and January 2023:

The respondent shall provide data in accordance with the categories listed below:

* Total number of trips.
* Total number and percentage of scheduled trips (Trips arranged in advance of a medical appointment or service) by level of assistance as described below.
  + Unassisted trips
    - Mass transit and public transportation systems.
    - Multi-load passenger van.
    - Private vehicle.
    - Taxi.
    - Transportation network companies.
  + Assisted trips.
    - Ground ambulances subcontracted for use as stretcher vans.
    - Ground and air ambulances.
    - Medical vehicles (wheelchair or stretcher vans).
    - Private non-profit agencies.
* Total number and percentage of unscheduled trips (See **Attachment B**, **Section II.B**.) by level of assistance, as described above.
* Total number and percentage of scheduled trips where the enrollee arrived on-time for the appointment.
  + Total number and percentage of scheduled trips established by standing orders (e.g., routine scheduled appointments for services such as renal dialysis, and cancer treatments) where the enrollee arrived on-time for the appointment.
* Total number and percentage of missed trips.
  + The respondent shall identify the number and percentage of missed trips where the trip was missed due to fault of the NET provider.
  + The respondent shall identify the number and percentage of missed trips where the trip was missed due to fault of the enrollee.
* Total number and percentage of scheduled Leg A trips (Trips to take the enrollee to an appointment) where the NET provider picked up the enrollee within fifteen (15) minutes of the scheduled time for pick-up.
* Total number and percentage of scheduled Leg B trips (Trips to return an enrollee from an appointment) where the NET provider picked up the enrollee within thirty (30) minutes of the scheduled time for pick-up.
* Total number and percentage of trips to take an enrollee to an urgent care center where the NET provider picked up the enrollee within three (3) hours of receiving the request.
* Total number and percentage of trips to return an enrollee from a hospital following discharge where the NET provider picked up the enrollee within three (3) hours of receiving the request.
* Total number and percentage of complaints and grievances pertaining to NET per one thousand (1,000) enrollees (unscored).

The respondent shall also identify whether it currently uses technological capabilities to track NET trips in real-time utilizing geo-mapping to locate providers at any time during service delivery and assesses completed or missed trips prior to adjudicating claims for those trips.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Non-Emergency Transportation tab, located at <https://ahca.myflorida.com/procurements>, to provide its responses to Non-Emergency Transportation Performance.

**Evaluation Criteria:**

1. The extent of NET trips that resulted in an enrollee arriving on time for an appointment.
2. The extent of NET trips that resulted in an enrollee arriving late for an established, standing order appointment.
3. The extent of NET Leg A trips that resulted in pick-up of an enrollee within fifteen (15) minutes of the scheduled time.
4. The percentage of NET Leg B trips that resulted in pick-up of an enrollee within thirty (30) minutes of the scheduled time.
5. The extent of NET service requests for transporting an enrollee to an urgent care center.
6. The percentage of NET service requests for transporting enrollee following discharge from a hospital fulfilled within three (3) hours of receiving the request.
7. The extent of missed NET trips due to fault of the NET provider.
8. Whether the respondent identifies that it currently uses technological capabilities to track NET trips in real-time utilizing geo-mapping to locate providers at any time during service delivery.
9. Tracking Capability to track and assess completed or missed trips prior to adjudicating claims for those trips.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-NET tab.

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## SRC# 39 – Consumer Assessment of Healthcare Providers and Systems Results: AUTOSCORED

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent (including respondent’s parent, affiliate(s), or subsidiary(ies)) shall include the target population (TANF, ABD, dual eligible, Medicaid expansion), and the respondent’s results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2022 survey for its adult and child populations. The respondent shall include in table format, the target population, and the respondent’s results for the CAHPS Home and Community-Based Services Survey (HCBS CAHPS) items/composites specified below for the 2022 survey for its long-term care (LTC) members receiving HCBS. Respondents shall provide the data requested in **Exhibit A-5-a-V3,** CAHPS Measurement Tool, to provide results for the following CAHPS items/composites and HCBS CAHPS items/composites.

Health Plan CAHPS:

* Health Plan Rating (percent rating 9 and 10).
* Health Care Rating (percent rating 9 and 10).
* Getting Needed Care (composite) (percent reporting Usually and Always).
* Getting Care Quickly (composite) (percent reporting Usually and Always.
* Health Plan Information & Services (composite) (percent reporting Usually and Always).

HCBS CAHPS:

* Rating of Case Manager (percent rating 9 and 10/Excellent).
* Rating of Homemaker (percent rating 9 and 10/Excellent).
* Choosing the Services that Matter to You (composite)(percent reporting All/Yes).

