

**AHCA ITN 005-19/20  
ADDENDUM NO. 1**

**Item #1**

**Attachment A**, Instructions and Special Conditions, **Section A.1.**, Instructions, **Sub-Section A.**, Overview, **Item 5.**, Procurement Officer, is hereby amended to now read as follows:

**5. Procurement Officer**

Crystal Demott  
Agency for Health Care Administration  
2727 Mahan Drive  
Mail Stop #15  
Tallahassee, FL 32308-5403  
Email: [solicitation.questions@ahca.myflorida.com](mailto:solicitation.questions@ahca.myflorida.com)

**Item #2**

**Attachment A**, Instructions and Special Conditions, **Section A.1.**, Instructions, **Sub-Section A.**, Overview, **Item 6.**, Solicitation Timeline, **TABLE 1**, is hereby deleted in its entirety and replaced as follows:

<b>TABLE 1</b>		
<b>SOLICITATION TIMELINE</b>		
<b>ACTIVITY</b>	<b>DATE/TIME</b>	<b>LOCATION</b>
Solicitation Issued by Agency	January 14, 2020	Electronically Posted <a href="http://myflorida.com/apps/vbs/vbs_main_menu">http://myflorida.com/apps/vbs/vbs_main_menu</a>
Deadline for Receipt of Written Questions	January 28, 2020 2:00 p.m.	<a href="mailto:solicitation.questions@ahca.myflorida.com">solicitation.questions@ahca.myflorida.com</a>
Date for Agency Responses to Written Questions	February 18, 2020	Electronically Posted <a href="http://myflorida.com/apps/vbs/vbs_main_menu">http://myflorida.com/apps/vbs/vbs_main_menu</a>
Deadline for Receipt of Responses	March 9, 2020 2:00 p.m.	Crystal Demott Agency for Health Care Administration Mailroom Building 4 2727 Mahan Drive Tallahassee, FL 32308-5403
Public Opening of Responses	March 9, 2020 3:00 p.m.	2727 Mahan Drive, Building 2 Operations Conference Room, 2nd Floor, Room 200 Tallahassee, FL 32308-5403

**AHCA ITN 005-19/20  
ADDENDUM NO. 1**

TABLE 1		
SOLICITATION TIMELINE		
ACTIVITY	DATE/TIME	LOCATION
<b>Anticipated</b> Dates for Negotiations	April 20, 2020 through May 29, 2020	2727 Mahan Drive, Building 2 Operations Conference Room, 2nd Floor, Room 200 Tallahassee, FL 32308-5403
<b>Anticipated</b> Posting of Notice of Intent to Award	June 22, 2020	Electronically Posted <a href="http://myflorida.com/apps/vbs/vbs_main_menu">http://myflorida.com/apps/vbs/vbs www.main menu</a>

**Item #3**

**Attachment A**, Instructions and Special Conditions, **Exhibit A-4**, Submission Requirements and Evaluation Criteria Components (Technical Response), is hereby deleted in its entirety and replaced with **Attachment A**, Instructions and Special Conditions, **Exhibit A-4**, Submission Requirements and Evaluation Criteria Components (Technical Response) (February 17, 2020).

**Item #4**

**Attachment A**, Instructions and Special Conditions, **Exhibit A-5**, Cost Proposal, is hereby deleted in its entirety and replaced with **Attachment A**, Instructions and Special Conditions, **Exhibit A-5**, Cost Proposal (February 17, 2020).

**Item #5**

**Attachment B**, Scope of Services, is hereby deleted in its entirety and replaced with **Attachment B**, Scope of Services (February 17, 2020).

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**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Deltek	Attachment A	A.1. Instructions	A. Overview	14. Term of Contract	a. The anticipated term of the resulting contract. b. Extension options.	6	Will the services in the resulting contract be a recurring need for the Agency?	The Vendor shall perform the activities/services according to Attachment B., Scope of Services, Section B.3., Services Provided by the Vendor, Sub-Section A. General Responsibilities during the term of the resulting Contract.
Qsource	Attachment B	II	B.5	Category D	Scope of Services	9	What are the current published requirements? Is AHCA looking to make changes?	Federal regulations regarding external quality review (EQR) including network adequacy are located at 42 CFR § 438.358.  Federal Centers for Medicare & Medicaid Services (CMS) has not released the protocol for the validation of network adequacy.  Upon CMS' release of the protocol for the validation of network adequacy, the Vendor shall perform the activity according to the federal requirements.
Qsource	Attachment B	II	B.5	Category D	Scope of Services	9	How many carriers will be evaluated? How many networks?	Twenty-one (21) health plans will be evaluated.  The Vendor may find a list of the health plans provided through the Florida Statewide Medicaid Managed Care (SMMC) program including the regions they serve at the below link: <a href="http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml">http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml</a>
Qsource	Attachment B	II	B.5	Category D	Scope of Services	9	Are any of the carriers specialty plans (dental, vision, behavioral health only)?	Yes, the Florida SMMC program has dental plans.  The Vendor may find a list of the dental plans provided through the SMMC program at the below link: <a href="http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml">http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml</a>
Qsource	Attachment B	II	B.5	Category D	Scope of Services	9	Is the frequency monthly or annually?	The Vendor shall validate each health plan's network adequacy annually.
Qsource	Attachment B	II	B.5	Category D	Scope of Services	9	Is network adequacy measured against population or enrollment data?	Federal CMS has not released the protocol for the validation of network adequacy.
Qsource	Attachment B	II	B.5	Category D	Scope of Services	9	Is there an existing process in place for carriers to submit provider network rosters in a consistent format?	There is an existing process in place for health plans to submit provider network rosters in a consistent format.  The SMMC Managed Care Report Guide is a companion guide to each managed care plan contract with the Agency. It provides details of health plan reporting requirements including instructions, location of templates, and submission deadlines. The SMMC Managed Care Report Guide can be located at the below link: <a href="https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Report_Guides/April_2019/SMMC_Report_Guide_Effective_4-1-2019.pdf">https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Report_Guides/April_2019/SMMC_Report_Guide_Effective_4-1-2019.pdf</a>
Qsource	Attachment B	II	B.4	Category C	Scope of Services	8	What is the volume of secret shopper calls? Is this part of the EQRO or Agency responsibilities?	See Chapter 43 and Chapter 44 for additional information on submission criteria for provider network rosters.
Qsource	Attachment B	II	B.4	Category C	Scope of Services	8	What is the volume of secret shopper calls? Is this part of the EQRO or Agency responsibilities?	Secret shopper calls are a part of the Agency's responsibilities. The volume of secret shopper calls varies.
Qsource	Attachment B	III. Method of Payment	A. Invoicing	2. Travel		29 of 45	Since this contract requires on-site visits to conduct contract activities will these travel expenses be approved as part of the contract or will it require additional approval?	The Agency will not pay the Vendor separately for any travel expenses related to the provision of services in the resulting Contract. The Vendor's travel costs should be built into the Vendor's proposed "Cost Proposal" (Exhibit A-5) and "Detailed Budget" (Exhibit A-5-a).

**EXHIBIT A-1  
QUESTIONS AND  
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VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Qsource	Attachment B	III. Method of Payment	A. Invoicing	Detailed Budget	Exhibit A-5-a	2 of 3	There is no line item for travel expenses. Where do we put the expense of on-site travel that is required by the contract?	The Agency will not pay the Vendor separately for any travel expenses related to the provision of services in the resulting Contract. The Vendor's travel costs should be built into the Vendor's proposed "Cost Proposal" (Exhibit A-5) and "Detailed Budget" (Exhibit A-5-a).
Qsource	Attachment B	III. Method of Payment	A. Invoicing	Renewal Period Detailed Budget	Exhibit A-5-b	2 of 3	There is no line item for travel expenses. Where do we put the expense of on-site travel that is required by the contract?	The Agency will not pay the Vendor separately for any travel expenses related to the provision of services in the resulting Contract. The Vendor's travel costs should be built into the Vendor's proposed "Cost Proposal" (Exhibit A-5) and "Detailed Budget" (Exhibit A-5-a).
Qsource	Attachment A			SRC#6	Exhibit A-4	56	Did ACHA intend for the last sentence of the first paragraph to read "... Item 3., Category B: Validation of Performance Measures."	Yes. AHCA intended for the last sentence to read: "The respondent shall demonstrate its capability to provide the requirements described in Attachment B., Scope of Services, Section B.3., Services Provided by the Vendor, Sub-Section C., Category B: Validation of Performance Measures."
Qsource	Attachment B	II	B.2	Category A	Scope of Services	5	Is the EQRO's role to develop the collaborative projects?	No, the EQRO's role is not to develop the collaborative projects.  The EQRO's role is to use the current mandatory CMS protocol for conducting external quality reviews of PIPs to determine whether a health care quality performance improvement project was designed, conducted, and reported in a methodologically sound manner and in accordance with applicable federal rules and regulations including 42 CFR, Part 438.
Qsource	Attachment B	II	B.3	Category B	Scope of Services	6	Is this intended to be "Validation of Performance Measures"?	Yes. AHCA intended for this to state "Validation of Performance Measures".
Qsource	Attachment B	II	B.3	Category B.3.b	Scope of Services	7	How many performance measures are reported that are not HEDIS? If the measures do not fall under the scope of the HEDIS audit, is the EQRO expected to perform a Performance Measure Validation outlined in Protocol 3?	The required performance measures that the health plans collect and report on can be located in the model contracts at the following link:  <a href="http://ahca.myflorida.com/medicaid/statewide_mc/plans_FY18-23.shtml">http://ahca.myflorida.com/medicaid/statewide_mc/plans_FY18-23.shtml</a>  <b>Managed Medical Assistance (MMA) Program</b> - Attachment II, Exhibit II-A, Section IX., Quality, Sub-Section B., Performance Measures.  <b>Long-Term Care (LTC) Managed Care Program</b> - Attachment II, Exhibit II-A, Section IX., Quality, Sub-Section B., Performance Measures.  <b>Child Welfare (CW)</b> - Attachment II, Exhibit II-C., Section IX., Quality, Sub-Section B., Performance Measures.  <b>Children with Special Health Care Needs</b> - Attachment II, Exhibit II-C Section IX., Quality, Sub-Section B., Performance Measures.  <b>HIV/AIDS</b> - Attachment II, Exhibit II-C, Section IX., Quality, Sub-Section B., Performance Measures.  <b>Serious Mental Illness</b> - Attachment II, Exhibit II-C, Section IX., Quality, Sub-Section B., Performance Measures.  Performance measures are subject to change each state fiscal

