**Instructions to respondents for the completion of Exhibit A-4:**

All respondents to this solicitation shall utilize **Exhibit A-4**, Submission Requirements and Evaluation Criteria Components (Technical Response), for submission of its response and shall adhere to the instructions below for each Submission Requirement Component (SRC).

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

Each SRC contains form fields. Population of the form fields with text will allow the form field to expand and cross pages. There is no character limit.

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

Agency evaluators will be instructed to evaluate the responses based on the narrative contained in the SRC form fields and the associated attachment(s), if applicable.

Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below unless otherwise identified in each SRC contained within **Exhibit A-4**.

|  |
| --- |
| **STANDARD EVALUATION CRITERIA SCALE** |
| **Point Score** | **Evaluation** |
| 0 | The component was not addressed. |
| 1 | The component contained significant deficiencies. |
| 2 | The component is below average. |
| 3 | The component is average. |
| 4 | The component is above average. |
| 5 | The component is excellent. |

The SRCs in **Exhibit A-4** may not be retyped and/or modified and must be submitted in the original format.

**Exhibit A-4** is available for respondents to download at:

[http://ahca.myflorida.com/procurements/index.shtml](http://ahca.myflorida.com/Procurements/index.shtml).

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**Respondent Name:**

**SRC# 1: Table of Contents**

The respondent shall include a Table of Contents in its response. The Table of Contents shall contain section headings and subheadings along with corresponding page numbers.

**Evaluation Criteria:**

No points will be awarded for the Table of Contents.

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**SRC# 2: Executive Summary**

The respondent shall include an executive summary that indicates a thorough understanding of the overall need for and purpose of the services described in this solicitation, and adequately summarizes its approach to delivering these services according to the specifications of this solicitation.

**Response:**

**Evaluation Criteria:**

No points will be awarded for the Executive Summary.

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**SRC# 3: Organizational Structure and History**

The respondent shall describe its organizational structure and history. The description shall include, at a minimum:

1. A detailed description of the respondent’s organizational structure, history, legal structure, ownership, affiliations, and location(s); and
2. A copy of the respondent’s organizational chart, including the total number of employees.

**Response:**

**Evaluation Criteria:**

The respondent shall demonstrate its capability to provide the services described in this solicitation by describing its organizational structure and history.

1. The adequacy of the respondent’s ability to provide the services described in this solicitation based on its organizational structure, history, legal structure, ownership, affiliations, and location(s).
2. The adequacy of the respondent’s organizational chart, including the total number of employees.

Score: This Section is worth a maximum of **10** raw points with each of the above components being worth a maximum of 5 points.

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**SRC# 4: Experience and Qualifications**

The respondent shall demonstrate its capability to successfully meet the requirements of this solicitation by describing its experience, in auditing or examining Medicaid cost reports within the last five (5) years from the date of solicitation issuance, as specified in **Attachment A,** Instructions and Special Conditions, **Section A.1.,** Instructions, **Sub-Section A.,** Overview, **Item 4.,** Date of Issuance, per the Centers for Medicare and Medicaid Services (CMS) publication 15-1 and Reimbursement Plans and the respondent’s experience with a Medicaid Program and a Medicaid Disproportionate Share Hospital Program. Additional points will also be awarded for the respondent’s experience with a Medicaid Program.

1. Respondents shall submit a list of current or previous contracts for which it provided services within the last five (5) years from the date of solicitation issuance, as specified in **Attachment A,** Instructions and Special Conditions, **Section A.1.,** Instructions, **Sub-Section A.,** Overview, **Item 4.,** Date of Issuance that are similar in nature to those described in this solicitation.
2. For each identified contract, at a minimum, the following information shall be provided:
3. The name and address of the client;
4. The title of the project;
5. The start and end date of the contract;
6. A brief narrative describing the role of the respondent and scope of the work performed, under the contract;
7. The annual number of examinations completed, and/or required number to be completed;
8. Services provided by subcontractors, if applicable; and
9. A disclosure of liquidated or punitive damages imposed or sought against the respondent, including the circumstances and amounts involved.

