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## SCORED SUBMISSION REQUIREMENTS & EVALUATION CRITERIA INSTRUCTIONS

Instructions to Respondents for the Completion of **Exhibit A-5-V2** and the Associated Attachments

All respondents to this solicitation shall utilize **Exhibit A-5-V2** 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,** Submission Requirements and Evaluation Response Template,Respondent Information tab. This information will be auto-populated into all other relevant SRC templates included in **Exhibit A-5-a**. The respondent must use these same three (3) contracts in all Evaluator Scored 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 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. Commercial contracts

Completion of Responses

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

Each SRC includes response criteria as follows:

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | *Yes/No* |
| **Narrative Response Required?** *If yes, list in form field below.* | *Yes/No* |
| **Character Limit?** *Character limits are inclusive of spaces.* | *Unlimited, N/A, or ###* |
| **Attachments Allowed?** *If yes, list in form field below.* | *Yes/No* |
| **SRC Template Required?** *Original format must be submitted.* | *Yes/No* |

Each SRC contains form fields to be used when indicated in the Response Criteria. 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. Text responses must be formatted for 8-1/2” x 11” paper, single-spaced, and in a size 11 Arial font.

Attachments are acceptable for any SRC response when indicated in the Response Criteria and must be referenced in the form field for the respective SRC and located behind each respective SRC response. Attachments do not count toward character limits. Respondents shall name and label attachments to refer to respective SRCs by SRC identifier number.

The SRCs in **Exhibit A-5-V2,** Scored Submission Requirements and Evaluation Criteria, may not be retyped and/or modified and must be submitted in the original format.

In addition to the electronic, PDF copy of **Exhibit A-5-V2** required in **Attachment A**, Instructions and Special Conditions, **Section C.**, Response Submission Requirements, **Sub-Section 1.**, Hardcopy and Electronic Submission Requirements, **Item c.**, Electronic Copy of Response, the respondent should submit its response to each SRC in a separate electronic folder that is labeled with the SRC number. The electronic folder for each SRC response should contain the response to the SRC along with attachments applicable to the SRC.

The SRCs in **Exhibit A-5-V2** andthe associated autoscoring procurement intake tools**,** **Exhibit A-5-a**, Submission Requirements and Evaluation Response Criteria Template, **Exhibit A-5-b**, SRC #21 - Expanded Benefits - Defined Template, and **Exhibit A-5-c-V2**, SRC #23 - Dental Provider Network Tool, may not be retyped and/or modified and must be submitted in the original format.

**Exhibit A-5-V2, Exhibit A-5-a,** **Exhibit A-5-b**, and **Exhibit A-5-c-V2** 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 Score section of the SRC.

Each Autoscored SRC includes a description of the scoring methodology in the Score section of the SRC.

**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# 19 – Organizational Commitment to Quality: AUTOSCORED

For the three contracts identified through the Order of Contract Selection (page 2, **Exhibit A-5-V2**), the respondent shall report on three completed [through at least two remeasurement periods] quality improvement (QI) projects through which the respondent achieved improved dental and oral 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 Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **Yes** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://ahca.myflorida.com/procurements>, Org 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 percentage of the enrollees targeted by the respondent’s QI project.
3. The focus of the respondent’s QI project.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Org Commitment to Quality tab.

**% improvement in the key metric:**

20% or higher = 15 points

16-19.99% = 12 points

11-15.99% = 9 points

6-10.99% = 6 points

1-5.99% = 3 points

Less than 1% = 0 points

**% of enrollees targeted in the QI project:**

20% or higher = 15 points

16-19.99% = 12 points

11-15.99% = 9 points

6-10.99% = 6 points

1-5.99% = 3 points

Less than 1% = 0 points

**Project Focus**

Reducing preventable dental-related ED visits = 3.33 points

Improving follow-up after dental related ED visits = 3.33 points

Improving dental outcomes = 3.33 points

Improving delivery of services to target populations = 3.33 points

Other focus = 0 points

**Weighting will be applied to points table for each contract based on the contract line of business:**

Medicaid Contract Quality Improvement project points will be 100% of the points received.

CHIP Contract Quality Improvement project points will be 90% of the points received.

Commercial Contract Quality Improvement project points will be 80% of the points received.

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## SRC# 20 – Dental Quality Measurement Experience: AUTOSCORED

For the three contracts identified through the Order of Contract Selection, the respondent shall provide its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include the respondent’s results for the Child Core Set measures specified below for each of the last three (3) years (calendar year 2020, calendar year 2021, and calendar year 2022). For reference, the Florida Medicaid Statewide Weighted Means for each of the named calendar years is provided below.

|  |
| --- |
| **CHILD CORE SET MEASURES – FL MEDICAID STATEWIDE WEIGHTED MEANS** |
| **Measure** | **CY 2020** | **CY 2021** | **CY 2022** |
| Oral Evaluation, Dental Services (OEV-CH)  – Total  | 32.26% | 35.74% | 34.07% |
| Sealant Receipt on Permanent First Molars (SFM-CH) – At least 1 | 24.69% | 37.84% | 48.08% |
|  |

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **Yes** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a,** Submission Requirements and Evaluation Response Template, located at <https://ahca.myflorida.com/procurements>, Dental Quality Measurement Exp tab, to provide data on its dental quality measures.

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:
2. Exceeded the Florida Medicaid statewide mean for each quality measure indicator reported.
3. Showed improvement from the first year to the second year reported.
4. Showed improvement from the second year to the third year reported.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria is indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Dental Quality Measurement Experience tab.

There are eighteen (18) opportunities (two (2) measure rates, three (3) contracts each, three (3) years each contract) for a respondent to report prior experience in meeting or exceeding standards for Child Core Set measures. For each measure rate, a total of 16.65 points is available per contract reported.

* 3.33 points if the reported rate exceeded the Florida Medicaid statewide mean, for each available year, for each available contract.
* An additional 3.33 points for each measure rate where the second year’s rate is an improvement over the first year’s rate, (e.g., where the CY 2021 rate is better than the CY 2020 rate).
* An additional 3.33 points for each measure rate where the third year’s rate is an improvement over the second year’s rate, (e.g., where the CY 2022 rate is better than the CY 2021 rate).