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Qsource	Attachment B	II	B.4	Category C.a	Scope of Services	8	Please confirm that the Agency is conducting the audits and the EQRO is only assisting in the development of the review criteria and aggregating the results.	<p>The Agency conducts its own assessment of plans' compliance with federal Medicaid managed care regulations.</p> <p>The EQRO will be responsible for reviewing the Agency's compliance review activities to ensure the activities are in accordance with Federal CMS requirements for compliance with federal standards.</p> <p>The Vendor shall also be responsible for drafting a final report describing the state's compliance activities in accordance with 42 C.F.R § 438.350.</p> <p>The Vendor shall be responsible for conducting EQR-related activities including "Review of Compliance with Federal Standards" in accordance with Federal CMS' EQR protocols. The protocols may be located at the below link: <a href="https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html">https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html</a></p>
Qsource	Attachment B	II	B.2	Category A	Scope of Services	5	<p>a. The MMA Model Health Plan Contract indicates that each MCP conducts 4 PIPs, the first three being collaborative. In addition to developing potential methodologies for collaborate PIPs, what role will the EQRO plan in implementing the collaborative projects?</p> <p>b. Do Collaborative PIPs have a typical average life cycle?</p> <p>c. Do PIP requirements apply to comprehensive, MMA and LTC plans?</p>	<p>The EQRO will not play a role in implementing the collaborative PIPs.</p> <p>The EQRO's role is to use the current mandatory CMS protocol for conducting external quality reviews of PIPs to determine whether a health care quality performance improvement project was designed, conducted, and reported in a methodologically sound manner and in accordance with applicable federal rules and regulations including 42 CFR, Part 438.</p> <p>Collaborative PIPs have a typical average life cycle of three to four years.</p> <p>PIP requirements apply to comprehensive, LTC plus, specialty, and dental plans.</p>
Qsource	Attachment B	II	B.4	Category C	Scope of Services	8	<p>a. Please confirm that the EQRO will not be conducting the review directly, only assisting the Agency with planning and implementing their own review activities, and preparing the final report of Agency review results.</p> <p>b. Are separate review conducted for all comprehensive, MMA, and LTC plans?</p>	<p>The Agency conducts its own assessment of plans' compliance with federal Medicaid managed care regulations.</p> <p>The EQRO will be responsible for reviewing the Agency's compliance review activities to ensure the activities are in accordance with Federal CMS requirements for compliance with federal standards.</p> <p>The Vendor shall be responsible for conducting EQR-related activities including "Review of Compliance with Federal Standards" in accordance with Federal CMS' EQR protocols. The protocols may be located at the below link: <a href="https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html">https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html</a></p>
Qsource	Attachment B	II	B.5	Category D	Scope of Services	9	<p>a. Are they able to expand on NCQA standards that would produce a statistically valid review?</p> <p>b. Are separate reviews conducted for all comprehensive, MMA and LTC plans?</p>	<p>The Vendor may use other nationally recognized standards that will produce a statistically valid review.</p> <p>The Vendor shall conduct a review of each health plan's network adequacy.</p>

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Qsource	Attachment B	II	B.6	Category E	Scope of Services	10	a. Please confirm that the Encounter Data Validation activity includes both capitated and fee for service data. b. Does this apply to all comprehensive, MMA, and LTC plans?	The Encounter Data Validation (EDV) activity does not include FFS data.  The EDV activity applies to all comprehensive, specialty, LTC plus, and dental plans (as applicable) for the study.
Qsource	Attachment B	II	B.6	Category F	Scope of Services	12	Are there separate technical reports for each plan type or are they all combined in one statewide report?	No, a separate technical report will not be required for each health plan. There will be one, annual technical report that describes the EQR-related activities for all of the health plans.
Qsource	Attachment B	II	B.12	Category K&L	Scope of Services	18-20	Are there anticipated dates for when these evaluations will need to be done?	No, there are no anticipated dates for when these evaluations will need to be done.  Categories K (Managed Medical Assistance Waiver Program) & L (Long-Term Care Waiver Program) may not be activities in the resulting Contract. Categories K & L's activities are contingent upon successful negotiation through the solicitation process.
Qsource	General Question	n/a	n/a	n/a	n/a	n/a	If the revised CMS EQRO Protocols are released prior to the required response date, should the respondent prepare its response according to the revised protocols (including sample tool templates and reports where requested) or use the current protocols as in documented in this RFP?	The Vendor should prepare its response according to the current protocols as documented in this Invitation to Negotiate.
Qsource	Attachment A	A.1	C	1.b	Hardcopy Submission	11	Should the cost proposal be included in the same binder as the other exhibits, or submitted separately?	The Cost Proposal shall be submitted in the same binder as the other Exhibits in the response.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B		7 b		1 N/A	11	Please confirm whether separate technical reports are required for each health plan.	No, a separate technical report will not be required for each health plan. There will be one, annual technical report that describes the EQR-related activities for all of the health plans.
Keystone Peer Review Organization, Inc. (KEPRO)	MCO Core Contract	C		1 b	N/A	114	For staffing and pricing purposes, please provide the estimated number of PIPs per health plan requiring validation.	The Agency anticipates that the Vendor will validate two (2) PIPs for each of the eighteen (18) managed care health plans annually ("Transportation" and "Behavioral Health" PIPs).  The Agency anticipates that the Vendor will validate one (1) PIP for each of the three (3) managed care dental plans annually ("Preventative Dental Services").  The Vendor shall also conduct two (2) pseudo validations for each of the eighteen (18) health plans ("Birth Outcomes" and "Potentially Preventable" PIPs).  The Vendor shall also conduct one pseudo validation for each of the three (3) dental plans on "Reducing Potentially Preventable Dental-Related Emergency Department Visits in Collaboration with the SMMC plans".  The Vendor should expect the volumes to remain steady over the Contract term.
Keystone Peer Review Organization, Inc. (KEPRO)	MCO Core Contract	D		2 A	N/A	117	Are both the health plan and the EQRO required to administer provider satisfaction surveys?	The health plans are currently contractually required to administer provider satisfaction surveys.  The Vendor of the resulting Contract will be required to administer provider satisfaction surveys.

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment A	A.1. Instructions	14. Term of Contract	d	N/A	6	RFP States: "it is the Agency's policy to reduce the overall payment amount by the Agency to the successful respondent by at least 5% during the period of contract renewal, unless it would affect the level and quality of services" Question: Holding the price flat for 5 years then reducing it by 5% in the renewal period is not feasible while maintaining quality levels for deliverables that are highly labor based. Due to labor costs increasing each year how would the agency recommend we handle this condition while providing the best value? We don't want to inflate the price in the initial contract term to be compliant with the 5% renewal price reduction.	Respondents shall complete Exhibit A-5 in accordance with the instructions provided within the Exhibit.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B	II. Manner of service(s) Provision	B. Services Provided by the Vendor	12. Category K. Managed Medical Assistance (MMA) Program Waiver	N/A	134	RFP States: "The current MMA waiver evaluation will not be an activity for this Contract; however, a future MMA evaluation may be included as an activity in this Contract." Question: Please confirm Category K should not have associated costs for the term of this contract and the renewal term of contract.	The current MMA waiver evaluation will be completed on December 31, 2023. There should be associated costs for a portion of the term of this Contract since the anticipated term of this Contract is September 1, 2020 through August 31, 2025. There should also be associated costs for the renewal term of the Contract.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment A	SRC# 4	N/A		1 Exhibit A-4	4	Should respondents include only Medicaid contracts?	The Respondent should provide a brief narrative describing the role of the respondent and scope of the work performed, including services provided (current or previous), location of services (i.e. Florida or another state) and whether it was for a Medicaid or commercial contract.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment A	SRC# 4	N/A		1 Exhibit A-4	4	Understanding businesses may have a significant number or commercial contracts, is it intended that respondents provide only Florida-specific current or previous contracts?	The Respondent should provide a brief narrative describing the role of the respondent and scope of the work performed, including services provided (current or previous), location of services (i.e. Florida or another state) and whether it was for a Medicaid or commercial contract.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B	II. Manner of service(s) Provision	B. Services Provided by the Vendor	2. Category A: Validation of Performance Improvement Projects	N/A	121	Can the state please estimate the volume of Performance Improvement Plans (PIPs) the vendor will be completing annually? Should the vendor expect the volumes to remain steady over the contract term and renewal years? If not, can the state please provide historical volume data?	The Agency anticipates that the Vendor will validate two (2) PIPs for each of the eighteen (18) managed care health plans annually ("Transportation" and "Behavioral Health" PIPs).  The Agency anticipates that the Vendor will validate one (1) PIP for each of the three (3) managed care dental plans annually ("Preventative Dental Services").  The Vendor shall conduct two (2) pseudo validations for each of the 18 health plans ("Birth Outcomes" and "Potentially Preventable" PIPs).  The Vendor shall also conduct one (1) pseudo validation for each of the three (3) dental plans on "Reducing Potentially Preventable Dental-Related Emergency Department Visits in Collaboration with the SMMC plans".  The Vendor should expect the volumes to remain steady over the Contract term.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B	II. Manner of service(s) Provision	B. Services Provided by the Vendor	3. Category B: Validation of Performance Measures	N/A	122-123	Can the state please estimate the volume of Health Plans the vendor will review for this category? Should the vendor expect the volumes to remain steady over the contract term and renewal years? If not, can the state please provide historical volume data?	The Agency anticipates that the Vendor will review all of the plans covered under the SMMC program eighteen (18) health plans and 3 dental plans) for the "Validation of Performance Measures" activity.  The Vendor should expect the volumes to remain steady over the Contract term.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B	II. Manner of service(s) Provision	B. Services Provided by the Vendor	5. Category D: Review of Network Adequacy	N/A	125	Can the state please estimate the volume of Health Plans the vendor will review for this category? Should the vendor expect the volumes to remain steady over the contract term and renewal years? If not, can the state please provide historical volume data?	The Agency anticipates that the Vendor will perform the "Network Adequacy" activity for all of the plans covered under the SMMC program (18 health plans and 3 dental plans).