**Response:**

**Evaluation Criteria:**

The respondent shall demonstrate its capability to successfully meet the requirements of this solicitation, by describing its experience, in auditing or examining Medicaid cost reports within the last five (5) years from the date of solicitation issuance, as specified in **Attachment A,** Instructions and Special Conditions, **Section A.1.,** Instructions, **Sub-Section A.,** Overview, **Item 4.,** Date of Issuance, per CMS’ publication 15-1 and Reimbursement Plans. Points will also be awarded for the respondent’s experience with a Medicaid Program and the respondents experience with auditing a Medicaid Disproportionate Share Hospital Program. This component shall be evaluated based on the following:

1. The adequacy of the respondent’s experience for auditing or examining Medicaid cost reports as described above.
2. The adequacy of the respondent’s experience based on the number of examinations completed or scheduled to be completed as specified in the respondent’s list of current or previous contracts for which it provided similar services.
3. The adequacy of the respondent’s experience and capability to perform this type of service based on the number and nature of instances in which liquidated or punitive damages have been imposed or sought against the respondent.
4. The adequacy of the respondent’s experience with a Medicaid Program.

Score: This Section is worth a maximum of **25** raw points, as described below:

* For Items a. – d., each component is worth a maximum of five (5) points each for a total cumulative score of 20 points.
* Respondents who demonstrate experience with Medicaid as described in items a. – d., shall receive up to five (5) additional points as follows:
* If the cumulative score for items a. – d. above is 1 – 5, the respondent shall receive 1 additional point.
* If the cumulative score for items a. – d. above is 6 - 10, the respondent shall receive 3 additional points.
* If the cumulative score for items a. – d. above is 11 - 15, the respondent shall receive 4 additional points.
* If the cumulative score for items a. – d. above is 16 – 20, the respondent shall receive 5 additional points.

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**SRC# 5: Examinations**

The respondent shall describe its ability and proposed approach to performing LIP Cost Limit Examinations and Reconciliations as described in **Attachment B,** Scope of Services. At a minimum, the description shall:

1. Demonstrate the respondent’s understanding of the Medicaid Low Income Pool (LIP) Cost Limit Examination;
2. Demonstrate the respondent’s understanding of the Florida Medicaid LIP Cost Reporting Requirements, both State and Federal; and
3. Demonstrate the respondent’s plan to adhere to State and Federal Program requirements in accordance with 1115 Managed Medical Assistance Waiver Special Terms and Conditions (STCs) and the Reimbursement and Funding Methodology Document (RFMD).

**Response:**

**Evaluation Criteria:**

The respondent shall describe, in detail, how it intends to perform the full scope examinations and home office examinations as described in **Attachment B,** Scope of Services. The description shall be evaluated based on the following:

1. The adequacy and viability of the respondent’s plan to adhere to requirements as described in **Attachment B,** Scope of Services.
2. The adequacy of the respondent’s demonstrated understanding of the Florida Medicaid LIP Cost Reporting Requirements, both State and Federal, in accordance with 1115 Managed Medical Assistance Waiver STCs and the RFMD.
3. The adequacy and viability of the respondent’s plan to adhere to the Florida Medicaid LIP Cost Reporting Requirements, both State and Federal, in accordance with 1115 Managed Medical Assistance Waiver STCs and the RFMD.

Score: This Section is worth a maximum of **15** raw points with each of the above component being worth a maximum of 5 points.

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**SRC# 6: IGT Review**

The respondent shall describe its ability and proposed approach to performing Intergovernmental Transfer (IGT) Reviews as described in **Attachment B,** Scope of Services. At a minimum, the description shall:

1. Demonstrate the respondent’s understanding of the IGT Review;
2. Demonstrate the respondent’s understanding of the IGT requirements, both State and Federal;
3. Demonstrate the respondent’s plan to ensure that the IGT funds are compliant with 42 Code of Federal Regulations (CFR) Part 433 Subpart B.
4. Demonstrate the respondents plan to determine if the IGT transfer, or source of funds transferred, complies with the Medicaid state plan, Title XIX of the Social Security Act, or any State or Federal regulations or policies implementing Title XIX of the Social Security Act, including but not limited to Section 1903(w) of the Social Security Act; 42 CFR Part 433, Subpart B; and CMS State Medicaid Director Letter #14-004 (May 9, 2014).