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## SRC# 21 – Expanded Benefits - Defined: AUTOSCORED

For its **proposed expanded benefits**, the respondent shall indicate and provide information relative to providing additional services to:

* Enrollees ages twenty (20) years and younger.
* Enrollees ages twenty-one (21) years and older.
* Enrollees with intellectual and developmental disabilities as identified by the Agency.
* Enrollees who are pregnant.
* Enrollees ages 65 years and older in addition to the standard benefit package and at no additional cost to the State.
1. The respondent shall indicate its proposed expanded benefits for all enrollees and targeted groups identified in this SRC:
2. Acclimation Visits for Individuals with Intellectual and Developmental Disabilities
3. Anterior Root Canals for Individuals with Intellectual and Developmental Disabilities and Seniors Aged 65+
4. Dental Crowns for Individuals with Intellectual and Developmental Disabilities and Seniors Aged 65+
5. Preventive Dental Care for Individuals 21+
6. Extra Dental Cleanings for Individuals with Intellectual and Developmental Disabilities and Pregnant Women
7. Fillings for Individuals 21+
8. OTC Benefits
9. Periodontal Services for Individuals 21+
10. Screenings for Individuals 21+
11. X-Rays for Individuals 21+
12. The respondent shall provide information for the proposed expanded benefits indicated that address the needs of all individuals and the targeted groups identified in this SRC.

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes\*** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a,** Expanded Benefits-Defined tab, and **Exhibit A-5-b**, SRC #21 - Expanded Benefits – Defined, located at <https://ahca.myflorida.com/procurements>, to provide its Expanded Benefits responses. **Exhibit A-5-b** does not generate a score. However, **failure to submit a completed Exhibit A-5-b may result in rejection of the response.**

The respondent shall submit internal reports and documentation describing the expanded benefits proposed in response to this SRC.

**Evaluation Criteria:**

1. The extent acclimation visits are offered as expanded benefits for individuals with intellectual and developmental disabilities.
2. The extent anterior root canals are offered as expanded benefits for individuals with intellectual and developmental disabilities and seniors ages sixty-five (65) years and older.
3. The extent dental crowns are offered as expanded benefits for individuals with intellectual and developmental disabilities and seniors ages sixty-five (65) years and older.
4. The extent preventive dental care is offered as expanded benefits for individuals ages twenty-one (21) years and older.
5. The extent extra dental cleanings are offered as expanded benefits to individuals with intellectual and developmental disabilities and pregnant women.
6. The extent fillings are offered as expanded benefits for individuals ages twenty-one (21) years and older.
7. The extent OTC benefits are offered quarterly as expanded benefits for all individuals ($10 per individual, $30 per family).
8. The extent periodontal services are offered as expanded benefits for individuals ages twenty-one (21) years and older.
9. The extent screenings are offered as expanded benefits for individuals ages twenty-one (21) years and older.
10. The extent x-rays are offered as expanded benefits for individuals ages twenty-one (21) years and older.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria is indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Expanded Benefits - Defined tab.

|  |  |
| --- | --- |
| **Expanded Benefit** | **Scoring** |
| Acclimation Visits | YES = 4 points; NO = 0 points |
| Anterior Root Canals | YES = 8 points; NO = 0 points |
| Dental Crowns | YES = 8 points; NO = 0 points |
| Preventative Dental Care | YES = 17 points; NO = 0 points |
| Extra Dental Cleanings | YES = 8 points; NO = 0 points |
| Fillings | YES = 10 points; NO = 0 points |
| OTC benefits  | YES = 12 points; NO = 0 points |
| Periodontics | YES = 6 points; NO = 0 points |
| Screenings | YES = 17 points; NO = 0 points |
| X-rays | YES = 10 points; NO = 0 points |

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## SRC# 22 – Value-Based Purchasing (VBP): AUTOSCORED

For the three contracts identified through the Order of Contract Selection (page 2, **Exhibit A-5-V2**), the respondent shall provide its experience in value-based purchasing (VBP). VBP contracts between the dental plans and its providers are intended to maximize high value care, reduce inappropriate care, and reward best-performing providers. Claims-based expenditures include all claim-based expenditures of the attributable enrollees, whether or not the cost is included in the VBP contract. Attributable enrollees are defined as enrollees that attribute to the dental provider(s) and meet the enrollee qualifications under the VBP contract..The respondent shall provide the following information for each state contract:

1. The percentage of in-network dentists who were in at least one LAN2A+ VBP agreement for CY 2020, 2021, and 2022.
2. The percentage of dentists in LAN2A+ VBP agreements who were paid more than $10,000 in rewards because of achieving or surpassing VBP outcomes for CY 2020, 2021, and 2022.
3. The percentage of total claim-based expenditures in LAN 3A+ VBP agreements in CY 2020, 2021, and 2022.

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **Yes** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

The respondent shall use **Exhibit A-5-a,** Submission Requirements and Evaluation Response Template, located at <https://ahca.myflorida.com/procurements>, Value Based Purchasing tab, to provide information on its proposed Value Based Purchasing Program.

**Response:**

**Evaluation Criteria:**

1. The extent of three (3)-year average percentage of dentists who were in a LAN 2A+ VBP agreement.
2. The extent of three (3)-year average percentage of dentists in a LAN 2A+ VBP agreement who earned VBP rewards greater than **$10,000** per year.
3. The extent of three (3)-year average percentage of total claim-based expenditures in LAN 3A+ VBP agreements.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria is indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Value-Based Purchasing tab.