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B	II. Manner of service(s) Provision	B. Services Provided by the Vendor	6. Category E: Encounter Data Validation	N/A	126	Can the state please estimate the volume of Health Plans the vendor will review for this category? Should the vendor expect the volumes to remain steady over the contract term and renewal years? If not, can the state please provide historical volume data?	The Agency anticipates that the Vendor will review all of the plans that have data applicable to the EDV study that is being conducted. The State's SMMC program has 18 health plans and 3 dental plans.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B	II. Manner of service(s) Provision	B. Services Provided by the Vendor	9. Category H: Administration of Provider Satisfaction Surveys	N/A	131	Can the state please elaborate on the differences between unit prices required for this category? Also, can the state please estimate the volume of Health Plans the vendor expect the volumes to remain steady over the contract term and renewal years? If not, can the state please provide historical volume data?	There is a fixed unit cost per documented completion of administering a provider survey and a fixed unit cost for one final report that includes information as described in Category H: Administration of Provider Satisfaction Surveys. (See also Attachment A, Exhibit A-5.)  The Vendor should expect that the number of health plans covered under the SMMC program (18 health plans and 3 dental plans) will remain steady over the contract term.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B	II. Manner of service(s) Provision	B. Services Provided by the Vendor	6. Category I: Quality Initiatives	N/A	131-133	Can the state please elaborate on the differences between the hourly rate and unit cost rate required? In addition, can the state please estimate the volume of Health Plans the vendor will review for this category? Should the vendor expect the volumes to remain steady over the contract term and renewal years? If not, can the state please provide historical volume data?	There is an hourly rate per documented completion of services provided for the quality initiative and a unit cost to produce a report summarizing the findings, implications, and a roadmap for improvement for the quality initiative.  The Agency expects the Vendor will review all of the plans that have members applicable to the quality initiative. The State's SMMC program has eighteen (18) health plans and three (3) dental plans.  The Vendor should expect the volumes to remain steady over the Contract term.
Keystone Peer Review Organization, Inc. (KEPRO)	Attachment B	II. Manner of service(s) Provision	B. Services Provided by the Vendor	6. Category K&L: MMA Program Waiver & LTC Program Waiver	N/A	134-137	Can the state please estimate the volume of Health Plans the vendor will review for this category? Should the vendor expect the volumes to remain steady over the contract term and renewal years? If not, can the state please provide historical volume data?	The Agency expects the Vendor to review eighteen (18) health plans and three (3) dental plans. The Vendor should expect the volumes to remain steady over the Contract term.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions	Section A.1., Instructions	Sub-Section B., Response Preparation and Content	Item 1.c, General Instructions		7 of 28	The ITN indicates "Respondents shall not retype and/or modify required forms and must submit required forms in the original format."  Please confirm if respondents can include customized headers to categorize its responses to each Submission Requirement Component (SRC) in Exhibit A-4 Submission Requirements and Evaluation Criteria Components.	Respondents shall not retype and/or modify required forms and must submit required forms in the original format
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions	Section A.1., Instructions	Sub-Section C., Response Submission Requirements	Item 1.b.3.c., Hardcopy and Electronic Submission Requirements		12 of 28	Attachment A, Instructions and Special Conditions, at A.1.C.1.b.3.b does not include Attachment B, Scope of Services as a component of the response. There are several items under Attachment B, Section II, B. Services Provided by the Vendor (e.g.: 8. Category G: Dissemination and Meetings; 10. Category I: Quality Initiatives; 11. Category J: Technical Assistance on EQR-Related Activities; 19. System Modifications; 20. Database Creation; 21. Data Exchange; 22. Quality Assurance/Internal Quality Control Program) that are not specifically referenced in the SRCs of Exhibit A-4.  Please confirm if these sections require a response, and if so, where the response should be included in the proposal.	Please complete the requested Exhibits per Attachment A, Instructions and Special Conditions, Section A. 1. Instructions, Sub-Section C. Response Submission Requirements.



**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions	Section A.1., Instructions	Sub-Section C., Response Submission Requirements	Item 1.b.3.c., Hardcopy and Electronic Submission Requirements		12 of 28	Attachment A, Instructions and Special Conditions, at A.1.C.1.b.3.b does not include Attachment B, Scope of Services as a component of the response. There are several items under Attachment B, Section II, B. Services Provided by the Vendor (e.g.: 14. Vendor Qualifications; 15. Implementation Plan; 16. Training, Education, and Outreach; 17. Vendor Staffing) that the Exhibit A-4 SRC #s refer to, but are not specified.  Please confirm if these sections require a response, and if so, where the response should be included in the proposal.	Please complete the requested Exhibits per Attachment A, Instructions and Special Conditions, Section A. 1. Instructions, Sub-Section C. Response Submission Requirements.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions	Section A.1., Instructions	Sub-Section C., Response Submission Requirements	Item 1.c.5., Electronic Copy of the Response		14 of 28	The ITN indicates an electronic redacted copy of the response "shall" be submitted.  If the respondent's proposal does not contain any confidential or proprietary information, does an electronic redacted copy need to be submitted?	If a redacted copy is not provided, the Agency will release the original response in the event of a public records request.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions	Section A.1., Instructions	Sub-Section D., Response Evaluation, Negotiations and Contract Award	Item 3., Non-Scored Requirements		16 of 28	Can the respondent include a Cover Letter on its letterhead, in addition to the Transmittal (Cover) Letter in Exhibit A-2, Transmittal Letter? If so, can it be placed in the front of the response?	Respondents shall complete Exhibit A-2 in accordance with the instructions provided within the Exhibit.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-3 Required Certifications and Statements	3 of 6	The ITN at Exhibit A-3 attests that the respondent understands "the Agency will not consider supplemental response narrative for evaluation which is not contained within the response sections contained in Exhibit A-4, Submission Requirements and Evaluation Criteria Components (Technical Response)." However, Exhibit A-4 indicates "Attachments are acceptable for any SRC but must be referenced in the form field for the respective SRC and located behind each respective SRC response."  Please confirm if attachments to the SRCs can be included if they are referenced and located behind their respective form fields.	Attachments are acceptable for any SRC but must be referenced in the form field for the respective SRC and located behind each respective SRC response.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-4 Submission Requirements and Evaluation Criteria Components (Technical Response)	2 of 22	The ITN at SRC #1 indicates "The Table of Contents shall be provided as an attachment." The ITN does not list a Table of Contents in the Packaging and Delivery section on Attachment A, page 12 of 28.  Is the Table of Contents specific to and only required for the SRCs or is a Table of Contents required for the entire proposal?	The Table of Contents is specific to the SRCs.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-4 Submission Requirements and Evaluation Criteria Components (Technical Response)	12 of 22	Has AHCA or the health plans conducted evaluations of network adequacy in the last three years? If so, will AHCA make these findings and/or reports available to the Bidders?	The Agency does not have reports that can be produced because the review of network adequacy is an activity that is conducted through an electronic process. Upon release of Federal CMS' protocol for conducting a review of network adequacy, the Agency will provide any relevant documentation to the Vendor of the resulting Contract.

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-4 Submission Requirements and Evaluation Criteria Components (Technical Response)	12 of 22	Will the health plans submit provider network data for the Network Adequacy Validation (NAV) directly to the Vendor, or will data be provided to the Bidder by AHCA or another vendor? Please describe the frequency and format/layout of provider data available for NAV.	CMS has not released the protocol for conducting network adequacy validations. Upon release of Federal CMS' protocol for conducting a review of network adequacy, the Agency will provide any relevant documentation to the Vendor of the resulting Contract.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-4 Submission Requirements and Evaluation Criteria Components (Technical Response)	12 of 22	In addition to summarizing annual NAV results in the annual EQR Technical Report, does AHCA anticipate that the Vendor will compile the annual NAV results into a stand-alone report that is separate from the annual EQR Technical Report? If AHCA anticipates receiving a stand-alone NAV report, please confirm whether separate reports are needed for each health plan, versus an aggregate report that contains health plan-specific results.	The Agency anticipates that the Vendor will compile the annual NAV results in a stand-alone report that is separate from the annual EQR Technical Report. The stand-alone NAV report will be an aggregate report that contains plan-specific results.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-4 Submission Requirements and Evaluation Criteria Components (Technical Response)	12 of 22	How frequently do the health plans submit network adequacy reports to AHCA (e.g., monthly, annually)?	The Agency requires that the health plans submit network adequacy reports to the Agency on a weekly basis in order to comply with State contract requirements.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-4 Submission Requirements and Evaluation Criteria Components (Technical Response)	12 of 22	Does AHCA anticipate that previously published access standards will be used for the proposed network analyses or would the Vendor be responsible for working with AHCA to create new network adequacy standards? If previously published access standards are applicable, will AHCA make this information available to the Bidders.	The Agency is awaiting the release of Federal CMS' protocol for conducting a review of network adequacy in order to determine whether the Vendor will be responsible for working with the Agency to create new network adequacy standards. Upon release of Federal CMS' protocol, the Agency will provide any relevant documentation to the Vendor of the resulting Contract.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-4 Submission Requirements and Evaluation Criteria Components (Technical Response)	18 of 22	Exhibit A-4, SRC #13, System Functionality Requirements refers to the requirements in Attachment B, Scope of Services, Section X., System Functionality on page 37 of 45. There is an additional section regarding System Functionality in Attachment B, Section II.B.18 on page 25 of 45.  Please confirm if the System Functionality requirements in Attachment B, Section II.B.18, also require a response as part of SRC #13.	No, the "System Functionality" requirements in Attachment B, Section II.B.18, do not require a response as a part of SRC #13.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-4 Submission Requirements and Evaluation Criteria Components (Technical Response)	20 of 22	The ITN references "Attachment B, Scope of Services, Section XI., Information Technology, Sub-Section U". Att. B, Section XI only goes through Sub-Section T on page 41 of 45.  Please advise if the reference should be to another Sub-Section.	This has been revised as part of the addendum. Please refer to Attachment A, Instructions and Special Conditions, Exhibit A-4, Submission Requirements and Evaluation Criteria Components (Technical Response) (February 17, 2020).
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-5 Cost Proposal	2 and 3	For Category H: Administration of Provider Satisfaction Surveys, can you please define the unit for the survey administration?	There is a fixed unit cost per documented completion of administering a provider survey and a fixed unit cost for one final report that includes information as described in Category H: Administration of Provider Satisfaction Surveys. (See also Attachment A, Exhibit A-5.)

