TITLE PAGE
FLORIDA DEPARTMENT OF HEALTH
DOH 17-026

10-2017

INVITATION TO NEGOTIATE (ITN)
for
CMS Managed Care Plan

Respondent Name: _____

Respondent Mailing Address: _____

City, State, Zip: _____

Phone: ( ) _____ **Fax Number:** ( ) _____

E-Mail Address: _____

Federal Employer Identification Number (FEID): _____

BY AFFIXING MY SIGNATURE ON THIS REPLY, I HEREBY STATE THAT I HAVE READ THE ENTIRE ITN TERMS, CONDITIONS, PROVISIONS AND SPECIFICATIONS AND ALL ITS ATTACHMENTS, INCLUDING THE REFERENCED PUR 1000 AND PUR 1001. I hereby certify that my company, its employees, and its principals agree to abide to all of the terms, conditions, provisions and specifications during the competitive solicitation and any resulting contract including those contained in the Standard Contract or Department of Terms and Conditions.

Signature of Authorized Representative: _____

Printed (Typed) Name and Title: _____

*An authorized representative is an officer of the Respondent's organization who has legal authority to bind the organization to the provisions of the replies. This usually is the President, Chairman of the Board, or owner of the entity. document establishing delegated authority must be included with the Reply if signed by other than the authorized representative.

TABLE OF CONTENTS

SECTION 1.0: Introductory Materials

SECTION 2.0: Procurement Process, Schedule & Constraints

SECTION 3.0: Subject of Solicitation

SECTION 4.0: Instructions for Reply Submittal

SECTION 5.0: Reply Evaluation Process and Criteria

ATTACHMENT A: Evaluation Criteria and Instructions

ATTACHMENT A-1: Evaluation Criteria

ATTACHMENT A-1-a: Criteria #9 – General Performance Measurement Tool

ATTACHMENT A-1-b: Criteria #17 – In Lieu of and Expanded Benefits Tool

ATTACHMENT A-1-c: Criteria #18 – Additional Expanded Benefits Template

ATTACHMENT A-1-d: Criteria #21 – Standard CAHPS Measurement Tool

ATTACHMENT A-1-e: Criteria #54 – Provider Network Agreements/Contracts

ATTACHMENT A-1-f: Criteria #55 – Provider Network Agreements/Contracts Essential Providers

ATTACHMENT B: Statement of Non-Collusion

ATTACHMENT C: Application Data Security and Confidentiality

ATTACHMENT D: Cost Reply Instructions

ATTACHMENT D-1 – Full Risk Cost Reply Template

ATTACHMENT D-2 – Phased-in Risk Cost Reply Template

ATTACHMENT D-3 – Data Book

EXHIBIT 1 - Respondent Staffing Requirements for Children's Health and Behavioral Health Benefit Administration
EXHIBIT 2 - Respondent Staff Training Requirements
EXHIBIT 3 - Qualification of Respondent Eligibility
EXHIBIT 4 - Provider Service Network Certification of Ownership and Controller Interest
EXHIBIT 5 - Summary of Managed Care Savings
EXHIBIT 6 - Network Adequacy Standards

SECTION 1.0: INTRODUCTORY MATERIALS

1.1 Statement of Purpose

This solicitation is being issued by the State of Florida, Department of Health, Office of Children's Medical Services' Children's Medical Services Managed Care Plan, hereinafter referred to as the "DOH" or, "Department", to select a Respondent to provide Statewide Medicaid Managed Care Program and Children's Health Insurance Program (CHIP) services.

1.2 Definitions

Agency for Health Care Administration (AHCA) Prime Contract ("the Prime Contract"): The current Contract between AHCA and the Department, as amended, or its replacement, and any amendments to it. The current Prime Contract is referenced as AHCA Contract No. FP031, available at: https://facts.fldfs.com/Search/ContractDetail.aspx?AgencyId=680000&ContractId=FP031

Balance Sheet: Statement of total assets, liabilities and net worth at the end of the audit period(s).

Business days: Monday through Friday, excluding state holidays.

Business hours: 8 a.m. to 5 p.m., Eastern Time on all business days.

Calendar days: All days, including weekends and holidays.

Cash Flow Statement(s): Statement(s) that reflect the inflow of revenue versus the outflow of expenses resulting from operating, investing, and financing activities during the audit period(s).

CMS Plan Requirements: The specific requirements placed on Provider which are Title XIX, Title XXI, Title V, the AHCA Prime Contract, the Medicaid handbook requirements, 42 CFR 438.230, 42 CFR 455.104.42, 42 CFR 455.105, and 42 CFR 455.106. It also includes all, state and federal laws, state and federal reporting requirements, and HIPAA.

Contract: The formal agreement that will be awarded to the successful Respondent under this ITN, unless indicated otherwise.

Contract Manager: An individual designated by the Department to be responsible for the monitoring and management of the Contract.

Department: The Department of Health; may be used interchangeably with DOH.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Pub. L. No. 104-191: United States legislation that provides data privacy and security provisions for safeguarding medical information. This includes the Federal Privacy and Security

Regulations Developed by the U.S. Department of Health and Human Services at 45 C.F.R. parts 160 and 164.

Minor Irregularity: As used in the context of this solicitation, indicates a variation from the ITN terms and conditions which does not affect the price of the Reply or give the Respondent an advantage or benefit not enjoyed by other Respondents or does not adversely impact the interests of the Department.

Reply: The complete written response of the Respondent to the ITN (technical and cost replies), including properly completed forms, supporting documents, and attachments.

Respondent: The entity that submits a Proposal in response to this ITN. This term also may refer to the entity awarded a contract by the Department in accordance with terms of this ITN.

Revenue and Expense Statement(s): Statement(s) of profit or loss (for not-for-profits it is the excess of revenues over expenses) during the audit period(s).

Standards for Systems of Care for Children and Youth with Special Health Care Needs Version 2.0: The foundational goals of the Department are based on the National Standards for Systems of Care for Children and Youth with Special Health Care Needs Version 2.0 as outlined by the Association of Maternal & Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP) and include: Download the updated National Standards. For more information about CYSHCN, visit www.amchp.org.

Title V: A section of the federal Social Security Act which provides authorization of appropriations to the state of Florida through a block grant program for increasing access to health care services for children with special health care needs in accordance with 42 U.S.C. 701 and section 391.026(13), Florida Statutes.

Title XIX: A section of the federal Social Security Act that covers Medicaid, administered in Florida by AHCA, with eligibility determination performed by and through the Department of Children and Families (DCF), Title XIX of the Social Security Act, 42 U.S.C. sec. 1396 and regulations promulgated thereunder, as administered in the state of Florida under sections 409.901 to 409.925, Florida Statutes.

Title XXI: A section of the federal Social Security Act that covers the state children's health insurance program known as KidCare in Florida and administered by the Florida Healthy Kids Corporation pursuant to section 409.818, Florida Statutes. Title XXI of the Social Security Act, 42 U.S.C. sec. 2101 and regulations there under and section 409.810, Florida Statutes.

Vendor Bid System (VBS): Refers to the State of Florida internet-based vendor information system at: http://fcn.state.fl.us/owa_vbs/owa/vbs_www.main_menu.

SECTION 2.0: PROCUREMENT PROCESS, SCHEDULE & CONSTRAINTS

2.1 Procurement Officer

The Procurement Officer assigned to this solicitation is:

Florida Department of Health
Attention: Diana Trahan / Olyn Long
4052 Bald Cypress Way, Bin B07
Tallahassee, FL 32399-1749
Email: Diana.Trahan@flhealth.gov / Olyn.Long@flhealth.gov

2.2 Restriction on Communications

Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response. Section 287.057(23), Florida Statutes

2.3 Term

2.3.1 Contract Term - The anticipated term of the resulting Contract will be from January 1, 2019 through September 30, 2023.

2.3.2 Each October 1 through September 30 within the Contract term will be defined as a Contract Year; however, the first Contract Year (Year 1) will be defined as the date of Contract execution through September 30, 2019.

2.3.3 The final contract is subject to modification based on the contract/agreement between AHCA and the Department.

2.4 Timeline

EVENT	DUE DATE	LOCATION
ITN Advertised / Released	**January 30, 2018**	**Posted to the Vendor Bid System at:** http://vbs.dms.state.fl.us/vbs/main_menu

Questions Submitted in Writing	**Must be received PRIOR TO:** **February 21, 2018** **2:30 PM EST**	**Submit to:** Florida Department of Health Central Purchasing Office **Attention:** Diana Trahan Suite 310 4052 Bald Cypress Way, Bin B07 Tallahassee, FL 32399-1749 E-mail: Diana.Trahan@flhealth.gov
Answers to Questions (Anticipated Date)	**March 2, 2018**	**Posted to Vendor Bid System at:** http://vbs.dms.state.fl.us/vbs/main_menu
Sealed Technical and Cost Replies Due **(Must be Sealed)**	**Must be received PRIOR TO:** **April 27, 2018** **3:00 PM EST**	**Submit to:** Florida Department of Health Central Purchasing Office **Attention: Diana Trahan** 4052 Bald Cypress Way, Bin B07 Tallahassee, FL 32399-1749
Technical Replies Opened	**April 27, 2018** **3:00 PM EST**	**PUBLIC OPENING** Florida Department of Health 4052 Bald Cypress Way Suite 310 Tallahassee, FL 32399
Evaluation of Replies (Anticipated Date)	**May 7, 2018**	Evaluation Team Members to begin evaluations individually.
Respondent Negotiation Notification (Anticipated Date)	**May 25, 2018**	The Procurement Officer will notify the Respondents with whom the Department intends to negotiate with.
Beginning of Negotiations (Anticipated Date)	**June 4, 2018**	Negotiations are not public meetings; however, they are recorded.

Posting of Intent to Award (Anticipated Date)	**June 26, 2018**	**Posted to the Vendor Bid System at:** http://vbs.dms.state.fl.us/vbs/main_menu

2.5 Addenda

If the Department finds it necessary to supplement, modify, or interpret any portion of the solicitation during the procurement process, a written addendum will be posted on the MyFlorida.com Vendor Bid System, http://vbs.dms.state.fl.us/vbs/main_menu. It is the responsibility of the Respondent to be aware of any addenda that might affect their Reply.

2.6 Identical Tie Replies

Where there is identical pricing or scoring from multiple Respondents, the Department will determine the order of negotiations or award in accordance with Florida Administrative Code Rule 60A-1.011.

2.7 Federal Excluded Parties List

In order to comply with Federal grant requirements, and/or determining vendor responsibility in accordance with sections 287.057(1), (2) and (3), Florida Statutes, and Florida Administrative Code Rule 60A-1.006(1),, a Respondent or subcontractor(s) that, at the time of submitting a Bid for a new Contract or renewal of an existing Contract is on the Federal Excluded Parties List, is ineligible for, may not submit a Bid for, or enter into or renew a Contract with an agency for goods or services, if any federal funds are being utilized.

2.8 Certificate of Authority

All limited liability companies, corporations, corporations not for profit, and partnerships seeking to do business with the State must be registered with the Florida Department of State in accordance with the provisions of Chapters 605, 607, 617, and 620, Florida Statutes, respectively prior to Contract execution. The Department retains the right to ask for verification of compliance before Contract execution. Failure of the selected contractor to have appropriate registration may result in withdrawal of Contract award.

2.9 Respondent Registration

Each Respondent doing business with the State of Florida for the sale of commodities or contractual services as defined in section 287.012, Florida Statutes, must register in the MyFloridaMarketPlace system, unless exempted under Florida Administrative Code Rule 60A-1.030. State agencies must not enter into an agreement for the sale of commodities or contractual services as defined in section 287.012, Florida Statutes, with any Respondent not registered in the MyFloridaMarketPlace system, unless exempted by rule. The successful Respondent must be registered in the MyFloridaMarketPlace system within 5 days after posting of intent to award.

Registration may be completed at:
https://vendor.myfloridamarketplace.com/vms-web/spring/login?execution=e2s1
Respondents lacking internet access may request assistance from MyFloridaMarketPlace Customer Service at 866-352-3776 or from State Purchasing, 4050 Esplanade Drive, Suite 300, Tallahassee, FL 32399.

2.10 Minority and Service-Disabled Veteran Business-Participation

The Department encourages Minority, Women, Service-Disabled Veteran, and Veteran-Owned Business Enterprise participation in all its solicitations.

2.11 Standard Contract

Respondents must become familiar with the Department's Standard Contract which contains administrative, financial, and non-programmatic terms and conditions mandated by federal law, state statute, administrative code rule, or directive of the Chief Financial Officer.

Use of the Standard Contract is mandatory for Departmental contracts and the terms and conditions contained in the Standard Contract are non-negotiable.
The Standard Contract terms and conditions are located at: http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/_documents/DOH-Standard-Contract.pdf.

2.12 Questions

This provision takes precedence over General Instruction #5 in PUR1001.

Questions related to this solicitation must be received, in writing (either via U.S. Mail, courier, e-mail, fax, or hand-delivery), by the Procurement Officer identified in **Section 2.1**, within the time indicated in the Timeline. Verbal questions or those submitted after the period specified in the Timeline will not be addressed.

Answers to questions submitted in accordance with the ITN Timeline will be posted on the MyFlorida.com Vendor Bid System web site: http://vbs.dms.state.fl.us/vbs/main_menu.

2.13 Subcontractors

Respondent may enter into written subcontracts for performance of specific services (but not all Contract services) under the Contract resulting from this solicitation, as specified in the terms of the Standard Contract. Anticipated subcontract agreements known at the time of Reply submission and the amount of the subcontract must be identified in the Reply. If a subcontract has been identified at the time of Reply submission, a copy of the proposed subcontract must be submitted to the Department. No subcontract that the Respondent enters into with respect to performance under the Contract will in any way relieve the Respondent of any responsibility for performance of its contractual responsibilities with the Department. The Department reserves the right to request and review information in conjunction with its determination regarding a subcontract request.

2.14 Performance Bond

Within 30 days after notification of award, the successful Respondent must submit a performance bond in the amount of $1,000,000.00 for each regional cluster in which the Respondent is awarded a Contract. If the Respondent is awarded a Contract in more than one regional cluster, the Respondent must furnish a single performance bond for the total amount (e.g., if the Respondent is awarded a Contract in two regional clusters, the Respondent must submit one bond for $2,000,000.00). If a successful Respondent fails to provide the required performance bond within the time designated, the Department, in its sole discretion, may withdraw the award and proceed with the next responsive Respondent or re-procure. The bond must be renewed annually before the end of the Contract period and must be issued by a surety company licensed to do business in the state of Florida. The cost of the performance bond will be borne by the Respondent.

2.15 Performance Measures

Pursuant to section 287.058, Florida Statutes, the resulting Contract must contain performance measures which specify the required minimum level of acceptable service to be performed. These will be established based on final determination of tasks and deliverables.

2.16 Financial Consequences

Pursuant to section 287.058, Florida Statutes, the Contract resulting from this solicitation must contain financial consequences that will apply if Provider fails to perform in accordance with the Contract terms. The financial consequences will be established based on final determination of the performance measures and Contract amount.

2.17 Conflict of Law and Controlling Provisions

Any Contract resulting from this ITN, plus any conflict of law issue, will be governed by the laws of the state of Florida. Venue will be Leon County, Florida.

2.18 Records and Documentation

To the extent that information is used in the performance of the resulting Contract or generated as a result of it, and to the extent that information meets the definition of "public record" as defined in section 119.011(12), Florida Statutes, said information is hereby declared to be and is hereby recognized by the parties to be a public record and absent a provision of law or administrative rule or regulation requiring otherwise, Respondent must make the public records available for inspection or copying upon request of the Department's custodian of public records at cost that does not exceed the costs provided in Chapter 119, Florida Statutes, or otherwise, and must comply with Chapter 119 at all times as specified therein. It is expressly understood that the Respondent's refusal to comply with Chapter 119, Florida Statutes, will constitute an immediate breach of the Contract resulting from this ITN and entitles the Department to unilaterally cancel the Contract agreement.

Unless a greater retention period is required by state or federal law, all documents pertaining to the program contemplated by this ITN must be retained by the Respondent for a period of six years after the termination of the resulting Contract or

longer as may be required by any renewal or extension of the Contract. During the records retention period, the Respondent agrees to furnish, when requested to do so, all documents required to be retained. Submission of such documents must be in the Department's standard word processing format. If this standard should change, it will be at no cost incurred to the Department. Data files will be provided in a format readable by the Department.

Respondent must maintain all records required to be maintained pursuant to the resulting Contract in such manner as to be accessible by the Department upon demand. Where permitted under applicable law, access by the public must be permitted without delay.

SECTION 3.0: SUBJECT OF SOLICITATION

3.1 Questions Being Explored:

The Department of Health is the state of Florida's designated Title V Maternal and Child Health Block Grant Agency. The Office of Children's Medical Services Managed Care Plan (Office) within the Department, administers the children with special health care needs portion of the Title V MCH Block Grant and serves children and youth with special health care needs through a variety of programs. The Office operates the Children's Medical Services Managed Care Plan (CMS Plan), which services children eligible for Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program).

3.2 Facts Demonstrating Need:

Pursuant to Florida Statutes, under Medicaid, the Department operates as a Medicaid specialty plan for children with chronic conditions through the Prime Contract with the Agency for Health Care Administration (AHCA) (under the Statewide Medicaid Managed Care (SMMC) program.

The Department is statutorily authorized under Chapters 391 and 409, Florida Statutes, to operate a managed system of care for low-income children with special health care needs eligible for Title XXI (CHIP). The Department is the CHIP plan that provides services to children ages 1-19 who have a special health care need.

The Department also serves children who meet both the clinical eligibility requirements for the Department and who have serious behavioral or emotional conditions and receive Behavioral Health Network (BNET) services. Children enrolled in BNET receive their medical services through the Department.

CMS Plan Title XIX and XXI enrolled children with life-threatening conditions are eligible to receive Partners in Care: Together for Kids (PIC:TFK) services. PIC:TFK is Florida's Program for All Inclusive Care for Children (PACC) and is designed for children 20 years of age or younger. This program provides pediatric palliative care support services throughout the illnesses trajectory. The program's focus is to provide pain and symptom management services, thus improving quality of life.

The foundational goals of the CMS Managed Care Plan are based on the Standards for Systems of Care for Children and Youth with Special Health Care Needs Version 2.0 and include:

- Care is family-centered and participant-driven.
- Care is provided in a manner that is culturally competent, linguistically appropriate, and accessible to children and their families.
- Coverage is accessible, affordable, comprehensive, and continuous.
- The program will provide evidence-based care, when possible, and evidence-informed or based on promising practice when evidence-based approaches are not available.

The Department currently serves more than 62,000 Title XIX and Title XXI children and youth with special health care needs throughout the state. Children and youth must meet certain financial and clinical criteria to be eligible for the CMS Managed Care Plan.

3.3 Specific Goals

The Department intends to award one state-wide Contract to a Respondent to assist with the administration of the CMS Plan. The Department will award additional contracts only if there is no acceptable state-wide Respondent for all areas of the state. The Department reserves the right to award more than one contract based on regional clusters. Respondents may propose statewide or on a regional cluster with either a full risk model or a phased in risk model. Respondents may opt to be full risk in one or two regional clusters and partial risk in the others and may submit a statewide and regional cluster reply simultaneously.

Respondents must provide services for both Title XIX and Title XXI enrollees in every regional cluster for which they submit a reply. Regional clusters are as follows: Northern Florida-AHCA Regions 1-4, Central/Southwestern Florida- AHCA Regions 5-8, and South/Southeastern Florida-AHCA Regions 9-11. Respondent should offer comprehensive, quality-driven provider networks, streamlined processes that enhance the enrollee and provider experience, expanded benefits targeted to improve outcomes for enrollees, top quality scores, and high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model.

In addition to the objectives stated above, the Department intends to award a Contract to a Respondent that offers innovative and evidence-based approaches in meeting the following goals under the CMS Plan:

- Reduce potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services;
- Culturally competent, linguistically appropriate, family centered and participant driven care; and
- Care that is evidence based, where possible and evidence-informed or based on promising practice when evidence-based approaches are not available.

3.4 Legal Authority

Children's Medical Services Managed Care Plan (CMS Plan, a Medicaid specialty plan for children with chronic conditions operated by the Department, as further defined in Chapter 391, Chapter 409, Parts II and IV, including section 409.974(4), Florida Statutes, through the AHCA Prime Contract.

3.5 Experience and Qualifications

Respondent should have the following minimum level of experience and qualifications:

3.5.1 Managed Care Experience – Respondent will provide evidence of a **minimum of five years' experience** in medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support).

3.5.2 Florida Experience – Respondent will provide documentation to show to what extent it has experience operating as a Florida Medicaid or CHIP health plan statewide.

3.5.3 Florida Presence – Respondent will provide information regarding the

location of the corporate headquarters, whether the Respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the state of Florida, and identifying the number of full-time staff, by operational function, that will be located in the state of Florida and out of state.

3.5.4 HEDIS Measures – Respondent will provide evidence of a minimum of two years' experience as one of three states for the last two years.

3.6 Application Data Security and Confidentiality

Respondent, its employees, subcontractors, and agents must comply with all cyber security procedures of the Department in performance of the contract resulting from this solicitation as specified in **Attachment C**.

SECTION 4.0: INSTRUCTIONS FOR REPLY SUBMITTAL

4.1 General Instructions to Respondents (PUR1001)

This section explains the general instructions of the solicitation process to Respondents (PUR 1001), and is a downloadable document incorporated into this solicitation by reference. This document should not be returned with the Reply: http://dms.myflorida.com/content/download/2934/11780

The terms of this solicitation will control over any conflicting terms of the PUR1001.

4.2 General Contract Conditions (PUR1000)

The General Contract Conditions (PUR 1000) form is a downloadable document incorporated in this solicitation by reference, which contains general contract terms and conditions that will apply to any contract resulting from this ITN, to the extent they are not otherwise modified. This document should not be returned with the Reply. http://dms.myflorida.com/content/download/2933/11777

The terms of this solicitation will control over any conflicting terms of the PUR1000. Paragraph 31 of PUR 1000 does NOT apply to this solicitation or any resulting contract.

4.3 Renewal

The Contract resulting from this solicitation may be renewed. Renewals may be made on a yearly basis for no more than three years beyond the initial contract, or for the term of the original Contract, whichever is longer. Renewals must be in writing, subject to the same terms and conditions set forth in the initial Contract and any written amendments signed by the parties. Renewals are contingent upon satisfactory fiscal and programmatic performance evaluations as determined by the Department and are subject to the availability of funds.

4.4 Reply Format

The Department discourages lengthy replies. Respondents are asked to use the following format:

1. Replies should be on paper that is 8.5 by 11 inches.

2. The font size and style is at the discretion of the Respondent but should be at least 11 point.

3. The pages should be numbered, and one-inch margins should be used.

4. Technical replies should include an index identifying the page number and section where information can be located in the Reply.

4.5 Reply Submission Requirements

4.5.1 General Provision

Electronic submissions via MyFloridaMarketPlace will not be accepted for this solicitation.

4.5.2 Hardcopies of the Reply

4.5.2.1 Original Reply

Respondent will submit one Original Reply. The Original Reply will be marked as the "Original" and contain the transmittal letter that bears the original signature of the binding authority. The box that contains the Original Reply will be marked "Contains Original". All forms requiring signature will bear an original signature with the original reply.

4.5.2.2 Duplicate Copies of the Original Reply

Respondent will submit five duplicate copies of the Original Reply.

4.5.2.3 Packaging and Delivery

a. Hard copy replies will be bound individually and submitted in up to three, three-inch, three-ring binders or secured in a similar fashion to contain pages that turn easily for review.

b. Each component of the hard copy reply will be clearly labeled and tabbed in the order specified below:

1) **Exhibit 3**, Qualification of Respondent Eligibility;
2) **Exhibit 4**, Provider Service Network Certification of Ownership and Controlling Interest (if applicable) (only if marking PSN on **Exhibit 3**);
3) Performance Bond;
4) Financial Information – tabbed separately as follows:
   - Financial Statements
   - Pro Forma Financial Statements
   - Surplus
   - Insolvency Protection;
5) **Exhibit A-1**, Evaluation Criteria and applicable attachments/exhibits;
6) **Exhibit 5**, Summary of Managed Care Savings; and
7) **Attachment D**, Cost Reply Instructions, including applicable exhibits.
   - **Attachment D-1,** Full Risk Cost Reply Template (Please note if proposed for Year 3 and beyond only or if beginning in Year 1) – Respondent Name. **Note: Respondents will use this naming convention for Attachment D-1;** and
   - **Attachment D-2,** Phased-In Risk Cost Reply

Template – Year 1 and 2 – Respondent Name. **Note: Respondents will use this naming convention for Attachment D-2.**

c. Hard copy replies will be double sided.

d. Hard copy replies must be submitted in a sealed package (i.e., outer boxes must be sealed, individual binders within the box do not require individual sealing), to the Procurement Officer identified in **Section 2.1**, no later than the time indicated in **Section 2.4** Timeline.

Hard copy replies will be submitted via United States (U.S.) mail, courier, or hand delivery. Replies sent by fax or email will not be accepted. The Department will not consider replies received after the date and time specified in **Section 2.4** Timeline, and any such replies will be returned to the Respondent unopened.

4.6 Electronic Copy of the Reply

4.6.1 Respondent will submit one electronic copy of the entire Reply on a USB flash drive.

4.6.2 The electronic copy of the Reply, including all attachments, will be submitted as Portable Document Format (PDF) documents. The PDF documents must be searchable, allow printing and must not be password protected (unlocked).

4.6.3 The electronic copy of the PDF documents will be saved on the USB flash drive, with each component listed below saved separately in individual file folders:

1) **Exhibit 3**, Qualification of Respondent Eligibility;
2) **Exhibit 4**, Provider Service Network Certification of Ownership and Controlling Interest (if applicable) (only if marking PSN on **Exhibit 3**);
3) Performance Bond;
4) Financial Information – tabbed separately as follows:
   - Financial Statements
   - Pro Forma Financial Statements
   - Surplus
   - Insolvency Protection;
5) **Exhibit A-1**, Evaluation Criteria and applicable attachments/exhibits;
6) **Exhibit 5**, Summary of Managed Care Savings; and
7) **Attachment D**, Cost Reply Instructions, including applicable exhibits;
   - **Attachment D-1,** Full-Risk Cost Reply Template (Please note if proposed for Year 3 and beyond only or if beginning in Year 1) – Respondent Name. **Note: Respondents will use this naming convention for Attachment D-1;** and
   - **Attachment D-2,** Phased-In Risk Cost Reply Template – Year 1 and 2 – Respondent Name. **Note: Respondents will use**

this naming convention for Attachment D-2.