For purposes of identifying the respondent’s parent, affiliate(s), and subsidiary(ies), see “business relationship” as defined in Section 409.966(3)(b), F.S.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, CAHPS tab, located at <https://ahca.myflorida.com/procurements>, to provide CAHPS results.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent to which the respondent exceeded the national Medicaid mean for each Health Plan CAHPS survey item/composite reported.

1. The extent to which the respondent exceeded the Florida Medicaid mean for each HCBS CAHPS survey item reported.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-CAHPS tab.

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# BUSINESS OPERATIONS AND ADMINISTRATION

## SRC#40 – Encounter Data Submission Compliance: EVALUATOR SCORED

Section 409.967(2)(e), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(e) Encounter data. —The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall provide its experience and compliance with encounter data submissions.

1. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how it assures accuracy, timeliness, and completeness of encounter data. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness, and completeness.
2. Completeness of encounter submission requires that key fields are populated accurately for every encounter submission. The respondent shall demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (i.e., Achieved Savings Rebate, FMMIS, special submissions) and across providers and provider types.
   1. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.
   2. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.
   3. The respondent’s approach must ensure that all providers, including subcapitated providers, subcontractors, atypical providers, and non-participating providers, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, the respondent must describe its approach to ensuring the amount or cost of the Medicaid service provided is the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.
3. The respondent shall submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements, as well as resubmission within thirty (30) days of failed encounter submissions.
4. The respondent shall include documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframes for completing corrective actions.

**Response:**

Limit your written response to a maximum of 50,000 characters, including spaces, exclusive of attachments (charts, tables, exhibits, etc.).

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The adequacy of the respondent’s ability to implement timely corrective actions to compliance ratings, if indicated. (5 pts.)
2. The adequacy of the respondent’s encounter data submission historical compliance rating, including compliance actions and liquidated damages, if indicated. (5 pts.)
3. The adequacy of the respondent’s process for converting paper claims to electronic encounter data. (5 pts.)
4. The adequacy of the tools and methodologies used to determine compliance. (5 pts.)
5. The adequacy of the respondent’s approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State. (5 pts.)
6. The adequacy of the tool to ensure that all encounters are submitted. (5 pts.)

**Score:** This section is worth a maximum of 225 points. Each of the above components is worth a maximum of 5 points each, based on the Standard Evaluation Criteria Scale, for a maximum subtotal of 30. The subtotal will then be multiplied by a factor of 7.5.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below.

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| **STANDARD EVALUATION CRITERIA SCALE** | |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed anywhere in the response submission. |
| 1 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 4 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 5 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 41 – Management Experience and Retention: AUTOSCORED

Section 409.981(3)(a), F.S.

(3) In addition to the criteria established in Section 409.966, the agency shall consider the following factors in the selection of eligible plans:

(a) Evidence of the employment of executive managers with expertise and experience in serving aged and disabled persons who require long-term care.

For the respondent’s highest-ranking contract identified through the Order of Selection, the respondent shall describe the extent to which executive managers (e.g., CEO, COO, CFO, CMO, vice presidents, senior managers) have expertise and experience in serving elders and adults with disabilities who require long-term services and supports and document such expertise and experience.

**Response:**

Respondents shall use **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Mgmt Exp & Retention tab, located at <https://ahca.myflorida.com/procurements>, to provide its Management Experience information.

The respondent shall submit internal reports and documentation used to substantiate the data provided in response to this SRC.

**Evaluation Criteria:**

1. The extent to which the respondent provides evidence, data, or metrics to demonstrate the relevant experience of their current management team.

**Score:** See scoring methodology in **Exhibit A-5-a-V3,** Submission Requirements and Evaluation Response Template, Scoring-Mgmt Exp & Retention tab.

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## SRC# 42 – Fraud and Abuse Compliance Program: EVALUATOR SCORED

Section 409.967(2)(g), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(g) Program integrity. —Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

1. A provider credentialing system and ongoing provider monitoring, including maintenance of written provider credentialing policies and procedures which comply with federal and agency guidelines;

2. An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

3. Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

4. Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

5. Designation of a program integrity compliance officer.

The respondent shall describe its compliance program including the Compliance Officer’s level of authority and reporting relationships. (See **Attachment B**, Scope of Services – Core Provisions, Section IX. Administration and Management, Sub-Section F. Fraud and Abuse Prevention.) The respondent shall describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. The respondent shall include a resume or curriculum vitae for the Compliance Officer. The respondent shall include an organizational chart that specifies which staff are involved in compliance, their levels of authority, and reporting relationships.

**Response:**

Limit your written response to a maximum of 3,500 characters, including spaces.