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-5 Cost Proposal	2 and 3	For Category E – Encounter Data Validation: The proposed fixed Unit cost indicated per Comparative Analysis Per Health Plan. Please clarify if the Comparative Analysis should be per encounter type per Health Plan e.g., Comparative Analysis for professional encounters per Health Plan.	The proposed fixed unit cost will be per "Comparative Analysis Per Health Plan". The comparative analysis will not be "Per Encounter Type Per Health Plan".
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-5 Cost Proposal	2 and 3	For Category E – Encounter Data Validation: Should the cost for the medical record review component be bundled into the proposed fixed Unit cost per Comparative Analysis Per Health Plan?	The cost for the medical record review will not be bundled into the proposed fixed unit cost per comparative analysis per health plan.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-5-a Detailed Budget	1 of 3	Please validate AHCA currently has a contract for Long Term Care Evaluation with Florida State University through 4/30/2021, therefore bidders shouldn't include the cost for the program for the period 9/1/2020-4/30/2021.	Yes, the Agency has a contract with Florida State University through April 30, 2021.  Bidders should include the cost for the program beginning in September 2021.
Health Services Advisory Group, Inc.	Attachment A, Instructions and Special Conditions				Exhibit A-6 – Summary of Respondent Commitments	1 of 2	Exhibit A-6 is titled "Summary of Respondent Commitments" but the content is regarding added value services.  Please confirm if respondents should list a summary of commitments, and if so, in which section of its proposal.	Respondents shall complete Exhibit A-6 in accordance with the instructions provided within the Exhibit.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 2., Category A: Validation of Performance Improvement Projects		5 of 45	Under header b, second paragraph, please confirm the health plans will be required to select interventions to test using a series of PDSA cycles and the vendor will review and validate the health plan processes for the interventions selected.	The health plans will be required to select interventions to test using a series of PDSA cycles and the Vendor will review and validate the health plan processes for the interventions selected.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 2., Category A: Validation of Performance Improvement Projects		5 of 45	Please confirm the number of PIPs per plan to be validated annually.	The Agency anticipates that the Vendor will validate two (2) PIPs for each of the eighteen (18) managed care health plans annually ("Transportation" and "Behavioral Health" PIPs).  The Agency anticipates that the Vendor will validate one (1) PIP for each of the three (3) managed care dental plans annually ("Preventative Dental Services").  The Vendor shall also conduct two (2) pseudo validations for each of the eighteen (18) health plans ("Birth Outcomes" and "Potentially Preventable" PIPs).  The Vendor shall also conduct one pseudo validation for each of the three (3) dental plans "Reducing Potentially Preventable Dental-Related Emergency Department Visits in Collaboration with the SMMC plans".  The Vendor should expect the volumes to remain steady over the Contract term.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 2., Category A: Validation of Performance Improvement Projects		6 of 45	Please confirm the number of pseudo validations per plan to be conducted annually.	The Vendor shall conduct two (2) pseudo validations for each of the eighteen (18) health plans ("Birth Outcomes" and "Potentially Preventable" PIPs).  The Vendor shall also conduct one pseudo validation for each of the three (3) dental plans "Reducing Potentially Preventable Dental-Related Emergency Department Visits in Collaboration with the SMMC plans".

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 2., Category A: Validation of Performance Improvement Projects		6 of 45	Is it the Agency's expectation that the vendor produce an annual PIP summary report for the review of PIP plans, results, summary of best practices, and potential statewide collaborative projects that could be conducted during each contract year?	Yes, it is the Agency's expectation that the Vendor produce an annual PIP summary report for the review of PIP plans, results, summary of best practices, and potential statewide collaborative projects that could be conducted during each contract year.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 4., Category C: Review of Compliance with Federal Standards		8 of 45	When was the last comprehensive review of compliance completed by AHCA?	The Agency has not completed a comprehensive review of compliance that meets federal standards.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	For budgetary purposes, what is the maximum number of Medicaid managed care providers that should be used for sampling each year?	The Vendor shall work collaboratively with the Agency to determine the maximum number of Medicaid managed care providers.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	Please confirm the survey administration methodology that should be used (e.g., mail and online protocol).	The Vendor should provide a detailed description of the proposed survey administration process, including the methodology.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	Please confirm that one (1) survey instrument will be used each year (i.e., one survey instrument will be administered to capture data on all plans).	The following three (3) survey instruments will be administered each year: - Dental Provider Survey -LTC Provider Survey -MMA Provider Survey
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	What is the maximum length of the provider survey instrument that would be administered?	The current provider survey instruments include up to twenty-one (21) questions.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	What is the anticipated number of plans that will require a report each year?	The Agency anticipates that there will be one report that summarizes the provider satisfaction survey findings for all of the plans covered under the SMMC program (18 health plans and 3 dental plans).
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	Please confirm that plan-specific reports are the only deliverable required for the Provider Satisfaction Surveys.	The Vendor shall be responsible for producing a final report that assesses providers' overall satisfaction with the health plans. The Vendor will not be responsible for developing plan-specific reports for the Provider Satisfaction Survey deliverable.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	Will the Agency provide the Vendor with the provider survey instrument that should be utilized?	Initially, the Agency will provide the Vendor with the provider survey instruments that should be utilized; however, the Agency may require the Vendor to assist in updating existing tools or to create new survey instruments.

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	Will the Agency provide the Vendor with a list of eligible providers?	Yes, the Agency will provide the Vendor with a list of eligible providers.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 9., Category H: Administration of Provider Satisfaction Surveys		15 of 45	Is the Agency able to provide valid email addresses for its providers in order to send providers targeted survey and reminder emails?	The Agency will be able to provide the email addresses that are on file for its providers.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 12., Category K: Managed Medical Assistance (MMA) Program Waiver		17 of 45	For purposes of budgeting and the cost proposal, when should the Vendor assume starting work on the MMA waiver evaluations if no work will be performed by the vendor on the current MMA waiver evaluation?	The current MMA waiver evaluation will be completed on December 31, 2023. The Vendor should assume that work on the MMA waiver will begin in January 2024.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 12., Category K: Managed Medical Assistance (MMA) Program Waiver		18 of 45	In Attachment B - Scope of Services under Category K (MMA Waiver Evaluation), the ITN notes "Federal CMS approved a second extension of the MMA 1115 waiver demonstration for a period of five (5) years beginning August 3, 2017 through June 30, 2022. The current MMA waiver evaluation will not be an activity for this Contract; however, a future MMA evaluation may be included as an activity in this Contract." Given that the current MMA waiver evaluation will not be conducted under this contract, should the response to the scope of services address the vendor's experience/approach in conducting 1115 waiver evaluations for possible future evaluations, or should the response address the 9 evaluation components approved by CMS?	The response to the scope of services should address the Vendor's experience in conducting 1115 waiver evaluations. The Vendor should also include experience with the ten components approved by Federal CMS.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 12., Category K: Managed Medical Assistance (MMA) Program Waiver		18 of 45	In Attachment B - Scope of Services under Category K (MMA Waiver Evaluation), the ITN notes "Federal CMS approved a second extension of the MMA 1115 waiver demonstration for a period of five (5) years beginning August 3, 2017 through June 30, 2022. The current MMA waiver evaluation will not be an activity for this Contract; however, a future MMA evaluation may be included as an activity in this Contract." If the vendor is directed to engage in the MMA waiver evaluations in the future, will the vendor be required to design the evaluation plan and/or implement (conduct) the approved evaluation plan?	Yes, the Vendor will be required to design the evaluation plan and/or implement (conduct) the approved evaluation plan if a future MMA evaluation is included as an activity in this Contract.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 12., Category K: Managed Medical Assistance (MMA) Program Waiver		19 of 45	In 12. Category K: Managed Medical Assistance (MMA) Program Waiver, under b.1) there is text "The most recently approved STCs are located at the below link:" but there is no corresponding link. Is the following the appropriate link, if not please provide: <a href="https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_MMA_Technical_Edit_STCs_07201902.pdf">https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_MMA_Technical_Edit_STCs_07201902.pdf</a>	Yes, that is the correct link.

**EXHIBIT A-1  
QUESTIONS AND  
ANSWERS**

VENDOR NAME	ATTACHMENT IDENTIFIER	SECTION IDENTIFIER	SUB-SECTION REFERENCE	ITEM REFERENCE	ATTACHMENT EXHIBIT	PAGE NUMBER	QUESTION	ANSWERS
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 13., Category L: Long-Term Care (LTC) Program Waiver		20 of 45	The RFP states "The LTC program evaluation may be included as an activity in this Contract." For purposes of budgeting and the cost proposal, when should the Vendor assume starting work on the LTC waiver evaluation if the option is exercised?	The Vendor should assume that work on the LTC waiver evaluation will begin in September 2021.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 13., Category L: Long-Term Care (LTC) Program Waiver		20 of 45	Additionally, for any future LTC waiver evaluation the vendor may conduct, will the Agency provide or procure the cost-effectiveness component of the evaluation as is often done in 1915(b) waiver evaluations or is the vendor responsible for also conducting that component?	The Vendor will be responsible for conducting the cost-effectiveness component of the LTC waiver evaluation.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services	Section B.II., Manner of Service(s) Provision	Sub-Section B., Services Provided by the Vendor	Item 15., Implementation Plan		22 of 45	Does the Agency require the "project office" to manage implementation activities be located in Florida?	The Agency does not require the "project office" be located in Florida to manage implementation activities; however, the Agency will require that staff be available 8:00 am - 5:00 pm ET.
Health Services Advisory Group, Inc.	Attachment B, Scope of Services				Exhibit B-1 Deliverables and Performance Standards	2 of 6	The footer of Attachment B, Exhibit B-1 indicates there are 6 pages, but the ITN only contacts pages 1 and 2 of 6. Please confirm if there should be additional pages 3-6.	Attachment B, Exhibit B-1 has been revised as part of this addendum.

# EXHIBIT A-4 SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)

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

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

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

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

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

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

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

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

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

Failure to submit, **Exhibit A-4**, may result in the rejection of response.

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

<http://ahca.myflorida.com/procurements/index.shtml>.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**Respondent Name:**

**SRC# 1: TABLE OF CONTENTS**

The respondent shall include a Table of Contents in its response. The Table of Contents shall contain Section headings and subheadings along with corresponding page numbers. The Table of Contents shall be provided as an attachment.

**Score: No points will be awarded for the Table of Contents.**

**SRC# 2: EXECUTIVE SUMMARY**

The respondent shall include an Executive Summary that demonstrates the respondent's overall understanding of the Scope of Services and describes the salient features of the respondent's Technical Proposal.

**Score: No points will be awarded for the Executive Summary.**

**Response:**



**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 3: ORGANIZATIONAL STRUCTURE AND HISTORY**

The respondent shall demonstrate its capability to provide the services described in this solicitation by describing its organizational structure and history. At a minimum, the description shall include:

1. A detailed description of the respondent's organizational structure, history, legal structure, ownership and affiliations;
2. An organizational chart, including the total number of employees and the respondent's corporate qualifications; and
3. A detailed description of the respondent's proposed physical business locations, in or outside of the State of Florida and how those locations will be utilized to effectively provide the services required by this solicitation.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's detailed description of its organizational structure, history, legal structure, ownership and affiliations;
2. The adequacy of the respondent's staffing levels for this project based on the organizational chart and the respondent's corporate qualifications; and
3. The adequacy of the respondent's capability to effectively provide services based on its physical business in or outside of the State of Florida.