4.6.3.1 In addition to the PDF submission, the following attachments and exhibits will be submitted in Microsoft Excel 2016, utilizing the CMS Plan provided templates and will be saved on the USB flash drive.

- **Exhibit A-1-a** Criteria #9 - General Performance Measurement Tool;
- **Exhibit A-1-b** Criteria #17 Expanded Benefits Template;
- **Exhibit A-1-c** Criteria #18 – Additional Expanded Benefits Template;
- **Exhibit A-1-d** Criteria #22 - Standard CAHPS Measurement Tool;
- **Exhibit A-1-e** Criteria #54 – Provider Network Agreements/Contracts;
- **Exhibit A-1-f** Criteria #55 – Provider Network; Agreements/Contracts Statewide Essential Providers; and
- **Exhibit 5**, Summary of Managed Care Savings.

4.7 Electronic Redacted Copies

- Respondent will submit an electronic redacted copy of the reply suitable for release to the public in one PDF document on the USB flash drive. The electronic copy will be saved in a separate file folder on the USB flash drive from the rest of the reply. The file folder will be identified as "Redacted Version Suitable for Public Release."

- The PDF document must be searchable, allow printing, and must not be password protected (unlocked).

- Any confidential or trade secret information covered under section 812.081, Florida Statutes, should be redacted as described below. The redacted reply will be marked as the "redacted" copy.

4.8 Reply Labeling

4.8.1 Technical Reply

The Technical Reply must be sealed and identified as follows:

DOH17-026
Invitation to Negotiate for
CMS Managed Care Plan Due:
Respondent's Name
TECHNICAL REPLY

4.8.2 All Replies must be sent or delivered to the Department of Health, Central Purchasing Office, 4052 Bald Cypress Way Bin B07, Tallahassee, Florida 32399.

4.9 Instructions for Submittal

4.9.1 Respondents are required to complete, sign, and return the "Title Page" with the Reply submittal. **(Mandatory Requirement)**

4.9.2 Respondents must submit all technical data in the formats specified in the ITN.

4.9.3 Replies must be sent via mail, courier, or hand delivered to the location indicated in the Timeline. **(Mandatory Requirement)**

4.9.4 Replies submitted via electronic mail (email) or facsimile will not be considered.

4.9.5 The Department is not responsible for improperly addressed or labelled replies.

4.9.6 It is the Respondent's responsibility to ensure its Reply is submitted at the proper place and time indicated in the ITN Timeline.

4.9.7 The Department's clocks will provide the official time for Reply receipt.

4.9.8 Materials submitted will become the property of the state of Florida and accordingly, the state reserves the right to use any concepts or ideas contained in Respondent replies.

4.10 Documentation

Respondents must complete and submit the following information or documentation as part of their Technical Reply:

4.10.1 Statement of Non-Collusion

Respondents must sign and return with their reply the **Statement of Non-Collusion** form, **Attachment C.**

4.10.2 Surplus - Respondent will describe and provide calculations used to demonstrate how it will fund the required surplus for the particular Contract type.

- The required surplus must be in the form of assets allowable as admitted assets by the Office of Insurance Regulation (OIR), and restricted funds of deposits (CMS Plan insolvency account, OIR restricted deposits), the greater of $1.5 million, ten percent total liabilities, or two percent annualized premiums. (section 641.225, Florida Statutes).

4.10.3 Insolvency Protection Account - Respondent will describe and provide calculations used to demonstrate how it will fund the CMS Plan Insolvency Protection Account, as specified below by Contract type. The Department will evaluate the audited financial reports of the Respondent and parent entity to determine the Respondent's ability to fund the CMS Plan Insolvency Protection Account. If funding for the CMS Plan Insolvency Protection Account will come from a source other than the Respondent or parent entity, the Respondent will indicate the source and provide an audit, bank statement, and/or bank letter demonstrating the ability to fund this

requirement.

- Capitated Managed Care Plans – five percent of the estimated monthly capitation amount that would be paid to the successful Respondent by DOH each month until a maximum total of two percent of the annualized total Contract amount is funded. Respondent will provide a calculation of the five percent estimate and indicate the anticipated source and method of funding this requirement.

4.10.4 Financial Information

Respondent will submit the following financial information.

4.10.4.1. Financial Statements – Respondent will submit its most recent audited financial statements prepared using Statutory Accounting Principles (SAP) for the past three years as described in Table 2, Financial Statement Requirements, below, based upon one of the following entity types:

a) An entity with at least three years of financials
b) An entity without three years of its own financials
c) An entity without three years of its own financials and without a parent entity

Table 2
Financial Statement Requirements

An entity with at least three years of financials	An entity without three years of its own financials	An entity without three years of its own financials and without a parent entity
•Respondent's most recent audited financial statements for the past three years. •Respondent's National Association of Health Insurance Commissioners' annual Health Statement for the most recent three ears. PSNs may submit only the first four schedules (Assets; Liabilities, Capital and Surplus; Revenue and Expenses Statement; and Cash Flow Statement). •The most recent audited financial statements for the past	•The most recent audited financial statements of its parent entity for the past three years. •An organizational chart showing the relationship between the Respondent and parent entity.	•The most recent audited financial statements for the past three years of individuals with five percent or more ownership interest in the Respondent as documented through the Respondent's submission of a completed CMS-1513 Disclosure of Ownership and Control Interest Statement Form.

Table 2 Financial Statement Requirements		
An entity with at least three years of financials	**An entity without three years of its own financials**	**An entity without three years of its own financials and without a parent entity**
three years of its parent entity or of individuals with five percent or more ownership interest, as applicable.		

4.10.4.2 Pro Forma Financial Statements – Respondent will provide the following pro forma financial statements for the Respondent's Florida operation, broken down by line of business. The pro forma financial statements must be prepared on an accrual basis by month for the first three years (or until profitable) beginning with the first month of recipient enrollment into the CMS plan, assuming initial enrollment in January 2019, and include: (Note: January 2019 is provided as an initial enrollment date solely for the purpose of this item.)

a) A statement of monthly revenue and expenses based upon the anticipated CMS plan enrollment in the region by the last month of the third year of operation;
b) A monthly cash flow analysis; and
c) A balance sheet for each month.

4.11 Cost of Preparation

Neither the Department nor the State is liable for any costs incurred by a Respondent in responding to this solicitation.

4.12 Public Records and Trade Secrets

Notwithstanding any provisions to the contrary, public records must be made available pursuant to the provisions of the Public Records Act. If the Respondent considers any portion of its Reply to be confidential, exempt, trade secret, or otherwise not subject to disclosure pursuant to Chapter 119, Florida Statutes, the Florida Constitution or other authority, the Respondent must segregate and clearly mark the document(s) as "**CONFIDENTIAL**".

Simultaneously, the Respondent will provide the Department with a separate redacted paper and electronic copy of its Reply and briefly describe in writing the grounds for claiming exemption from the public records law, including the specific statutory citation for such exemption. This redacted copy must contain the solicitation name, number, and the name of the Respondent on the cover, and must be clearly titled "**REDACTED COPY**".

The redacted copy must be provided to the Department at the same time the Respondent submits its Reply and must only exclude or redact those exact portions which are claimed confidential, proprietary, or trade secret. Respondent will be responsible for defending its determination that the redacted portions of its Reply are confidential, trade secret, or otherwise not subject to disclosure. Further, the Respondent must protect, defend, and indemnify the Department for any and all claims arising from or relating to the determination that the redacted portions of its Reply are confidential, proprietary, trade secret, or otherwise not subject to disclosure. If the Respondent fails to submit a redacted copy with its Reply, the Department is authorized to produce the entire documents, data or records submitted by the Respondent in answer to a public records request for these records.

4.13 Special Accommodations

Any person who requires special accommodations at the Department's Purchasing office because of a disability should call the Department's Purchasing Office at (850) 245-4199 at least five work days prior to any pre-Reply conference, reply opening, or meeting to arrange the necessary accommodations. If hearing or speech impaired, contact Purchasing by using the Florida Relay Service, at 1-800-955-8771 (TDD).

4.14 Responsive and Responsible (Mandatory Requirement)

Respondents must complete and submit the following **mandatory** information or documentation as a part of its Reply. Any Reply which does not meet these requirements or contain this information will be deemed non-responsive.

a. Replies must be received (**per Section 4.7.3**) by the time specified in the Timeline (**Section 2.4**).

b. The Title Page of this ITN must be completed, signed, and returned with the Technical Reply.

c. Respondent will complete and submit **Exhibit 3**, Qualification of Respondent Eligibility.

d. Each Respondent will indicate if its reply is for all regions of the state or for one or more specific regions.

e. Each Respondent will certify its eligibility to provide services under the SMMC pursuant to section 409.962(7), Florida Statutes.

f. Reply Guarantee

1) Respondent's Original Reply must be accompanied by a Reply Guarantee payable to the state of Florida in the amount of $500,000. The Reply Guarantee is a firm commitment the Respondent will, upon the Department's acceptance of its reply, execute such contractual documents as may be required within the time specified.

2) Respondent must be the guarantor. If responding as a joint venture or legal partnership, at least one party of the joint venture or legal partnership will be the guarantor.

3) The Reply Guarantee will be in the form of a bond, cashier's check, treasurer's check, bank draft, or certified check. The Department will not accept a letter of credit in lieu of the Reply Guarantee.

4) All Reply Guarantees will be returned upon execution of the Contract with the successful Respondent and receipt of a performance bond required under **Section 2.14** of this solicitation. If the successful Respondent fails to execute a Contract within 10 consecutive calendar days after a Contract has been presented to the successful Respondent for signature, the Reply Guarantee will be forfeited to the State.

5) The Reply Guarantee must not contain any provisions that shorten the time from bringing an action to a time less than that provided by the applicable Florida Statute of Limitations (see section 95.03, Florida Statutes).

4.15 Late Replies (Mandatory Requirement)

The Procurement Officer must receive replies pursuant to this ITN no later than the date and time shown in the Timeline (refer to **Section 2.4**). Replies that are not received by the time specified will not be considered.

4.16 Conflict of Interest

Section 287.057(17)(c), Florida Statutes, provides "A person who receives a Contract that has not been procured pursuant to subsections (1)-(3) to perform a feasibility study of the potential implementation of a subsequent Contract, who participates in the drafting of a solicitation or who develops a program for future implementation, is not eligible to Contract with the agency for any other Contracts dealing with that specific subject matter, and any firm in which such person has any interest is not eligible to receive such Contract. However, this prohibition does not prevent a Respondent who responds to a request for information from being eligible to Contract with an agency."

The Department considers participation through decision, approval, disapproval, recommendation, preparation of any part of a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, auditing, or any other advisory capacity to constitute participation in drafting of the solicitation.

Refer to Statement of Non-Collusion**, Section 4.10.1.**

SECTION 5.0: REPLY EVALUATION PROCESS AND CRITERIA

5.0 Introduction

The Department will evaluate and score replies to establish a reference point from which to make negotiation decisions. The Department reserves the right to short list Respondents deemed to be in the competitive range to conduct negotiations prior to final determination of Contract award. The Department may choose to enter into concurrent negotiations with more than one Respondent.

The Department may accept or reject any and all replies, or separable portions thereof, and to waive any minor irregularity if the Department determines that doing so will serve the State's best interests.

Successful negotiations do not guarantee award of a Contract. Award of a Contract does not guarantee placement of order for services.

The Department reserves the right to award more than one contract as a result of this ITN.

5.1 Evaluation Criteria

5.1.1. Financial Evaluation

a) A Certified Public Accountant will evaluate each Respondent's financial information, as required by Section 4.10.2, Financial Information. Respondents can receive a maximum score of 20 points based on an analysis in Table 3, Financial Information Evaluation Point Scale, below:

Table 3
Financial Information Evaluation Point Scale

Criteria	Scale	Points
What is the likelihood that the Respondent will have sufficient financial resources to perform the Contract requirements outlined in this solicitation? Respondents will be scored as 'likely' to meet financial requirements if cash and cash equivalents exceed $2,000,000, the Respondent's current assets exceed current liabilities and total assets exceed total liabilities by at least $1,000,000. Respondents who do not meet two of the three criteria listed above will be scored as 'questionable'. Respondents who meet one or fewer of the above criteria will be scored as 'unlikely' to meet minimum financial requirements.	Likely	20
	Questionable	10
	Unlikely	0

b) Respondents determined to have insufficient financial resources to perform the Contract requirements outlined in this solicitation will be disqualified at the Department's sole discretion.

c) The Department reserves the right to evaluate and score financial information one time and apply the score to all regions for which the Respondent submits a reply.

5.1.2 Technical Reply Evaluation

a) Replies will be independently evaluated and awarded points based on the criteria and points scale indicated in **Exhibit A-1**, Evaluation Criteria for the detailed evaluation criteria components.

b) Each Reply will be individually scored by at least three evaluators, who collectively have experience and knowledge in the program areas and service requirements for which contractual services are sought by this solicitation. The financial responsiveness will be determined by a CPA.

c) The scores of all evaluators will be computed for each Respondent's score sheets to determine a total score based on the detailed evaluation criteria components indicated in **Exhibit A-1**, Evaluation Criteria and the weight factor specified in Table 4, Summary Score Sheet below:

The Department will evaluate replies against all evaluation criteria set forth in **Attachment A** in order to establish a competitive range of replies reasonably susceptible of negotiation. **The maximum points possible for the total Reply submission is: 4378**.

5.1.3. Scoring of Technical Replies

Technical Replies will be scored by the Evaluation Team in the areas indicated below. The raw scores in each evaluation area from each team member will be averaged together. These average scores will be added to determine each Respondent's Technical Reply score.

Table 4		Evaluation Criteria*		
Number**		Maximum Raw Score Possible	Weight Factor	Maximum Points Available
	Financial Information*	20	10	200
	Technical Reply			
	A. CMS - Respondent Background/Experience	190	2	380
1	Statewide	100		200
2	Managed Care Experience	25		50
3	Florida Experience	30		60
4	Florida Presence	15		30
5	Contract Performance	20		40
	B. CMS Plan Goals	599	2	1198
6	Care Coordination and/or Case Management	160		320
7	Disease Management	60		120
8	Transitions of Care	64		128
9	HEDIS Measures	120		240
10	HEDIS Measures – Standards	10		20
11	HEDIS Data Sources	15		30
12	Potentially Preventable Events	45		90
13	Patient Centered Medical Home	25		50
14	Telemedicine	20		40
15	Quality Measures	60		120
16	CMS Physician Incentive Program	20		40
	C. CMS - Recipient Experience	445	2	890
17	Expanded Benefits and In Lieu of Services	240		480
18	Additional Expanded Benefits	10		20
19	Quality Enhancement	20		40
20	Online Provider Directory	10		20
21	Enrollee Grievance and Appeal System	30		60
22	CAHPS Results	15		30
23	PCP Timely Access Standards	15		30
24	Provider Network Development	60		120
25	Provider Network Development - Network Development Plan	30		60
26	PCP Assignment	15		30
	D. CMS - Provider Experience	180	3	540
27	Provider Engagement Model	30		90
28	Dispute Resolution	35		105
29	Claims Processing and Payment Process	30		90
30	Provider Credentialing	35		105

31	Value-Based Purchasing	50		150
	E. CMS - Delivery System Coordination	405	1	405
32	Utilization Management	45		45
33	Utilization Management - Ease of Use	30		30
34	Coordination of Benefits	40		40
35	EPSDT	25		25
36	Behavioral Health/Primary Care Integration	15		15
37	Transportation	40		40
38	Coordination of Carved Out Services	15		15
39	Vignette 1 - Complex health, workflows, innovation, care delivery, experience, holistic health, systems	85		85
40	Vignette 2 - Complex health, workflows, innovation, care delivery, experience, holistic health, systems	85		85
41	Provider Network	25		25
	F. CMS - Oversight and Accountability	585	1	585
42	Subcontractor Oversight	30		30
43	Subcontractor Oversight - Disaster Contingency Plan	20		20
44	System Modification Protocol	35		35
45	Encounter Data Submission	65		65
46	Encounter Data Submission for Sub-capitated, Sub-contracted, Non-pay and Atypical	40		40
47	Fraud and Abuse/Compliance Office	20		20
48	Fraud and Abuse Special Investigations Unit	20		20
49	Disaster Recovery Procedures	45		45
50	Management Experience and Retention	15		15
51	Statutory Community Partnerships	20		20
52	Organization Commitment to Quality	30		30
53	Health Plan Accreditation	5		5
54	Provider Network Agreements/Contracts	240		240
	G. CMS - Statutory Requirements	90	2	180
55	Provider Network Agreements/Contracts - Essential providers	40		80
56	Data reporting	40		80
57	Electronic Visit Verification	10		20
	CMS Totals:	**2514**		**4378**

5.1.4 Cost Reply

The Department will review and consider the cost replies submitted by Respondents who are invited to negotiations during the negotiation phase. The cost replies will not be opened or scored in the initial evaluations of the technical

reply. During negotiations, the cost reply will be evaluated utilizing rates determined by state of Florida actuaries as part of the total reply by the Respondent.

5.1.5 Ranking of Replies

a. A total score will be calculated for each reply based the total maximum points available as included in Table 4, Summary Score Sheet, above based on the total maximum available points of 4,398.

b. The total point scores will be used to rank the replies by evaluator. An example is provided below to illustrate the steps in the process.

EXAMPLE:

a) Step 1

A total point score will be calculated for each reply. The total point score includes Evaluator (A, B, C or D) Evaluation Criteria score and Financial Stability score for the Respondent.

Below is a summary example of how the total point score is calculated: (Respondent 1).

Evaluator A evaluation criteria score:	391
Financial evaluation score for Respondent 1:	10
Total Point Score for Evaluator A, Respondent 1	**401**
Evaluator B evaluation criteria score:	341
Financial evaluation score for Respondent 1:	10
Total Point Score for Evaluator B, Respondent 1	**351**
Evaluator C evaluation criteria score:	256
Financial evaluation score for Respondent 1:	10
Total Point Score for Evaluator C, Respondent 1	**266**
Evaluator D Evaluation Criteria score:	358
Financial evaluation score for Respondent 1:	10
Total Point Score for Evaluator D, Respondent 1	**368**

b) Step 2

The total point scores will be used to rank the replies by evaluator (Reply with the highest number of points = 1, second highest = 2, etc.).

POINTS SUMMARY

Evaluator A		Evaluator B		Evaluator C		Evaluator D	
Respondent 1	446 pts.	Respondent 1	396 pts.	Respondent 1	311 pts.	Respondent 1	413 pts.
Respondent 2	425 pts.	Respondent 2	390 pts.	Respondent 2	443 pts.	Respondent 2	449 pts.
Respondent 3	397 pts.	Respondent 3	419 pts.	Respondent 3	389 pts.	Respondent 3	435 pts.
Respondent 4	410 pts.	Respondent 4	388 pts.	Respondent 4	459 pts.	Respondent 4	325 pts.

RANKING SUMMARY

Evaluator A		Evaluator B		Evaluator C		Evaluator D	
Respondent 1	1	Respondent 1	2	Respondent 1	4	Respondent 1	3
Respondent 2	2	Respondent 2	3	Respondent 2	2	Respondent 2	1
Respondent 3	4	Respondent 3	1	Respondent 3	3	Respondent 3	2
Respondent 4	3	Respondent 4	4	Respondent 4	1	Respondent 4	4

c) Step 3

An average rank will be calculated for each reply for all the evaluators.

Respondent 1	1+2+4+3=10+4=**2.5**
Respondent 2	2+3+2+1=8+4=**2.0**
Respondent 3	4+1+3+2=10+4=**2.5**
Respondent 4	3+4+1+4=12+4=**3.0**

5.2 Contract Negotiations

The Department reserves the right to negotiate with as many respondents as it determines appropriate pursuant to **Section 5.1.2**. The Department will schedule negotiations at its discretion. If the Department is unable to negotiate a satisfactory contract with any of the respondents, negotiations may be reinstated. Negotiations may continue until an agreement is reached or all replies are rejected. Negotiations do not guarantee award of a contract.

5.3 Notice of Agency Decision

At the conclusion of Reply evaluations and contract negotiations, the Department will announce its intended decision. Notice will be posted on the state's Vendor Bid System. The Department will award to the responsible, responsive Respondent determined to provide the best value, based upon the negotiations.

The Department reserves the right to award more than one contract as a result of this ITN.

5.4 Agency Inspectors General

It is the duty of every state officer, employee, agency, special district, board, commission, contractor, and subcontractor to cooperate with the inspector general in any investigation, audit, inspection, review, or hearing pursuant to this section.

5.5 Protests

Failure to file a protest within the time prescribed in section 120.57(3), Florida Statutes, or failure to post a bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under Chapter 120, Florida Statutes.

Only documents delivered by the U.S. Postal Service, a private delivery service, in person, or by facsimile during business hours (8:00 a.m. - 5:00 p.m., Eastern Time) will be accepted. Documents received after hours will be filed the following business day. **No filings may be made by email or by any other electronic means**. All filings must be made with the Agency Clerk ONLY and are only considered "filed" when stamped by the official stamp of the Agency Clerk. It is the responsibility of the filing party to meet all filing deadlines.

Do not send replies to the Agency Clerk's Office. Send all replies to the Procurement Officer and address listed in the Timeline.

The Agency Clerk's mailing address is:
Agency Clerk, Florida Department of Health
4052 Bald Cypress Way, BIN A-02
Tallahassee, Florida 32399-1703
Telephone No. (850) 245-4005

The Agency Clerk's physical address for hand deliveries is:
Agency Clerk, Department of Health
2585 Merchants Row Blvd.
Tallahassee, Florida 32399
Fax No. (850) 413-8743

ATTACHMENT A
EVALUATION CRITERIA INSTRUCTIONS

Instructions to Respondents for the completion of **Exhibit A-1** (including **Exhibits A-1-a**)

All Respondents to this solicitation will utilize **Exhibit A-1** for submission of its reply as specified in **Attachment A**., Evaluation Criteria Instructions. Respondents will adhere to the instructions below for each Evaluation Criteria.

Respondents will not include website links, embedded links and/or cross references between Evaluation Criteria.

Each Evaluation Criteria 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. All Evaluation Criteria, must be identical for each region in which the Respondent submits a reply. For timeliness of reply evaluation, the Department will evaluate each Evaluation Criteria once and transfer the score to each applicable evaluation score sheet(s).

Attachments are acceptable for any Evaluation Criteria but must be referenced in the form field for the respective Evaluation Criteria and located behind each respective Evaluation Criteria reply. Respondents will name and label attachments to refer to respective Evaluation Criteria by Evaluation Criteria identifier number.

Department designated evaluators will be instructed to evaluate the replies based on the narrative contained in the Evaluation Criteria form fields and the associated attachment(s), if applicable.

Each reply 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 Evaluation Criteria contained within **Exhibit A-1**.

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 Evaluation Criteria in **Exhibit A-1** may not be retyped or modified and must be submitted in the original format.

Exhibit A-1 is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

ATTACHMENT A-1
EVALUATION CRITERIA

RESPONDENT NAME: _____

A. RESPONDENT BACKGROUND / EXPERIENCE

Criteria #1-Statewide or Regional Reply

Respondent will indicate if their reply is statewide or for a regional cluster, the priority of the reply, and whether the reply is risk or non-risk using the following information:

CMS Regional Clusters

CMS Regional Cluster A - Northern Florida-AHCA Regions 1-4,

CMS Regional Cluster B-Central/Southwestern Florida- AHCA Regions 5-8

CMS Regional Cluster C- South/Southeastern Florida-AHCA Regions 9-11

Delivery System Phase in Options

Option I - MCO

- **Capitated Managed Care Plan** — A Managed Care Plan that is licensed or certified as a fully risk-bearing entity in the State, or qualified as a provider service network pursuant to section 409.962, Florida Statutes, that is paid a prospective per-member-per-month capitation payment for covered services provided to eligible enrollees (section 409.968(1) and (2), Florida Statutes).

Option II - Risk Phase In

- **Non-risk Prepaid Inpatient Health Plan** – For the first two years, the CMS Plan will operate as a cost reimbursement Contract for pharmacy (Year 1 only) and Inpatient (Year 1 and Year 2) claims. The Department will make interim non-risk payments to the Department on a quarterly basis and more frequently based on the Respondents satisfactory performance of its duties and responsibilities as set forth in the Contract. Those payments will be settled to actual expenditures, based on utilization, at the Medicaid FFS fee schedule rate for Medicaid and the established rate(s) for CHIP services.

- **Prepaid Ambulatory Health Plan** – For the first two years, the CMS Plan will operate as a Prepaid Ambulatory Health Plan for Outpatient (Year 1 and Year 2) and Pharmacy (Year 2 only) claims. Respondent will be licensed or certified as a fully risk-bearing entity in the State, or qualified as a provider service network pursuant to section 409.962, Florida Statutes that is paid a prospective per-member-per-month capitation payment for covered services provided to eligible enrollees (section 409.968(1), Florida Statutes).

ATTACHMENT A-1
EVALUATION CRITERIA

Reponses:

Please complete the chart below indicating the Priority Replies, Regions and Delivery System Phase In

PRIORITY 1 REPLY

	Option I (MCO)		Option II (RISK PHASE IN)
Regional Reply			
Cluster A (1-4)		*or*	
Cluster B (5-8)		*or*	
Cluster B (9-11)		*or*	
	OR		
	Option I (MCO)		Option II (RISK PHASE IN)
Statewide Reply		*or*	

PRIORITY 2 REPLY

	Option I (MCO)		Option II (RISK PHASE IN)
Regional Reply			
Cluster A (1-4)		*or*	
Cluster B (5-8)		*or*	
Cluster B (9-11)		*or*	
	OR		
	Option I (MCO)		Option II (RISK PHASE IN)
Statewide Reply		*or*	

Evaluation Criteria

Respondent may submit a combination of replies with different priorities. For example, the Respondent may submit a statewide reply as its first priority but may agree to also reply to a single regional cluster in the event that another Respondent submits a winning reply for two regional clusters.