**Evaluation Criteria:**

1. The extent to which the respondent’s compliance plan meets or exceeds compliance with all State and federal requirements. (5 pts.)
2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program. (5 pts.)
3. The extent to which there are sufficient staff to implement the compliance program. (5 pts.)
4. The extent to which the respondent’s compliance program documents the respondent’s experience identifying subcontractor and internal fraud and abuse in managed health care programs and referring internal fraud and abuse to the Agency. (5 pts.)

**Score:** This section is worth 50 points. Each of the above components is worth a maximum of 5 points each using the Standard Evaluation Criteria Scale, for a subtotal of 20. The subtotal will be multiplied by a factor of 2.5 for the final score.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below.

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| --- | --- |
| **STANDARD EVALUATION CRITERIA SCALE** | |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed anywhere in the response submission. |
| 1 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 4 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 5 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 43 – Fraud and Abuse Special Investigations Unit (SIU) Manager: EVALUATOR SCORED

Section 409.967(2)(g), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(g) Program integrity.—Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

1. A provider credentialing system and ongoing provider monitoring, including maintenance of written provider credentialing policies and procedures which comply with federal and agency guidelines;

2. An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

3. Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

4. Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

5. Designation of a program integrity compliance officer.

The respondent shall describe its Special Investigations Unit (SIU) Manager’s level of authority and reporting relationships. (See **Attachment B**, Scope of Services – Core Provisions, Section IX. Administration and Management, Sub-Section F. Fraud and Abuse Prevention.) The respondent shall describe its experience for prevention and detection of potential or suspected fraud and abuse and overpayment in health care programs. The respondent shall include a resume or curriculum vitae for the SIU Manager. The respondent shall summarize its experience in implementing an anti-fraud plan and conducting or contracting for investigations of possible fraudulent or abusive acts.

**Response:**

Limit your written response to a maximum of 3,500 characters, including spaces.

**Evaluation Criteria:**

1. The extent to which the respondent’s Anti-Fraud Plan meets or exceeds compliance with all State and federal requirements. (See Section 409.91212, F.S.) (5 pts.)
2. The extent to which the respondent has identified an individual who is independent from the respondent and has adequate corporate governance reporting relationships to effectively implement and maintain the SIU program. (5 pts.)
3. The extent to which the SIU Manager can exercise prevention and detection of fraud and abuse by providers in the Medicaid program, including those that may require internal system reviews. (5 pts.)
4. The extent to which the respondent has demonstrated successful experience related to referrals of fraud and abuse to the single state agency or law enforcement. (5 pts.)

**Score:** This section is worth 50 points. Each of the above components is worth a maximum of 5 points each using the Standard Evaluation Criteria Scale, for a subtotal of 20. The subtotal will be multiplied by a factor of 2.5 for the final score.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below.

|  |  |
| --- | --- |
| **STANDARD EVALUATION CRITERIA SCALE** | |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed anywhere in the response submission. |
| 1 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 4 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 5 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 44 – Fraud and Abuse Special Investigations Unit (SIU): EVALUATOR SCORED

Section 409.967(2)(g), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(g) Program integrity.—Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

1. A provider credentialing system and ongoing provider monitoring, including maintenance of written provider credentialing policies and procedures which comply with federal and agency guidelines;

2. An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

3. Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

4. Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

5. Designation of a program integrity compliance officer.

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee. The respondent shall also include an organizational chart that specifies which staff are involved in the SIU unit, along with specific roles and duties. (See **Attachment B**, Scope of Services – Core Provisions, Section IX. Administration and Management, Sub-Section F. Fraud and Abuse Prevention.)

**Response:**

Limit your written response to a maximum of 3,500 characters, including spaces.

**Evaluation Criteria:**

1. The extent to which the respondent uses a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment; emphasis is placed upon automated approaches and the implementation of multiple types of controls. (5 pts.)
2. The extent to which the investigative team documents a prevention process which includes onsite reviews, claims systems, pre-payment review procedures, provider denial procedures, provider terminations, and electronic visit verification. (5 pts.)
3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment. (5 pts.)
4. The extent to which the respondent shows their collaborative efforts with regard to combatting fraud and abuse resulting in terminations, referrals, recoupments, etc. (5 pts.)

**Score:** This section is worth 50 points. Each of the above components is worth a maximum of 5 points each using the Standard Evaluation Criteria Scale, for a subtotal of 20. The subtotal will be multiplied by a factor of 2.5 for the final score.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below.

|  |  |
| --- | --- |
| **STANDARD EVALUATION CRITERIA SCALE** | |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed anywhere in the response submission. |
| 1 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 4 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 5 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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