**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.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 4: EXPERIENCE AND QUALIFICATIONS**

The respondent shall demonstrate its capability to provide the services described in this solicitation by describing its qualifications and experience in providing services similar in nature to those described in this solicitation as well as its proposed subcontractor's experience and qualifications, if applicable. At a minimum, the description shall include:

1. Respondents shall submit a list of current or previous contracts for which it provided services within the last five (5) years from the date of solicitation issuance, as specified in **Attachment A**, Instructions and Special Conditions, **Section A.1.**, Instructions, **Sub-Section A.**, Overview, **Item 4.**, Date of Issuance, that are similar in nature to those described in this solicitation..
2. For each identified Contract, the following information shall be provided:
  - a. The name and address of the client;
  - b. The name of the Project;
  - c. The time period of the Project;
  - d. A brief narrative describing the role of the respondent and scope of the work performed, including services provided (current or previous), location of services (i.e. Florida or another state) and whether it was for a Medicaid or commercial contract;
  - e. The scheduled and actual completion dates for development and implementation. The description shall include any barriers encountered that hindered implementation, as applicable, and the respondent's resolution for overcoming them;
  - f. Significant accomplishments and achievements; and
  - g. The use of any subcontractor(s) on each Project, their scope of work, and the percentage of the work on the Project completed by subcontractors.
3. List any monetary penalty or liquidated damages for insufficient performance by a State or Federal government within the last two (2) years from the date of solicitation issuance, as specified in **Attachment A**, Instructions and Special Conditions, **Section A.1.**, Instructions, **Sub-Section A.**, Overview, **Item 4.**, Date of Issuance.
4. A detailed description of the respondent's experience with providing federally mandated and optional external quality review (EQR)-related activities, as defined in 42 Code of Federal Regulations (CFR) 438.358.
5. A description of any relevant accreditations or certifications that the respondent has received.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

6. A detailed description of previous innovative approaches implemented to reduce costs or improve the quality of care to Medicaid enrollees.
7. A draft sixty (60) calendar day EQR Implementation Plan, no more than five (5) pages in length, describing the activities that the respondent shall undertake during the implementation phase (to begin upon resulting contract execution) and must include, at a minimum, the following:
  - a. Deadlines and timeframes;
  - b. Staff responsible for each activity/step;
  - c. Types of policies, procedures, and templates to be developed for the Florida EQR program;
  - d. Identification of any respondent expectations regarding participation by the Agency in the activities stated in the implementation plan and dependencies between these implementation activities; and
  - e. Identification of risks and barriers that may be encountered during the implementation phase and the respondent's approach to overcoming them.
8. A detailed description of staff to be assigned to the resulting Contract, including resumes, relevant experience, and certifications.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's capability to provide services required for the Program based on the description of its cumulative experience in the performance of current or previous contracts for which it is/was the lead Vendor on any Projects that are similar in size, scope, and complexity as the services outlined in this solicitation.
2. The adequacy of the respondent's experience with providing federally mandated and optional EQR-related activities, as defined in 42 CFR 438.358.
3. The adequacy of the respondent's relevant accreditations or certifications that the respondent has received.
4. The adequacy of the respondent's previous innovative approaches implemented to reduce costs or improve the quality of care to Medicaid enrollees.
5. The adequacy of the respondent's draft EQR Implementation Plan including:
  - a. Deadlines and timeframes;

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

- b.** Staff responsible for each activity/step;
  - c.** Types of policies, procedures, and templates to be developed for the Florida EQR program;
  - d.** Identification of any respondent expectations regarding participation by the Agency in the activities stated in the implementation plan and dependencies between these implementation activities; and
  - e.** Identification of risks and barriers that may be encountered during the implementation phase and the respondent's approach to overcoming them.
- 6.** The adequacy of the respondent's proposed staff to be assigned to the resulting Contract, including resumes, relevant experience, and certifications.

**Score:** This Section is worth a maximum of 50 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 5: TECHNICAL APPROACH TO VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS UNDER PROTOCOL 3.**

The respondent shall describe its capability to meet the requirements of the validation of performance improvement projects (PIPs) under EQR Protocol 3 and the services described within **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item 2.**, Category A: Validation of Performance Improvement Projects. At a minimum, the description shall include:

1. A description of the respondent's experience with both a traditional PIP cycle and a rapid PIP cycle (or similarly expedited PIP cycle), including lessons learned and best practices. The Agency's current approach is the traditional PIP process, which involves an average 3-year improvement cycle. A rapid cycle (or similarly expedited PIP cycle) approach would involve a shorter improvement cycle (approximately 18 months), and will validate whether or not an intervention works more quickly.
2. A description of the respondent's approach for developing, implementing, and managing an expedited PIP cycle, including a reporting schedule.
3. A draft transition plan to move the Agency staff and its health plans from a traditional PIP process to a more streamlined PIP process to include, at a minimum, the following:
  - a. timeline;
  - b. communication and training needs;
  - c. technical assistance;
  - d. types and frequency of data reported;
  - e. potential issues and solutions; and, at a minimum, the below templates:
    - 1) sample PIP Submission Template; and
    - 2) sample PIP Evaluation Template.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's experience with rapid cycle PIPs (or similarly expedited PIP cycles), traditional PIP cycles and/or developing a streamlined traditional PIP cycle, including lessons learned and best practices.
2. The adequacy of the respondent's plan for developing, implementing, and managing a rapid cycle PIP methodology, including a reporting schedule.
3. The adequacy of the respondent's draft transition plan.
4. The adequacy of the respondent's proposed PIP Submission Template.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

5. The adequacy of the respondent's proposed PIP Evaluation Template.

**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.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 6: TECHNICAL APPROACH TO VALIDATION OF PERFORMANCE MEASURES UNDER PROTOCOL 2.**

The respondent shall demonstrate its capability to provide the requirements described in **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item 3.**, Category B: Validation of Performance Improvement Projects. At a minimum, the respondent shall provide the following:

1. The respondent's methodology for reviewing the independently audited Medicaid Healthcare Effectiveness Data and Information Set or HEDIS® access and quality of care indicators, the Medicaid HEDIS® Data Submission Tools, and Final Audit reports for each Agency contracted health plan to determine the extent to which Medicaid specific performance measures reported to the Agency are calculated according to Agency specifications.
2. The respondent's methodology for reviewing other quality indicator measurements for the same purpose of validation when HEDIS® measurements are not required by the individual managed care type. The description should include proposed quality indicator measurements.
3. The respondent's methodology to evaluate current Agency practices including specifying the level(s) of material bias and data completeness necessary for performance measures to be considered valid.
4. The respondent's sample template and draft outline for the preliminary and final report of performance measure validation findings.
5. A sample outline for a Plan-Specific Performance Measure Validation Report.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's methodology for reviewing the independently audited Medicaid HEDIS® access and quality of care indicators, the Medicaid HEDIS® Data Submission Tools, and Final Audit reports for each Agency contracted health plan to determine the extent to which Medicaid specific performance measures reported to the Agency are calculated according to Agency specifications.
2. The adequacy of the respondent's methodology for reviewing other quality indicator measurements for the same purpose of validation when HEDIS® measurements are not required by the individual health plan type, including other proposed quality indicator measurements.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

3. The adequacy of the respondent's methodology to evaluate current Agency practices specifying the level(s) of material bias and data completeness necessary for performance measures to be considered valid.
4. The adequacy of the respondent's sample template and draft outline for the preliminary and final report of performance measure validation findings.
5. The adequacy of the respondent's outline for a Plan-Specific Performance Measure Validation Report.

**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.



**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 7: TECHNICAL APPROACH TO ASSESSING AGENCY COMPLIANCE REVIEW ACTIVITIES AND RESULTS**

The respondent shall demonstrate its capability to provide the requirements described in **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item 4.**, Category C: Review of Compliance with Federal Standards. At a minimum, the respondent shall provide the following:

1. A sample outline for a Final Report of Agency Compliance Review Activities and Results.
2. A description of the respondent's approach and experience for conducting compliance reviews and reporting on state compliance review activities as required by the Centers for Medicare and Medicaid Services (CMS) EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations.
3. A description of the respondent's approach and experience with reviewing a state's established compliance monitoring structure and working with the state to implement and integrate innovative approaches to meet the CMS requirements for compliance with Federal standards.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's sample outline for a Final Report of Agency Compliance Review Activities and Results.
2. The adequacy of the respondent's approach and experience conducting compliance reviews and reporting on activities as required by the CMS EQR Protocol 1.
3. The adequacy of the respondent's approach and experience with reviewing a state's established compliance monitoring structure and working with the state to implement and integrate innovative approaches to meet the CMS requirements for compliance with Federal standards.

**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.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 8: TECHNICAL APPROACH TO VALIDATION OF NETWORK ADEQUACY**

The respondent shall demonstrate its capability to provide the requirements described in **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item 5.**, Category D: Review of Network Adequacy. At a minimum, the respondent shall provide the following:

1. A detailed description of the respondent's experience with conducting Network Adequacy studies for Medicaid Managed Care programs.
2. A detailed description of the respondent's process for conducting a Network Adequacy study.
3. A proposed sample outline of a Network Adequacy Study report.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's experience conducting Network Adequacy studies for Medicaid Managed Care programs.
2. The adequacy of the respondent's process for conducting a Network Adequacy study.
3. The adequacy of the respondent's outline for a proposed Network Adequacy Study Report.

**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.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 9: TECHNICAL APPROACH TO VALIDATION OF ENCOUNTER DATA**

The respondent shall demonstrate its capability to provide the requirements described in **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item 6.**, Category E: Encounter Data Validation. At a minimum, the respondent shall include the following:

1. A description of the respondent's proposed encounter data validation processes that ensure the accuracy, completeness, and integrity of encounter data by comparing encounter data with the health plan's administrative data in accordance with CMS EQR Protocol 4: Validation of Encounter Data;
2. A description of the respondent's proposed encounter data validation processes to validate provider-reported encounter data against medical and clinical records; and
3. A detailed description of the respondent's proposed method to provide technical assistance and training to Managed Care staff in data submission, analysis, and a road-map for quality improvement.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's proposed encounter data validation processes that ensure the accuracy, completeness, and integrity of encounter data by comparing encounter data with the health plan's administrative data in accordance with the applicable EQR Protocol.
2. The adequacy of the respondent's proposed encounter data validation processes to validate provider-reported encounter data against medical and clinical records.
3. The adequacy of the respondent's proposed method to provide technical assistance and training to Managed Care staff in data submission, analysis, and quality improvement.