**Response:**

**Evaluation Criteria:**

The respondent shall describe, in detail, how it intends to perform the full scope examinations and home office examinations as described in **Attachment B,** Scope of Services. The description shall be evaluated based on the following:

1. The adequacy the respondent’s understanding of the IGT Review.
2. The adequacy of the respondent’s understanding of the IGT requirements, both State and Federal.
3. The adequacy and viability of the respondent’s plan to ensure that the IGT funds are compliant with 42 CFR Part 433 Subpart B.
4. The adequacy and viability of the respondent’s plan to determine if the IGT transfer, or source of funds transferred, complies with the Medicaid state plan, Title XIX of the Social Security Act, or any State or Federal regulations or policies implementing Title XIX of the Social Security Act, including but not limited to Section 1903(w) of the Social Security Act; 42 CFR Part 433, Subpart B; and CMS State Medicaid Director Letter #14-004 (May 9, 2014).

Score: This Section is worth a maximum of **20** raw points with each of the above component being worth a maximum of 5 points.

**SRC# 7: Reporting**

The respondent shall describe its ability and approach to ensuring timely and accurate reporting to the Agency as described in **Attachment B,** Scope of Services. At a minimum, the description shall include:

1. The respondent’s approach to compiling information to include in its monthly status report of all incomplete examinations;
2. How the respondent shall ensure accurate and timely reporting of all incomplete examinations to the Agency; and
3. A description of the data systems and software that will be used to submit electronic work papers and the final report.

**Response:**

**Evaluation Criteria:**

The response shall describe the respondent’s ability and approach to ensuring timely and accurate reporting to the Agency as specified in **Attachment B,** Scope of Services. The description shall be evaluated based on the following:

1. The adequacy of the respondent’s approach to compiling information to include in its monthly status report of all incomplete examinations.
2. The adequacy of the respondent’s approach to ensuring accurate and timely reporting to the Agency.
3. The adequacy of the respondent’s description of the data systems and software that will be used to submit electronic work papers and the final report.

Score: This Section is worth a maximum of **15** raw points with each of the above component being worth a maximum of 5 points.

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**SRC# 8: Staffing**

The respondent shall demonstrate its capability to provide staffing levels as described in **Attachment B,** Scope of Services, by describing the qualifications and experience of its proposed staff. The description shall include, at a minimum:

1. A staff organization chart that identifies reporting relationships and all positions to be assigned to the resulting Contract, including position titles. A description of dedicated staff and applicable variable staff if needed, assigned to the resulting Contract, including their qualifications, licenses, credentials and time assigned/dedicated to the resulting Contract. The respondent shall describe the decision making authority of these staff within the organization;
2. The respondent shall propose a Contract Manager at the Partner, Shareholder, Member Manager or Principal level, who has at least three (3) years managerial experience with Medicaid cost report examinations. The Contract Manager must have a current Florida Certified Public Accountant licensure as described in **Attachment B,** Scope of Services and identifying Florida Medicaid experience, if applicable;
3. Recruitment plan for ensuring adequate examination staff will be available within thirty (30) calendar days of the execution of the resulting contract; and
4. A description indicating which positions will be filled by a current employee of the respondent, and which positions will need to be filled.