**The three (3)-year average percentage of dentists who were in at least one LAN2A+ VBP agreement.**

20% or higher = 11.11 points

10% to 19.99% = 5 points

1% to 9.99% = 1 point

Less than 1% = 0 points

**The three (3)-year average percentage of dentists in a LAN 2A+ VBP agreement who were paid more than $10,000 in rewards for achieving or surpassing VBP outcomes.**

20% or higher = 11.11 points

10% to 19.99% = 5 points

1% to 9.99% = 1 point

Less than 1% = 0 points

**The three (3)-year average percentage of total claim-based expenditures in LAN 3A+ VBP agreements.**

20% or higher = 11.11 points

10% to 19.99% = 5 points

1% to 9.99% = 1 point

Less than 1% = 0 points

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# DELIVERY SYSTEM ENHANCEMENTS AND INTEGRATION

## SRC# 23 – Dental Provider Network Agreements/Contracts: AUTOSCORED

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 robust, quality-driven dental provider networks that will provide necessary dental services in a timely manner to Medicaid enrollees.

|  |
| --- |
| **Dental Providers:*** General Dentists
* Pediatric Dentists
* Endodontists
* Orthodontists
* Oral Surgeon
 |
| **Dental Providers who hold the following sedation permits:*** Permit for Moderate Sedation
* Permit for General Sedation
* Permit for Pediatric Moderate Sedation
 |
| **Ambulatory Surgical Centers (ASCs)** that are accessible for the provision of dental services, especially for adults and children with special health care needs. |
| **Hospitals with outpatient settings** which are accessible for the provision of dental services, especially for adults and children with special health care needs. |

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **No** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-c-V2**, SRC #23 **-** Dental Provider Network Tool, located 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 statewide.
			2. The extent of the respondent’s progress with executing provider agreements or contracts with providers holding and utilizing sedation permits for each of the regions statewide.
			3. The extent of the respondent’s progress with executing provider agreements or contracts with Ambulatory Surgical Centers (ASCs) for each of the regions statewide.
			4. The extent of the respondent’s progress with executing provider agreements or contracts with Hospitals where outpatient units are available for providing dental services. (unscored)

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria is indicated in **Exhibit A-5-c-V2**, SRC #23 - Dental Provider Network Tool.

**% of General Dentists contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**% of Pediatric Dentists contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**% of Endodontists contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**% of Orthodontists contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**% of Oral Surgeons contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**% Permitted for Moderate Sedation contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**% Permitted for General Sedation contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**% Permitted for Pediatric Moderate Sedation contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**% ASCs contracted:**

75.1% or higher = 1.11 points

50.1-75% = 0.8325 points

25.1-50% = 0.555 points

1-25% = 0.2775 points

Less than 1% = 0 points

**2 or more ASCs contracted in all Counties with 2 or more ASCs in the Region:**

Yes = 1.11 points

No = 0 points

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## SRC# 24 – Provider Network Enhancements: AUTOSCORED

For its **proposed provider network**, the respondent shall provide evidence of a network that will be highly effective in improving health outcomes for Dental Plan enrollees, which includes people with higher needs for oral health care. The respondent shall provide the following information about its provider network:

1. Percentage of dentists in proposed network that have completed training in special needs dentistry within the past six (6) years of proposal submission. For this SRC, training in special needs dentistry includes, at a minimum, didactic learning and direct patient clinical experiences in the dental care for people with intellectual and developmental disabilities. Training may have occurred in a Commission on Dental Accreditation (CODA)-accredited or Commission-accredited dental school, CODA-accredited advanced dental education program (*e.g.*, pediatric dentistry), or professional certification in special needs dentistry from a Florida Board of Dentistry-approved continuing education provider.
2. Percent of dentists in proposed network who are Black.
3. Percent of dentists in proposed network who are Hispanic.
4. Percent of dentists in proposed network who fluently speak English and Spanish.
5. Percent of dentists in proposed network who practice in an accredited patient-centered medical home (PCMH) or patient-centered dental home (PCDH). Accreditation may be from the Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA), or the Joint Commission.

 **Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a,** Submission Requirements and Evaluation Response Template, Provider Network Enhancements tab, located at <https://ahca.myflorida.com/procurements>, to provide its Provider Network Enhancements 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 dentists in proposed network with special needs dentistry training.
2. The extent of dentists in proposed network who are Black.
3. The extent of dentists in proposed network who are Hispanic.
4. The extent of dentists in proposed network who fluently speak English and Spanish.
5. The extent of dentists in proposed network who practice in an accredited patient-centered medical home (PCMH) or patient-centered dental home (PCDH). Accreditation may be from the Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA), or the Joint Commission.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Provider Network Enhancements tab.

**% of dentists in proposed network with special needs dentistry training:**

75% or higher = 29 points

50-74.99% = 21.75 points

10-49.99% = 14.5 points

1-9.99% = 7.25 points

Less than 1% = 0 points

**% of dentists in proposed network who are Black:**

4% or higher = 14 points

Under 4% = 0 points

**% of dentists in proposed network who are Hispanic:**

25% or higher = 14 points

10-24.99% = 8 points

5-9.99% = 5 points

1-4.99% = 3 points

Less than 1% = 0 points

**% of dentists in proposed network who fluently speak English and Spanish:**

20% or higher = 14 points

10-19.99% = 9 points

5-9.99% = 6 points

1-4.99% = 3 points

Less than 1% = 0 points

**% of dentists in proposed network who practice in an accredited patient-centered medical home (PCMH) or patient-centered dental home (PCDH).**

50% or higher = 29 points

25-49.99% = 18 points

1-24.99% = 4.5 points

Less than 1% = 0 points

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## SRC# 25 – Vignette – Dental Provider Experience, Onboarding and Practice Support: EVALUATOR SCORED

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

Dr. Alberta graduated from a Florida dental school ten years ago, obtained a New York dental license, and worked in a New York private dental practice in good standing. Last month, she moved to Florida (Region B) to be closer to family. She was hired as a full partner by a private dental practice into a full-time position. Dr. Alberta was also appointed as an adjunct faculty member at a Florida dental school because of her prior teaching awards and interest in training the future of her profession. Dr. Alberta’s new Florida practice had contracts with all state Medicaid dental plans, but she needed to obtain a license from the Florida Board of Dentistry, enroll as a Medicaid provider, credential with the dental plans, and complete necessary continuing education and other training. That onboarding process took six months.

Within a month of Dr. Alberta’s dentistry licensure and credentialing, her clinic schedule filled with Dental Plan enrollees seeking appointments. The dental plan’s provider directory contained wrong information for her practice and the process to change the information was time-consuming and prolonged. For each new patient appointment, her office spent 2 hours collecting demographic information, verifying Medicaid status, determining dental plan enrollment, importing the patient’s dental history into the chart, finding an acceptable day and time for the appointment, answering questions about out-of-pocket expenses, and assisting with transportation arrangements when needed. Despite calls, texts, and emails, the missed or canceled appointment rate in Dr. Alberta’s clinic was 33%. Half of the missed or canceled appointments were because of transportation issues arising the morning of the appointment. Dr. Alberta and her staff did not have the time or resources to rapidly respond to the transportation issues. Consequently, both the patient and the dentist missed opportunities to improve oral health.