**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.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 10: TECHNICAL APPROACH TO ANNUAL TECHNICAL REPORT**

The respondent shall demonstrate its capability to provide the requirements described in **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item 7.**, Category F: Annual Technical Report. At a minimum, the respondent shall provide the following:

1. A detailed project work plan, timeline for completion and dissemination of the technical report to the Agency and, upon request, to interested parties.
2. A template and draft outline for the Annual Technical Report and Strategic Executive Summary.
3. A description of the respondent's proposed approach to data collection and analysis used to aggregate data on plan-specific quality outcomes, including timeliness of and access to services.
4. A description of recommendations for comparative analyses, including sources of benchmark data and industry standards.
5. A description of methods for identifying best practices and quality improvement strategies that have demonstrated success;

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's proposed project work plan and timeline for completion and dissemination of the technical report to the Agency and, upon request, to interested parties.
2. The adequacy of the respondent's proposed template and draft outline for the Annual Technical Report and Strategic Executive Summary.
3. The adequacy of the respondent's proposed approach to data collection and analysis used to aggregate data on plan-specific quality outcomes, including timeliness of and access to services.
4. The adequacy of the respondent's proposed recommendations for comparative analyses, including sources of benchmark data and industry standards.
5. The adequacy of the respondent's proposed methods for identifying best practices and quality improvement strategies that have demonstrated success.

**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.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 11: TECHNICAL APPROACH TO ADMINISTRATION OF PROVIDER SATISFACTION SURVEYS**

The respondent shall demonstrate its capability to provide the requirements described in **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item 9.**, Category H: Administration of Provider Satisfaction Surveys.

At a minimum, the respondent shall provide the following:

1. A detailed description of the respondent's experience with administering provider satisfaction surveys.
2. A detailed description of the respondent's process for administering provider satisfaction surveys.
3. A proposed sample outline of a plan-specific report analyzing provider satisfaction survey results, including recommendations for the health plan.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's experience with administering provider satisfaction surveys.
2. The adequacy of the respondent's process for administering provider satisfaction surveys.
3. The adequacy of the respondent's sample outline for a plan-specific report analyzing provider satisfaction survey results, including recommendations for the health plan.

**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.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 12: TECHNICAL APPROACH TO THE MANAGED MEDICAL ASSISTANCE (MMA) PROGRAM AND THE LONG-TERM CARE (LTC) PROGRAM WAIVERS**

The respondent shall demonstrate its capability to provide the requirements described in **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item 12.**, Category K: Managed Medical Assistance (MMA) Program Waiver and **Item 13.**, Category L: Long-Term Care (LTC) Program Waiver.

At a minimum, the respondent shall provide the following:

1. A description of the respondent's experience with evaluating Medicaid medical assistance programs.
2. A description of the respondent's experience with evaluating Medicaid LTC programs.
3. A description of the respondent's approach for conducting a comprehensive evaluation of Medicaid medical assistance and LTC programs. The description must include the respondent's strategy for incorporating knowledge of how Florida Medicaid programs operate in their approach to develop a comprehensive evaluation that is specific to how Florida Medicaid programs operate.
4. A description of the respondent's strategy for avoiding the overuse of caveats that potentially diminish evaluation findings and ensuring that the Agency is provided with actionable recommendations from evaluation findings.
5. A sample outline of the proposed deliverables essential to conducting a comprehensive evaluation of the MMA and LTC waiver programs.
6. A proposed sample outline of a report evaluating Medicaid medical assistance care and LTC programs comprehensively.
7. A description of the respondent's experience with analyzing data in the evaluation of Medicaid programs.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's experience with evaluating Medicaid medical assistance programs.
2. The adequacy of the respondent's experience with evaluating LTC programs.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

3. The adequacy of the respondent's approach for conducting a comprehensive evaluation of the Medicaid medical assistance and LTC waiver programs including the respondent's strategy for incorporating knowledge of how Florida Medicaid programs operate in their approach to develop a comprehensive evaluation that is specific to how Florida Medicaid programs operate.
4. The adequacy of respondent's strategy for avoiding the overuse of caveats that potentially diminish evaluation findings and ensuring that the Agency is provided with actionable recommendations from evaluation findings.
5. The adequacy of the sample outline of the proposed deliverables essential to conducting a comprehensive evaluation of the Medicaid medical assistance and LTC waiver programs.
6. The adequacy of the sample outline for a report evaluating the Medicaid medical assistance and LTC programs comprehensively.
7. The adequacy of the respondent's experience with analyzing data in the evaluation of Medicaid programs.

**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.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 13: SYSTEM FUNCTIONALITY REQUIREMENTS**

The respondent shall demonstrate its capability and approach to provide the System Functionality Requirements described in **Attachment B**, Scope of Services, **Section X.**, System Functionality.

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's capability and approach to have the capacity (hardware, software, and personnel) sufficient to access and generate all data and reports needed for the Contract resulting from this solicitation.
2. The adequacy of the respondent's capability and approach to comply with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Act.
3. The adequacy of the respondent's capability and approach to have protocols and internal procedures for ensuring system security and the confidentiality of recipient identifiable data.

**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.



**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 14: INFORMATION TECHNOLOGY REQUIREMENTS**

The respondent shall demonstrate its capability and approach to provide the Information Technology Requirements described in **Attachment B**, Scope of Services, **Section XI**, Information Technology.

**Response:**

**Evaluation Criteria:**

The adequacy of the respondent's capability and approach to meet the Information Technology Requirements described in **Attachment B**, Scope of Services, **Section XI**, Information Technology. .

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

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**SRC# 15: SECURITY RATING SCORE REQUIREMENTS**

The respondent shall demonstrate its capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section XI.**, Information Technology, **Sub-Section T.**

**Response:**

**Evaluation Criteria:**

1. The adequacy of the respondent's capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section XI.**, Information Technology, **Sub-Section T.**

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

**Category 16: DISASTER RECOVERY REQUIREMENTS**

**SRC# 16:**

The respondent shall demonstrate its capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section XII.**, Disaster Recovery.

**Response:**

**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 twenty-four (24) clock hours and ensures compliance with all requirements under the resulting Contract.
3. The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan shall be developed and maintained by the Vendor for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting 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 Vendor to conduct the requirements of the resulting Contract.
5. The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that shall eliminate 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 thirty (30) calendar days prior to the resulting 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 Agency and at no additional cost to the Agency.
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 Agency at all times.

**EXHIBIT A-4**  
**SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**  
**COMPONENTS (TECHNICAL RESPONSE) (February 17, 2020)**

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 Agency.

**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.

## EXHIBIT A-5 COST PROPOSAL (February 17, 2020)

**Instructions:**

- A.** Where indicated in **Table A**, Initial Contract below, the respondent shall propose a one-time fixed cost to complete all implementation tasks and activities as specified in the Agency-approved final implementation plan for the initial five (5) year Contract term.
- B.** Where indicated in **Table A**, Initial Contract below, in Categories A through L, the respondent shall propose a fixed unit cost for SFY 2020-2021, SFY 2021-2022, SFY 2022-2023, SFY 2023-2024 and SFY 2024-2025 Operations.
- C.** The respondent must include the required **Exhibit A-5-a**, Detailed Budget with this cost proposal, to support and justify its proposed one-time fixed implementation cost, and each of its proposed Category fixed unit operation year costs for the initial five (5) year Contract term.
- D.** Where indicated in **Table B** below, in Categories A through L, the respondent shall propose a fixed unit cost for SFY 2025-2026, SFY 2026-2027, SFY 2027-2028, SFY 2028-2029 and SFY 2029-2030 Renewal Period Operations.
- E.** The respondent must include the required **Exhibit A-5-b**, Renewal Period Detailed Budget with this cost proposal, to justify and explain each of its proposed Category fixed unit operation year costs for Renewal Period Operations.

<b>TABLE A – INITIAL CONTRACT</b>	
<b>Implementation Cost</b>	
<b>Proposed Fixed <u>One-Time</u> Implementation Cost</b>	<b>\$</b>
<b>CATEGORY A – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Validation of Performance Improvement Projects</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Performance Improvement Plan</b>	<b>\$</b>
<b>CATEGORY B – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Validation of Performance Measures</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Health Plan</b>	<b>\$</b>
<b>CATEGORY C – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Review of Compliance with Federal Standards</b>	
<b>Proposed <u>Hourly Rate</u> per Completed Required Services</b>	<b>\$</b>
<b>CATEGORY D – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Review of Network Adequacy</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Health Plan</b>	<b>\$</b>

<b>CATEGORY E – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Encounter Data Validation</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Comparative Analysis Per Health Plan</b>	<b>\$</b>
<b>Proposed Fixed <u>Unit Cost</u> per Medical Record Review Per Health Plan</b>	<b>\$</b>
<b>CATEGORY F – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Annual Technical Report</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Report</b>	<b>\$</b>
<b>CATEGORY G – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Dissemination and Meetings</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Medicaid Quality Meeting</b>	<b>\$</b>
<b>Proposed Fixed <u>Unit Cost</u> per Quarter for Maintenance of Secure Web Portal</b>	<b>\$</b>
<b>CATEGORY H – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Administration of Provider Satisfaction Surveys</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Documented Completion of Administering a Survey</b>	<b>\$</b>
<b>Proposed Fixed <u>Unit Cost</u> per Report</b>	<b>\$</b>
<b>CATEGORY I – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Quality Initiatives</b>	
<b>Proposed <u>Hourly Rate</u> per Documented Completion of Services</b>	<b>\$</b>
<b>Proposed Fixed <u>Unit Cost</u> per Report</b>	<b>\$</b>
<b>CATEGORY J – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Technical Assistance on External Quality Review Related Projects</b>	
<b>Proposed <u>Hourly Rate</u> per Completed Technical Assistance</b>	<b>\$</b>
<b>CATEGORY K &amp; L – Year One (1) through Year Five (5) Operations (July 1, 2020 through June 30, 2025) Managed Medical Assistance Program Waiver Program and the Long-Term Care Waiver Program Comprehensively</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Report</b>	<b>\$</b>