Respondent may also submit a combination of risk and non-risk delivery systems. For example, the Respondent may submit a statewide reply with two Regions having risk delivery systems and the third delivery system having a non-risk phase in.

ATTACHMENT A-1
EVALUATION CRITERIA

Score

This section is worth a maximum of 100 points.

Submission of a state-wide reply is worth 100 points regardless of the combination of at-risk or non-risk delivery systems.

Submission of a reply solely for two regional clusters is worth 30 points with an additional 20 points given if the reply is to provide services in both regions on an at-risk basis.

Submission of a reply solely for one regional cluster is worth 10 points with an additional 10 points given if the reply is to provide services on an at-risk basis.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #2 – Managed Care Experience

Respondent, including Respondent's parent, affiliate(s) and subsidiary(ies), will provide a list of all current and/or recent (within five years of the issue date of this solicitation), contracts for managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support).

Respondent will provide the following information for each identified contract:

a. The Medicaid population served (such as TANF, ABD, dual eligible, children, persons with disabilities) and the CHIP population served;
b. The Medicaid population served (such as TANF, ABD, dual eligible, children, persons with disabilities) and the CHIP population served;
c. The name and address of the client;
d. The name of the contract;
e. The specific start and end dates of the contract;
f. A brief narrative describing the role of the Respondent and scope of the work performed, including covered populations and covered services;
g. The use of administrative and/or delegated subcontractor(s) and their scope of work;
h. The annual contract amount (payment to the Respondent) and annual claims payment amount;
i. The scheduled and actual completion dates for contract implementation;
j. The barriers encountered that hindered implementation (if applicable) and the resolutions;
k. Accomplishments and achievements;
l. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid, CHIP); and
m. Whether the contract was capitated, FFS or other payment method.

In addition, the Respondent will describe its experience in delivering managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support), to Medicaid and CHIP populations similar to children and youth with medical complexity identified in this solicitation.

For this Criteria, the Respondent may include experience provided by subcontractors for which the Respondent was contractually responsible, if the Respondent plans to use those same subcontractors for the CMS Plan.

Reply:

Evaluation Criteria:

1. The extent of the Respondent's experience with providing services to children and youth with medical complexity and integrated medical and behavioral health services.

2. The extent of the Respondent's subcontractors' experience in coordinating or providing services to Medicaid and CHIP recipients.

3. The extent to which the barriers to implementation experienced by the Respondent have clear resolutions outlined.

4. The extent to which the Respondent has listed accomplishments and achievements that are relevant to this solicitation.

5. The extent to which the Respondent's Medicaid and CHIP populations served are similar to the populations served by the Department and includes children with medical complexity.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of five points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #3 – Florida Experience

Respondent will provide documentation of the extent to which it has experience operating as a Florida Medicaid or CHIP health plan statewide. If applicable, the Respondent will provide the Medicaid Plan or CHIP Contract number and the regions of operation to show it has experience providing managed care services in Florida. Respondent will provide documentation of any Medicare Advantage Plan contracts for counties in the State of Florida.

Reply:

Evaluation Criteria:

For the Respondent that is proposing to provide services under this solicitation, whether the Respondent has:

1. An existing statewide SMMC Contract;
2. An existing SMMC Contract in a subset of regions in the state of Florida;
3. An existing CHIP Contract;
4. A Medicare Advantage Plan contract statewide or in a subset of regions;
5. An existing insurance contract.

Score: This section is worth a maximum of 30 raw points as outlined below.

1. 20 points if the Respondent already has a statewide SMMC or CHIP Contract to provide services (MMA, LTC and/or Specialty).

2. 15 points if the Respondent has an SMMC or CHIP Contract in a subset of regions in the State and the Respondent is proposing to cover a statewide contract.

3. 10 points if the Respondent has an SMMC or CHIP Contract in a subset of regions in the State and the Respondent is proposing to cover only those regions covered in the current SMMC or CHIP contracts.

4. 5 additional points will be awarded if the Respondent has a comprehensive (MMA & LTC) SMMC Contract to provide Medicaid services.

5. 5 additional points will be awarded if the Respondent has a Medicare Advantage Plan to provide services.

6. 0 points will be awarded if the Respondent does not have an SMMC Contract in Florida or a Medicare Advantage Plan contract.

Criteria #4 – Statutorily Required Florida Presence

Respondent will provide information regarding whether each operational function, as defined in section 409.966(3)(c)3, Florida Statutes, will be based in the state of Florida, and the extent to which operational functions will be conducted by staff in-house or through contracted arrangements, located in the State of Florida. This includes:

a. Specifying the location of where the Respondent's corporate headquarters will be located (as defined by section 409.966(3)(c)3, Florida Statutes);

b. Indicating whether the Respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and

c. Identifying the number of full-time staff, by operational function (as defined in section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

Note: Pursuant to section 409.966(3)(c)6., Florida Statutes, reply to this submission requirement will be considered for negotiations.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1
EVALUATION CRITERIA

Reply:

Evaluation Criteria:

1. Whether the Respondent's corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).

2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida.

Score: This section is worth a maximum of 15 raw points. Each of the above components is worth a maximum of 5 points each as described below. 5 additional points will be awarded if Respondent meets Items 1(a) and 2(a) below.

For Item 1:

(a) 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
(b) 0 points if no relevant corporate headquarters in Florida.

For Item 2:

(a) 5 points if all functions will be performed in Florida;

(b) 4 points for 6-7 functions to be performed in Florida;

(c) 3 points for 4-5 functions to be performed in Florida;

(d) 2 points for 2-3 functions to be performed in Florida;

(e) 1 point for 1 function to be performed in Florida;

(f) 0 points for no functions to be performed in Florida;

(g) 0 points if only community outreach, medical director and State administrative functions will be performed in Florida.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #5 – Contract Performance

Respondent will state whether, in the past five years it has voluntarily terminated all or part of a managed care contract under which it provided health care services as the insurer; has had such a contract partially or fully terminated before the contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address and telephone number of the client/other party. If the Contract was terminated based on the Respondent's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the Respondent as well as the Respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries.

Reply:

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.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each as described below.

For Item 1:

(a) 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction and no service area withdrawals;
(b) 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

For Item 2:

(a) 5 points for no involuntary terminations;
(b) 0 points for any involuntary termination based on performance.

For Item 3:

(a) 5 points for no contract terminations related to patient care;
(b) 0 points if termination related to patient care.

For Item 4:

(a) 5 points for no contract terminations related to provider network management, claims processing or solvency concerns;
(b) 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

B. CMS Plan GOALS

Criteria #6 - Care Coordination and/or Case Management

Respondent will describe its approach for identifying, assessing, and implementing interventions for enrollees who present with high service utilization and consistently access services at the highest level of care.

Respondent will propose care coordination and/or case management activities to meet the unique needs of the specialty population being proposed for this solicitation, including specific disease management interventions or special condition management relevant to the specialty population. Respondent (including Respondents' parent, affiliate(s) or subsidiary(ies)) will describe its experience in providing care coordination/case management for populations similar to the specialty population being proposed, including experience with disease management or other special condition management. Respondent will describe proposed interventions, evidence-based risk assessment tools, self-management practices, practice guidelines, etc., relevant to the specialty population proposed. Respondent will describe any other care coordination/case management activities proposed to meet the needs of the specialty population.

Respondent will describe how disease management functions will be integrated with care management.

Respondent will describe how Care Coordinators/Case Managers will be trained to address social determinants of health including but not limited to referring families to WIC, utility payment assistance, etc. as well as creation of a statewide resource for Care Coordinators/Case Managers and families to utilize to access Quality Enhancements such as referral to Legal Aid and local parenting classes or wellness classes available in each community.

Respondent will describe its proposed approach to implementation of Case Management for children residing in nursing facilities, receiving private duty nursing and at risk for institutionalization and emergency room use.

Respondent's description will include:

a. A description of the overall proposed case management program;

b. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level with at least two percent of the children with high utilization of services in addition to all children receiving nursing facility and private duty nursing services receiving case management;

c. A description of evidence-based guidelines utilized in the care coordination approach, including interventions deployed to improve enrollee engagement and improve treatment adherence;

d. A description of how the case management program is integrated with disease management program to ensure that all children in the CMS Plan are assigned to a Care Coordinator/Case Manager;

e. A description of performance metrics used to evaluate the efficacy of the case management program, including cost-savings, reduction in the use of higher cost services, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics;

f. A description of the process to assess each child and develop a person-centered care plan including the number of anticipated face-to-face contacts for each child per risk level annual. At least one face-to-face visit must be conducted in the home annually. Other acceptable face-to-face visits can be completed in the community, at doctor's offices, or through another HIPAA compliant mode including video communications technology;

g. A description of minimum contact frequencies and contact type for each severity and/or risk level including a description of the number of face-to-face versus telephonic contacts for each level as well as the assessment tool and care plan development requirements to be used by the Case Management staff. At a minimum, all children should have quarterly face-to-face visits with plan of care reviews, monthly telephone/e-mail contact, and semi-annual assessments and plan of care development;

h. A description of the maximum caseloads for each Care Coordinator/Case Manager (ratio requirements) and case management support staff (note: the caseloads for children in nursing facilities should not exceed 1:15; for children receiving private duty nursing should not exceed 1:40; and for all other high utilizing children should not exceed 1:90);

i. A description of the qualifications of the case management staff who will interact with enrollees;

j. A description of the Respondent's plan to hire qualified current CMS state employees for Care Coordinator/Case Manager positions and how that plan will ensure that the CMS current enrollees do not have a gap in case management prior to implementation (i.e., offering letters of intent to employ with delayed on-boarding for current CMS Care Coordinators/Case Managers); and

k. A description of the Respondent's plan to co-locate Care Coordinators/Case Managers at large volume children's hospitals or provider practices/ clinics or to work with existing Care Coordinators/Case Managers at specialty clinics and other locations, i.e. pediatric and specialty practices, to manage enrollees who are high utilizers of care or at high risk of institutionalization or emergency room use.

Reply:

Evaluation Criteria:

1. The extent of experience (e.g., number of contracts, enrollees or years) in providing care coordination/case management to similar target populations, including disease or special condition management.

2. The extent to which the described experience demonstrates the ability to effectively provide care coordination/case management to the population proposed.

3. The extent to which the care coordination/case management activities proposed by the Respondent are relevant to the specialty population proposed and include community specific resources such as an on-line search capability for community resources available to Care Coordinators/Case Managers and enrollees. The resource should include contacts for Medicaid and CHIP financial eligibility, SNAP, WIC, utility payment assistance, referral to Legal Aid and local parenting classes or wellness classes available in each community.

4. The extent to which the Respondent proposes an innovative and evidence-based approach to case management for at least the following conditions:

   (a) Cancer;

   (b) Diabetes;

   (c) Asthma;

   (d) Sickle Cell Anemia;

   (e) Phenylketonuria (PKU) and other metabolic conditions;

   (f) Developmental disabilities including Autism;

   (g) Rare congenital conditions including cleft lip/palate, spina bifida, congenital heart disease;

   (h) Mental health including ADHD and Severe Emotional Disturbance;

   (i) Substance abuse;

   (j) Hemophilia;

   (k) HIV/AIDS; and

   (l) "Children with special health care needs" which means those children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children. This includes: arthritis, cerebral palsy, epilepsy, hearing impairments, liver

diseases, multiple sclerosis, paralysis of extremities (complete or partial), speech impairments, and visual impairments.

5. The adequacy of the Respondent's description of how its respective disease management program will be incorporated into its overall Case Management approach to advance the CMS Plan's goals.

6. The extent to which the Respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized and ensures that all children will receive Disease/Case Management.

7. The extent to which the Respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.

8. The extent to which the Respondent's approach includes the use of predictive modeling.

9. The extent to which the Respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.

10. The adequacy of the Respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.

11. The efficacy of the Respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, transitioning children out of institutional settings, and diverting institutionalization, etc.

12. The extent to which the Respondent's case management programs include at least the following components:

- Assessment;
- Plan of Care development;
- Diversion from or transition from institutional care as needed;
- Solution-oriented follow-up after emergency room or institutional care to identify opportunities for care improvement to prevent re-institutionalization;
- Identification of gaps in care including accessibility issues;
- Identification of service needs to support children in their homes;
- Symptom management;
- Medication support;
- Emotional support;
- Behavior change;
- Parent training regarding diagnoses, medications, symptoms;
- Arranging transportation;
- Communication with schools in the development of an Individual Education Plan, 504 plan or other education plan; and
- Communication/education with providers, including the PCP/specialists.

13. The extent to which the Respondent has described a methodology for evaluating the impact of the case management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

14. The extent to which the frequency and intensity of the case management services (i.e., maximum caseload and minimum contact requirements) are aligned with the Respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.

15. A description of how the Respondent will hire current State Employee Care Coordinators/Case Managers experienced with coordinating care for children with medical complexity (e.g., job fairs, language for Care Coordinator/Case Manager employment transition without gaps, etc.).

16. A description of how the Respondent will work with high volume children's hospitals and clinics to co-locate Care Coordinators/Case Managers and to leverage existing specialty clinic Care Coordinator/Case Manager staff to avert institutionalization, emergency room utilization and readmissions.

Score: This section is worth a maximum of 160 raw points with each component being worth a maximum of 10 points each.

(a) 10 points if the component is excellent;
(b) 8 points if the component is above average;
(c) 6 points if the component is average;
(d) 4 points if the component is below average;
(e) 2 points if the component contained significant deficiencies;
(f) 0 points if the component was not addressed.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #7 – Disease Management (DM) Program

Respondent will describe its proposed approach to implementation of specific disease management programs and how they will be used to advance the CMS Plan's goals. Respondent's description will include:

a. A description of the overall proposed disease management program and each targeted disease;

b. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;

c. A description of the evidence-based guidelines utilized in the approach;

d. A description of how the disease management program is integrated with case management/care coordination programs to ensure that all children in the CMS Plan are assigned to either a Care Coordinator/Case Manager;

e. A description of performance metrics used to evaluate the efficacy of the disease management program, including cost-savings, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics;

f. A description of the process to assess each child and develop a person-centered care plan including the number of anticipated contacts for each child per risk level annual;

g. A description of the number of face-to-face versus telephonic contacts for each level as well as the assessment tool and care plan development requirements to be used by the Care Coordinators/Case Managers performing Disease Management. At least one face-to-face visit must be conducted in the home annually. Other acceptable face-to-face visits can be completed in the community, at doctor's offices, or through another HIPAA compliant mode including video communications technology;

h. A description of the qualifications of the disease management staff who will interact with enrollees and

i. A description of the Respondent's plan to hire qualified current CMS state employees for Care Coordinator/Case Manager positions performing disease management and how that plan will ensure that the CMS current enrollees do not have a gap in care management prior to implementation (i.e., offering letters of intent to employ with delayed on-boarding for current CMS Care Coordinators/Case Managers). Respondent's plan should include an exception process for current CMS staff not meeting the minimum professional qualifications established.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent proposes an innovative and evidence-based approach to disease management for at least the following conditions:

    (a) Cancer;
    (b) Diabetes;
    (c) Asthma;
    (d) Sickle Cell Anemia;
    (e) Phenylketonuria (PKU) and other metabolic conditions;
    (f) Developmental disabilities including Autism;
    (g) Rare congenital conditions including cleft lip/palate, spina bifida, congenital heart disease;
    (h) Mental health including ADHD and Severe Emotional Disturbance;
    (i) Substance abuse;
    (j) Hemophilia;
    (k) HIV/AIDS; and
    (l) "Children with special health care needs" which means those children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children. This includes: arthritis, cerebral palsy, epilepsy, hearing impairments, liver diseases, multiple sclerosis, paralysis of extremities (complete or partial), speech impairments, and visual impairments.

2. The adequacy of the Respondent's description of how its respective disease management program will be incorporated into its overall Case Management approach to advance the CMS Plan's goals.

3. The extent to which the Respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized and ensures that all children will receive disease management.

4. The adequacy of the Respondent's description of how its disease management programs will be integrated into case management/care coordination programs.

5. The extent to which the Respondent's disease management programs include at least the following components:

    (a) Assessment;
    (b) Plan of Care development;
    (c) Diversion from or transition from institutional care as needed;
    (d) Solution-oriented follow-up after emergency room or institutional care to identify opportunities for care improvement to prevent re-institutionalization;
    (e) Identification of gaps in care including accessibility issues;
    (f) Identification of service needs to support children in their homes;
    (g) Symptom management;
    (h) Medication support;
    (i) Emotional support;
    (j) Behavior change;
    (k) Parent training regarding diagnoses, medications, symptoms;
    (l) Arranging transportation;
    (m) Communication with schools in the development of an Individual Education Plan, 504 plan or other education plan; and
    (n) Communication/education with providers, including the PCP/specialists.

6. The extent to which the Respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

Score: This section is worth a maximum of 60 raw points with each component being worth a maximum of 10 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #8 – Transitions of Care:

Respondent will describe how it will address the transition of care between service settings, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home. Identify specific methodologies for ensuring that transition planning ensures appropriate primary care and behavioral health follow up, where appropriate. Provide an example of an effective transition plan.

1. Respondent will describe its experience with transitioning individuals from institutional to community settings and strategies to ensure individuals maintain successful community placement including:

a. Experience and strategies pertaining to deploying transitional care coordinators and using evidence-based practices with support from other clinical resources and community- based organizations.

b. Experience and strategies pertaining to individuals who reside in an institutional setting, or have otherwise resided in a facility for less than one year.

c. Experience and strategies pertaining to individuals who have resided in an institutional setting for more than one year.

2. Respondent will also describe how it will address the transitions of care for each child in Case Management and Disease Management between the children's and adult service systems. Description should include:

a. Identification of specific milestones that would trigger need for or that should be addressed in transition plan.

b. Process for ensuring that transition planning includes the child and his/her family, children's providers and adult providers.

c. An example of an effective transition plan.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's process and example address all three transition circumstances (A-C) and the following transition of care requirements:

(a) Assessment criteria for ensuring the enrollee can be served safely in the community;

(b) The extent to which the Respondent identifies how it will coordinate care with all individuals and/or entities necessary including collaboration with providers' (e.g., hospitals, institutional settings, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;

(c) The extent to which the Respondent assesses potential caregiver willingness and availability in supporting the transition;

(d) The extent to which the Respondent's description addresses transitioning enrollees with special circumstances or medical conditions (e.g., complex needs); enrollees with ongoing needs; and enrollees who at the time of their transition have existing prior authorization or approval for ancillary services;

(e) The extent to which the Respondent demonstrates through data its success rate at transitioning individuals from institutional to community settings;

(f) The extent to which the Respondent addresses referral and scheduling assistance coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred;

(g) The extent to which the Respondent describes processes to prevent unnecessary hospital or nursing facility readmissions;

(h) The extent to which the Respondent demonstrates through data its success rate at maintaining individuals who have transitioned from an institutional placement to community placements;

(i) The child to adult transition process incorporates the following principles at a minimum:

- A systematic and formalized transition process.
- Early preparation with milestones identified.
- Identification of a transition coordinator.
- A communication plan.
- An individual transition plan identifying:
  - The child's housing, education and employment goals.
  - The child's need to change from pediatric to adult specialists and the transfer of any medical records necessary.
  - Guardianship or health proxy documents, if needed.
  - The need to address physical, mental or social barriers or risk factors.
  - Teaching self-knowledge of diagnoses, medication, and medical professionals in order to empower, engage, and enable the young person to self-manage to the extent developmentally appropriate.
  - Follow-up and evaluation.

2. The extent to which the Respondent's process and example ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

Score: This section is worth a maximum of 64 raw points with each of the 9 criteria in 1. worth 2 points each for each of the three experiences outlined in the above component 1 (a-c) and criterion 2. being worth 10 points.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #9 – HEDIS Measures

Respondent will describe its experience in achieving quality standards with medically complex children's populations. Respondent will include, in table format, the target population (CHIP, TANF, ABD, and dual eligible populations), the Respondent's results for the HEDIS measures specified below for each of the last two years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the Respondent's three largest Medicaid or CHIP Contracts (measured by number of enrollees). If the Respondent does not have HEDIS results for at least three Medicaid or CHIP Contracts, the Respondent will provide commercial HEDIS measures for the Respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it will include the Florida Medicaid experience as one of three states for the last two years.

Respondent will provide the data requested in **Exhibit A-1-a**, General Performance Measurement Tool to provide results for the following HEDIS measures:

- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the first 15 months (six or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the third, fourth, fifth and sixth years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

For members ages 18-21

- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (seven day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase;
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia; and
- Adults' Access to Preventive/Ambulatory Health Services (Total).

Reply:

Evaluation Criteria:

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

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

Score: This section is worth a maximum of 120 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 110 points as described below:

Exhibit A-1-a, General Performance Measurement Tool, provides for 96 opportunities for a Respondent to report prior experience in meeting quality standards 16 measure rates, three states each, two years each).

For each of the measure rates, a total of 10 points is available per state reported (for a total of 480 points available). Respondent will be awarded 2 points if their reported plan rate exceeded the national Medicaid mean and 2 points if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. Respondent will be awarded an additional 2 points for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and Respondents will receive a final score of 0 through 120 corresponding to the number and percentage of points received out of the total available points. For example, if a Respondent receives 100 percent of the available 480 points, the final score will be 120 points (100 percent). If a Respondent receives 432 (90 percent) of the available 480 points, the final score will be 108 points (90 percent). If a Respondent receives 48 (10 percent) of the available 480 points, the final score will be 12 points (10 percent).

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1-a
GENERAL PERFORMANCE MEASUREMENT TOOL

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/HEDIS 2017 performance measure data for the selected HEDIS measures for the Respondent's three largest Medicaid or CHIP contracts (measured by number of enrollees).

If the Respondent does not have HEDIS results for at least three Medicaid or CHIP Contracts, the Respondent will provide commercial HEDIS measures for the Respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it will include the Florida Medicaid experience as one of three states for the last two years.

The performance measures that Respondents are required to report on can be found on the Performance Measure Group A tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid or CHIP population for the appropriate calendar year.

Attachment A-1-a is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1-a
GENERAL PERFORMANCE MEASUREMENT TOOL

RESPONDENT NAME:						
Group A						
	State #1:	**Florida**	**State #2:**	**Hawaii**	**State #3:**	**Georgia**
HEDIS Performance Metric	**CY 2015 Rate**	**CY 2016 Rate**	**CY 2015 Rate**	**CY 2016 Rate**	**CY 2015 Rate**	**CY 2016 Rate**
Adolescent Well-Care Visits - (AWC)						
Antidepressant Medication Management - (AMM)						
Adult BMI Assessment						
Childhood Immunization Status – (CIS) – Combo 2 and 3						
Comprehensive Diabetes Care – (CDC) Hemoglobin A1c (HbA1c) testing HbA1c poor control HbA1c control (<8%) Eye exam (retinal) performed Medical attention for nephropathy						
Follow-up Care for Children Prescribed ADHD Medication – (ADD)						
Immunizations for Adolescents – (IMA)						
Chlamydia Screening in Women – (CHL)						
Prenatal and Postpartum Care – (PPC)						
Medication Management for People with Asthma – (MMA)						
Well-Child Visits in the First 15 Months of Life – (W15)						
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34)						

ATTACHMENT A-1-a
GENERAL PERFORMANCE MEASUREMENT TOOL

RESPONDENT NAME:						
Group A						
	State #1:	**Florida**	**State #2:**	**Hawaii**	**State #3:**	**Georgia**
HEDIS Performance Metric	**CY 2015 Rate**	**CY 2016 Rate**	**CY 2015 Rate**	**CY 2016 Rate**	**CY 2015 Rate**	**CY 2016 Rate**
Children and Adolescents' Access to Primary Care Practitioners - (CAP)						
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - (IET)						
Ambulatory Care - (AMB)						
Lead Screening in Children – (LSC)						
Annual Monitoring for Patients on Persistent Medications - (MPM)						
Frequency of Ongoing Prenatal Care - (FPC)						
Metabolic Monitoring for Children and Adolescents on Antipsychotics – (APM)						
Use of Multiple Concurrent Antipsychotics in Children and Adolescents - (APC)						
Follow-Up After Emergency Department Visit for Mental Illness – (FUM)						
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Treatment – (FUA)						
Diabetes Screening for People with Schizophrenia or Bipolar Who are Using Antipsychotic Medications SSD						
ED visits per 1,000-member months						
Follow-Up after Hospitalization for Mental Illness – (FHM)						
Inpatient Utilization Discharges/1,000 Member Months/Years						

ATTACHMENT A-1-a
GENERAL PERFORMANCE MEASUREMENT TOOL

RESPONDENT NAME:	

Group A						
	State #1:	Florida	State #2:	Hawaii	State #3:	Georgia
HEDIS Performance Metric	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Total Points	0					

Criteria #10 – HEDIS Measures - Standards

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract- required standards were met, but improvement was desirable.

- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the third, fourth, fifth, and sixth Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

For Members 18-21

- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase;
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia; and
- Access to Preventive/Ambulatory Health Services (Total).

Reply:

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.

2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

Criteria #11 – HEDIS (Data Sources)

Respondent will describe:

a. The extent to which it has used the following standard supplemental data sources for its HEDIS and other performance measures:

- Laboratory result files;
- Immunization data in State or county registries;
- Transactional data from behavioral healthcare Respondents; and
- Current or historic State transactional files in a standard electronic format.

b. The extent to which it has used supplemental data from electronic health record Respondent systems and data from certified eMeasure Respondents for HEDIS and other performance measures.

c. The extent to which it has experience reporting HEDIS measures collected using Electronic Clinical Data Systems.

Reply:

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare Respondents; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures.

2. The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) Respondent systems and data from certified eMeasure Respondents for HEDIS and other performance measures.