The respondent shall describe its operations that support dental providers in caring for Dental Plan enrollees, including detailed descriptions of procedures, automated workflows, responsible personnel, innovations in provider recruitment and retention, and methods of ongoing evaluation and response to provider experience. The respondent is asked to describe how it:

* Expedites Dental Provider New and Renewal Application for State Licensure
* Expedites Dental Provider New and Renewal Medicaid Provider Enrollment
* Expedites Dental Provider Credentialing within Provider Network
* Assists Dental Providers in Maintaining and Keeping Track of Required Continuing Education Credits
* Assists New Patient Onboarding in the Dental Practice
* Expedites Enrollee Eligibility Verification
* Coordinates Transportation For Medicaid Enrollees to make Dental Provider Appointments, including Same-Day Need
* Reduces Missed or Canceled Appointments
* Compensates Dental Providers for Missed or Canceled Appointments

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **Yes** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **10,000** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **No** |

**Response:**

**Evaluation Criteria:**

1. The extent to which the respondent:
2. Expedites Dental Provider New and Renewal Application for State Licensure
3. Expedites Dental Provider New and Renewal Medicaid Provider Enrollment
4. Expedites Dental Provider Credentialing within Provider Network
5. Assists Dental Providers in Maintaining and Keeping Track of Required Continuing Education Credits
6. Assists New Patient Onboarding in the Dental Practice
7. Expedites Enrollee Eligibility Verification
8. Coordinates Transportation For Medicaid Enrollees to make Dental Provider Appointments, including Same-Day Need
9. Reduces Missed or Canceled Appointments
10. Compensates Dental Providers for Missed or Canceled Appointments

**Score:**

This section is worth a maximum of 100points. Each of the above components is worth the maximum points as reflected in the Standard Evaluation Criteria Scale below.

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. |
| 2.22 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 4.44 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 6.67 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 8.89 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 11.11 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 26 – Vignette – Dental Provider Experience, Special Needs Dentistry: EVALUATOR SCORED

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

For Dr. Alberta’s dental practice, manually submitting electronic claims through the dental plan’s provider portal took an average of 30 minutes per claim, which became too time-consuming for her busy practice. Therefore, she paid to use an electronic claims clearinghouse to automate her billing and attach patient dental records for the dental plans’ utilization management review processes. Dr. Alberta and her staff excelled at caring for people with intellectual or developmental disabilities (I/DD). Although she completed a residency in pediatric dentistry and was certified by the American Board of Pediatric Dentistry, she was interested in obtaining continuing education in special needs dentistry. However, Dr. Alberta and her staff were challenged to find the time, the right program, and financial support to participate in continuing dental education. Often, chair time for I/DD patients exceeded one hour and required a dentist, a hygienist, and a dental assistant, for which no group of codes paid for the encounter’s true cost of care. Dr. Alberta did not have a sedation permit from the Florida Board of Dentistry, but she was interested in achieving that qualification if time, program, and financial support became available to her. Without a sedation permit, Dr. Alberta used a nearby hospital’s operating room (OR) and anesthesiology group for cases requiring sedation. However, it was challenging to reserve hospital OR time amidst the hospital’s other medical and surgical procedures. Typically, the hospital offered late afternoon OR timeslots that were subject to short-notice cancelation when other surgeries ran late. The other option for Dr. Alberta and her patients was to use an ambulatory surgery center (ASC) that provided facility support and anesthesiology services. Although the Dental Plan paid the ASC for the procedure, the payment was not sufficient to pay the anesthesiologist costs.

The respondent shall describe its operations that support dental providers in caring for Dental Plan enrollees, including detailed descriptions of procedures, automated workflows, responsible personnel, innovations in provider recruitment and retention, and methods of ongoing evaluation and response to provider experience. The respondent is asked to describe how it:

* Reduces Administrative Burden of Submitting Electronic Claims.
* Assists Dental Providers in Completing Certificates for Special Needs Dentistry.
* Assists Dental Providers in obtaining sedation permits from the Florida Board of Dentistry.
* Maximizes support and fairly pays Dental Providers and their Practices in Caring for People with Special Needs, such as I/DD.
* Supports Dental Providers with their patients’ anesthesiology needs.
* Assists Dental Providers in acquiring operating room time in hospitals and ambulatory surgery centers.
* Maximizes Support and fairly pays hospitals and ambulatory surgery centers for the facility and anesthesiology costs of care.

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **Yes** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **10,000** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **No** |

**Response:**

**Evaluation Criteria:**

* 1. The extent to which the respondent:
1. Reduces Administrative Burden of Submitting Electronic Claims
2. Assists Dental Providers in Completing Certificates for Special Needs Dentistry
3. Assists Dental Providers in obtaining sedation permits from the Florida Board of Dentistry
4. Maximizes support and fairly pays Dental Providers and their Practices in Caring for People with Special Needs, such as I/DD
5. Supports Dental Providers with their patients’ anesthesiology needs
6. Assists Dental Providers in acquiring operating room time in hospitals and ambulatory surgery centers
7. Maximizes Support and fairly pays hospitals and ambulatory surgery centers for the facility and anesthesiology costs of care

**Score:**

This SRC is worth a maximum of 100 points. Each of the above components is worth the maximum points reflected below in the Standard Evaluation Criteria Scale.

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. |
| 2.86 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 5.72 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 8.57 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 11.43 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 14.29 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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# RESPONDENT BACKGROUND AND EXPERIENCE

## SRC# 27 – Compliance History: AUTOSCORED

For the three contracts identified through the Order of Contract Selection (page 2, **Exhibit A-5-V2,** 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)) as directed below. The respondent shall also provide all contract terminations as directed below, not limited to the three contracts identified through the Order of Contract Selection.

* + - 1. The respondent shall provide 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 contract years.
* **Sanctions** - The respondent shall disclose whether any monetary or non-monetary penalty was imposed upon it for the previous three (3) full contract 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 contract years.
	+ - 1. The respondent shall also disclose, for the past five (5) years (since October 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 Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **1. Above - Yes****2. Above - No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a,** Submission Requirements and Evaluation Response Template, located at <https://ahca.myflorida.com/procurements>, Compliance tab and Compliance-Terminations tab, 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:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Compliance tab and Compliance-Terminations tab.