<b>TABLE B – RENEWAL PRICING</b>	
<b>CATEGORY A – Year Six (6) through Year Ten (10) Operations (July 1, 2025 through June 30, 2030) Validation of Performance Improvement Projects</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Performance Improvement Plan</b>	<b>\$</b>
<b>CATEGORY B – Year Six (6) through Year Ten (10) Operations (July 1, 2025 through June 30, 2030) Validation of Performance Measures</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Health Plan</b>	<b>\$</b>
<b>CATEGORY C – Year Six (6) through Year Ten (10) Operations (July 1, 2025 through June 30, 2030) Review of Compliance with Federal Standards</b>	
<b>Proposed <u>Hourly Rate</u> per Completed Required Services</b>	<b>\$</b>
<b>CATEGORY D – Year Six (6) through Year Ten (10) Operations (July 1, 2025 through June 30, 2030) Review of Network Adequacy</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Health Plan</b>	<b>\$</b>
<b>CATEGORY E – Year Six (6) through Year Ten (10) Operations (July 1, 2025 through June 30, 2030) Encounter Data Validation</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Comparative Analysis Per Health Plan</b>	<b>\$</b>
<b>Proposed Fixed <u>Unit Cost</u> per Medical Record Review Per Health Plan</b>	<b>\$</b>
<b>CATEGORY F – Year Six (6) through Year Ten (10) Operations (July 1, 2025 through June 30, 2030) Annual Technical Report</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Report</b>	<b>\$</b>
<b>CATEGORY G – Year Six (6) through Year Ten (10) Operations (July 1, 2025 through June 30, 2030) Dissemination and Meetings</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Medicaid Quality Meeting</b>	<b>\$</b>
<b>Proposed Fixed <u>Unit Cost</u> per Quarter for Maintenance of Secure Web Portal</b>	<b>\$</b>
<b>CATEGORY H – Year Six (6) through Year Ten (10) Operations (July 1, 2025 through June 30, 2030) Administration of Provider Satisfaction Surveys</b>	
<b>Proposed Fixed <u>Unit Cost</u> per Documented Completion of Administering a Survey</b>	<b>\$</b>

Proposed Fixed <u>Unit Cost</u> per Report	\$
<b>CATEGORY I – Year Six (6) through Year Ten (10) Operations          (July 1, 2025 through June 30, 2030)          Quality Initiatives</b>	
Proposed <u>Hourly Rate</u> per Documented Completion of Services	\$
Proposed Fixed <u>Unit Cost</u> per Report	\$
<b>CATEGORY J – Year Six (6) through Year Ten (10) Operations          (July 1, 2025 through June 30, 2030)          Technical Assistance on External Quality Review          Related Projects</b>	
Proposed <u>Hourly Rate</u> per Completed Technical Assistance	\$
<b>CATEGORY K &amp; L – Year Six (6) through Year Ten (10) Operations          (July 1, 2025 through June 30, 2030)          Managed Medical Assistance Program Waiver Program and the          Long-Term Care Waiver Program Comprehensively</b>	
Proposed Fixed <u>Unit Cost</u> per Report	\$

\_\_\_\_\_  
 Respondent Name

\_\_\_\_\_  
 Authorized Official Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Authorized Official Printed Name

\_\_\_\_\_  
 Authorized Official Title

1. The intent of this solicitation is to solicit a firm fixed price implementation fee; a fixed unit cost operations fee for the remainder of the original term of the resulting Contract; a fixed monthly operations fee for any renewal period; and a fixed unit cost operations fee for the optional expansion of existing services.
2. Exhibit A-5, Cost Proposal, shall not include a cost that exceeds the maximum contract amount listed in Attachment A, Instructions and Special Conditions, Section A.1., Instructions, Sub-Section A., Overview, Item 13., Type and Amount of Contract Contemplated. A response which contains a cost proposal that exceeds the Agency's maximum contract amount will be rejected.
3. The Agency will not agree to caveat language for pricing within this Exhibit A-5, Cost Proposal, including Exhibits A-5-a, Detailed Budget and A-5-b, Renewal Period Detailed



**Budget. Responses which include caveat language for pricing will be viewed as a conditional response and the Agency may reject the response at its sole discretion.**

- 4. In the event the resulting Contract is renewed, the costs outlined in Exhibits A-5, Cost Proposal and A-5-b, Renewal Period Detailed Budget shall apply for the renewal period(s).**
- 5. Failure to submit Exhibit A-5, Cost Proposal, signed by an authorized official may result in the rejection of response.**

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**ATTACHMENT B  
SCOPE OF SERVICES (February 17, 2020)**

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#### **I. Service(s) to be Provided**

##### **A. Background**

The Agency for Health Care Administration (Agency) is the single state agency responsible for administering the Medicaid Program in Florida. The State of Florida has offered Medicaid services since 1970. Medicaid is funded by both the State and Federal government to provide health care coverage for eligible children, seniors, disabled adults, parents of children and pregnant women.

In 2002, the Federal Centers for Medicare and Medicaid Services (CMS) released final rules for the Balanced Budget Act (BBA) passed by Congress in 1997. Implemented in August 2003, the rules represented the first comprehensive revision to Federal statutes governing Medicaid managed care in over a decade.

The BBA rules require each state Medicaid agency contracting with a managed care organization (MCO) to develop and implement a written strategy to assess and improve the quality of managed care services. (See 42 Code of Federal Regulations (CFR) 438.202.) The strategy must comply with the provisions established by the Department of Health and Human Services (DHHS) issued in the Federal Register.

The BBA requires that the quality strategy either adopt (1) DHHS protocols for independent external review of MCO compliance with Federal quality standards (See 42 CFR 438.358), released by DHHS February 11, 2003; or (2) be consistent with them. Pursuant to this directive, the Agency implemented the Medicaid Managed Care External Quality Review (EQR) Program.

The 2011 Florida Legislature passed the House Bill 7107 (creating part IV of Chapter 409, Florida Statutes (F.S.)) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services. The Vendor may find information related to the Statewide Medicaid Managed Care (SMMC) program is found at the below link:

[http://ahca.myflorida.com/medicaid/statewide\\_mc/index.shtml](http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml)

The SMMC program has three components: the Managed Medical Assistance (MMA) program, the Long-term Care (LTC) program and the Dental program. The Agency submitted an 1115 demonstration waiver application and received approval from Federal CMS on July 31, 2014 to operate the MMA program. The Special Terms and Conditions (STCs) approved by Federal CMS require that an independent evaluator conduct an evaluation of the MMA demonstration. The Agency received approval from Federal CMS on February 1, 2013, under Section 1915 (b) and (c) waivers, to administer the LTC program. Federal CMS requires that an independent assessment be completed and submitted for the first two (2) approval periods of a Section 1915 (b) waiver.

The Vendor may find information related to the MMA Program Waiver in Category K at the below link:

[http://ahca.myflorida.com/medicaid/Policy\\_and\\_Quality/Policy/federal\\_authorities/federal\\_waivers/mma\\_fed\\_auth.shtml](http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml)

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The Vendor may find information related to the LTC Program Waiver in Category L at the below link:

[http://ahca.myflorida.com/medicaid/Policy\\_and\\_Quality/Policy/federal\\_authorities/federal\\_waivers/ltc\\_fed\\_auth.shtml](http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/ltc_fed_auth.shtml)

Currently, activities for the EQR program, MMA program evaluation, and LTC program evaluation are conducted through separate contracts, with different vendors providing the services for each program. The Agency's goal is to transition from individual contracts for each program to one contract, where the vendor that is conducting the EQR program activities will also provide a comprehensive, independent assessment of the MMA and LTC programs.

#### **B. Overview/Purpose**

State Medicaid agencies are required to ensure that a qualified External Quality Review Organization (EQRO) perform an annual EQR for each contracting managed care organization (MCO), Prepaid Ambulatory Health Plan (PAHP) or Prepaid Inpatient Health Plan (PIHP), hereinafter referred to as health plan. (See 42 CFR 438.350.) The Agency's dental program provides benefits through prepaid ambulatory health plans (PAHPs); therefore, the dental program is also required to be covered under EQR activities. The data obtained from the mandatory EQR activities, must be used for the annual EQR.

The purpose of this solicitation is to solicit proposals from qualified external quality review organizations for the Agency's EQR activities and to conduct a comprehensive, independent assessment of the MMA and LTC programs. At a minimum, the Agency intends to achieve the following goals:

- To establish a cost efficient contract for external quality review services that drives health care quality improvement for the Agency.
- To secure a vendor that is not only an independent reviewer of the Agency and health plan compliance with Federal requirements as they pertain to Medicaid external quality review, but also a strategic partner in improving quality of care and providing innovative approaches on how to address health care needs.
- To secure a strategic partner that understands the needs of Florida, its health care landscape, demographics and diversity of its population, geography, and the overarching vision and mission of the Agency.
- To ensure the best value for the Agency and for the State of Florida.

#### **C. Order of Precedence**

The Vendor shall perform its contracted duties in accordance with this Contract, AHCA ITN 005-19/20, including all addenda, the Vendor's Response to AHCA ITN 005-19/20 and information provided through negotiations. In the event of conflict among contract documents, any identified inconsistency in this Contract shall be resolved by giving precedence in the following order:

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1. This Contract, including all attachments, exhibits and any subsequent amendments;
2. AHCA ITN 005-19/20, including all addenda; and
3. The Vendor's response to AHCA ITN 005-19/20, including information provided through negotiations.

**II. Manner of Service(s) Provision**

**A. Services Provided by the Agency**

The Agency shall provide the following to assist the Vendor in meeting the requirements of this Contract:

1. Monitor and evaluate the Vendor's compliance with the requirements of this Contract. The Agency reserves the right to request additional information in support of monitoring the Vendor's performance to ensure compliance with the requirements of this Contract;
2. Review of all deliverables (i.e., reports, invoices, documents, etc.) submitted by the Vendor. The Agency reserves the right to approve, deny or require revision to any submitted deliverables;
3. Provide or arrange to provide certain information and data to be used by the Vendor. The frequency with which this information will be provided shall be arranged between the Agency and the Vendor;
4. Provide or arrange to provide responses to Vendor recommendations related to EQR-related activities at an agreed upon date to assist the Vendor in completion of the Annual Technical Report, as defined in Section II., Manner of Service(s) Provision, Sub-Section B., Services Provided by the Vendor, Item 7., Category F: Annual Technical Report;
5. Interpret any Contract requirement at the written request of the Vendor. When an interpretation of this Contract is sought, the Vendor shall submit a written request to the Agency's designated Contract Manager;
6. Provide the Vendor with Agency held data and with reports submitted by the health plans for EQRO activities; and
7. Facilitate the health plans' submission of health plan data and reports to the EQRO as needed.

**B. Services Provided by the Vendor**

**1. General Responsibilities**

The Vendor shall perform EQR-related activities as set forth in 42 CFR 438.358 and shall be in accordance with the most recent protocols set forth by Federal CMS, unless otherwise approved by Federal CMS and the Agency. The EQR-related activities are included herein as Categories A. through J., below.

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In addition to the EQR-related activities, the Vendor shall also ensure Agency compliance with the 1115 MMA waiver requirements and the 1915(b) LTC waiver requirements (Categories K. and L., below). Provision of Categories K. and L. are contingent upon successful negotiation of the services through the solicitation process.