3. The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS).

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #12 – Potentially Preventable Events

Respondent will describe its organizational commitment to quality improvement as it relates to reducing potentially preventable events. More specifically, the Respondent will describe its overall approach and specific strategies that will be used to ensure a reduction in potentially preventable hospital admissions and readmissions, a reduction in the use of the emergency department for non-emergent/urgent visits, and a reduction in the use of unnecessary ancillary services during hospitalization and outpatient visits. Respondent's approach will also include:

- A description of the Respondent's assessment (using available data sources) of hospital utilization rates and the potential for improvement;
- A description of performance benchmarks for each area of focus;
- A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings; and
- A description of evidence-based interventions and strategies that will be used to target super-utilizers, particularly related to pain management and behavioral health conditions.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the Respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health).

2. The extent to which the Respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers.

3. The extent to which the Respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples.

4. The extent to which the Respondent plans to include the use of AHCA's Event Notification System as a means to extract relevant data from hospitals.

5. The adequacy of the Respondent's description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.

6. The extent to which the Respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid and CHIP patients).

7. The extent to which the Respondent proposed local performance benchmarks for:

(a) Reducing potentially preventable hospital admissions and readmissions;
(b) Reducing use of the emergency department for non-emergent/urgent visits; and
(c) Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #13 – Patient Centered Medical Homes

Respondent will describe its experience with patient centered medical homes (PCMHs) including the Respondent's efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvement in quality measures.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:

(a) Enhanced access;
(b) Coordinated and/or integrated care; and
(c) Achievement of improved quality outcomes.

2. The extent to which the Respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH as their PCP.

3. The extent to which the Respondent's description of recognizing PCMHs addresses methodologies and processes to improve child health outcomes for enrollees assigned to a PCMH as their PCP.

4. The extent to which the Respondent's description of recognizing PCMHs that focus on improving enrollee/family satisfaction.

Score: This section is worth a maximum of 25 raw points with point 1 being worth 10 points and each of the above components (2-4) being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #14 – Telemedicine

Respondent will describe its overall approach to utilizing telemedicine services, in particular as it relates to enhanced access to the following providers within the Respondent's network:

a. Pediatric Primary Care Physicians (including General Practitioners and Family Practitioners)
b. Board Certified Pediatric Cardiologists
c. Board Certified Pediatric Endocrinologists
d. Board Certified Pediatric Nephrologists
e. Board Certified Pediatric Neurologists
f. Board Certified Pediatric Psychiatrists
g. Board Certified Rheumatologists
h. Licensed mental health clinicians

Respondent will describe any limitations placed on telemedicine services within its network and the percentage of providers with the network that are authorized to provide telemedicine services for the specialty types referenced above and those actually providing telemedicine.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the service delivery to medically complex children in order to improve access to:

- Pediatric Primary Care Physicians (including General Practitioners and Family Practitioners)
- Board Certified Pediatric Cardiologists
- Board Certified Pediatric Endocrinologists
- Board Certified Pediatric Nephrologists
- Board Certified Pediatric Neurologists
- Board Certified Pediatric Psychiatrists
- Board Certified Rheumatologists
- Licensed mental health clinicians

Particularly in rural areas or areas where DOH CMS clinics could transition to Respondent network managed telemedicine.

2. The extent to which the Respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.

3. The extent to which the Respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:

- The percentage of providers authorized to provide telemedicine services for the provider types referenced; and

- The percentage and type of authorized providers that provided telemedicine services during the 2016 and 2017 calendar year.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #15 – Quality Measures:

Respondent will propose quality management activities to address the needs of the specialty population(s) being proposed for this solicitation, including specific quality measures relevant to the specialty population(s). Respondent (including Respondents' parent, affiliate(s) or subsidiary(ies)) will describe its experience in quality management for population(s) similar to the specialty population(s) being proposed for this solicitation. Include experience with standardized measures, such as HEDIS and Contract-required measures, relevant to the specialty population(s) proposed. Identify specific quality measures relevant to the specialty population(s) the Respondent proposes to collect and report to the Department. Describe any other quality management activities the Respondent proposes to improve performance. Describe any instances of failure to meet HEDIS or Contract-required quality standards and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract required standards were met, but improvement was desirable.

Reply:

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, including HEDIS or Contract required measures.

2. The extent to which the quality measures proposed are relevant to the specialty population(s) being proposed for this solicitation.

3. The extent to which the quality management activities proposed demonstrates the ability to improve quality for the population(s) proposed in a meaningful way including a performance improvement project on improving transition of care as outlined in the Prime Contract.

4. The extent to which the Respondent met quality measure targets, successfully remediated all failures, or achieved improvement to overall performance.

Score: This section is worth a maximum of 60 raw points with each of the above components being worth a maximum of 15 points each.

Criteria #16 – CMS Physician Incentive Program (PIP)

Respondent will describe its plan for ensuring physician compensation rates are equal to or exceed Medicare rates for MMA covered services and the metrics required for the specific physician groups to receive the rate equal to or in excess of, the Medicare rate.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's reply to improve quality can be tied to redirecting costs to pay higher physician rates.

2. The extent to which the Respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.

3. The extent to which the Respondent incorporates quality initiatives goals or incentives for improvement of child health outcomes.

4. The extent to which the Respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

C. Recipient Experience

Criteria #17 – Expanded Benefits and In Lieu of Services (ILS):

Based upon the benefits listed in **Exhibit A-1-b**, Expanded/ILS Benefits Tool, the Respondent will identify the benefits it proposes to offer CMS Plan enrollees by eligible population (TANF, ABD, CHIP, dual eligible,). **Exhibit A-1-b**, Expanded/ILS Benefits Tool outlines specific benefits, including category, procedure code descriptions and procedure codes. When electing to offer benefits included in **Exhibit A-1-b**, Expanded/ILS Benefits Tool, the Respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in **Exhibit A-1-b**.

Reply: Respondent will select the following benefits it will offer, as listed in **Exhibit A-1-b**, Expanded/ILS Benefits Tool (Respondent will check all that apply):

- Respondent will implement a tool for Care Coordinators/Case Managers to determine if a child should receive an In Lieu of Services (ILS) cost-effective benefit or Expanded Benefit. The tool should allow the Care Coordinator/Case Manager to apply for specialized services or other ILS/Expanded Benefits that may be deemed necessary by the Respondent to enable the child to live in their home and community or to be discharged from an institutional setting.

In Lieu of Services

- Emergency Respite to divert or shorten an institutional stay in addition to PACC/PIC:TFK respite services that a child may be eligible for under the contract.
- Crisis Stabilization unit and freestanding psychiatric hospitals in lieu of inpatient psychiatric hospital care (Class III and IV).
- Housing-related supports/modifications to divert or shorten an institutional stay (e.g., bed bug treatment to prevent hospitalization or building a ramp or modifying a vehicle to allow a child in a wheel chair to shorten an institutional stay) or to provide safety for a child (e.g., interior door locks for a child with Autism who wanders).

Note: the following are suggested ILS

- Nursing Facility in lieu of hospital services
- Detoxification or addictions receiving facilities in lieu of inpatient detoxification hospital care
- Partial hospitalization in a hospital in lieu of inpatient psychiatric hospital care
- Mobile crisis assessment and intervention for enrollees in the community in lieu of emergency behavioral health care
- Ambulatory detoxification services in lieu of inpatient detoxification hospital care
- The following in lieu of community behavioral health services:
    - Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services.
    - Respite Care Services in lieu of Specialized Therapeutic Foster Care services.
    - Drop-In Center in lieu of Clubhouse services.
    - Infant Mental Health Pre- and Post Testing Services in lieu of

Psychological Testing services.
- Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services.
- Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.

Expanded Benefits:

- Planned Respite in addition to PACC/PIC:TFK respite services that a child may be eligible for under the contract
- Home maintenance and minor home or environmental adaptations that contribute to community integration or wellness of a child such as In-Home Pest Control for homeowners up to $500 per calendar year
- Non-medical transport
- Financial coaching/benefits counseling
- Parenting classes
- Education/supports for Wellness including
  - Gym memberships
  - Cooking classes
  - Free Healthy Living Coaching for families with kids ages 7-13 who qualify
  - Hypoallergenic bedding for people with asthma, allergies, and chronic respiratory or pulmonary conditions up to a $100 one-time credit
  - Healthy Behavior Reward program – members can earn points for healthy activities like going to the doctor and eating healthy
- Specialized recreational opportunities for Wellness and community integration (e.g., adaptive baseball, basketball, fees for physical activities)

ATTACHMENT A-1
EVALUATION CRITERIA

Evaluation Criteria:

Score: This section is worth a maximum of 240 raw points as outlined below.

1. Respondent will implement a Value-Added Services tool for Care Coordinators/Case Managers to determine if a child should receive a cost-effective benefit. (55 pts)
2. **In Lieu of Services**
    - Emergency Respite to divert or shorten an institutional stay (25 pts)
    - Crisis Stabilization unit and freestanding psychiatric hospitals in lieu of psychiatric hospital care (25 pts)
    - Housing-related supports/modifications to divert or shorten an institutional stay (e.g., bed bug treatment to prevent hospitalization or building a ramp or modifying a vehicle to allow a child in a wheel chair to shorten an institutional stay) or to provide safety for a child (e.g., interior door locks for a child with Autism who wanders) (25 pts)
    - Nursing Facility in lieu of hospital services (10 pts)
    - Detoxification or addictions receiving facilities in lieu of inpatient detoxification hospital care (10 pts)
    - Partial hospitalization in a hospital in lieu of inpatient psychiatric hospital care (10 pts)
    - Mobile crisis assessment and intervention for enrollees in the community in lieu of emergency behavioral health care (10 pts)
    - Ambulatory detoxification services in lieu of inpatient detoxification hospital care (10 pts)
    - The following in lieu of community behavioral health services:
        - Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services. (10 pts)
        - Respite Care Services in lieu of Specialized Therapeutic Foster Care services. (10 pts)
        - Drop-In Center in lieu of Clubhouse services. (10 pts)
        - Infant Mental Health Pre and Post Testing Services in lieu of Psychological Testing services. (10 pts)
        - Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services. (10 pts)
        - Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services. (10 pts)

3. Expanded Benefits

- Planned Respite — 25 pts
- Home maintenance and minor home or environmental adaptations that contribute to community integration or wellness of a child such as In-Home Pest Control for homeowners up to $500 per calendar year — 10 pts
- Non-medical transport — 10 pts
- Financial coaching/benefits counseling — 10 pts
- Parenting classes — 10 pts
- Education/supports for Wellness including but not limited to
  - Gym memberships
  - Cooking classes
  - Free Healthy Living Coaching for families with kids ages 7-13 who qualify
  - Hypoallergenic bedding for people with asthma, allergies, and chronic respiratory or pulmonary conditions up to a $100 one-time credit — 10 pts
  - Healthy Behavior Reward program – members can earn points for healthy activities like going to the doctor and eating healthy
  - Specialized recreational opportunities for Wellness and community integration (e.g., adaptive baseball, basketball, fees for physical activities)

Attachment A-1-b is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/invitation-to-negotiate/index.html

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1-b
CRITERIA #17 – In LIEU OF and EXPANDED BENEFITS TOOL

Category	Sub-category	Procedure Code Description	Procedure/CPT Code	Min Age	Max Age	Current Florida Medicaid Coverage	Expanded Benefit Coverage (Units)
Emergency and Planned Respite	Respite	Respite Care-in home Respite Care-out of home	S9125-in-home H0045-out of home	0	21 yrs	For model and DD waiver enrollees, this is covered via FFS	For non-model and DD waiver enrollees, 200 hours a year for in home. 10 days of out of home.
Behavioral Health		Crisis Stabilization	0910	2 yrs	21 yrs		As needed to divert hospitalization, emergency room visits, or prevent out-of-home placement
Modifications to divert institutional stay or home maintenance and minor home or environmental modifications including vehicle modifications		Home maintenance and minor home/environmental modifications	s5165	0	21 yrs	Only in MMC-LTC program-no limit	$5,000 every 3 years.
Housing related supports/supplemental adaptive device or equipment		Home helper catalog item		0	21 yrs	Not covered	1 item a year.

ATTACHMENT A-1-b
CRITERIA #17 – In LIEU OF and EXPANDED BENEFITS TOOL

Category	Sub-category	Procedure Code Description	Procedure/CPT Code	Min Age	Max Age	Current Florida Medicaid Coverage	Expanded Benefit Coverage (Units)
Housing related supports/supplemental adaptive device or equipment		hypoallergenic bedding		0	21 yrs	$100 1x credit	$100 1x credit
Community Behavioral Health		Self-Help/Peer	H0038	0	21 yrs		In lieu of Psychosocial Rehabilitation
Mobile Crisis		Crisis Intervention	S9485; H2011	0	21 yrs		As needed to divert hospitalization, emergency room visits, or prevent out-of-home placement
Healthy Behavior Reward Program		healthy community reward program		0	21 yrs		As outlined in health plan literature submitted in ITN reply
Professional consultation between primary care provider and specialist or medical team conference without patient/family present		case consultation	99367 or 99368	0	21 yrs		Limited to 2 per year for team

ATTACHMENT A-1-b
CRITERIA #17 – In LIEU OF and EXPANDED BENEFITS TOOL

Category	Sub-category	Procedure Code Description	Procedure/CPT Code	Min Age	Max Age	Current Florida Medicaid Coverage	Expanded Benefit Coverage (Units)
Family Training		family support and education	S5110	0	21 yrs		12 visits a year.
social determinant of health		benefits counseling	H2014 SE	0	21 yrs	Not covered	3 sessions annually.
Partial hospitalization		Partial hospitalization	H0035 or S9480 (Mental Health), H0015 (Substance Use Disorder), Use of Revenue codes (0172, 0173, 0175, 0176),	0	21 yrs		Covered as needed in lieu of inpatient hospitalization
Detoxification or withdrawal management in an ambulatory or non-hospital residential setting		Withdrawal management	H0010, H0011, H0012, H0014,	0	21 yrs		Covered as needed in lieu of inpatient hospital detoxification
Drop-in Center		Drop-in Center	H2030 or H2031	16	21 yrs		Covered as needed in lieu of clubhouses

ATTACHMENT A-1-b
CRITERIA #17 – In LIEU OF and EXPANDED BENEFITS TOOL

Category	Sub-category	Procedure Code Description	Procedure/CPT Code	Min Age	Max Age	Current Florida Medicaid Coverage	Expanded Benefit Coverage (Units)
Non-medical transport		Transportation	A0090, A0100, A0110, A0120, A0130, A0170, T2003	0	21 yrs		Covered as needed for community integration
Nutritional Counseling		Nutritional Counseling, diet	S9470	0	21 yrs	Covered as medically necessary for children with diabetes, Phenylketonuria (PKU) and other metabolic conditions, eating disorders, Obesity, and children at risk of metabolic disorders under EPSDT	For wellness counseling for at-risk children
Supports for Wellness		healthy living coaching		7 yrs	13 yrs		12 visits a year.
Education/Supports for Wellness		Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in “remarks”	T1999				Covered up to $200 per year

ATTACHMENT A-1-b
CRITERIA #17 – In LIEU OF and EXPANDED BENEFITS TOOL

Category	Sub-category	Procedure Code Description	Procedure/CPT Code	Min Age	Max Age	Current Florida Medicaid Coverage	Expanded Benefit Coverage (Units)
Housing Supports	Pest control	Pest Control (in-home)	S5121	0	21 yrs	Only available on Project Aids Care Waiver $25 a job/$150 a year.	$500 max annually.
Social Determinant of Health	Financial Counseling	Financial counseling	T2013 SE	0	21 yrs	Not covered	6 sessions annually.

Criteria #18 – Additional Expanded Benefits

Respondent will identify each additional expanded benefit that it proposes to offer its enrollees by eligible population (TANF, ABD, CHIP, dual eligible). For the purposes of this Criteria, the Respondent must not select expanded benefits that are included in **Exhibit A-1-c**, Expanded Benefits Tool described in Criteria #7. Respondent will include the name of the benefit, procedure code descriptions, procedure codes and any limitations (frequency/duration, etc.).

Respondent will submit documentation that includes the calculations used to determine the per-member-per-month (PMPM) cost and the data source used for the calculations (e.g. previous SMMC experience, commercial experience). The submitted PMPM cost must be developed on a "total member" basis, rather than a "per user" or "per benefit eligible" basis (e.g., if the benefit is for low protein foods only, do not submit the expected monthly cost per user but rather the expected cost per member; or, if the benefit is for the household, its expected monthly cost must be converted to the expected cost per member) and should exclude administrative costs. Respondent will submit **Exhibit A-1-c**, Additional Expanded Benefits Template.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent identifies the expanded benefits it will provide and the information included in **Exhibit A-1-c**, Additional Expanded Benefits Template (Regional).

Score: This section is worth a maximum of 10 raw points with the above component being worth a maximum of 10 points.

Note: Pursuant to section 409.966(3)(c)6., Florida Statutes, reply to this submission requirement will be considered for negotiations.

Attachment A-1-c is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1-c
CRITERIA #18 - ADDITIONAL EXPANDED BENEFITS TEMPLATE

Category	Sub-category	Procedure Code Description	Procedure/CPT Code	Min Age	Max Age	Current Florida Medicaid Coverage	Expanded Benefit Coverage (Units)

Criteria #19 Quality Enhancements

Respondent will describe in detail its approach for providing quality enhancements including how it will educate enrollee's and their families on the availability of quality enhancements:

1. **Database of information for Families**

   Respondent will create and maintain a searchable database of community resources available to families, Care Coordinators/Case Managers. The resource will be available to families to understand how to obtain referrals to WIC, utility payment assistance, Legal Aid and local parenting classes or wellness classes available in each community.

   Respondent will develop and maintain written policies and procedures to implement QEs through this database.

   Respondent will provide information in the enrollee and provider handbooks on the QEs and how to access related services.

   Respondent will offer QEs in community settings accessible to enrollees.

   Respondent is encouraged to partner with other entities that provide online resource information such as 2-1-1 and Florida's Help Me Grow.

   Respondent is encouraged to actively collaborate with community agencies and organizations, including CHDs, local Early Intervention Programs and local school districts in offering these services.

   If the Respondent involves the enrollee in an existing community program for purposes of meeting the QE requirements, the database will ensure documentation in the enrollee's medical/case record of referrals to the community program and follow up on the enrollee's receipt of services from the community program.

2. **Children's Programs**

   a. Respondent will provide regular general wellness programs targeted specifically toward enrollees from birth to the age of five years, or the Respondent will make a good faith effort to involve enrollees in existing community children's programs.

   b. Children's programs will promote increased use of prevention and early intervention services for at-risk enrollees. Respondent will authorize covered services recommended by the Early Intervention Program when medically necessary. Respondent will collaborate with the Local Early Intervention Program Office to negotiate and maintain agreements that establish methods of communication and procedures for the timely approval of services covered by Medicaid pursuant to s. 391.308, Florida Statutes.

   c. Respondent will provide education to families regarding the "Help Me Grow" which is the Florida Department of Education-funded programs that connects children birth-8 years of age with community resources (including Early Steps

and Part B services).

3. Domestic Violence

Respondent will ensure that PCPs screen enrollees for signs of domestic violence and will offer referral services, as applicable, to domestic violence prevention community agencies.

4. Pregnancy Prevention

Respondent will conduct regularly scheduled pregnancy prevention programs for adolescents, or will make a good faith effort to involve enrollees in existing community pregnancy prevention programs. The programs will be targeted towards teen enrollees, but will be open to all enrollees, regardless of age, gender, pregnancy status, or parental consent.

5. Healthy Start Services

a. Respondent will develop agreements with local Healthy Start Coalitions as necessary to provide risk-appropriate care coordination/case management for pregnant women and infants.

b. The program for pregnant women and infants must be aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes.

c. Respondent will collaborate with the Healthy Start care coordinator within the enrollee's county of residence to assure delivery of risk-appropriate care.

d. Respondent will submit a completed Practitioner Disease Report Form (DH Form 2136) to the Perinatal Hepatitis B Prevention Coordinator at the local CHD for all prenatal or postpartum enrollees and their infants who test HBsAg-positive.

6. Nutritional Assessment/Counseling

a. Respondent will ensure that its providers supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children.

b. Respondent will determine the need for non-covered services and referral of the enrollee for assessment and refer the enrollee to the appropriate service setting (to include referral to WIC and Healthy Start and other social services) with assistance.

c. Respondent will:

(1) Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes.
(2) Offer a mid-level nutrition assessment.
(3) Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or physician following the nutrition assessment.

(4) Refer all enrollees under the age of five and pregnant, breast-feeding and postpartum enrollees to the local WIC program office using the Florida WIC Program Medical Referral Form (DH 3075).

For subsequent WIC certifications, the Respondent will ensure that providers coordinate with the local WIC office to provide the above referral data from the most recent well-child visit.

Each time the provider completes a WIC referral form, the Respondent will ensure that the provider gives a copy of the form to the enrollee.

7. Behavioral Health Programs

Respondent will provide outreach to populations of enrollees at risk of juvenile justice system involvement, as well as those enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity will be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system.

Reply:

Evaluation Criteria:

1. Respondent has provided a description of its approach for providing quality enhancements along with a plan on how it will educate enrollee's and families on the availability of the quality enhancements.
2. Respondent will provide one or more of the following suggested Quality Enhancements:
   a. Database of Information for Families
   b. Children's Programs
   c. Domestic Violence
   d. Pregnancy Prevention
   e. Healthy Start Services
   f. Nutritional Assessment/Counseling
   g. Behavioral Health Programs

Score: This section is worth a maximum of 20 raw points as outlined below.

a. 20 points for providing a description in 1 and all of the quality enhancements in 2.
b. 15 points for providing a description in 1 and some but not all of the quality enhancement in 2, including at a minimum 2a.
c. 10 points for providing a description in 1 and some but not all of the quality enhancement in 2, but not including 2a.
d. 5 points for providing a description in 1 and including quality enhancements not on the State's suggested list.
e. 0 points for proposing no quality enhancements or not including a description in 1.

Criteria #20 – Online Provider Directory

Respondent will describe the provider search function for the online provider directory, including submission of:

a. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether or not the online provider directory is mobile friendly.

b. Screen shots for each mouse click required from the start of the Respondent's home page to actual search results for a provider, using durable medical equipment providers and zip code as the search elements.

c. A list of performance indicators the Respondent will include for each provider type listed in its provider directory.

d. A description of the Respondent's process for verification of provider information in the online provider directory, including delegated subcontractor provider information, and the method(s) the Respondent uses to ensure the weekly network file submission to the Department is accurate.

Reply:

Evaluation Criteria:

1. The extent of the Respondent's search functions for the Respondent's online directory and ease of access for enrollees' navigation of the online provider directory, including whether or not the online directory is mobile friendly.

2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five.

3. The extent and relevance of the performance indicators available in the Respondent's provider directory for each provider type listed.

4. The extent of the Respondent's efforts to ensure information in the Respondent's online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.

5. The extent to which the Respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Department as required ensuring the information the Respondent displays on its website align with the Department's information.

Score: This section is worth a maximum of 10 raw points with each of the above components being worth a maximum of 2 points each.

Criteria #21 – Enrollee Grievance and Appeal System:

Respondent will provide a flowchart and written description of how the Respondent will execute its enrollee grievance and appeal system, including identifying, tracking and analysis of enrollee complaints, grievances, appeals and Medicaid fair hearing data. Respondent will include in the description detail regarding how data resulting from the grievance and appeal system are used to improve the operational performance of the Respondent.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages.

2. The extent to which the Respondent's timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements.

3. The extent to which the Respondent's complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.

4. The extent to which the Respondent's complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.

5. The extent to which the Respondent is able to ensure all complaints (including those submitted to the Respondent by the Department or Respondent's subcontractors) are tracked and resolved as part of the Respondent's established complaint, grievance and appeal process.

6. The extent to which the Respondent's grievance and appeal system data resulted in operational improvements of the Respondent.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #22 – CAHPS Results:

Respondent (including Respondents' parent, affiliate(s), or subsidiary(ies)) will include in table format, the target population (TANF, ABD, CHIP, dual eligible) and the Respondent's results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the Respondent's three largest Medicaid and/or CHIP Contracts (as measured by number of enrollees). If the Respondent does not have Medicaid and/or CHIP CAHPS results for at least three states, the Respondent will provide commercial CAHPS results for the Respondent's largest Contracts. If the Respondent has Florida Medicaid and/or CHIP CAHPS results, it will include the Florida Medicaid and/or CHIP experience as one of three states reported. Respondents will provide the data requested in **Exhibit A-1-d**, Standard CAHPS Measurement Tool, to provide results for the following CAHPS items/composites:

a. Health Plan Rating;
b. Health Care Rating;
c. Getting Needed Care (composite);
d. Getting Care Quickly (composite); and
e. Getting Help for Customer Service (composite).

Reply:

Evaluation Criteria:

1. The extent to which the Respondent exceeded the national Medicaid mean for each CAHPS survey item/component reported.

Score: This section is worth a maximum of 15 raw points as described below.

Exhibit A-4-a-4, Standard CAHPS Measurement Tool, provides for 30 opportunities for a Respondent to report prior experience in providing desirable experiences with health care (five measures, three states each, adult population for each, and child population for each). For each of the five measures, a total of six points are available.

Respondent will be awarded one point if their reported plan rate exceeded the national Medicaid and/or CHIP mean, for each available state, for adults and for children, respectively. An aggregate score will be calculated and Respondents will receive a final score of 0 through 20 corresponding to the number and percentage of points received out of the total available points. For example, if a Respondent receives 100 percent of the available 30 points, the final score will be 15 points (100 percent). If a Respondent receives 27 (90 percent) of the available 30 points, the final score will be 13.5 points (90 percent). If a Respondent receives three (10 percent) of the available 30 points, the final score will be 1.5 points (10 percent).

ATTACHMENT A-1
EVALUATION CRITERIA

INSTRUCTIONS:

Respondents should provide results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the Respondent's three largest Medicaid or CHIP contracts (as measured by number of enrollees).

If the Respondent does not have Medicaid and/or CHIP CAHPS results for at least three states, the Respondent will provide commercial CAHPS results for the Respondent's largest Contracts. If the Respondent has Florida Medicaid and/or CHIP CAHPS results, it will include the Florida Medicaid and/or CHIP experience as one of three states reported.