**Liquidated Damages - % Total Revenue Imposed**

0-0.099% = 1 point

0.1-0.199% = 0.5 points

0.2% or greater = 0 points

**Number of Sanctions**

0 = 5.3 points

1+ = 0 points

**Number of CAPs**

0 = 2 points

1+ = 0 points

**Number of Terminations**

0 = 25 points

1+ = 0 points

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## SRC# 28 – Required Florida Presence: AUTOSCORED

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.

For purposes of this SRC, “Corporate Headquarters” refers to the location of its executive management and key managerial staff as identified in **Attachment B,**  Scope of Service – Core Provisions, **Section IX.**,Administration and Management, **Sub-Section B.**, Organizational Governance and Staffing, **Item 2.**, Minimum Staffing.

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

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **No** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a,** Submission Requirements and Evaluation Response Template, FL 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:

1. Corporate Headquarters,
2. Claims Processing,
3. Member Services,
4. Provider Services.
5. Utilization Management,
6. Prior Authorization,
7. Case Management, and
8. Quality.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria is indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the FL Presence tab.

**Presence in Florida:**

Corporate Headquarters - Yes = 10 points; No = 0 points

Claims Processing - Yes = 16 points; No = 0 points

Member Services - Yes = 16 points; No = 0 points

Provider Services - Yes = 16 points; No = 0 points

Utilization Management - Yes = 5 points; No = 0 points

Prior Authorization - Yes = 5 points; No = 0 points

Case Management - Yes = 16 points; No = 0 points

Quality - Yes = 16 points; No = 0 points

The total number of points is the sum of all individual points earned.

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## SRC# 29 – Managed Care Experience: AUTOSCORED

The respondent, including respondent’s parent, affiliate(s), and subsidiary(ies), shall provide a list of up to ten (10) of its current and/or recent (within five (5) years of the issue date of this solicitation (since October 1, 2018)) capitated contracts for managed dental care services. 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 contract number as assigned by the contractor.
	2. The line of business (Medicaid, CHIP, or Commercial).
	3. The state in which the contract is held (two-letter abbreviation).
	4. Whether or not the contract is statewide.
	5. The specific contract implementation date (first date of services provided) and end date of the contract (last date of services provided or to be provided). Note: The respondent will enter the contract end date as it appears in the applicable contract. However, dates after October 1, 2023, will not be counted toward the actual length of contract in years.
	6. Total unduplicated population served under the contract.
	7. Premium revenue for latest contract year.

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **No** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

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

**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 October 1, 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 of the respondent’s experience with population.
5. Enter the premium revenue for the latest Contract year. (Unscored)

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Managed Care Experience tab.

**Line of business**

Medicaid = 2.5 points

CHIP = 2.3 points

Commercial = 1 point

**Length of Contract**

Less than 1 year = 0 points

1 year to less than 3 years = 1 point

3 years to 5 years = 2 points

Greater than 5 years = 3 points

\*\*Future contract years will not be counted toward the length of the contract.

**Statewide Coverage**

Yes = 2.5 point

No = 2 points

**Total Unduplicated Population Under Contract**

Greater than or equal to 500,000 enrollees = 2.5 points

250,000 to 499,999 enrollees = 1.25 points

Less than 250,000 enrollees = 0 points

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## SRC# 30 – Accreditation: AUTOSCORED

The respondent shall provide information regarding its current accreditation status by a nationally recognized accrediting body. 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.*, full, provisional, conditional).

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

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

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 health plan accreditation or Full Medicaid health 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 health plan accreditation (e.g., provisional for NCQA, conditional for URAC, or one (1) year or six (6) months for AAAHC); or
4. No managed care plan accreditation or denied accreditation.
5. Evidence of dental plan accreditation:
	1. Full three (3) year dental plan accreditation from URAC; or
	2. Conditional dental plan accreditation from URAC; or
	3. No dental plan accreditation from URAC.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Accreditation tab.

**Managed Care Plan Accreditation**

Full 3-Year Accreditation = 50 points

Partial/Conditional Accreditation = 20 points

No Accreditation/Denied Accreditation = 0 points

**Dental Plan Accreditation**

Full 3-Year Accreditation = 50 points

Partial/Conditional Accreditation = 20 points

No Accreditation/Denied Accreditation = 0 points

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# RECIPIENT AND PROVIDER EXPERIENCE

## SRC# 31 – Vignette - Working with Individuals with Intellectual Disabilities: EVALUATOR SCORED

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

*Harold is thirty-five (35) year-old Dental Plan Enrollee and lives in an Agency for Persons with Disabilities licensed group home (GH) in a rural community. He is an iBudget enrollee and is a Dual Eligible recipient. His diagnoses are autism, epilepsy, depression, anxiety, and diabetes. He is non-verbal. Harold receives five hours a week of ongoing Behavior Analysis (BA) services from a Registered Behavior Analyst through the iBudget Waiver for self-injurious behaviors and aggression. His triggers are physical touch, loud noises, changes in routine, and bright light. His behavior plan currently requires one group home staff and his BA provider to attend all medical and dental appointments. Harold is ambulatory but needs physical assistance when transferring from chairs and walking on uneven terrain. Regarding Harold’s dental hygiene, he will not brush his teeth and becomes more aggressive when anyone tries to do so or touch his face. Because of Harold’s aggression, GH staff are only able to brush his teeth once per day and note his gums bleed on every occasion. The last time Harold had a dental exam and cleaning was November 2018, which was covered through the iBudget waiver. At that prior appointment, Harold’s oral examination revealed a few gum locations with pocket depths of 4 mm, one small intact filling, no new cavities, and unsealed teeth. The dentist treated Harold since 2009 and provided in-office, non-intravenous sedation, with the use of extra personnel, calm setting, acclimation visits, and personalized accommodations. However, this dentist will not enroll as a Medicaid provider because of the reimbursement rates, the administrative burden, and their wish to limit the number of Medicaid patients in the practice. Attempts to see another dentist through his current Medicaid dental plan have been unsuccessful due to lack of dental providers in network who have the staff and time to care for Harold and lack of in-office sedation in the area. His sister has Durable Power of Attorney.*

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

* Oral Health Risk Assessment
* Care Coordination/Case Management
* Provider Engagement
* Service Planning
* Specialist Services
* Healthy Behaviors
* Grievance and Appeals

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

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **Yes** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **10,000** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **No** |

**Response:**

**Evaluation Criteria:**

1. The extent to which the respondent identifies caregivers and guardian, or legally authorized responsible persons involved in the enrollee’s care.
2. The extent the respondent describes methods of care planning involving all identified caregivers and guardian or legally authorized responsible persons.
3. The extent to which the respondent Identifies service needs (covered and non-covered) and a description for service referral processes.
4. The extent to which the respondent demonstrates innovative and evidence-based alternative dental treatment options (e.g., treatments for medication induced oral issues).
5. The extent to which the respondent describes and implements care delivery in the most appropriate and cost-effective setting which improves enrollee participation.
6. The extent to which the respondent demonstrates experience in providing services to enrollees with IDD and provides evidence of strategies utilized that resulted in improved dental health outcomes.