**Response:**

**Evaluation Criteria:**

The respondent shall demonstrate its capability to provide staffing levels as described in **Attachment B,** Scope of Services, by describing the qualifications and experience of its proposed staff. This component will be evaluated based on the following:

1. The adequacy of the respondent’s proposed staff organization chart that identifies reporting relationships and all positions to be assigned to the resulting Contract, and their titles. The adequacy of the respondent’s proposed dedicated staff and applicable variable staff if needed, assigned to the resulting Contract, including their qualifications, licenses, credentials and time assigned/dedicated to the resulting Contract and the decision making authority of these staff within the organization.
2. The adequacy of the respondent’s proposed Contract Manager in meeting the requirements described in **Attachment B**, Scope of Services.
3. The adequacy of the respondent’s proposed Contract Manager in regards to experience with Florida Medicaid.
4. The adequacy of the respondent’s proposed staff recruitment plan for ensuring adequate examination staff will be available within thirty (30) calendar days of the execution of the resulting Contract.
5. The adequacy of the respondent’s proposed staffing plan for utilizing filled positions (current employees) and positions which will need to be filled.

Score: This Section is worth a maximum of **25** raw points with each of the above component being worth a maximum of 5 points.

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**SRC# 9: Internal Quality Assurance**

The respondent shall describe its proposed written internal quality assurance policies and procedures for meeting the requirements as described in **Attachment B,** Scope of Services. The description shall include, at a minimum:

1. A copy of the respondent’s existing or proposed Standard Operating Procedures including but not limited to: Quality Assurance and Disaster Recovery Plans; written internal quality control policies and procedures; and a description of any existing or proposed quality control committees or staff, and their responsibilities; and
2. An overview of how the respondents existing or proposed quality assurance policies and procedures will ensure oversight of staff and resources, quality assessment, internal review of work performed by employees, and performance improvement.

**Response:**

**Evaluation Criteria:**

The response shall describe the respondent’s written internal quality assurance policies and procedures for meeting the requirements described in **Attachment B,** Scope of Services. The description shall be evaluated based on the following:

1. The adequacy of the respondent’s existing or proposed Standard Operating Procedures including but not limited to: Quality Assurance and Disaster Recovery Plans and written internal quality control policies and procedures.
2. The adequacy of the respondent’s existing or proposed description of quality control committees or staff and their responsibilities.
3. The adequacy of the respondent’s existing or proposed quality assurance policies and procedures will ensure oversight of staff and resources, quality assessment, internal review of work performed by employees, and performance improvement.

Score: This Section is worth a maximum of **15** raw points with each of the above component being worth a maximum of 5 points.

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**SRC# 10: Business Associate Agreement**

The respondent shall describe its ability to ensure security of Medicaid data and Protected Health Information (PHI) as described in **Attachment A,** Instructions and Special Conditions, **Exhibit A-7,** Standard Contract, **Attachment II,** Business Associate Agreement. The description shall include, at a minimum:

1. How the respondent shall ensure proper security of Medicaid data and how the respondent will restrict access in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards;
2. How the respondent shall ensure HIPAA standards for data and document management will be met and ensure that any PHI released is done so in accordance with HIPAA requirements; and
3. The respondent’s approach to ensuring all incidents whereby PHI may have been released inappropriately are reported to the Agency without unreasonable delay, within ten (10) business days of discovery if the disclosure of PHI is to an unauthorized party, within twenty-four (24) hours of discovery if the disclosure is due to a security incident, and at least on a monthly basis, including if no breaches occurred during that period.

**Response:**

**Evaluation Criteria:**

The response shall describe the respondent’s ability and approach to ensuring proper security of Medicaid data and PHI, as described in **Attachment A,** Instructions and Special Conditions, **Exhibit A-7,** Standard Contract, **Attachment II,** Business Associate Agreement. The description shall be evaluated based on the following:

1. The adequacy of the respondent’s approach to ensuring proper security of Medicaid data and to restrict access in compliance with the HIPAA of 1996 standards.
2. The adequacy of the respondent’s approach to ensuring HIPAA standards for data and document management will be met and that any PHI released is done so in accordance with HIPAA requirements.
3. The adequacy of the respondent approach to ensure all incidents whereby PHI may have been released inappropriately are reported to the Agency without unreasonable delay, within ten (10) business days of discovery if the disclosure of PHI is to an unauthorized party, within twenty-four (24) hours of discovery if the disclosure is due to a security incident, and at least on a monthly basis including if no breaches occurred during that period.

Score: This Section is worth a maximum of **15** raw points with each of the above component being worth a maximum of 5 points.