The CAHPS items/composites that the Respondent is required to report on are located in the CAHPS Results tab.

Use the drop-down box to select the state for which you are reporting and enter the CAHPS results (to the hundredths place, or XX.XX) for that state's Medicaid and/or CHIP population for the 2017 survey.

Attachment A-1-d is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1-d
CRITERIA #22 – STANDARD CAHPS MEASUREMENT TOOL

RESPONDENT NAME:	

Group A						
	State #1:	Florida	State #2:	Hawaii	State #3:	Delaware
CAHPS Item/Composite	2017 Adult	2017 Child	2017 Adult	2017 Child	2017 Adult	2017 Child
Rating of Health Plan (the percentage of Respondents rating their plan an 8, 9, or 10 out of 10)						
Rating of Health Care (the percentage of Respondents rating their health care an 8, 9, or 10 out of 10)						
Getting Needed Care Composite (the percentage of Respondents reporting it is usually or always easy to get needed care)						
Getting Care Quickly Composite (the percentage of Respondents reporting it is usually or always easy to get care quickly)						
Getting Help from Customer Service Composite (the percentage of Respondents reporting it is usually or always easy to get help needed from customer service						
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life						

Total Points	0

Criteria #23 – PCP Timely Access Standards:

Respondent will describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in **Exhibit 6**, Network Adequacy Standards. Respondent will also describe the process and methodology it uses for determining whether a PCP has the capacity to accept new patients.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in **Exhibit 6**, Network Adequacy Standards.

2. The extent to which the Respondent's monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.

3. The extent to which the Respondent's process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #24 – Provider Network Development

Respondent will submit a draft network development and management plan demonstrating how it will ensure timely access to primary and specialty care services, necessary to promote the CMS Plan's goals, including:

a. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);

b. Strategies that will be deployed to address identified gaps, increase provider capacity and meet the needs of enrollees where network gaps have been identified;

c. Strategies (including a description of data sources utilized) for measuring timely access to appointments, including but not limited to, the following provider types:

- **(1)** Cardiologists (pediatric);
- **(2)** Neurologists (pediatric);
- **(3)** Pulmonologists (pediatric);
- **(4)** Endocrinologists (pediatric);
- **(5)** Internists (adult);
- **(6)** Psychiatrists (pediatric and adult);
- **(7)** Nutritionists;
- **(8)** Private Duty Nursing (pediatric and adult);
- **(9)** Licensed mental health clinicians (pediatric);
- **(10)** Pediatric Primary Care Physicians (including General Practitioners and Family Practitioners);
- **(11)** Board Certified Pediatric Nephrologists; and
- **(12)** Board Certified Rheumatologists.

d. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider's success in making progress towards the CMS Plan goals.

e. Strategies for inclusion of specialties who historically received CMS Plan clinic or supplemental funding (see procurement library for a listing).

f. Procedures for ensuring that child specialties for the following conditions are included in the network:

- **(1)** Cancer
- **(2)** Diabetes
- **(3)** Asthma;
- **(4)** Sickle Cell Anemia
- **(5)** Phenylketonuria (PKU) and other metabolic conditions
- **(6)** Developmental disabilities including Autism;
- **(7)** Rare congenital conditions including cleft lip/palate, spina bifida, congenital heart disease;
- **(8)** Mental health including ADHD and Severe Emotional Disturbance;
- **(9)** Substance abuse; and
- **(10)** "Children with special health care needs" which means those children younger than 21 years of age who have serious and chronic physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children." This includes: arthritis, cerebral palsy, epilepsy, hearing impairments,

liver diseases, multiple sclerosis, paralysis of extremities (complete or partial), speech impairments, and visual impairments.

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.

2. The adequacy of the Respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long- term interventions.

3. The adequacy of the Respondent's approach for measuring timely access for the specified provider types and the extent to which the Respondent's approach includes clear methodology for determining the following:

(a) Average wait time for an urgent appointment; and
(b) Average wait time for a routine appointment.

4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.

5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the Respondent.

6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the CMS Plan goals are transparent to providers, including the frequency with which providers will be able to access their progress.

Score: This section is worth a maximum of 60 raw points with each of the above components being worth a maximum of 10 points each.

5 additional points will be awarded to Respondents who demonstrate that providers will have real-time access to their progress in achieving quality and/or performance metrics.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #25 – Provider Network – Network Development Plan

Respondent will submit a draft network development and management plan demonstrating how it will ensure timely access to the following services:

- Physical therapy (pediatric);
- Speech-language pathology services (pediatric);
- Occupational therapy (pediatric);
- Private duty nursing services (pediatric);
- Intermittent skilled nursing (pediatric and adult);
- Early intervention services;
- Compounding pharmacies; and
- Specialized therapeutic foster care.

Respondent's approach will include at a minimum:

a. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);

b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;

c. Strategies that will be deployed to ensure retention of CMS Plan legacy providers to ensure access is maintained to physicians and specialists in the CMS Provider Network File as of January 2018, with initial contracting targets of 12 months retention for these physician providers;

d. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received;

e. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services;

f. Strategies for how the Respondent will analyze provider accessibility standards and will maintain these based on future population changes;

g. Strategies for considering enhanced reimbursement for providers not accepting Medicaid (i.e. difference between the private and Medicaid participation rates);

h. Strategies for implementing telemedicine in rural areas with access issues;

i. Strategies for working with regional providers to ensure access to unique network challenges; and

j. Strategies for working with the Department's medical director to ensure that children are receiving appropriate referrals to the correct specialists (regionally based such as neurologists versus developmental pediatricians/psychiatrists).

Reply:

ATTACHMENT A-1
EVALUATION CRITERIA

Evaluation Criteria:

1. The adequacy of the Respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region- specific identified gaps and future needs projection.

2. The adequacy of the Respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long- term interventions, including interventions that will be deployed to ensure retention of CMS Plan legacy providers to ensure access is maintained to physicians and specialists in the CMS Network File as of January 2018, with initial contracting targets of 12 months retention for these physician providers;

3. The extent to which the Respondent's plan includes strategies for measuring the time in- between when services are authorized and when they are received.

4. The extent to which the Respondent's update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.).

5. The extent to which the Respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations.

6. The extent to which the Respondent acknowledges the unique pediatric challenges and suggests creative solutions to the CMS Plan challenges of private duty nursing and neurology.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #26 – Primary Care Providers (PCP) Assignment:

Respondent will describe its overall process of assigning enrollees to primary care providers (PCPs), including its assignment algorithm. The reply will include the quality and/or performance metrics used to determine high quality PCPs, and the timeframes associated with processing an enrollee's request to change PCPs.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's description includes how quality and/or performance metrics are defined and utilized in the assignment process.

2. The extent to which the Respondent's algorithm includes assignment of enrollees to high quality PCPs.

3. The extent to which the Respondent can process requests for PCP changes within three business days.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

D. Provider Experience

Criteria #27 – Provider Engagement Model

Respondent will describe in detail its provider engagement model. Respondent will include the following elements in its description, at a minimum:

- **a.** Respondent's staff that play a role in provider engagement;
- **b.** The presence of local provider field representatives and their role;
- **c.** The mechanism to track interactions with providers (electronic, physical and telephonic);
- **d.** How the Respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;
- **e.** The metrics used to measure the overall satisfaction of network providers with the Respondent; and
- **f.** The approach and frequency of provider training on Respondent and CMS Plan requirements.

Reply:

Evaluation Criteria:

1. The extent to which Respondent leadership are involved in provider engagement.

2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.

3. The extent to which the method the Respondent uses to track interactions with providers is capable of producing meaningful data the Respondent will use to address both clinical and administrative problem areas.

4. The extent to which the method the Respondent uses to track interactions with providers addresses potential provider field representative training needs.

5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.

6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and Respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #28 – Dispute Resolution

Respondent will describe in detail its provider dispute resolution process for both Title XIX and Title XXI enrollees.

Note: Pursuant to section 409.966(3)(c), Florida Statutes, reply to this submission requirement will be considered for negotiations.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's process identifies claims related dispute trends and initiates process improvement activities/system enhancements.

2. The extent to which the Respondent's process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes resolved within required timeframes.

3. The extent to which the Respondent's process incorporates timely reply to Department requests related to complaint resolution in accordance with the Prime Contract and CMS Plan requirements.

4. The extent to which the Respondent integrates all complaints, regardless of the complaint referral source (e.g., Department, third party).

5. The extent to which the Respondent's resolution process includes the Respondent's participation in the Department claims dispute resolution program authorized in section 408.7057, Florida Statutes, as well as includes the following:

(a) Responding to requests for information from the State contracted independent dispute resolution organization;

(b) A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and

(c) Prompt payment of final orders issued by the Department related to claims arbitration case determinations.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #29 – Claims Processing and Payment Process

In a manner suitable for the provider community, the Respondent will submit key components of its claims processing and payment process, addressing both paper and electronic claims submissions for both participating and non-participating providers.

The reply will include detailed information on the metrics to be employed by the Respondent to track timeliness and accuracy of claims adjudication and payment for claims submitted by participating providers and how these metrics will be used by line level and management staff to improve processes and provide for rapid cycle improvement.

The reply will also include a detailed description of how the Respondent will make data and metrics regarding claims and payment available to the Department and will ensure that network providers have access to real-time and trend data regarding claims processing and payment by the Respondent and all applicable proposed subcontractors.

Note: Pursuant to section 409.966(3)(c)6., Florida Statutes, reply to this submission requirement will be considered for negotiations.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Reply:

Evaluation Criteria:

1. The extent to which the Respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.

2. The extent to which the Respondent has included detailed metrics to be employed by the Respondent to track timeliness and accuracy of the claims processing and payment process.

3. The extent to which the Respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.

4. The extent to which the Respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Department and that the described process provides sufficient opportunity for the Department to access this data.

5. The extent to which the Respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.

6. The extent to which the Respondent has included its applicable proposed subcontractors in its reply, with each component addressed for each applicable proposed subcontractor.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria# 30– Provider Credentialing

Respondent will describe its proposed process to credential and re-credential providers (including subcontractors' processes, if applicable), including credentialing timeframes, internal continuous quality improvement initiatives for re-credentialing, transparency for providers on their application status and the steps the Respondent or its subcontractors will take to ensure the Respondent and the Department have accurate provider demographic information in-between credentialing cycles.

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's description of its credentialing and re-credentialing criteria, certified credential verification organization processes, and utilization of a third-party credentialing vendor.

2. The extent to which the Respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of 120 days.

3. The adequacy of the Respondent's approach to providing transparency to providers throughout the credentialing and re-credentialing processes, including how providers will be informed at each step of the application process. The proposed method for educating and assisting providers through the credentialing process including a description of specific tools, websites or specially assigned staff to help support this process. This includes any tools, websites, special staffing, special processes for atypical providers, etc.

4. The extent to which the Respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its re-credentialing process.

5. The extent to which the Respondent and its subcontractors incorporate the Department's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and re-credentialing processes.

6. The extent to which the Respondent outlines steps the Respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the Respondent in-between credentialing cycles.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #31 – Value Based Purchasing

d) Respondent will include a strategy outlining its plans for value based purchasing.

(a) Designation and contact information for the individual in the Respondent's organization responsible for development and execution of the Respondent's VBP implementation and development strategy;

(b) Discussion of target areas including the specific models and VBP arrangements proposed for implementation of the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated at least by topic area within primary care, specialty care and hospital-based care;

(c) Description of the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five Contract years, delineated by primary care, specialty care and hospital-based care;

(d) Description of the specific VBP arrangements it intends to implement and/or maintain in an effort to promote the CMS Plan's goals, delineated by topic area within primary care, specialty care and hospital-based care;

(e) Discussion of plans and strategies to develop provider readiness for VBP and evolution along the VBP continuum;

(f) Discussion of Respondent's approach to and experiences (if applicable) with episodic payment arrangements and the challenges and opportunities they present for implementation among providers serving the member population;

(g) Specific health outcomes and efficiency goals that will be tracked and evaluated for performance as part of each model and the specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by topic area within primary care, specialty care and hospital-based care;

(h) Description of how proposed or developing VBP arrangements align with Medicare initiatives or other Florida books of business. To the extent such alignment is relevant, the strategy should address how provider performance measurement and incentives align or will align across books of business in a way that maximizes the impact of such incentives while minimizing provider confusion caused by multiple, differing VBP arrangements;

(i) Discussion of how Respondent systems are designed to identify providers operating under VBP arrangements and track its performance;

(j) Discussion of how Respondent will share data with providers and support providers in using the data to improve performance;

(k) Methods and frequency for collecting and providing performance data to providers (please provide an example or template of a relevant, current data sharing report issued to providers);

(l) Specific objectives for VBP arrangement implementation, including scope, provider performance, and a timeline for implementation related to each of the proposed VBP approaches; and

(m) Plans for the provision of provider support to facilitate successful implementation and development of VBP arrangements, such as technical support, establishment of new data feedback systems, and financial support for provider infrastructure necessary to execute select model concepts.

Reply:

Evaluation Criteria:

1. The extent the Respondent has prior experience implementing VBP arrangements among its provider network and included a table indicating all of its current VBP arrangements across all lines of business and states. The table separately and explicitly identifies any applicable VBP arrangements across lines of business for children with medical complexity. Entries included the specific model type (e.g. Accountable Care Organizations). Respondent's tables addressed the following:

(a) Name of the VBP program
(b) Line(s) of business to which the program applies
(c) State(s) in which the program applies
(d) Description of the VBP program
(e) Whether the VBP program was required by the state
(f) Applicable HCP-LAN APM category/sub-category (e.g. Category 2c) in which the arrangement best fits
(g) Provider types governed under the arrangement
(h) Service types governed under the arrangement
(i) Quality requirements under the VBP program
(j) Percent of total medical spending (including drug spending) governed under the arrangement for the relevant line of business in for the most recent fiscal year
(k) Percent of total projected medical spending (including drug spending) governed under the arrangement for the relevant line of business for the most recent fiscal year

2. The extent to which the Respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.

3. The extent to which the Respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five Contract years, including a rationale for the intended percentages. Respondent is proposing an increase in the volume of contracts implemented or maintained through a VBP arrangement each year by at least 5 percent annually (from the submitted baseline in the ITN reply) for the first three years of the contract.

4. The extent to which the Respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum.

5. The extent to which the Respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.

6. The extent to which the Respondent describes how its VBP arrangements incorporate goals or incentives for improvement of child health outcomes.

7. The extent to which the Respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.

8. The extent to which the Respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of Respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

Score: This section is worth a maximum of 50 raw points with the first component being worth 15 points and each of the remaining components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

E. Delivery System Coordination

Criteria #32 – Utilization Management

1. Respondent will describe the following related to its utilization management (UM) approach:

(a) A description of the process used to determine whether a service should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid and CHIP benefit.

(b) A description of how the Respondent will ensure consistent application of the review criteria for authorization decisions.

(c) A description of how the Respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.

(d) A description of the approach used to determine whether a service will be needed short- term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the Respondent's service authorization approach (if any exists) based on the length of time that the service will be needed.

(e) To the extent that a service is needed long-term, a description of the strategies that the Respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.

(f) A description and example of how the Respondent will detect, monitor and evaluate under- utilization, over-utilization and inappropriate utilization as well as processes to identify and address opportunities for improvement.

(g) A description of the utilization guidelines adopted by the Respondent including national criteria and adapted for Florida Medicaid benefit design.

(h) A description of how the UM staff employed by the Respondent will coordinate with the Department employed CMS Plan Medical Director and clinical oversight staff.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Reply:

Evaluation Criteria:

1. The extent to which the Respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.

2. The adequacy of the processes used by the Respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.

3. The adequacy of the Respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for Respondent staff and network providers).

4. The adequacy of the review processes (data collection and analysis) deployed by the Respondent to ensure services are not arbitrarily being denied or reduced.

5. The adequacy of the review processes (data collection and analysis) deployed by the Respondent to identify aberrant utilization patterns (under and over utilization).

6. The adequacy of the Respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long- term (ongoing maintenance services/therapies).

7. The adequacy of the Respondent's approach at ensuring continuity of care, particularly as it relates to special needs populations.

8. The extent to which the Respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

9. The extent to which the Respondent utilizes national utilization review criteria adapted for Florida Medicaid and CHIP benefit design including ASAM for SUD treatment.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #33 – Utilization Management – Ease of Use

1. Respondent will describe the following related to its utilization management systems:

(a) A description of how the Respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;

(b) A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, subcontractors and the Respondent (to the extent any UM functions are delegated);

(c) A description of the Respondent's experience meeting timeliness standards for service authorization requests;

(d) A description of the approach that the Respondent will use to educate enrollees and providers about the process for seeking authorization;

(e) A detailed workflow of how "special service" requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the Respondent to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbooks/coverage policy or the associated fee schedule. This includes 1905(a) services regularly utilized by children with medical complexity including but not limited to:

- OTC medical supplies including vitamins, acetaminophen, etc.
- Additional dental services including medically necessary sedatives,
- Nutritional supplements and supports including low protein foods,
- In-home skilled nursing and therapies for chronic conditions, additional personal care beyond covered benefits,
- Incontinence supplies,
- A specially adapted car seat needed by a child because of a medical problem,
- Nutritional counseling necessary for addressing obesity; and

(f) A detailed workflow of how Medicaid and CHIP covered benefits under the contract including Value Added services and In-lieu of services necessary to maintain a child in the community and divert institutionalization and emergency room utilization will have expedited approval when necessary to ensure the health and welfare of a child.

ATTACHMENT A-1
EVALUATION CRITERIA

Reply:

Evaluation Criteria:

1. The extent to which the Respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the Respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the Respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.

2. The extent to which the Respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.

3. The extent to which the Respondent has demonstrated experience with meeting timeliness standards for service authorization requests.

4. The adequacy of the Respondent's education and training plan providers on the service authorization processes.

5. The extent to which the Respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).

6. The extent to which the workflow describing the Respondent's process for handling "special service" requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #34 – Coordination of Benefits:

Respondent will describe the strategies utilized in care coordination with other plans and insurers (e.g., Medicare) to provide necessary services for its enrollees when the third-party payer is the primary insurer. Respondent will include information on its approach in the following circumstances:

a. Florida Medicaid and/or CHIP does not cover the service, but it is available through the third-party payer;

b. Florida Medicaid and/or CHIP and the third-party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses. In this scenario, the Respondent will identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid;

c. The third-party carrier benefit limit is exhausted and the service is now a Medicaid/and or CHIP expense. In this scenario, the Respondent will identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid/CHIP; and

d. The service is not covered by the third party but is available through Florida Medicaid and/or CHIP.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1
EVALUATION CRITERIA

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's approach when:

- **(a)** Florida Medicaid/CHIP does not cover the service, but it is available through the third- party payer.
- **(b)** Florida Medicaid/CHIP and the third-party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.
- **(c)** The third-party carrier benefit limit is exhausted and the service is now a Medicaid expense.
- **(d)** The service is not covered by the third party but is available through Florida Medicaid/CHIP.

2. The extent to which the Respondent's approach includes:

- **(a)** Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials).
- **(b)** Processes used to identify non-covered services by the primary insurer for individual enrollees.
- **(c)** Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third-party insurer has been exhausted.

3. The extent to which Respondent's description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #35 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

Respondent will describe its approach to education and monitoring of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, including:

a. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.

b. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the Respondent (case management, utilization management, provider relations, etc.) as well as subcontractors.

c. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the Respondent and with subcontractors.

d. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the Respondent's approach towards coverage of the EPSDT benefit.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1
EVALUATION CRITERIA

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.

2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.

3. The adequacy of the Respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the Respondent/subcontractors. Respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.

4. The adequacy of the Respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the Respondent and with subcontractors.

5. The extent to which the Respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria# 36 – Behavioral Health/Primary Care Integration:

Respondent will describe its proposed approach in promoting integrated behavioral health and primary care models, including:

a. Identification of integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness.

b. Identification of opportunities for improvement across the Respondent's system of care (e.g., care management, provider network, utilization management, enrollee services) with the goal of advancing to more integrated care models.

c. Description of strategies the Respondent will deploy to overcome the barriers/gaps identified to increase its capacity for providing integrated care models, including use of alternative payment models/financing strategies.

d. Description of strategies the Respondent will deploy to specifically address pediatric behavioral health/primary care integration (e.g., child psychiatrist's consultation with pediatricians, addressing complex behavioral health/ mental illness cases, etc.).

Reply:

Evaluation Criteria:

1. The extent with which the Respondent thoroughly describes its current approach to and readiness for promoting/incentivizing and removing barriers to, integrating behavioral health and primary care throughout its system of care with an emphasis on pediatric practices and child behavioral health providers.

2. The extent to which the Respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. Respondent must also describe the data sources that focus on pediatric outcomes.

3. The extent to which the Respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the Respondent will implement across its systems to increase capacity for providing integrated pediatric care.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

Criteria# 37 – Transportation

Respondent will describe its experience and approach for coverage of non-emergency transportation services by providing the following:

a. A description of the software capabilities utilized to facilitate ease in scheduling and tracking of enrollee pickup adherence;

b. Strategies for determining the most appropriate mode of transportation; and

c. Providing data on the following performance metrics for calendar year 2016:

- **(1)** Percentage of trips where the enrollee arrived to their scheduled appointment on- time;
- **(2)** Percentage of missed trip requests (failed to pick up the enrollee regardless of reason);
- **(3)** Percentage of hospital discharge requests fulfilled within three hours of the request;
- **(4)** Percentage of urgent care requests fulfilled within three hours of the request; and
- **(5)** Number of transportation related complaints and grievances per 1,000 enrollees.

d. A description of how the Respondent uses the performance metric data above to identify areas in need of improvement and implements successful strategies that improve the provision of service.

e. Provider network by level of service and region.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence.

2. The extent to which the Respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee's individual needs.

3. The extent to which the Respondent's approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.

4. The adequacy of the Respondent's performance related to:

- **(a)** Percentage of trips where the enrollee arrived at their scheduled appointment on-time;
- **(b)** Percentage of missed trip requests;
- **(c)** Percentage of hospital discharge requests fulfilled within three hours of the request;
- **(d)** Percentage of urgent care requests fulfilled within three hours of the request; and
- **(e)** Number of transportation related complaints and grievances per 1,000 enrollees.

5. The extent to which the Respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.

6. Respondent describes its capacity to serve individuals with a wide spectrum of needs, including individual needs for physical accommodations or adult/support staff accompaniment. Respondent describes capacity to provide transportation services in a manner that furthers participant's community integration and independence. In addition, the Respondent describes its capacity to effectively serve individuals with complex conditions, including those with behavioral challenges, or those who may have exhausted a typical panel of providers.

7. Respondent outlines public transportation parameters appropriate to the CMS population.

8. Respondent outlines when adapted transportation may be required if a physically disabled child is enrolled in the program. Adapted transportation may be transportation provided in modified vehicles (such as vehicles with wheelchair or stretcher safe travel systems or lifts) that meet the participant's medical needs that cannot be met with the use of a standard passenger vehicle.

Score: This section is worth a maximum of 40 raw points with each of the above components described being worth a maximum of 5 points each.

Criteria# 38 – Coordination of Carved Out Services

Respondent will describe its approach to coordinating services that are not covered by the Respondent, but are covered by Florida Medicaid/CHIP either through the FFS delivery system (e.g., behavior analysis services, prescribed pediatric extended care) or through a prepaid dental plan.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent describes effective and efficient processes for reciprocal referral for needed services.

2. The adequacy of the Respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the Respondent and those that are available through other Medicaid delivery systems.

3. The extent to which the Respondent's description includes a process for ensuring Respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid/CHIP delivery systems.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1
EVALUATION CRITERIA

Criteria# 39 - Vignette:

Respondent will review the below case vignette, which describes potential Florida Medicaid and/or CHIP recipients. Note: The vignette included below is fictional.

> *Jose is a 15-year old male. He is diagnosed with bipolar disorder and is currently hospitalized under the Baker Act; this is his third psychiatric admission under the Baker Act in the past year. Up until six months ago, Jose lived with his mother and two younger siblings, but he moved in with his father after his behavior declined and his mother was unable to protect herself and his siblings from Jose's angry outbursts and verbal and physical aggression. His father is physically disabled from a work injury, and is concerned about managing Jose upon release, as Jose's behavior at home and school has significantly declined. At school, Jose is currently failing and has a notable number of absences and office referrals for altercations. Jose was diagnosed two months ago, during his second psychiatric admission, with bipolar disorder. Jose has been prescribed a low dose of Seroquel daily, but he does not take it consistently because of the side effects. He experiences drowsiness, dry mouth, and nausea. In his current admission, his laboratory testing results showed evidence of thyroid dysfunction. The hospital social worker assisted the family in completing and submitting a referral for Statewide Inpatient Psychiatric Program (SIPP) services, but the SIPP provider informed the social worker that authorization was denied. Jose's father has called the plan's enrollee help line for assistance with completing an expedited appeal. Jose was involved in outpatient therapy for the past six weeks. There have not been any adjustments to his medications to date. Jose has been enrolled in Medicaid since he was 5-years old. He has been enrolled in his health plan since July 2014.*

Respondent will describe its approach to coordinating care for an enrollee with Jose's profile, including a detailed description and workflow demonstrating notable points in the system where the Respondent's processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

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

ATTACHMENT A-1
EVALUATION CRITERIA

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's approach in addressing the following:

- **a.** Identification processes for enrollees with complex health conditions or who are in need of care coordination;
- **b.** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **c.** Application of the Respondent's case management risk stratification protocol;
- **d.** Identification of service needs (covered and non-covered) and a description for service referral processes that the Respondent has in place;
- **e.** Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
- **f.** Application of discharge and aftercare planning protocols that facilitate a successful transition;
- **g.** 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;
- **h.** Description of the assessment of provider capacity to meet the specific needs of enrollees;
- **i.** Identification of strategies that promote enrollee self-management and treatment adherence;
- **j.** Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
- **k.** Application of strategies to integrate information about the enrollee across the Respondent and various subcontractors when the Respondent has delegated functions.