**Score:**

This section is worth a maximum of 100 points. Each of the above components is worth the maximum points as reflected in the Standard Evaluation Criteria Scale.

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. |
| 3.33 | The component contained significant deficiencies. |
| 6.67 | The component is below average. |
| 10.02 | The component is average. |
| 13.35 | The component is above average. |
| 16.67 | The component is excellent. |

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## SRC# 32 – Claims Processing and Payment: AUTOSCORED

The respondent shall provide data and information relevant to its top-ranking contract identified through the Order of Contract Selection (page 2, **Exhibit A-5-V2**) 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.

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **Yes** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a,** Submission Requirements and Evaluation Response Template, located at <https://ahca.myflorida.com/procurements>, Claims Processing and Payment tab, 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 clean claims are paid or denied within seven (7) calendar days.
			2. The extent to which the respondent’s electronically submitted clean claims are paid or denied within fifteen (15) calendar days.
			3. The extent to which the respondent’s non-electronically submitted clean claims are paid or denied within ten (10) calendar days.
			4. The extent to which the respondent’s non-electronically clean submitted claims are paid or denied within fifteen (15) calendar days.
			5. The extent to which the respondent’s non-electronically submitted clean claims are paid or denied within twenty (20) calendar days.
			6. The extent to which the respondent’s electronically submitted clean claims are accurately processed.
			7. The extent to which the respondent’s non-electronically submitted clean claims are accurately processed.
			8. The extent to which the respondent’s clean claim disputes without the need for medical review are overturned.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Claims Processing and Payment tab.

**Timeliness of Electronically Submitted Clean Claims:**

**% Paid/Denied within 7 calendar days:**

90-100% = 20 Points

80-89.99% = 10 Points

79.99% and below = 0 Points

**% Paid/Denied within 15 calendar days:**

95-100% = 10 Points

94.99% and below = 0 Points

**Timeliness of Non-Electronically Submitted Clean Claims:**

**% Paid/Denied within 10 calendar days:**

90-100% = 20 Points

80-89.99% = 10 Points

79.99% and below = 0 Points

**% Paid/Denied within 15 calendar days**

95-100% = 15 Points

94.99% and below = 0 Points

**% Paid/Denied within 20 calendar days**

95-100% = 5 Points

94.99% and below = 0 Points

**Accuracy:**

**% Electronically Submitted Clean Claims Accurately processed**

98-100% = 10 Points

95-97.99% = 5 Points

90-94.99% = 1 Points

89.99% and below = 0 Points

**% Non-Electronically Submitted Clean Claims Accurately processed**

98-100% = 10 Points

95-97.99% = 5 Points

90-94.99% = 1 Points

89.99% and below = 0 Points

**Claim Appeals/Grievances:**

**% Claim Disputes Overturned without the need for medical review**

0-5.99% Overturned = 10 Points

6-10.99% Overturned = 5 Points

11-20.99% Overturned = 1 Points

21% or more Overturned = 0 Points

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## SRC# 33 – Provider Engagement Model: AUTOSCORED

The respondent shall provide data and information detailing its experience implementing its provider engagement model with the first Medicaid contract identified through the Order of Contract Selection (page 2, **Exhibit A-5-V2**). The respondent must use data relevant only to the Medicaid contract and provide three (3) years’ worth of data. Only data from Medicaid contracts will be considered for this SRC. 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 identify the areas of need for provider communication and training.

**3.** The 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 associations, including regularity, number of meetings during the contract year, and frequency of attendance at provider association meetings.

**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 other training topics, frequency of training, andmethods of presentation for the respondent’s training topics.

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **Yes** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, Provider Engagement Model 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 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 engages with provider associations, including regularity, number of meetings during the contract year, and frequency of attendance at provider association meetings.

**5.** 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.

**6.** The extent of the respondent’s program of training, including other training topics, methods of presentation, and frequency of training.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Provider Engagement Model tab.

**Responsiveness to Provider-Initiated Interactions**

Less than 24 hours = 8 points

24 to 48 hours = 4 points

More than 48 hours = 0 points

**Frequency of Review of Provider Complaint Reasons to Identify Training Needs**

Daily = 4 points

Weekly = 2.4 points

Monthly = 0.8 point

Less frequently than monthly = 0 points

**Frequency of Claim Denial Code Reviews to Identify Training Needs**

Daily = 4 points

Weekly = 2.4 points

Monthly = 0.8 point

Less frequently than monthly = 0 points

**Regularity of Meetings with Provider Associations**

Met regularly = 3 points

Met irregularly or not at all = 0 points

**Number of Meetings with Provider Associations During Review Period**

Met with 5 or more = 3 points

Met with 1 to 4 = 1.8 points

Did not meet = 0 points

**Frequency of Provider Association Meetings**

Monthly = 3 points

Quarterly = 1.8 points

Less than quarterly = 1 points

**Coverage of Provider Training Topics:**

All 7 topics indicated with additional topics added = 3 points

At least 5 topics indicated with additional topics added = 0.6 point

Less than five (5) topics indicated and/or did not add other topics = 0 points

**Routine Training Provider Live or In-Person**

At least 75% = 5.33 points

50 to 74.99% = 3.198 points

Less than 50% = 0 points

**Frequency of Routine Training Provided (unscored)**

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# PATHWAYS TO PROSPERITY

## SRC# 34 – Community Partnerships: AUTOSCORED

The respondent shall describe the extent to which it has established community partnerships with organizations that provide specialized oral health-related services aimed at improving access to preventive dental care, increasing provider networks, and ensuring that special populations receive adequate care. 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 oral health-related services and supports. In **Exhibit A-5-a,** Submission Requirements and Evaluation Response Template, the respondent shall list:

* The CBO name,
* Federal employer identification number (FEIN),
* Florida Division of Corporations (FDOC) document number,
* Principal address,
* Mailing address,
* Contract identification number with the CBO,
* Contract execution date,
* A description of the enrollee population(s) being served,
* A description of the oral health-related services and supports for said enrollees,
* Whether the CBO contract was designed to directly
	+ Improve access to dental services,
	+ Increase utilization of preventive care,
	+ Improve provider participation in Medicaid,
	+ Improve dental care for special populations,
	+ Improve oral health education and literacy,
* 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 Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **No** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

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

**Evaluation Criteria:**

* + - 1. The extent of unique, contracted CBOs with principal address in Florida.
			2. The extent to which each CBO provides services or supports in at least one of the following areas: Improving access to dental services, increasing utilization of preventive care, improving provider participation in Medicaid, improving dental care for special populations, and oral health education and literacy.
			3. The extent to which each CBOoffers financial assistance or incentives (loan forgiveness, bonuses, offering relocation expenses etc.) to recent dental school graduates.
			4. The extent to which each CBO has partnered with a Florida dental school.
			5. The extent to which each CBO has partnered with dental hygiene schools.
			6. The extent to which each CBO provides assistance with educational requirements for people still in school (i.e., clinical hours, on the job training etc.).
			7. The extent to which each CBO provides support for general dentistry/dental hygiene student training, certification, and education.
			8. The extent to which at least one CBO provides services or supports in each AHCA region.
			9. The extent to which each CBO has an established partnership with the respondent.
			10. The extent to which each CBO has a representative who serves on a respondent committee or advisory board.
			11. The extent of Florida counties with at least one CBO providing services and supports to enrollees (unscored).
			12. The extent to which each CBO uses a closed-loop software system to receive enrollee referrals from providers and verify with the respondent that services or supports were provided to enrollees (unscored).
			13. The extent to which each CBO receives a financial investment from the respondent (unscored).
			14. The extent to which each CBO receives in-kind support from the respondent (unscored).

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Community Partnerships tab.

* + - * 1. 0.3 points per CBO with a principal address in Florida, up to 6 points.
				2. 0.5 points to partnerships focused on improving access to dental services, up to 10 points.
				3. 0.35 points for partnerships aimed at improving care for special populations, up to 7 points.
				4. 0.3 points for partnerships supporting increased provider participation, utilization of preventive care, and oral health education, up to 6 points.
				5. One point for each CBOoffering financial assistance or incentives (loan forgiveness, bonuses, offering relocation expenses etc.) to recent dental school graduates, up to 20 points.
				6. 0.55 points for each CBO partnered with a Florida dental school, up to 11 points.
				7. 0.5 points for each CBO partnered with dental hygiene schools, up to 10 points.
				8. 0.35 points for each CBO providing assistance with educational requirements for people still in school (i.e., clinical hours, on the job training etc.), up to 7 points.
				9. 0.45 points for each CBO that provides supports in AHCA regions, up to 9 points.
				10. 0.175 points for length of relationship between each CBO and respondent one year or greater, up to 7 points.
				11. 0.35 points for each CBO that has a representative who serves on a respondent’s Committee or Advisory Board that supports core goals, and 0.175 points for each CBO that has a representative who serves on a respondent’s Committee or Advisory Board that supports other goals, up to 7 points.

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## SRC# 35 – Vignette - Patient Dental Care: EVALUATOR SCORED

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

*Antonio Montana is an eight (8)-year-old male who was recently diagnosed with type I diabetes. During his last well-child visit, his pediatrician noted that he has significant decay in several of his adult teeth as well as inflamed gums. This is in addition to elevated blood glucose levels despite receiving daily injections of insulin. Antonio’s pediatrician suspects he continues to consume a diet heavy in processed carbohydrates and sugar. When asked whether Antonio had seen a dentist in the past twelve (12) months, his mother responded that he had not and explained that no dentist near her would take someone on Medicaid. Antonio’s pediatrician also indicated that the mother lacks reliable transportation and has limited English proficiency. In response to questions about Antonio’s dental hygiene, his mother was unable to say how frequently he brushes his teeth and whether he uses mouthwash. She further explained that she had never heard of any benefits such as the school-based sealant program and knew Antonio had never had any preventive services such as regular fluoride treatments or sealants. Antonio was a Medicaid recipient in another state, and he became a member of Dental Plan when his family moved to Florida in July 2023.*

The respondent shall describe its operations in caring for this enrollee and his family, including detailed descriptions of internal processes. Specifically, the respondent is asked to describe how it:

* 1. Receives and responds to closed loop system of referrals from Managed Medical Assistance plan providers.
	2. Connects the enrollee with school-based sealant program(s).
	3. Connects the enrollee and their family with the county health department.
	4. Communicates with enrollee and his family.
	5. Coordinates care for the enrollee and his family.
	6. Coordinates the enrollee’s care with Dental provider.
	7. Provides dental health education to the enrollee and his family.

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

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **Yes** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **15,000** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes\*** |
| **SRC Template Required?** *Original format must be submitted.* | **No** |

\*Attachments allowed are limited to workflows.

**Response:**

**Evaluation Criteria:**

The extent to which the respondent:

1. Identifies stakeholders involved in the enrollee’s care.
2. Coordinates with the enrollee’s MMA plan through a closed-loop verification system.
3. Describes methods of care planning involving all identified stakeholders.
4. Includes workflows and narrative description of the timeframes for completion of each step in the care planning process.
5. Identifies service needs (covered and non-covered) and provides a description for service referral processes.
6. Describes the use of the interventions and strategies that would be used to facilitate compliance with the plan of care.
7. Demonstrates innovative and evidence-based strategies that will be used to coordinate the enrollee’s care across multiple service programs based on the needs of the enrollee.
8. Describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary emergency department use.
9. Demonstrates innovative and evidence-based strategies for providing dental health education that will be used to assist the enrollee and his family.
10. Includes application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
11. Documents coordination and communication efforts in the enrollee record, including any referrals to services (whether dental, or community-based) and follow up on the enrollee’s receipt of services.