2. The extent to which the Respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the Respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the Respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

ATTACHMENT A-1
EVALUATION CRITERIA

5. The extent to which the Respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the Respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the Respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #40 – Vignette:

Respondent will review the below case vignette, which describes potential Florida Medicaid and/or CHIP recipients. Note: The vignette included below is fictional.

> *Emma is 4 years old. She currently lives in a pediatric nursing facility. At the age of 2 she was admitted to PICU following a respiratory arrest during an acute illness. A further complication of her condition led to her requiring a tracheostomy to support her breathing. Following an acute exacerbation of her condition, she is now unable to breathe without the support of her ventilator when she is tired, asleep, or unwell. She is fully ventilated overnight. Her difficulties are compounded by complex seizures. Emma's doctor says Emma needs to have nurses or health care assistants with her at all times to monitor her ventilation. Emma's most recent developmental screening indicates the presence of an intellectual disability. Emma's condition has stabilized, but her mother is concerned about agreeing to bring her home permanently. Her mother is the sole income for their home, which includes three older siblings and Emma's maternal grandmother. Emma's grandmother is retired, and her ability to help the family is limited by severe rheumatoid arthritis.*
>
> *To be discharged to her home, Emma's physician has ordered a custom wheelchair that must be individually fabricated and assembled. Her physician also ordered an electronic tablet to provide cognition exercises for Emma. The tablet has a cognition exercise application that reduces the likelihood for any seizure activity that may occur with other similar tablets. Florida Medicaid does not cover the tablet nor the wheelchair, which includes a part that will make it easier for Emma to hold the tablet. Her mother is unable to bear the costs for these special service items. Further orders for Emma's transition to home care are:*
>
> - *Continuous pulse oximetry monitoring.*
> - *Apnea monitor when she is not on the ventilator.*
> - *A backup generator for the ventilator if the power goes out in the home.*
>
> *Emma is a new enrollee. Prior to her enrollment, all services were provided through the Medicaid FFS delivery system.*

Respondent will describe its approach to coordinating care for an enrollee with Emma's profile, including a detailed description and workflow demonstrating notable points in the system where the Respondent's processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

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

ATTACHMENT A-1
EVALUATION CRITERIA

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's approach in addressing the following:

- **a.** Identification processes for enrollees with complex health conditions or who are in need of care coordination;
- **b.** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **c.** Application of the Respondent's case management risk stratification protocol;
- **d.** Identification of service needs (covered and non-covered) and a description for service referral processes that the Respondent has in place;
- **e.** Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
- **f.** Application of discharge and aftercare planning protocols that facilitate a successful transition;
- **g.** 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;
- **h.** Description of the assessment of provider capacity to meet the specific needs of enrollees;
- **i.** Identification of strategies that promote enrollee self-management and treatment adherence;
- **j.** Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
- **k.** Application of strategies to integrate information about the enrollee across the Respondent and various subcontractors when the Respondent has delegated functions.

2. The extent to which the Respondents' workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the Respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the Respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoid unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

5. The extent to which the Respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the Respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the Respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #41 – Provider Network Standards

Respondent will propose provider network standards that meet the needs of the specialty population(s) being proposed for this solicitation, including specific provider access ratios that exceed MMA standards for provider types relevant to the specialty population(s). Respondent (including Respondents' parent, affiliate(s) or subsidiary(ies)) will describe its experience in managing provider networks for population(s) similar to the specialty population(s) being proposed for this solicitation, including experience with provider contracting and performance measurement relevant to the specialty population(s) proposed. Identify specific requirements for provider contracts, credentialing, provider handbooks, etc., the Respondent proposes for network providers serving the specialty population(s) proposed. Describe any additional provider services the Respondent proposes to make available to the provider network serving the specialty population(s).

Reply:

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) managing a provider network serving the proposed population(s).

2. The extent to which the described experience demonstrates the ability to manage a provider network relevant to the specialty population(s) proposed.

3. The extent to which the provider capacity ratios proposed ensure the adequacy of a provider network relevant to the specialty population(s) proposed.

4. The extent to which the provider requirements proposed are relevant to the provider network serving the specialty population(s) proposed.

5. The extent to which the additional provider services proposed are relevant to the provider network serving the specialty population(s) proposed.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

F. Oversight and Accountability

Criteria #42 – Subcontractor Oversight

Respondent will list any proposed subcontractors to which it will delegate the management of: provision of covered services, utilization management, provider networks or paying providers. Respondent will describe how it will oversee and monitor the performance of subcontractors in general, as well as any specific oversight planned for certain subcontractors, including any corresponding service level agreements. Respondent will include in its reply the schedule and type of monitoring and how findings are reported, remediated, and used for process improvements.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent provides a list of subcontractors it proposes to use under the CMS Plan for the delegation of work as described above.

2. The adequacy of the Respondent's oversight structure, including the extent of executive level staff participation.

3. The extent to which the Respondent uses and monitors for service level agreements consistent with the CMS Plan Scope of Services.

4. The adequacy of the Respondent's approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.

5. The adequacy of the Respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.

6. The extent to which the Respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #43 – Subcontractor Oversight – Disaster Contingency Plan

Respondent will submit a sample disaster contingency plan for the Respondent and its subcontractors it would enact in the event a subcontractor to which the Respondent has delegated authority to manage utilization and pay providers on behalf of the Respondent, files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent has outlined the data sources it would use to trigger the Respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.

2. The extent to which the Respondent outlines a communications strategy in the contingency plan.

3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.

4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #44 – System Modification Protocol

Respondent will describe, in detail the following change control IT processes:

a. How the Respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems;

b. How the Respondent will accommodate Department -directed IT modifications; and

c. How the Respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

For each of the descriptions, the Respondent will also include the expected timeframes for making modifications, the prioritization process employed, the communication processes used for planned or unplanned changes, as well as status updates provided to employees, Department staff, and providers. The descriptions will also address testing procedures, production control procedures, and any applicable claims/encounter reprocessing for historical or retroactive system changes.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's IT processes addressing internal modifications for its core systems and subcontractor's systems.

2. The extent to which the Respondent's IT processes documented for implementing the CMS Plan directed modifications is less than 90 days.

3. The adequacy of the Respondent's processes documented for handling production IT system issues.

4. The adequacy of the Respondent's communication process used when system issues/updates are identified and resolved by the Respondent and/or its subcontractors throughout the change control process.

5. The adequacy of the Respondent's approach to internal testing of the system in order to ensure the Respondent's and/or subcontractors' system changes/updates is accurate.

6. The adequacy of the Respondent's approach to integration testing to ensure the Respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.

7. The adequacy of the Respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #45 – Encounter Data Submission

a. Respondent will submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.

b. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. 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.

c. Respondent will demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.

d. Respondent will include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.

e. Respondent will include documentation of the most recent three years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.

f. Respondent will submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's process to ensure accurate, timely, and complete encounter data.

2. Demonstrated knowledge of the combination of key fields needed to identify services.

3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.

4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.

5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.

6. The completeness of the Respondent's flowcharts describing its encounter data submission process.

7. The adequacy of the Respondent's mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.

8. The adequacy of the Respondent's encounter data submission historical compliance ratings.

9. The adequacy of the Respondent's ability to implement timely corrective actions to compliance ratings, if indicated.

10. The adequacy of the tools and methodologies used to determine compliance.

11. The adequacy of the Respondent's process for converting paper claims to electronic encounter data.

12. 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.

13. The adequacy of the tool to ensure that all encounters are submitted.

Score: This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #46– Encounter Submission for Sub-Capitated, Subcontracted, Non-Pay and Atypical

Respondent will describe how it will work with providers, particularly sub-capitated providers, subcontractors, atypical providers, and non-participating providers to ensure the accuracy, timeliness, and completeness of encounter data.

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.

2. The adequacy of the Respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.

3. The adequacy of the Respondent's approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the Respondent's approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.

4. The adequacy of the Respondent's approach to educating and supporting providers who submit paper claims.

5. The adequacy of the Respondent's approach to encouraging providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.

6. The adequacy of the Respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.

7. The adequacy of the Respondent's approach to work with providers to comply with correct coding.

8. The adequacy of the Respondent's approach to ensure that all encounters are included in submissions.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #47 – Fraud and Abuse/Compliance Office

Respondent will describe its compliance program including the compliance officer's level of authority and reporting relationships. Respondent will describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. Respondent will include a résumé or curriculum vitae for the compliance officer. Respondent will also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's compliance program complies 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 has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #48 – Fraud and Abuse Special Investigations Unit (SIU)

Respondent will 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, including electronic verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.

2. The extent to which the Respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.

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 uses innovative technology for the purposes of verifying home-based visits and services.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #49 – Disaster Recovery Requirements

Respondent will demonstrate its capability and approach to meet the requirements described in the Prime Contract.

Reply:

Evaluation Criteria:

1. The adequacy of the Respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.

2. The adequacy of the Respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of 24 hours and ensures compliance with all requirements under the Contract.

3. The adequacy of the Respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the Respondent for the entire period of the Contract and submitted for review annually by the anniversary date of the Contract.

4. The adequacy of the Respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the Respondent to conduct the requirements of the Contract.

5. The adequacy of the Respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.

6. The adequacy of the Respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than 30 calendar days prior to the Contract effective date.

7. The adequacy of the Respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Department and at no additional cost to the Department.

8. The adequacy of the Respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Department at all times.

9. The adequacy of the Respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Department.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #50 – Management Experience and Retention:

Respondent will describe its approach to hiring, promoting and retention, throughout the Contract term, of executive managers (e.g., CEO, COO, CFO, CMO, vice presidents, and senior managers) who have expertise and experience in serving children with medical complexity, and document such expertise and experience. Respondent will describe the relevant experience of their current management team.

Reply:

Evaluation Criteria:

1. The extent to which executive managers have expertise and experience in implementing innovative care delivery systems serving children with medical complexity who require specialized services.

2. The extent to which executive managers have expertise and experience for their respective positions.

3. The degree to which the Respondent provides evidence, data, or metrics to demonstrate the effectiveness of its approaches to staff retention, including staff tenure, by contract, for the Respondent's two most recent contracts.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

G. Statutory Requirements

Criteria #51 – Statutory Community Partnerships

Respondent will describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees, including:

a. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.

b. Partnerships with local community organizations focused on addressing the following social determinants of health:

(1) Access to food;
(2) Employment and community inclusion;
(3) Housing stability and utility payment assistance;
(4) Education; and
(5) Exposure to crime/violence.

c. Participation in both grass-roots and grass-tops provider initiatives.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent provides details on how their local community partnerships, activities and initiatives support the local system of care.

2. The extent to which the Respondent has senior executive leadership staff who will be assigned to the resulting Contract who also participate on local health and human service related boards, councils, and commissions.

3. The extent to which the Respondent has partnerships with local agencies that focus on addressing social determinants of health.

4. The extent to which the Respondent jointly develops and incorporates change from grassroots and grass-tops provider initiatives.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

Criteria #52 – Organization Commitment to Quality (See section 409.966, Florida Statutes):

Respondent will describe its organizational commitment to quality improvement, including active involvement by the Respondent's medical and administrative leadership, and document its achievements with two examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.

2. The adequacy of the Respondent's approach to incorporating quality improvement activities into the culture and operations of the organization.

3. The extent to which the Respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.

4. The extent to which the Respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.

5. The extent to which the Respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.

6. The extent to which one of the quality improvement projects described by the Respondent is related to reducing potentially preventable events or improving birth outcomes.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #53 – Health Plan Accreditation (See section 409.966, Florida Statutes)

Respondent will specify its current accreditation status by a nationally recognized accrediting body. This will 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 (i.e., provisional, conditional, etc.). Respondent will attach documentation that supports this information.

Reply:

Evaluation Criteria:

1. Evidence that the Respondent has:

(a) Full health plan accreditation by a nationally recognized accrediting body; e.g., full three-year accreditation for the National Committee for Quality Assurance (NCQA), full three-year accreditation for Utilization Review Accreditation Commission (URAC), or full three-year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); or

(b) Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one year or six months for AAAHC); or

(c) No health plan accreditation or denied accreditation.

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

(a) 5 points for full health plan accreditation.

(b) 3 points for partial/conditional health plan accreditation.

(c) 0 points if health plan accreditation denied or no accreditation.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #54 – Provider Network Agreements/Contracts

Provider network agreements/contracts are available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

The Department has identified some of the key network service provider types that will be critical in order for the Respondent to promote the CMS Plan's goals.

Respondent will demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting **Exhibit A-1-e**, Provider Network Agreements/Contracts:

Reply:

Evaluation Criteria:

For each service provider type the Respondent may receive up to 20 points as described below. Points for each service provider type will be awarded as outlined in the table below:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	5
25.1%- 50%	10
50.1%- 75%	15
75.1% or greater	20

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

Attachment A-1-e is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

General Instructions:

Each Respondent shall complete the Agreements/Contracts scoring template worksheet. The respondent is required to submit the total number of individual providers with whom they have agreements/contracts per Provider Type by using column 'b' on the eleven regional worksheets.

Provider must also complete the 'Respondent Score' tab with the vendor name and region clusters they are bidding on. A final score is calculated on this tab based on the inputs on the regional tabs.

Required Provider Types Workbook Explanation

Service Provider Types to be Measured List
Board Certified or Board Eligible Adult Psychiatrist
Board Certified or Board Eligible Child Psychiatrist
Cardiology (PEDS)
Endocrinology (PEDS)
Oncology/Hematology, Pediatric
Pediatric Nephrologists
Pediatric Neurologists
Pediatric Rheumatologists
Pediatric Surgery
Pediatrics
Urology, Pediatric
Pulmonology, Pediatric

Statewide Essential Providers Scoring Template Fields

Field	Respondent Data Entry Required	Description
Service Provider Type	No	See Service Provider Types to be Measured List above
*Agreements/Contracts	Yes	*Agreement/Contracts count to be entered by respondent
Recipient Count	No	Recipient count utilized for as part of calculation for Ratio Results
Ratio	No	Regional provider ratio
Ratio Results	No	Shows service provider type requirement count for region using Recipient Count as the dividend and Ratio as the divisor
%	No	The number of agreement/contracts Respondent entered in column 'b', divided by the total number of providers and converted to a %

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Enter Respondent Name Below

CMS Plan Region Cluster	Bidding on Region (Y/N)	Recipient Count
A: North		N/A
B: Central - Southwest		N/A
C: South - Southeast		N/A

SCORE
0

Service Provider Type	Total Agreements/Contracts	Total Recipient Count	Ratio	Ratio Results	Total %	Total Score
Board Certified or Board Eligible Adult Psychiatrist	0	-	1,500	1.00	0.0%	0
Board Certified or Board Eligible Child Psychiatrist	0	-	6,000	1.00	0.0%	0
Cardiology (PEDS)	0	-	10,000	1.00	0.0%	0
Endocrinology (PEDS)	0	-	10,000	1.00	0.0%	0
Oncology/Hematology, pediatric	0	-	10,000	1.00	0.0%	0
Pediatric Nephrologists	0	-	10,000	1.00	0.0%	0
Pediatric Neurologists	0	-	10,000	1.00	0.0%	0
Pediatric Rheumatologists	0	-	30,000	1.00	0.0%	0
Pediatric Surgery	0	-	10,000	1.00	0.0%	0
Pediatrics	0	-	2,000	1.00	0.0%	0
Urology, pediatric	0	-	30,000	1.00	0.0%	0
Pulmonology, pediatric	0	-	30,000	1.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	5
25.1%	10
50.1%	15
75.1%	20

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 1

Service Provider Type	Agreements/Contracts	Recipient Count
Board Certified or Board Eligible Adult Psychiatrist		1,484
Board Certified or Board Eligible Child Psychiatrist		1,484
Cardiology (PEDS)		1,484
Endocrinology (PEDS)		1,484
Oncology/Hematology, pediatric		1,484
Pediatric Nephrologists		1,484
Pediatric Neurologists		1,484
Pediatric Rheumatologists		1,484
Pediatric Surgery		1,484
Pediatrics		1,484
Urology, pediatric		1,484
Pulmonology, pediatric		1,484

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 2		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		3,961
Board Certified or Board Eligible Child Psychiatrist		3,961
Cardiology (PEDS)		3,961
Endocrinology (PEDS)		3,961
Oncology/Hematology, pediatric		3,961
Pediatric Nephrologists		3,961
Pediatric Neurologists		3,961
Pediatric Rheumatologists		3,961
Pediatric Surgery		3,961
Pediatrics		3,961
Urology, pediatric		3,961
Pulmonology, pediatric		3,961

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 3		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		5,591
Board Certified or Board Eligible Child Psychiatrist		5,591
Cardiology (PEDS)		5,591
Endocrinology (PEDS)		5,591
Oncology/Hematology, pediatric		5,591
Pediatric Nephrologists		5,591
Pediatric Neurologists		5,591
Pediatric Rheumatologists		5,591
Pediatric Surgery		5,591
Pediatrics		5,591
Urology, pediatric		5,591
Pulmonology, pediatric		5,591

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 4		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		4,576
Board Certified or Board Eligible Child Psychiatrist		4,576
Cardiology (PEDS)		4,576
Endocrinology (PEDS)		4,576
Oncology/Hematology, pediatric		4,576
Pediatric Nephrologists		4,576
Pediatric Neurologists		4,576
Pediatric Rheumatologists		4,576
Pediatric Surgery		4,576
Pediatrics		4,576
Urology, pediatric		4,576
Pulmonology, pediatric		4,576

B-Central- SW Cluster

Service Provider Type	Agreements/Contracts	Recipient Count	Ratio	Ratio Results
Board Certified or Board Eligible Adult Psychiatrist	0	24,332	1,500	16.00
Board Certified or Board Eligible Child Psychiatrist	0	24,332	6,000	4.00
Cardiology (PEDS)	0	24,332	10,000	2.00
Endocrinology (PEDS)	0	24,332	10,000	2.00
Oncology/Hematology, pediatric	0	24,332	10,000	2.00
Pediatric Nephrologists	0	24,332	10,000	2.00
Pediatric Neurologists	0	24,332	10,000	2.00
Pediatric Rheumatologists	0	24,332	30,000	1.00
Pediatric Surgery	0	24,332	10,000	2.00
Pediatrics	0	24,332	2,000	12.00
Urology, pediatric	0	24,332	30,000	1.00
Pulmonology, pediatric	0	24,332	30,000	1.00

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 5		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		4,533
Board Certified or Board Eligible Child Psychiatrist		4,533
Cardiology (PEDS)		4,533
Endocrinology (PEDS)		4,533
Oncology/Hematology, pediatric		4,533
Pediatric Nephrologists		4,533
Pediatric Neurologists		4,533
Pediatric Rheumatologists		4,533
Pediatric Surgery		4,533
Pediatrics		4,533
Urology, pediatric		4,533
Pulmonology, pediatric		4,533

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 6		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		8,100
Board Certified or Board Eligible Child Psychiatrist		8,100
Cardiology (PEDS)		8,100
Endocrinology (PEDS)		8,100
Oncology/Hematology, pediatric		8,100
Pediatric Nephrologists		8,100
Pediatric Neurologists		8,100
Pediatric Rheumatologists		8,100
Pediatric Surgery		8,100
Pediatrics		8,100
Urology, pediatric		8,100
Pulmonology, pediatric		8,100

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 7		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		7,852
Board Certified or Board Eligible Child Psychiatrist		7,852
Cardiology (PEDS)		7,852
Endocrinology (PEDS)		7,852
Oncology/Hematology, pediatric		7,852
Pediatric Nephrologists		7,852
Pediatric Neurologists		7,852
Pediatric Rheumatologists		7,852
Pediatric Surgery		7,852
Pediatrics		7,852
Urology, pediatric		7,852
Pulmonology, pediatric		7,852

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 8		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		3,847
Board Certified or Board Eligible Child Psychiatrist		3,847
Cardiology (PEDS)		3,847
Endocrinology (PEDS)		3,847
Oncology/Hematology, pediatric		3,847
Pediatric Nephrologists		3,847
Pediatric Neurologists		3,847
Pediatric Rheumatologists		3,847
Pediatric Surgery		3,847
Pediatrics		3,847
Urology, pediatric		3,847
Pulmonology, pediatric		3,847

C-Southern-SE Cluster

Service Provider Type	Agreements/Contracts	Recipient Count	Ratio	Ratio Results
Board Certified or Board Eligible Adult Psychiatrist	0	21,612	1,500	14.00
Board Certified or Board Eligible Child Psychiatrist	0	21,612	6,000	3.00
Cardiology (PEDS)	0	21,612	10,000	2.00
Endocrinology (PEDS)	0	21,612	10,000	2.00
Oncology/Hematology, pediatric	0	21,612	10,000	2.00
Pediatric Nephrologists	0	21,612	10,000	2.00
Pediatric Neurologists	0	21,612	10,000	2.00
Pediatric Rheumatologists	0	21,612	30,000	1.00
Pediatric Surgery	0	21,612	10,000	2.00
Pediatrics	0	21,612	2,000	10.00
Urology, pediatric	0	21,612	30,000	1.00
Pulmonology, pediatric	0	21,612	30,000	1.00

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 9		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		5,638
Board Certified or Board Eligible Child Psychiatrist		5,638
Cardiology (PEDS)		5,638
Endocrinology (PEDS)		5,638
Oncology/Hematology, pediatric		5,638
Pediatric Nephrologists		5,638
Pediatric Neurologists		5,638
Pediatric Rheumatologists		5,638
Pediatric Surgery		5,638
Pediatrics		5,638
Urology, pediatric		5,638
Pulmonology, pediatric		5,638

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 10		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		7,482
Board Certified or Board Eligible Child Psychiatrist		7,482
Cardiology (PEDS)		7,482
Endocrinology (PEDS)		7,482
Oncology/Hematology, pediatric		7,482
Pediatric Nephrologists		7,482
Pediatric Neurologists		7,482
Pediatric Rheumatologists		7,482
Pediatric Surgery		7,482
Pediatrics		7,482
Urology, pediatric		7,482
Pulmonology, pediatric		7,482

ATTACHMENT A-1-e
PROVIDER NETWORK AGREEMENTS/CONTRACTS

Region 11		
Service Provider Type	**Agreements/Contracts**	**Recipient Count**
Board Certified or Board Eligible Adult Psychiatrist		8,492
Board Certified or Board Eligible Child Psychiatrist		8,492
Cardiology (PEDS)		8,492
Endocrinology (PEDS)		8,492
Oncology/Hematology, pediatric		8,492
Pediatric Nephrologists		8,492
Pediatric Neurologists		8,492
Pediatric Rheumatologists		8,492
Pediatric Surgery		8,492
Pediatrics		8,492
Urology, pediatric		8,492
Pulmonology, pediatric		8,492

Criteria #55 – Provider Network Agreements/Contracts Essential Providers

Respondent will submit **Exhibit A-1-f**, Provider Network Agreements/Contracts Essential Providers, to demonstrate its progress with executing agreements or contracts with Essential Providers by submitting **Exhibit A-1-f**:

Reply:

Evaluation Criteria:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	10
25.1%- 50%	20
50.1%- 75%	30
75.1% or greater	40

Score: This section is worth a maximum of 40 raw points based on the above point scale.

Attachment A-1-f is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT A-1-f
PROVIDER NETWORK/CONTRACTS
STATEWIDE ESSENTIAL PROVIDERS

General Instructions:

Each Respondent shall complete the Managed Medical Assistance Agreements/Contracts scoring template worksheet. The respondent is required to submit the total number of agreements/contracts with Statewide Essential Providers by using column 'b' on the worksheet.

Statewide Essential Providers Scoring Workbook Explanation:

Statewide Essential Providers List
Tampa General Hospital
Shands Teaching Hospital
Shands-Jacksonville
Jackson Memorial Hospital, Jackson Health System
Sacred Heart Hospital
Winnie Palmer Hospital at Arnold Palmer Medical Center, Orlando Health
NEO: All Children's Hospital
OB: Bayfront Medical Center
St. Mary's Medical Center
Broward General Medical Center
Memorial Regional Medical Center-
Lee Memorial Health System
University of Florida College of Medicine
University of Miami School of Medicine
University of South Florida College of Medicine
University of Central Florida College of Medicine
Nova Southeastern University College of Osteopathic Medicine
Florida State University College of Medicine
Florida International University College of Medicine
All Children's Hospital
Miami Children's Hospital
Nemours
Shriners Hospitals for Children

Statewide Essential Providers Scoring Template Fields		
Field	*Respondent Data Entry Required?*	*Description*
Service Provider Type	*No*	*Statewide Essential Provider*
**Agreements/Contracts*	*Yes*	*Agreements/Contracts count shall be entered by Respondent*
Statewide Essential Count	*No*	*Total number of available statewide essential providers (see Statewide Essential Providers list above)*
%	*No*	*The number of agreements/contracts Respondent entered in column 'b', divided by the total number of Statewide Essential Providers and converted to a %*
Score	*No*	*Specific statewide essential provider type score*

ATTACHMENT A-1-f
PROVIDER NETWORK/CONTRACTS
STATEWIDE ESSENTIAL PROVIDERS

Enter Respondent Name Below

ATTACHMENT A-1-f
PROVIDER NETWORK/CONTRACTS
STATEWIDE ESSENTIAL PROVIDERS

Criteria Score
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Statewide Essential Count	Ratio	Ratio Results	%	Score
Statewide Essential	0	*NA*	*NA*	23	*NA*	*NA*	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.00%	0
1.0% - 25%	10
25.1%- 50%	20
50.1%- 75%	30
75.1% or greater	40

Criteria #55– Provider Network Agreements/Contracts/Essential Providers

Provider network agreements/contracts are available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #56 – Data reporting

Respondent will describe its organizational commitment to providing the Department with real-time data dashboards and reporting, including hospital admission and discharge data and emergency room utilization.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent provides examples of dashboards that will be regularly provided to the Department for a data-driven quality improvement cycle.