**Score:**

This section is worth a maximum of 100 points. Each of the above components is worth 6.25 points as reflected in the Standard Evaluation Criteria Scale.

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. |
| 1.25 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 2.5 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 3.75 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 5 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 6.25 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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# BUSINESS OPERATIONS AND ADMINISTRATION

## SRC# 36 – Encounter Data Submission Compliance: EVALUATOR SCORED

For the Medicaid and CHIP contracts identified through the Order of Contract Selection (page 2, **Exhibit A-5-V2**),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, resubmission, and completeness of encounter data. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness, resubmission, 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, even if the amount is zero dollars.
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) contract years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframes for completing corrective actions.

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **Yes** |
| **Narrative Response Required?** *If yes, list in form field below.* | **Yes** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **50,000** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **No** |

**Response:**

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 encounter data submission process related to how it supports compliance with encounter accuracy, timeliness, resubmission, and completeness of encounter data requirements.
2. The adequacy of the tools and methodologies used to comply with and improve compliance with encounter accuracy, timeliness, resubmission, and completeness of encounter data requirements.
3. The adequacy of the respondent’s encounter submission quality control procedures related to their support of the submission of accurate key fields on each encounter, including the amount or cost of the Medicaid service provided.
4. The adequacy of the respondent’s encounter submission quality control procedures related to their support of monitoring encounter submissions and revisions, including a methodology to eliminate duplicate data.
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.
6. The adequacy of the respondent’s encounter data submission historical compliance ratings, including compliance actions and liquidated damages, if indicated.

**Score:**

This section is worth a maximum of 100 points. Each of the above components is worth a maximum of 16.67 points each, based on the Standard Evaluation Criteria Scale.

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. |
| 3.33 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 6.67 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 10.02 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 13.35 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 16.67 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 37 – Fraud and Abuse Compliance Program: EVALUATOR SCORED

The respondent shall describe its compliance program including the Compliance Officer’s level of authority and reporting relationships. (See **Attachment B**, Scope of Service – 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 Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **Yes** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **3,500** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **No** |

**Response:**

**Evaluation Criteria:**

1. The extent to which the respondent’s compliance plan meets or exceeds compliance with all State and federal requirements.
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.
3. The extent to which there are sufficient staff to implement the compliance program.
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.

**Score:**

This section is worth 100 points. Each of the above components is worth a maximum of 25 points each using the Standard Evaluation Criteria Scale.

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. |
| 5 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 10 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 15 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 20 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 25 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 38 – Fraud and Abuse Special Investigations Unit (SIU) Manager: EVALUATOR SCORED

The respondent shall describe its Special Investigations Unit (SIU) Manager’s level of authority and reporting relationships. (See **Attachment B**, Scope of Service – 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 also provide a summary report on its experience in implementing an anti-fraud plan and conducting or contracting for investigations of possible fraudulent or abusive acts.

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **Yes** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **3,500** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **No** |

**Response:**

**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.)
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.
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.
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.

**Score:**

This section is worth a maximum of 100 points. Each of the above components is worth a maximum of 25 points each using the Standard Evaluation Criteria Scale.

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. |
| 5 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 10 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 15 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 20 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 25 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 39 – Fraud and Abuse Special Investigations Unit (SIU): EVALUATOR SCORED

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 Service – Core Provisions, **Section IX.**, Administration and Management, **Sub-Section F.**, Fraud and Abuse Prevention.)

**Response Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **No** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **3,500** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **No** |

**Response:**

**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.
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.
3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.
4. The extent to which the respondent shows their collaborative efforts with regard to combatting fraud and abuse resulting in terminations, referrals, recoupments, etc.

**Score:**

This section is worth a maximum of 100 points. Each of the above components is worth a maximum of 25 points each using the Standard Evaluation Criteria Scale.

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. |
| 5 | The component is unsatisfactory. It contained significant deficiencies and omissions and lacked meaningful detail. |
| 10 | The component is poor. It met some of the minimum requirements but did not address all elements requested. |
| 15 | The component is adequate. It met the minimum requirements with minimal content and detail. |
| 20 | The component is good. It exceeded the minimum requirements and contained good content and detail. |
| 25 | The component is excellent. It exceeded the minimum requirements and contained exceptional content and detail. |

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## SRC# 40 –Grievances and Appeals: AUTOSCORED

The respondent shall provide data and information relevant to its top-ranking contract identified through the Order of Contract Selection (page 2, **Exhibit A-5-V2**) 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 Criteria:**

|  |
| --- |
| **RESPONSE CRITERIA** |
| **Order of Contract Selection Required?** *See page 2.* | **Yes** |
| **Narrative Response Required?** *If yes, list in form field below.* | **No** |
| **Character Limit?** *Character limits are inclusive of spaces.* | **N/A** |
| **Attachments Allowed?** *If yes, list in form field below.* | **Yes** |
| **SRC Template Required?** *Original format must be submitted.* | **Yes** |

**Response:**

The respondent shall use **Exhibit A-5-a,** 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:**

* + - 1. The percentage of grievances not resolved within ninety (90) days.
1. The percentage of grievances per total population.
2. The percentage of appeals not resolved within thirty (30) days.
3. The percentage of appeals per total population.
4. The percentage of Medicaid Fair Hearings overturned.

**Score:**

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the Scores table at the bottom of the Grievances tab.

**% Grievances Not Resolved within 90 days**

0-5.99% = 20 Points

6-10.99% = 15 Points

11-25.99% = 10 Points

26% or higher = 0 Points

**% Grievances Per Total Population**

0-5.99% = 20 Points

6-10.99% = 15 Points

11-25.99% = 10 Points

26% or higher = 0 Points

**% Appeals Not Resolved Within 30 days**

0-5.99% = 20 Points

6-10.99% = 15 Points

11-25.99% = 10 Points

26% or higher = 0 Points

**% Appeals Per Total Population**

0-5.99% = 20 Points

6-10.99% = 15 Points

11-25.99% = 10 Points

26% or higher = 0 Points

**% Medicaid Fair Hearings Overturned**

0-5.99% = 20 Points

6-10.99% = 15 Points

11-25.99% = 10 Points

26% or higher = 0 Points

**REMAINDER OF PAGE INTENTIONALLY LEFT BLANK**