2. The extent to which the Respondent provides the following:

- **a.** An interactive internet-based performance dashboard for Department staff that provides visual displays of key Respondent and system performance measures relative to goals and benchmarks;
- **b.** The dashboard's compatibility with modern mobile technology (e.g., computers, smart phones, tablets, iPads) that are accessible 24 hours a day, 7 days a week, via mobile technology for identified CMS staff;
- **c.** A secure internet-based portal or application available to identified and trained Department staff for generating standard and ad hoc reports; and
- **d.** Standard reports required under the ITN would be contained the identified portal.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 20 points each.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Criteria #57 -Electronic Visit Verification (EVV)

Respondent will describe how it will comply with the requirements for visit verification for personal care and home health services described in the 21st Century Cures Act including the verification of:

- Type of service performed
- Individual receiving service
- Date of service
- Location of service delivery
- Individual providing services
- Time the service begins and ends

Respondent also will include a description of the EVV system reports and costs.

Reply:

Evaluation Criteria:

1. The extent to which the Respondent currently utilizes or has a concrete plan to secure the use of an EVV system and includes a description of the EVV system reports and costs.
2. The extent to which the description of the Respondent's system meets all six 21st Century Cures Act data collection requirement.

Score: This section is worth a maximum of 10 raw points, 4 points for criteria #1 and 1 point for meeting each data collection requirement. 0 points awarded if the Respondent does not have nor intends to secure and EVV system.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

ATTACHMENT B
STATEMENT OF NON-COLLUSION

I hereby certify that my company, its employees, and its principals, had no involvement in performing a feasibility study of the implementation of the subject Contract, in the drafting of this solicitation document, or in developing the subject program. Further, my company, its employees, and principals, engaged in no collusion in the development of the instant Bid, proposal or reply. This Bid, proposal or reply is made in good faith and there has been no violation of the provisions of Chapter 287, Florida Statutes, the Administrative Code Rules promulgated pursuant thereto, or any procurement policy of the Department of Health. I certify I have full authority to legally bind the Provider, Respondent, or Vendor to the provisions of this Bid, proposal or reply.

_____ _____

Signature of Authorized Representative* Date

*An authorized representative is an officer of the Respondent's organization who has legal authority to bind the organization to the provisions of the Bids. This usually is the President, Chairman of the Board, or owner of the entity. A document establishing delegated authority must be included with the Bid if signed by other than the President, Chairman or owner.

ATTACHMENT C
Application Data Security and Confidentiality

This attachment is for the purpose of ensuring adequate information security protection is in place in at all times during this contract between the Department of Health hereinafter referred to as "the (Department") and service providers, vendors, and information trading partners, all referenced hereinafter together referred to as "Providers" in this attachment.

1. **Hosting Data or Applications** – This section applies to all contracts whereby a Provider is hosting data, or hosting an application that processes data, on behalf of the Department. Provider will comply with the following:

   a. Provider, its employees, subcontractors, and agents will comply with all security and administrative requirements of the Department in performance of this contract. Provider will provide immediate notice to the Department's Information Security Manager (ISM), or their designee, in the event it becomes aware of any security breach and any unauthorized transmission of State Data as described below or of any allegation or suspected violation of security requirements of the Department.

   b. Provider will produce, upon entering a contract, a current security audit (no more than 12 months old) performed by a third party that is certified to perform such audits that demonstrates the use of sound security measures and practices by the Provider hosting the data or application that is processing data, as defined by a nationally recognized security framework. Provider will produce a status of any corrective action plans underway to address deficiencies found in the security audit. Provider must provide an annual update on any open corrective action plans associated with the most recent audit's noted deficiencies. The Department has the right to require Provider to produce a new or updated audit every three years during the contract term, at Provider's expense.

   c. At the request of the Department, Provider will obtain a current American Institute of Certified Public Accountants (AICPA) "Standards for Attestation Engagements no. 16" (SSAE 16).

   d. Loss or Breach of Data: In the event of loss of any State Data or records, where such loss is due to the negligence of Provider or any of its subcontractors or agents, Provider will be responsible for recreating such lost data, if possible, in the manner and on a schedule set by the Department at Provider's sole expense. This will be in addition to any other damages the Department may be entitled to by law or the Contract. Provider may be subject to administrative sanctions for failure to comply with section 501.171, Florida Statutes, for any loss or breach of data, due to a failure to maintain adequate security and any costs to the Department for the loss or breach of security caused by Provider.

   e. Data Protection: No State data or information will be stored in, processed in, or shipped to offshore locations or outside of the United States of America, regardless of method, except as required by law. Access to State data will only be available to approved and authorized staff, including offshore Provider personnel, that have a legitimate business need. Requests for offshore access will be submitted in accordance with the Department established processes and will only be allowed with express written approval from the Deputy Secretary of Operations. Third parties may be granted time-limited terminal service access to IT resources as necessary for fulfillment of related responsibilities with prior written approval by the ISM. Third parties will not be granted remote access via VPN, private line, or

firewall holes, without an approved exemption. Requests for exceptions to this provision must be submitted to the ISM for approval. When remote access needs to be changed, the ISM will be promptly notified. Provider will abide by all Department and State data encryption standards regarding the transmission of confidential or confidential and exempt information. Documented encryption standards will be provided upon request. Offshore data access must be provided via a trusted method such as SSL, TLS, SSH, VPN, IPSec or a comparable protocol approved by the ISM. Confidential information must be encrypted using an approved encryption technology when transmitted outside of the network or over a medium not entirely owned or managed by the Department. Provider agrees to protect, indemnify, defend, and hold harmless the Department and State from and against any and all costs, claims, demands, damages, losses and liabilities arising from or in any way related to Provider's loss or breach of data or the negligent acts or omissions of Provider related to this subsection.

f. Notice Requirement: Provider will notify the Department upon detection of anomalous or malicious traffic within the scope of contracted services. To the extent applicable, failure to notify the Department of events or incidents that result in breach will subject Provider to administrative sanctions, together with any costs to the Department of such breach of security.

g. Data Retention: Provider must retain data as follows:

i. Copies: At contract termination or expiration, submit copies of all finished or unfinished documents, data, studies, correspondence, reports and other products prepared by or for Provider under the contract; submit copies of all state data to the Department in a format to be designated by the Department in accordance with section 119.0701, Florida Statutes; shred or erase parts of any retained duplicates containing personal information of all copies to make any personal information unreadable.

ii. Originals: At contract termination or expiration--retain its original records, and maintain, in confidence to the extent required by law, Provider's original records in un-redacted form, until the records retention schedule expires and to reasonably protect such documents and data during any pending investigation or audit.

iii. Both Copies and Originals: Upon expiration of all retention schedules and audits or investigations and upon notice to the Department, destroy all state data from Provider's systems including, but not limited to, electronic data and documents containing personal information or other data that is confidential and exempt under Florida public records law.

2. **Application Provisioning** – This section applies to all contracts whereby a Provider is making available a software application to be used by the Department for collecting, processing, reporting, and storing data. Provider's software application used for the Department's automation and processing must support, and not inhibit, each of the following Department security requirements:

a. Users must never share account passwords or allow other users to use their account credentials. Users are responsible for all activities occurring from the use of their account credentials.

i. Department employees are responsible for safeguarding their passwords and other authentication methods by not sharing account passwords, email encryption passwords, personal identification numbers, smart cards, identification badges, or other devices used for identification and authentication purposes.

ii. Passwords will not be passed or stored in plain text. Passwords must be encrypted or secured by other means when stored or in transit.

b. Department employees will be accountable for their account activity.

i. Audit records will allow actions of users to be uniquely traced for accountability purposes.

ii. User accounts must be authenticated at a minimum by a complex password. Department accounts will require passwords of at least ten (10) characters to include an upper and lowercase letter, a number, and a special character.

iii. Department employees must log-off or lock their workstations prior to leaving the work area.

iv. Workstations must be secured with a password-protected screensaver with the automatic activation feature set at no more than 10 minutes.

c. Department employees must not disable, alter, or circumvent Department security measures.

d. Computer monitors must be protected to prevent unauthorized viewing.

e. Consultation involving confidential information must be held in areas with restricted access.

f. Confidential information must be printed using appropriate administrative, technical, and physical safeguards to prevent unauthorized viewing.

g. Access to data and information systems must be controlled to ensure only authorized individuals are allowed access to information and that access is granted upon a “need-to-know” basis only.

h. User accounts will be deleted or disabled, as appropriate, within 30 days of employment termination, non-use of account for 60 consecutive days, or under direction of a manager or Personnel and Human Resource Management’s notification of a security violation.

i. Confidential information will not be disclosed without proper authority. It is the responsibility of each member of the workforce to maintain the confidentiality of information and data. Any employee who discloses confidential information will ensure sufficient authorization has been received, the information has been reviewed and prepared for disclosure as required, and no revocation of the requesting document has been received.

j. All employees are responsible for protecting Department data, resources, and assets in their possession.

k. All employees are responsible for immediately notifying their local information security coordinator of any violation of Department security policies, or suspected/potential breach of security.

l. All employees will be knowledgeable of the classifications of data and information and the proper handling of data and information.

3. **Data Interchange** – This section applies to contracts whereby the Department will be sending data transmissions to, or receiving data transmissions from, a Provider for the purpose of independent processing. Examples include: sending laboratory orders to a laboratory, receiving laboratory results, sending billing information to a clearing house, receiving billing results or notification of payment, sending vital statistics to the Social Security Administration, sending physician licensing information to Florida's Agency for Healthcare Administrative, receiving continuing education credit information for medical profession licensees, etc. Data interchange contracts must have a data sharing agreement in place. Provider will comply with the following:

   a. Follow all Department and State data encryption standards regarding the transmission of confidential or confidential and exempt information between the Department and the Provider. Documented encryption standards will be provided upon request. All transmission of confidential or confidential and exempt data must utilize a protected protocol such as SSL, TLS, SSH, VPN, IPSec or a comparable protocol approved by the ISM.

   b. Use of any connection to the Department's network will be for retrieving information delivered by the Department, or sending data to the Department, and not for any other access to resources on the Department's network.

   c. Protect and maintain the confidentiality of all data, files, and records, deemed to be confidential or confidential and exempt, retrieved from the Department pursuant to this agreement. The user will immediately notify the Department's ISM of any loss or breach of information originating from the Department and retrieved by Provider.

   Provider agrees to protect, indemnify, defend, and hold harmless the Department and State from and against any and all costs, claims, demands, damages, losses and liabilities arising from or in any way related to Provider's loss or breach of data originating from the Department, or the negligent acts or omissions of Provider related to this subsection.

4. **All IT Services** – This section applies to all contracts whereby a Provider is providing IT services to the Department.

   Provider will protect and maintain the confidentiality of all data, files, and records, deemed to be confidential or confidential and exempt, acquired from the Department pursuant to this agreement. Except as required by law or legal process and after notice to the Department, Provider will not divulge to third parties any confidential information obtained by Provider or its agents, distributors, resellers, subcontractors, officers or employees in the course of performing contract work, including, but not limited to, security design or architecture, business operations information, or commercial proprietary information in the possession of the state or the Department.

CMS MANAGED CARE PLAN COST REPLY INSTRUCTIONS -

JANUARY 19, 2018

Florida Department of Health Children's Medical Services Plan

CONTENTS

Overview of Cost Reply Instructions 164

Specifications for Respondent Replies 164

CMS Plan Data Book 166

Cost Reply Materials 166

Rate Adjustments to be Excluded from the Cost Reply 171

Final Rate development 172

Caveats 173

OVERVIEW OF COST REPLY INSTRUCTIONS

The purpose of this document is to provide respondents with instructions for completing the Children's Medical Services Plan (CMS Plan) Reply (cost reply) required in **Attachment D** of this solicitation.

This document provides instructions and guidance to respondents as they complete their cost replies. The format of the cost reply templates follows the general format of the methodology used by the CMS Plan and its consulting actuaries to develop actuarially sound capitation rates. The CMS Plan anticipates using a similar methodology (CMS Plan's rate methodology) to assess the reasonability and competitiveness of respondent cost replies.

SPECIFICATIONS FOR RESPONDENT REPLIES:

1. Respondents may bid statewide or on a regional cluster with either a full-risk model (Option 1: MCO) or a risk phase-in model (Option II: Risk Phase-In), as described in **Exhibit A-1**, Criteria #1.

   The Respondent may opt to be full-risk in one or two regional clusters and phased-in-risk in the others and may submit a statewide and regional cluster bid simultaneously. Cost replies submitted must be consistent with the respondent's response to Criteria #1.

   The Respondent must bid on services for both Title XIX and Title XXI enrollees in every regional cluster for which they submit a bid. The three regional clusters are as follows:

   A. North Florida-AHCA Regions 1–4

   B. Central/SW Florida- AHCA Regions 5–8

   C. South/SE Florida-AHCA Regions 9–11

   The Respondent shall indicate if its bid is statewide or for a regional cluster, the priority of the bid as described in Criteria #1, and whether the bid is risk or phased-in risk (non-risk).

2. Respondents must submit cost replies using the provided cost reply template.

   Respondents are to enter information only in cells shaded yellow. Respondents must not change any formulas in the cost reply template and must submit the cost reply template with the original sheet and workbook protection intact.

3. Within the cost reply template(s), respondents must enter their organization name on the Reply Summary Tab. Additionally, respondents should use the following file naming convention when submitting their cost reply templates:

   A. Respondents should replace the "Respondent" portion of the cost reply template Excel file name with their organization's name.
   B. Respondents should replace the "X-X-X" portion of the file name with the applicable regional clusters. In the file name, include "A" for North, "B" for Central – SW and "C" for South – SE.

      If the respondent does not bid on all 3 regional clusters or has both full-risk and phased-in risk bids, include ONLY the regional clusters in the applicable cost reply template.

4. Respondents must enter a numeric value into each and every yellow cell on all required tabs (except for the vendor name and program change specifications). If numeric values are not entered into each required yellow cell, the cost reply template will not appropriately calculate a proposed capitation rate from the respondent's input base data and adjustments. If a particular adjustment factor does not apply for a given region/regional cluster, title, or service category, enter 0.0% adjustment in the required input cells to allow the cost reply template to appropriately calculate a proposed capitation rate.

5. All cells other than respondent inputs have been protected.

6. Do not insert rows or columns in the template, or use the "cut" command on any cells within the template. If the respondent requires more columns for adjustments than provided, please combine adjustments so that they can be entered into the number of columns in the template and include a description of each adjustment and its value in the Actuarial Memorandum that accompanies the cost reply template (along with Excel numerical support as needed).

7. Cost replies are to be quoted for the 12-month period of January 2019 through December 2019 (CY2019). If necessary due to implementation timing or change in rate cycle, the Department will adjust the final negotiated capitation rates to reflect any changes to that rate period, including appropriate trend, seasonality and programmatic change effect.

8. The cost reply template is pre-populated with the base data from the published ITN Data Book. These pre-populated per member per months (PMPMs) are the starting point for each bid, and represent Mercer's estimate of ultimate incurred claim experience for the

period, as described in the Data Book. The respondent may use adjustments in the provided columns to adjust the base data, with supporting documentation in the Actuarial Memorandum. Adjustments to the base data must be input as a one-time adjustment to the data. Trend factors entered must be annual trend rate and are applied for 30 months from the midpoint of the base data period (January 1, 2017) to the midpoint of the contract period (July 1, 2019).

9. Cost replies are to be quoted net of patient responsibility, third party liability (TPL) recoveries, and fraud, waste and abuse recoveries.

10. Respondents must include an Actuarial Memorandum in support of their cost reply. The required contents of the Actuarial Memorandum are discussed in a later section in this document.

CMS PLAN DATA BOOK

The published ITN includes a Data Book that provides relevant background information that respondents will find useful in the development of their response to this ITN. The Data Book contains cost and utilization data specific to CMS Plan enrollees, in addition to information on covered services for each population. The document includes a description of the data sources and all adjustments applied to the data to produce the Data Book, in addition to adjustments considered in rate development.

The published Data Book can be accessed in the following location (Exhibit D-3, CMS Plan Data Book):

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

Respondents must consider the information in the published ITN Data Book when developing their cost replies and completing the cost reply template(s), but they are not obligated to rely on it in developing their own replies. Respondents are not restricted to the data and summaries provided by CMS Plan for use in preparing the cost reply; however, they are required to complete the cost reply template. Respondents are allowed to develop and use other data sources as needed to prepare a competitive cost reply. The structure of the cost reply template allows flexibility for respondents to use base data and adjustments different than those presented in the published CMS Plan data book and in the cost reply instructions and rate methodology narrative. Respondents are solely responsible for research and preparation of the cost reply.

COST REPLY MATERIALS

Respondents will include the following components in their cost replies, depending on the risk option(s) selected, as defined above:

ATTACHMENT D
COST REPLY INSTRUCTIONS

1. CMS Plan Capitated Plan Cost Reply template in Excel format, including capitated rate and non-medical expense components (as applicable)

2. CMS Plan Risk Phase-In Cost Reply template in Excel format, including capitated rate and non-medical expense components (as applicable)

3. CMS Plan Actuarial Memorandum

4. Managed Care Savings table

1. Capitated Plan Cost Reply Template (Exhibit D-1 – Full-Risk Cost Reply)

Respondents bidding full-risk in Year 1 should complete the Full-Risk Cost Reply Template, which is included as **Exhibit D-1**. This Excel file should be completed for all regions/regional clusters that the respondent intends to bid full-risk. The file contains detailed instructions for completion of the tabs.

This Excel file includes three distinct components:

1. The Title XIX Capitated-Risk Cost Reply Templates

    A. Bids are to be input for each of the 11 AHCA regions included in the full-risk bid. All regions in a regional cluster must be completed in the bid.

    B. The template aggregates TXIX bids to the applicable regional cluster(s) included in the full-risk bid.

2. The Title XXI Capitated-Risk Cost Reply Templates

    A. Bids are to be input for each of the three regional clusters included in the full-risk bid.

3. The Non-Benefit Expense Component related to the At-Risk services in Year 1

2. Risk Phase-In Cost Reply (Exhibit D-2 – Phased-in Risk Cost Reply Template)

Respondents bidding phased-in risk in Year 1 should complete the Phased-In Risk Cost Reply Template, which is included as **Exhibit D-2**. This Excel file should be completed for all regions/regional clusters that the respondent intends to bid phased-in risk. The file contains detailed instructions for completion of the tabs.

This Excel file includes three distinct components:

1. The Title XIX Capitated-Risk Cost Reply Templates

    A. Bids are to be input for each of the 11 AHCA regions included in the phased-in risk bid. All regions in a regional cluster must be completed in the bid.

B. The template aggregates TXIX bids to the applicable regional cluster(s) included in the phased-in risk bid.

2. The Title XXI Capitated-Risk Cost Reply Templates

   A. Bids are to be input for each of the three regional cluster(s) included in the full-risk bid

3. The non-benefit expense components related to the at-risk services in Year 1

4. The Non-Benefit Expense Component related to the At-Risk services [Pharmacy (Year 1 only) and Inpatient (Year 1 and 2)] services

Template Location

The Excel cost reply templates can be accessed in the following location:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

3. Actuarial Memorandum Requirements

Each respondent must provide detailed documentation in the form of an Actuarial Memorandum describing how the respondent's cost reply was developed. The Actuarial Memorandum should cover all regions and regional clusters and both Title XIX and Title XXI.

To the extent the respondent includes a full-risk bid for some regional clusters and a phased-in risk bid for other regional clusters, the respondent may submit their response for both risk scenarios in a single Actuarial Memorandum. If a single Actuarial Memorandum is submitted to for both risk scenarios, the respondent must clearly identify and describe which components of the bid apply to each risk scenario. Alternatively, the respondent may elect to submit two Actuarial Memoranda. For purposes of these instructions, we will refer to a single Actuarial Memorandum.

The Actuarial Memorandum is required to correspond to the sections of the CMS Plan Cost Reply Template(s) and the Non-Benefit Expense Cost Reply Template(s). The Actuarial Memorandum must each include the following information:

1. **Experience Adjustment:** Include any information on anticipated difference in experience from the published ITN Data Book base PMPMs. This adjustment should rely on the respondent's experience with the CMS plan or another similar population. Include supporting documentation, including data sources, data time periods, and justification for results of the adjustment.

2. **Acuity Adjustment:** The published ITN Data Book includes information related to population acuity changes. Describe any acuity adjustment applied in the cost reply. If no acuity adjustment is made or to the extent it differs from the adjustment in the Data Book, please provide supporting documentation related to the development of the adjustment and the magnitude of the adjustment. Include supporting documentation, including data sources, data time periods, justification for results of the adjustment.

3. **Program Changes:** The Data Book contains information about known changes to the program that have occurred or are expected and are expected to change the cost profile of the program. The cost reply template includes an input for the respondent to incorporate an aggregate program change adjustment. Provide supporting documentation on each specific program change included in the aggregated impact on the cost reply template. This documentation should include a description of the reason for the program change adjustment, the base data and base data time periods used to develop the program change impact, and other pertinent information. Include a table with the impact of each individual adjustment broken out separately by title, region/regional cluster, risk scenario, and service category.

4. **Managed Care Savings Adjustments:** The Cost Reply Template includes an input for an aggregate managed care savings adjustment. Document each managed care savings adjustment included in the aggregated impact on the cost reply template. For each managed care initiative, please provide the following information and document the data sources and methodology used to calculate the adjustment factors by Title, region/regional cluster, risk scenario, and service category:

    - Description of the managed care initiative
    - Implementation timing
    - Involvement of other organizations
    - Internal or external costs of developing and administering the initiative
    - Development of net cost savings by Title, region/regional cluster, risk scenario, and service category
        - Include support for the data, assumptions, and methodology underlying the net savings projection.

5. **Trend:** Describe the data sources and methodology used to develop the utilization and unit cost trend factors included in the Cost Reply Template. Include information regarding annualized trend assumptions by Title, region/regional cluster, risk scenario and service category. Include the time period used for trending. Include justification for any zero or

negative trends applied. Describe how the trend was developed for subcapitated services, if applicable. If the assumed trends vary by year rather than one overall annualized trend, each year of trend should be documented. If experience from other state Medicaid programs is used, please identify the state, clarify whether that state's program is fee-for-service (FFS) or managed care, and discuss the credibility of the data used.

Please note that final negotiated rates will be adjusted for changes to published Medicaid fee schedules for hospitals (inpatient and outpatient services), nursing homes, and federally qualified health care centers (FQHCs), as appropriate. Thus, unit cost trends for these provider types are expected to be negligible.

6. **Other Cost Reply Adjustments:** Document each additional adjustment used in the Cost Reply Template. Describe the reason for each adjustment and the data sources and methodology used to calculate the adjustment factors. If experience from other state Medicaid programs is used for these adjustments, please identify the state, clarify if that state's program is FFS or managed care, and discuss the credibility of the data used.

7. **Proposed Administrative Allowance:** Document the respondent's proposed administrative allowance for each title and regional cluster:

   - Source of information used to develop the proposed administrative allowance
   - Methodology used to allocate administrative costs between Title XIX and XXI (if applicable)
   - Methodology used to allocate administrative costs to each regional cluster (if applicable)
   - If different methodologies are used to allocate different types of costs, please document all applicable methodologies used

8. **Proposed Gain / Loss Margin:** Document the respondent's proposed gain/loss margin for each title and regional cluster.

Statement of Rate Adjustments Excluded from Cost Reply

Respondents must include a statement that their cost reply excludes adjustments for the items shown in the next section of this document.

Respondents can also list other potential rate adjustments they believe should be considered as part of the negotiation process but are excluded from the respondent's cost reply. Respondents must clearly note the additional excluded items and explain why the adjustments were excluded.

Supporting Exhibits: Large numerical exhibits must be submitted in Excel with active formulas retained.

Please number the response sections of the Actuarial Memorandum to match the numbering above. If the respondent's Actuarial Memorandum references information provided elsewhere in this solicitation response, please identify its exact location (file name, page number, Criteria number, etc.).

4. Summary of Managed Care Savings

The respondent shall complete and submit **Exhibit 5**, Summary of Managed Care Savings, as part of its response in accordance with the instructions contained therein.

RATE ADJUSTMENTS TO BE EXCLUDED FROM THE COST REPLY

Respondents should exclude the potential effects of the following elements from their cost reply development, to ensure comparativeness across replies and improve the accuracy of valuing certain types of program changes that are not known or not fully known at this time. The Department and its actuary will adjust the final negotiated capitation rates to reflect the effects of these items, as appropriate.

1. Changes to the Medicaid Fee Schedule for Hospital Inpatient and Outpatient services from schedules in effect during SFY 2016–2017.

2. Changes to the Medicaid Nursing Home Fee Schedule from those in effect during SFY 2016-2017.

3. Changes to the FQHC and Rural Health Clinic (RHC) Medicaid encounter rates from those in effect during SFY201–2017.

4. Development of the medical school faculty physician group value based purchasing arrangement (if necessary).

5. Other program changes excluded from the cost reply instructions or ITN Data Book.

6. Costs related to the federal health insurance provider fee (HIPF).

FINAL RATE DEVELOPMENT

The published ITN Data Book includes detailed documentation related to the base data development and high level information related to the development of the capitation rates. The format of the cost reply templates follows the general format of the methodology that will be used by the CMS Plan and its consulting actuaries to develop actuarially sound program capitation rates. The CMS Plan anticipates using a similar methodology to assess the reasonability and competitiveness of respondent cost replies. Ultimately, negotiated rates will be adjusted for appropriateness with the program implementation timing and all relevant changes to the program. Final rates will be certified as actuarially sound by a qualified actuary.

CAVEATS

Mercer has used and relied upon eligibility, claim and encounter data and information supplied by the CMS Plan and its vendors. The CMS Plan is solely responsible for the validity and completeness of these supplied data and information. Mercer has reviewed the summarized data in compliance with the Actuarial Standard of Practice (ASOP) on data quality (ASOP 23), but did not perform a complete audit.

This document assumes the reader is familiar with the CMS Plan Medicaid program, Medicaid eligibility rules and actuarial rating techniques. It is intended for CMS, AHCA, and potential vendors, and should not be relied upon by other parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these data. This document should only be reviewed in its entirety. Users of the Cost Reply worksheet and instructions are cautioned against relying solely on the data contained herein. The CMS Plan and Mercer provide no guarantee, either written or implied, that the Cost Reply worksheet and instructions are 100% accurate or error-free.

This document is being provided for informational purposes only. CMS and Mercer reserve the right to refine it as they see fit at any time.

The authors of this document, listed below, are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses described in this document.

Tom Dahl, FSA, MAAA

Bridget Huss, ASA, MAAA

ATTACHMENT D-1
FULL-RISK COST REPLY

Attachment D-1 is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

ATTACHMENT D-2
PHASED-IN RISK COST REPLY TEMPLATE

Attachment D-2 is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

ATTACHMENT D-3
DATA BOOK

Attachment D-3 is available for Respondents to download at:

http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html

EXHIBIT 1

Respondent Staffing Requirements for Children's Health and Behavioral Health Benefit Administration

Position/ Title	Florida Location Required (Yes/No)	CMS Requirements
Key Staff		
Contract Manager for Respondent to CMS Plan	Yes	Dedicate one hundred percent of their time employed with the Managed Care Vendor to this CMS Plan Contract
Administrator/CEO/COO	No	Oversees entire operation of Respondent
CFO	No	Full-time FTE devoted to CMS Plan finance
Information System Director	No	• Full-time FTE devoted to CMS Plan IT • Experience and expertise in Medicaid and CHIP data analytics and data systems. • Knowledge of all federal and state laws governing the confidentiality and security of protected health information, including confidential mental health and SUD information.
Medical Director for Children's Services (AHCA Required)	Yes	• Florida license as a physician • Minimum of five years of experience working with children in managed care settings or clinical settings (at least two years must be in a clinical setting) • Board certified in Pediatrics • The designated medical director will have the experience and knowledge of the unique and complex needs of the Medically Complex population and all needed state child serving systems. • Time allocation for this position must be at a minimum of 1 FTE. • Respondent may submit a request to waive the minimum allocation of time with appropriate documentation for CMS's review and approval.
Compliance Officer	Yes	• Dedicate one hundred percent of their time employed with the Managed Care Vendor to this CMS Plan Contract • Qualified by knowledge, training, and experience in health care or risk management

EXHIBIT 1
Respondent Staffing Requirements for Children's Health and Behavioral Health Benefit Administration

Position/ Title	Florida Location Required (Yes/No)	CMS Requirements
Clinical Director for Children's Services	Yes	• Florida license as a clinical professional • Minimum of seven years of experience in a managed care setting or clinical setting, including at least two years of managed care experience (preferably Medicaid or CHIP managed care) and at least five years with children. • Knowledge of Florida child serving systems required. • If the Respondent has more than 60,000 enrollees under age 21, the percent of effort must be full-time. If the Respondent has less than 60,000 enrollees under age 21, the percent of effort may be less than full-time and be negotiated with the CMS Plan.
Managerial Staff		
Member Services Manager	No	• Full time staff member. Experience in MC or clinical setting. • Experience managing member service call center operations. • Knowledge of the provider system serving children with medical complexity. • Knowledge of the benefits and program requirements for children, including the medically complex children's populations.
Provider Services and Provider Relations Manager	Yes	• Full time staff member • Experience in MC or clinical setting. • Experience managing provider issues including resolving grievances, coordinating site visits, and maintaining quality of care. • Knowledge of the provider system serving children with BH needs medically complex children and specialized services for children. • Demonstrated experience in network development for medically complex children. • Knowledge of and experience with principles of physical-BH integration. • Knowledge of family-centered, youth guided principles and development of services for children. • Knowledge of specific PH service needs of the children population.
Program Integrity Manager	No	Responsible for Fraud and Abuse Detection

EXHIBIT 1
Respondent Staffing Requirements for Children's Health and Behavioral Health Benefit Administration

Position/ Title	Florida Location Required (Yes/No)	CMS Requirements
UM Manager	Yes	• Master's Degree in health administration, public health, nursing or related health field. Licensed Practitioner (e.g., Nurse, Physician, or Physician's assistant) required if making medical necessity determinations. With MC or clinical experience • Experience working with community and family-based services recommended.
QM Manager	No	• Master's Degree in health administration, public health, nursing or related health field. • *Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers is preferred.* • Experience and expertise in quality improvement for children who are medically complex, children with mental health and SUD service needs, ideally in publicly-operated or publicly-funded programs. • Experience with managed care delivery systems. • Familiarity with recovery-oriented services. • Familiarity with family-centered, youth-guided service delivery for children and families. • Knowledge of appropriate performance measures (including HEDIS and QARR) for children.
Dispute and Appeal Manager	No	Responsible for member and provider disputes
CM Manager	Yes	• Five years of management/supervisory experience in the health care field. • RN or LCSW with at least three years' experience providing care coordination and two years in managed care or children's services. • Experience working in care management, children's specialty clinics, or with Patient Centered Medical Homes recommended. • Experience working with community and family-based services and experience in working across child serving systems recommended. • Knowledge of Florida child serving systems required.

EXHIBIT 1
Respondent Staffing Requirements for Children's Health and Behavioral Health Benefit Administration

Position/ Title	Florida Location Required (Yes/No)	CMS Requirements
Care Coordination/Case Management Supervisor(s)	Yes	Oversee case management staff, which will have the qualifications of a Care Coordinator/Case Manager and a minimum of three years of management/supervisory experience in the health care field.
Training Manager	Yes	• Significant experience and expertise in developing, tracking, and executing training to the Respondent's own and network provider's staff. • Significant experience and expertise in developing training programs related to systems for children and families. • Knowledge of needs associated with medically complex children and specialized services.
Pharmacy Manager	No	Florida licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Manager may be an employee or contractor of the Respondent.
Claims and Encounter Data Manager	No	• Experience managing provider issues including resolving payment and claims issues • Understanding of provider claims processing (i.e., professional and institutional) including appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available Respondent resources such as provider manuals, website, fee schedules, etc.
Behavioral Health Medical Director	Yes	Full time board certified psychiatrist in the State of Florida with 5 years of experience in MH and SUD
Liaison for Medically Complex Children	Yes	• Experience, expertise and knowledge of the unique complex needs (including trauma) of this population. • Knowledge of State child serving systems, Care Coordinators/Case Managers, patient centered health homes, children's specialty hospitals and clinics, and specialty providers responsible for addressing the healthcare needs of medically complex children.
Maternal Health/EPSDT Coordinator	Yes	Florida licensed nurse, physician, or Physician's assistant, or have a Master's degree in health services, public health, or health care administration or other related field or a CPHQ or CHCQM

EXHIBIT 1

Respondent Staffing Requirements for Children's Health and Behavioral Health Benefit Administration

Position/ Title	Florida Location Required (Yes/No)	CMS Requirements
Operational Staff		
UM	No	• Licensed Practitioner (e.g., Nurse or LCSW or other appropriate license for SUD review) • For UM, authorization decisions must be made by a licensed practitioner with minimum three years of experience treating children with similar conditions. • Knowledge and experience in Children's health and BH services, HCBS, specialized services, EPSDT services and social service programs.
Clinical Peer Reviewers	No	• Includes panel of reviewers to conduct denial and appeal reviews, peer review of psychological testing, or complex case review and other related consultations. • Peer reviewers must include: • Physicians who are board certified in Pediatrics; • Physicians who are board certified in the condition under review; • Physicians who are board certified in child psychiatry; or • Licensed doctoral level psychologists with experience treating children.
QM Specialists	No	• Experience and expertise in quality improvement for physical health, developmental disabilities, mental health and SUD services programs, ideally in publicly-operated or publicly-funded programs. • Knowledge of family-centered, youth-guided service delivery for children and families with complex needs. • Knowledge of appropriate performance measures (including HEDIS and QARR) for children.
Provider relations staff	Yes	• Experience in MC or clinical setting. • Experience managing children's specialty provider issues including resolving grievances, coordinating site visits, and maintaining quality of care. • Knowledge of the provider system serving children with BH/DD needs, medically complex children.

EXHIBIT 1

Respondent Staffing Requirements for Children's Health and Behavioral Health Benefit Administration

Position/ Title	Florida Location Required (Yes/No)	CMS Requirements
Care Coordinators/Case Managers	Yes	• State of Florida Licensed Registered Nurse with at least 2 years of pediatric experience or Licensed Practical nurse with 4 years of pediatric experience, or MA degree in social work with at least 1 year of related professional experience • Experience in managing care for including high-risk groups, such as children with SED, with co-occurring major mental disorders and SUD, who are involved in multiple services systems (education, justice, medical, welfare, and child welfare); Children with medical fragility/complex medical conditions requiring significant medical or technological health supports.

EXHIBIT 2
Respondent Staff Training Requirements

Respondent will modify its staff training program and provider contracting to include Florida and CMS specific rules. Respondent will ensure that all staff members have appropriate training, education, experience and orientation to fulfill their requirements of the position.

Training Topics to be completed 30 days prior to go-live	**Clinical Staff**	**Member Services**	**Provider Relations**
Initial and ongoing staff training that includes an overview of CMS, CMS/AHCA Policy and Procedure Manuals, and Contract and State and Federal requirements specific to individual job functions.	Required (R)	R	R
CMS's vision, mission, goals, operating principles for the children service and population expansion.	R	R	R
Understanding existing children's SPA services, EPSDT SPA services for children, including TAY, DD, and children ages 0–5.	R	R	R
Cultural competence outlining the impact of culture, ethnicity, race, gender, sexual orientation and social class within the service delivery process.	R	R	R
CMS eligibility requirements and protocols.	R	R	R
Knowledge of Medicaid or CHIP managed care regulatory requirements including: • Timeframes for completion of assessment and Plan of Care for children with medical complexity; • Procedures and State guidelines for approving services recommended in a Plan of Care; • Effective and efficient monitoring of the individual's progress, frequency of services, including identification of any deviations from approved plans of care; and • Coordination across departments responsible for compliance with Medicaid or CHIP requirements, including but not limited to reporting related to Medicaid and CHIP.	Manager (M)	M	M
Services for children with First Episode Psychosis as well as knowledge of service delivery consistent with evidence-based and promising practices for children, including Early Intervention services and peer and family support services.	R	R	
Care Management operational requirements (e.g., needs assessment, plans of care).	R	R	R
Specialized services for children.	R		R
BH/medical integration; co-occurring BH and medical disorders, co-occurring MH and SUD disorders; integrated CM principles.	R	R	R

EXHIBIT 2
Respondent Staff Training Requirements

Training Topics to be completed 30 days prior to go-live	Clinical Staff	Member Services	Provider Relations
Medical Necessity Criteria and service authorization requirements for covered benefits including any Value-Added Services or In-Lieu of Services.	R	R	
Network access standards.	R	R	R
New information systems, data collection tools (if applicable).	R		R
Reporting and monitoring requirements (e.g., critical incident reporting).	R		
Grievance, appeals including the appropriate identification and handling of quality of care/service concerns	R	R	R
After hours and crisis triage protocols.	R	R	R
Linkage requirements (i.e., with CMS, foster care agencies and other non-Medicaid and CHIP child serving agencies).	R	R	R
Network participation requirements (e.g., provider qualification validation).			R
Provider training and site visits.			R
Provider profiling and performance management.			R
Primary Care and BH Integration, including but not limited to appropriate screening and early identification tools for use in medical settings.	R		R
Transitions of Care between service settings, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home, as well as from children's to adult service systems	R	R	R
The Patient-Centered Medical Home Model & Practice — Roles and Responsibilities	R	R	R
Understanding the interaction of child serving systems, and navigating and coordinating systems of care.	R	R	R
Knowledge of working with children and their families using family-centered, youth-guided planning approaches and collaborating with child serving systems, including child welfare for children in foster care and coordination with local, State or federally-funded non-Medicaid service providers (e.g., education system).			
Trauma Informed Practices.	R		
Importance of Families and understanding how to assist families/caregivers to access services.	R	R	R
Family Psychoeducation.	R	R	R

EXHIBIT 2
Respondent Staff Training Requirements

Training Topics to be completed 30 days prior to go-live	Clinical Staff	Member Services	Provider Relations
Special Populations: Children with Developmental Disabilities; Children who are Medically Complex; Children receiving specialized services; Children in Foster Care;	R		
Special Populations: Transitions Age Youth.	R		
Special Populations: Children age 0–5.	R		

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

EXHIBIT 3
QUALIFICATION OF RESPONDENT ELIGIBILITY

RESPONDENT NAME: _____

1. IDENTIFICATION OF RESPONDENT TYPES

I hereby certify that my company is submitting a reply to DOH17-026 to operate as a Specialty Plan.

2. QUALIFICATION OF RESPONDENT ELIGIBILITY

I hereby certify my company currently operates as one of the following:

☐ HMO Health Maintenance Organization and possess a current Florida Certificate of Authority and Health Care Provider Certificate in at least one Florida county.

OR

☐ PSN that possesses a Florida Third Party Administrator License or a subcontract/letter of agreement with a Florida-licensed Third-Party Administrator. A copy of the Third-Party Administrator license, or subcontract/letter of agreement, must be submitted with the solicitation reply.

In addition, the Respondent will complete **Exhibit 4,** Provider Service Network Certification of Ownership and Controlling Interest.

OR

☐ Exclusive Provider Organization that meets the licensure requirements of Section 627.6472, Florida Statutes.

OR

☐ Accountable Care Organization authorized under federal law.

EXHIBIT 3
QUALIFICATION OF RESPONDENT ELIGIBILITY

Signature below indicates the Respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

_____

Respondent Name

_____ _____

Authorized Official Signature **Date**

_____

Authorized Official Printed Name

_____

Authorized Official Title

Failure to submit, Exhibit 3, Qualification of Respondent Eligibility, signed by an authorized official may result in the rejection of reply.

EXHIBIT 4
PROVIDER SERVICE NETWORK CERTIFICATION OF OWNERSHIP AND CONTROLLING INTEREST (only if marking PSN on Exhibit 3)

RESPONDENT NAME: _____

I hereby certify that the Respondent submitting this reply is a Provider Service Network ("PSN") as defined in sections 409.912(2)(b) and 409.962(14), Florida Statutes, or 409.962(9), Florida Statutes:

> A PSN is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the PSN network organization. subsection 409.912(2)(b) (2016), Florida Statutes.
>
> "PSN" means an entity qualified pursuant to section 409.912(2), Florida Statutes of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies. Subsection 409.962(14) (2016), Florida Statutes.

Please provide the following additional information.

1. The PSN's first year of operation: _____

2. The Department considers the first year of operation to begin on the date that the Respondent was organized. Please provide the articles of incorporation, articles of organization, partnership agreement, certificate of limited partnership, or other formation documentation demonstrating the first year of operation of the PSN.

3. Identify (in the field below) the health care provider or group of affiliated health care providers that have a controlling interest in the governing body of the PSN and the basis for such controlling interest.

EXHIBIT 4
PROVIDER SERVICE NETWORK CERTIFICATION OF OWNERSHIP AND CONTROLLING INTEREST (only if marking PSN on Exhibit 3)

4. To the extent that such health care provider or group of affiliated health care providers identified above is not the ultimate owner, then identify (in the field below) such owners and the affiliates of such health care provider or group of affiliated health care providers and their ultimate owners, indicating the percentage of such ownership. Please see the Affiliation Criterion to Determine Controlling Interest for Purposes of this solicitation below.

5. Provide a detailed explanation (in the field below), with references to documentation and other information required by this section, that demonstrates how the Respondent qualifies under the statutes and requirements of this solicitation to provide services as a PSN providing services as a Managed Care Respondent.

6. The individual that signed the Transmittal Letter or a person authorized in the Transmittal Letter to sign on behalf of the Respondent as required by **Attachment A**, Instructions and Special Conditions, Section B., Reply Preparation and Content, Sub-Section 2., Mandatory Reply Content, Item a., Transmittal (Cover) Letter, will sign the replies to these requests for additional information above.

Affiliation Criteria to Determine Controlling Interest for Purposes of the SMMC Solicitation

7. For purposes of responding to the above, use the following General Principles of Affiliation to determine whether a controlling interest exists.

a. Concerns and entities are affiliates of each other when one controls or has the power to control the other, or a third party or parties controls or has the power to control both. It does not matter whether control is exercised, so long as the power to control exists.

b. The Department considers factors such as ownership, management, previous relationships with or ties to another concern, and contractual relationships, in determining whether affiliation exists.

c. Control may be affirmative or negative. Negative control includes, but is not limited to, instances where a minority shareholder has the ability, under the concern's charter, by-laws, or shareholder's agreement, to prevent a quorum or otherwise block action by the board of directors or shareholders.

d. Affiliation may be found where an individual, concern, or entity exercises control indirectly through a third party.

e. In determining whether affiliation exists, the Department will consider the totality of the circumstances, and may find affiliation even though no single factor is sufficient to constitute affiliation.

8. Affiliation based on stock ownership.

a. A person (including any individual, concern or other entity) that owns, or has the power to control, fifty percent (50%) or more of a concern's voting stock, or a block of voting stock which is large compared to other outstanding blocks of voting stock, controls or has the power to control the concern.

b. If two or more persons (including any individual, concern or other entity) each owns, controls, or has the power to control less than fifty percent (50%) of a concern's voting stock, and such minority holdings are equal or approximately equal in size, and the aggregate of these minority holdings is large as compared with any other stock holding, the Department presumes that each such person controls or has the power to control the concern whose size is at issue. This presumption may be rebutted by a showing that such control or power to control does not in fact exist.

c. If a concern's voting stock is widely held and no single block of stock is large as compared with all other stock holdings, the concern's Board of Directors and CEO or President will be deemed to have the power to control the concern in the absence of evidence to the contrary.

9. Affiliation arising under stock options, convertible securities, and agreements to merge.

a. The Department considers stock options, convertible securities, and agreements to merge (including agreements in principle) to have a present effect on the power to control a concern. The Department treats such options, convertible securities, and agreements as though the rights granted have been exercised.

b. Agreements to open or continue negotiations towards the possibility of a merger or a sale of stock at some later date are not considered "agreements in principle" and are thus not given present effect.

c. Options, convertible securities, and agreements that are subject to conditions precedent which are incapable of fulfillment, speculative, conjectural, or unenforceable under State or federal law, or where the probability of the transaction (or exercise of the rights) occurring is shown to be extremely remote, are not given present effect.

d. An individual, concern or other entity that controls one or more other concerns cannot use options, convertible securities, or agreements to appear to terminate such control before actually doing so. The Department will not give present effect to individuals', concerns' or other entities' ability to divest all or part of their ownership interest in order to avoid a finding of affiliation.

10. Affiliation based on common management. Affiliation arises where one or more

officers, directors, managing members, or partners who control the board of directors and/or management of one concern also control the board of directors or management of one or more other concerns.

11. Affiliation based on identity of interest. Affiliation may arise among two or more persons with an identity of interest. Individuals or firms that have identical or substantially identical business or economic interests (such as family members, individuals or firms with common investments, or firms that are economically dependent through contractual or other relationships) may be treated as one party with such interests aggregated. An individual or firm may rebut that determination with evidence showing that the interests deemed to be one are in fact separate.

a. Firms owned or controlled by married couples, parties to a civil union, parents, children, and siblings are presumed to be affiliated with each other if they conduct business with each other, such as subcontracts or joint ventures or share or provide loans, resources, equipment, locations or employees with one another. This presumption may be overcome by showing a clear line of fracture between the concerns. Other types of familial relationships are not grounds for affiliation on family relationships.

b. The Department may presume an identity of interest based upon economic dependence if the concern in question derived seventy percent (70%) or more of its receipts from another concern over the previous three fiscal years. This presumption may be rebutted by a showing that despite the contractual relations with another concern, the concern at issue is not solely dependent on that other concern, such as where the concern has been in business for a short amount of time and has only been able to secure a limited number of contracts.

12. Affiliation based on newly organized concern. Affiliation may arise where former officers, directors, principal stockholders, managing members, or key employees of one concern organize a new concern in the same or related industry or field of operation, and serve as the new concern's officers, directors, principal stockholders, managing members, or key employees, and the one concern is furnishing or will furnish the new concern with contracts, financial or technical assistance, indemnification on reply or performance bonds, and/or other facilities, whether for a fee or otherwise. A concern may rebut such an affiliation determination by demonstrating a clear line of fracture between the two concerns. A “key employee” is an employee who, because of his/her position in the concern, has a critical influence in or substantive control over the operations or management of the concern.

EXHIBIT 4
PROVIDER SERVICE NETWORK CERTIFICATION OF OWNERSHIP AND CONTROLLING INTEREST (only if marking PSN on Exhibit 3)

Signature below indicates the Respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

_____
Respondent Name

_____ _____
Authorized Official Signature **Date**

_____
Authorized Official Printed Name

_____
Authorized Official Title

Failure to submit, Exhibit 4, Provider Service Network Certification of Ownership and Controlling Interest, signed by an authorized official may result in the rejection of reply.

EXHIBIT 5
SUMMARY OF MANAGED CARE SAVINGS

PURPOSE: CMS will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to identify managed care savings included by the respondent in response to this solicitation.		
CMS RESERVES THE RIGHT TO INCLUDE ANY OR ALL MANAGED CARE SAVINGS LISTED HEREIN, OR AS NEGOTIATED, AS PART OF THE RESULTING CONTRACT.		
INSTRUCTIONS: THE RESPONDENT SHALL IDENTIFY EACH MANAGED CARE SAVINGS PROPOSED IN ITS RESPONSE TO THIS SOLICITATION AND IDENTIFY BOTH THE SOLICITATION SECTION(S)/SUBSECTION(S)/ITEM(S), AND THE SECTION/COLUMN OF THE COST REPLY TEMPLATE (ATTACHMENT D) IN WHICH THE MANAGED CARE SAVINGS IS PROPOSED. (SEE EXAMPLE BELOW) ADDITIONAL PAGES MAY BE INCLUDED AS NEEDED.		
Managed Care Savings Activity (Brief Summary/Description)	**Solicitation Section Reference**	**Cost Reply Template (Attachment D) Reference**
Hospital Readmissions	**Example:** ***Attachment A-1****, Evaluation Criteria - Criteria #12 Potentially Preventable Events (Regional)*	**Example:** *Cost Reply Template (**Attachment D**)., Managed Care Savings Adjustments, #1*

EXHIBIT 5
SUMMARY OF MANAGED CARE SAVINGS

Respondent Name		
Authorized Official Signature		**Date**
Authorized Official Printed Name		
Authorized Official Title		

EXHIBIT 6
NETWORK ADEQUACY STANDARDS

Provider Network Standards Table					
	Urban County		**Rural County**		**Regional Provider Ratios**
Required Providers	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Maximum Time (minutes)*	*Maximum Distance (miles)*	*Providers per Recipient*
Primary Care Providers	30	20	30	20	1:1,500 enrollees
Specialists					
Allergy	80	60	90	75	1:20,000 enrollees
Cardiology (PEDS)	100	75	110	90	1:16,667 enrollees
Cardiovascular Surgery	100	75	110	90	1:10,000 enrollees
Chiropractic	80	60	90	75	1:10,000 enrollees
Dermatology	60	45	75	60	1:7,900 enrollees
Endocrinology (PEDS)	100	75	110	90	1:20,000 enrollees
Endodontist	80	60	90	75	1:5,000 enrollees
Gastroenterology	60	45	75	60	1:8,333 enrollees
General Dentist	50	35	75	60	1:1,500 enrollees
General Surgery	50	35	75	60	1:3,500 enrollees
Infectious Diseases	100	75	110	90	1:6,250 enrollees
Midwife	100	75	110	90	1:33,400 enrollees
Nephrology (PEDS)	100	75	110	90	1:39,600 enrollees
Neurology (PEDS)	100	75	110	90	1:22,800 enrollees
Neurosurgery	100	75	110	90	1:10,000 enrollees
Obstetrics/Gynecology	50	35	75	60	1:1,500 enrollees
Oncology	80	60	90	75	1:5,200 enrollees
Ophthalmology	50	35	75	60	1:4,100 enrollees
Optometry	50	35	75	60	1:1,700 enrollees
Oral Surgery	100	75	110	90	1:20,600 enrollees
Orthodontist	100	75	110	90	1:38,500 enrollees
Orthopedic Surgery	50	35	75	60	1:5,000 enrollees
Otolaryngology	80	60	90	75	1:3,500 enrollees
Pediatric Dentist	50	35	75	60	1:3,000 enrollees
Pediatrics	50	35	75	60	1:1,500 enrollees

Podiatry	60	45	75	60	1:5,200
24-hour Pharmacy	60	45	60	45	n/a
Pulmonology	60	45	75	60	1:7,600 enrollees
Rheumatology	100	75	110	90	1:14,400 enrollees
Therapist (Occupational)	50	35	75	60	1:1,500 enrollees
Therapist (Speech)	50	35	75	60	1:1,500 enrollees
Therapist (Physical)	50	35	75	60	1:1,500 enrollees
Therapist (Respiratory)	100	75	110	90	1:8,600 enrollees
Urology	60	45	75	60	1:10,000 enrollees
Facility/ Group/ Organization					
Hospitals (acute care)	30	20	30	20	1 bed: 275 enrollees
Hospital or Facility with Birth/Delivery Services (including Birthing Center)	30	20	30	20	1 bed: 275 enrollees
24/7 Emergency Service Facility	30	20	30	20	2: County
Home Health Agency	n/a	n/a	n/a	n/a	2: County
Hospice	n/a	n/a	n/a	n/a	2: County
DME/HME	n/a	n/a	n/a	n/a	As required in s 409.975(1)(e), F.S.
Behavioral Health					
Board Certified or Board Eligible Adult Psychiatrists	30	20	60	45	1:1,500 enrollees
Board Certified or Board Eligible Child Psychiatrists	30	20	60	45	1:7,100 enrollees
Licensed Practitioners of the Healing Arts	30	20	60	45	1:1,500 enrollees
Licensed Community Substance Abuse Treatment Centers	30	20	60	45	2: county
Inpatient Substance Abuse Detoxification Units	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees
Fully Accredited Psychiatric Community Hospital (Adult)	n/a	n/a	n/a	n/a	1 bed:2,000 enrollees
Fully Accredited Psychiatric Community Hospital (Child)	n/a	n/a	n/a	n/a	1 bed:4,000 enrollees