#### **2. Category A: Validation of Performance Improvement Projects**

##### **a. Background**

The health plans are required to follow contractual requirements for developing, implementing, managing, submitting, and monitoring performance improvement projects (PIP or PIPs). This section contains the general requirements for health plans, as required by the SMMC Core Contract Requirements. The SMMC model contracts, including the exhibits, can be found at the below link:

[http://ahca.myflorida.com/medicaid/statewide\\_mc/plans\\_FY18-23.shtml](http://ahca.myflorida.com/medicaid/statewide_mc/plans_FY18-23.shtml)

The health plans are required to develop, implement, and monitor PIPs. The health plans must achieve significant improvement in the quality of care and service delivery, through ongoing measurement of performance using objective quality indicators and ongoing interventions, sustained over time.

The health plans' PIP methodologies must comply with the most recent EQR protocols set forth by Federal CMS, Implementation of PIPs. Federal CMS protocols may be obtained from the below link:

<https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>

##### **b. The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:**

- 1)** Use the current mandatory Federal CMS protocol for conducting external quality reviews of PIPs to determine whether a health care quality performance improvement project was designed, conducted, and reported in a methodologically sound manner and in accordance with applicable Federal rules and regulations including 42 CFR, Part 438;
- 2)** Incorporate Plan-Do-Study-Act (PDSA) components into the PIP framework and methodology to further quality improvement. The Vendor shall determine which interventions will be tested using a series of PDSA cycles, by analyzing the real-time data methodology, process mapping, and/or failure modes effect analysis (FMEA) provided by the health plans;

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- 3) Provide ongoing validation of each health plans' PIPs. Provide ongoing pseudo-validation of each health plans' PIPs (as directed by the Agency) in instances where a standard validation cannot be completed. The pseudo-validation will consist of the Vendor providing feedback and recommendations instead of complete validation;
- 4) Provide technical assistance and feedback to the Agency and to the health plans in the form of conference calls, emails, and occasional in-person meetings (when necessary and mutually arranged), at no additional cost to the Agency. In providing technical assistance to the plans, the Vendor shall ensure that it identifies best practices and effective interventions of individual health plans, as well as potential for collaboration where there is a similarity across the health plans. The Vendor shall also provide education on the use of quality improvement tools and understanding the process of PIP life cycles for improvement in providing technical assistance;
- 5) Review PIP plans and results as well as Agency priorities in order to summarize best practices and to identify potential statewide collaborative projects that could be conducted during each contract year. The Vendor shall work with the Agency to select the topics for statewide implementation and then develop potential methodologies for such projects;
- 6) Review the Agency's traditional PIP approach and work with the Agency to develop and transition to a more streamlined PIP approach to ensure that quality improvement can occur more quickly; and
- 7) Develop templates and tools to assist the Agency and health plans in ensuring that approved PIP projects are valid and develop tools for evaluating the PIP projects. Tools and templates shall be considered part of the deliverable for PIPs at no additional cost to the Agency. Required tools and templates should be based, at a minimum, on the most recent EQR Protocol 3: Validating Performance Improvement Projects that is set forth by Federal CMS.

#### **3. Category B: Validation of Performance Measures**

##### **a. Background**

- 1) States are required to evaluate the accuracy of Medicaid performance measures reported by or on behalf of each health plan and determine the extent to which Medicaid-specific performance measure calculations followed state specifications. (See 42 CFR 438.358(b)(1)(ii))
- 2) All health plans authorized to transact business in the State of Florida are required to report to the Agency access and quality

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indicator data for Florida members covered under commercial, Medicaid and Medicare lines of business. Indicator data for each calendar year period are to be submitted by health plans no later than July 1<sup>st</sup> of the following year. (See Chapter 59B-13, Florida Administrative Code (FAC))

- 3)** As part of the Agency's annual reporting requirements and under the uniform data specification section of Chapter 59B-13, F.A.C., most of the health plans must use the Healthcare Effectiveness Data and Information Set or HEDIS® technical specifications for the calculation of indicators of access and quality of care required by the state. The remaining health plans must report other quality indicator data. Each health plan must deliver to the Agency with its annual submission of indicator data a certification by an independent National Committee for Quality Assurance (NCQA) certified auditor approved by the Agency. The independent auditor must certify that, in the indicator data reported to the Agency for the calendar year, there is a fair and accurate representation of the specified health care services afforded to Florida Medicaid enrollees.
  - 4)** Health plans utilizing HEDIS® are required to report independently audited data for Florida Medicaid members calculated according to HEDIS® technical specifications for HEDIS® defined measures and Agency defined measures. The health plans must report these measures annually. An aggregate assessment of HEDIS® data from independent audits reported by health plans is used by the Agency to annually evaluate plan performance levels.
- b.** The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:
- 1)** Review the independently audited Medicaid HEDIS® access and quality of care indicators, Medicaid HEDIS® Data Submission Tools, and Final Audit reports for each health plan to determine the extent to which Medicaid-specific performance measures reported to the Agency are calculated according to Agency specifications (i.e., HEDIS®, Medicaid Adult and Child Core set, Dental Quality Alliance, and Agency-defined technical specifications). Where HEDIS® measurements are not required by the individual health plan type, the same type of information shall be reviewed for other quality indicators measurement for the same purpose of validation; and
  - 2)** Compile its validation activities to produce a report annually on statewide and plan-specific performance measure validation activities and findings in accordance with the EQR Protocol for Validation of Performance Measures Reported by the health plan. The report shall include any areas of concern for performance measures reported by health plans and recommendations to the Agency for ways to improve and streamline validation of



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performance measures reported by the plans, including whether the Agency should explore calculating the measures on behalf of the health plans.

#### **4. Category C: Review of Compliance with Federal Standards**

##### **a. Background**

The Agency follows a process to conduct the compliance reviews that ensure consistency with the intent of the Federal CMS protocol regarding compliance with the Balanced Budget Act of 1997 (BBA) requirements. The Agency monitors its health plans to ensure that they comply with access, measurement, and structure and operations standards through various methods of review, including, but not limited to, weekly reviews of enrollee and provider complaints, analysis of required reports submitted by health plans, secret shopper calls to determine network adequacy and access to appointments, and site visits related to marketing, and verification of the health plans' provider networks. If health plans are out of compliance with their contract, the Agency may impose corrective actions, monetary liquidated damages, and sanctions (monetary or non-monetary). Compliance actions and associated liquidated damages, corrective action plans, and sanctions are posted publicly on the Agency's website.

EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, describes the process that states or their contractors may use every three (3) years to determine a health plan's compliance with Federal Medicaid managed care regulations. The Agency conducts its own assessment of plans' compliance with Federal Medicaid managed care regulations; therefore, the Vendor shall be responsible for drafting a final report describing the State's activities. (See 42 C.F.R § 438.350.)

##### **b. The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:**

- 1)** Review the Agency's compliance review activities to ensure the activities are in accordance with Federal CMS requirements for compliance with Federal standards;
- 2)** Review the Agency's established compliance monitoring structure and strategically plan, with the Agency, ways to implement and integrate innovative approaches to meet the Federal CMS requirements for compliance with Federal standards;
- 3)** A description of the scope of the project including responsibilities, activities and proposed number of hours to complete the project for Agency review and approval. An example of a project that may be used under this category is the development of tools and templates to assist the Agency with conducting its own compliance reviews that are consistent with Federal CMS requirements for compliance with Federal standards and/or modify the Agency's established tools and templates. Tools and

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templates should at a minimum, assist the Agency with meeting the requirements established in EQR Protocol 1.;

- 4) A description of the required deliverables and the performance evaluation requirements to determine satisfactory completion of a deliverable;
- 5) A timeline and due dates for the deliverables; and
- 6) Submission of timesheets and applicable documentation to support the invoice(s).

#### **5. Category D: Review of Network Adequacy**

##### **a. Background**

The 2016 Medicaid managed care final rule requires states to ensure that health plans maintain sufficient provider networks to provide adequate access to covered services for all enrollees. (See 42 CFR §438.68, §438.206, §457.1218, and §457.1230.) It requires states to develop provider network standards based on reasonable travel time and distance from enrollee homes to provider sites; strengthens requirements for states to monitor enrollees' access to care; and addresses the needs of people with disabilities or other special needs who increasingly are enrolled in health plans. States must conduct the EQR-related activity relating to the validation of network adequacy. Once the EQR protocol for the validation of network adequacy activity is published, the Vendor shall conduct the study in accordance with the requirements specific to the associated EQR-related activity protocol.

##### **b. Upon Federal CMS' release of the protocol for the validation of network adequacy, the Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:**

- 1) Validate each health plan's network adequacy during the preceding twelve (12) months annually. (See 42 CFR §438.358(2)(b)(1)(iv), and 42 CFR §438.14(b)(1).);
- 2) Adopt procedures required by any new relevant protocols and incorporate any best practices, guidelines, or toolkits issued by Federal CMS for network adequacy studies;
- 3) Establish a procedure to verify that each health plan is delivering the benefits within the required time frames, and that each health plan has an adequate provider network to ensure the effective and efficient delivery of health care services to Florida Medicaid enrollees;
- 4) Evaluate the adequacy of each health plan network using NCQA standards or other nationally recognized standards that will produce a statistically valid review; and

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- 5) Submission of timesheets and applicable documentation to support the invoice(s).

#### **6. Category E: Encounter Data Validation**

##### **a. Background**

States are required to ensure that each health plan maintains a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of this subpart. The health information system must provide information on areas including, but not limited to, utilization, grievances and appeals and disenrollment for reasons other than loss of Medicaid eligibility. (See 42 CFR 438.242)

All capitated health plans are required to submit encounters to Florida's Medicaid Fiscal Agent for all health care services rendered to their enrollees (excluding services paid directly by the Agency on a fee-for-service basis). Medicaid encounter data must be submitted in Version 5010, Version D.0 and Version 3.0, to ensure compliance with national standards. (See 45 CFR Part 162)

Encounter data provide a source of comparative information for health plans and is used for purposes such as monitoring service utilization, evaluating access and continuity for service issues, monitoring and developing quality and performance indicators, studying special populations and priority areas, and cost effectiveness analyses.

Data validation of the health plan's administrative systems and processes is essential to ensuring that encounter data submitted to the State is complete and accurately reflects the care provided to Medicaid enrollees. Data validation is also essential to minimize instances where the editing process rejects data for data quality deficiencies and to ensure that the report templates and quality measures accurately reflect the data that are truly comparable across all health plans.

##### **b. The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:**

- 1) Conduct an encounter-type focused validation as requested by the Agency. (See 42 C.F.R. §438.358(c)(1));
- 2) Review the accuracy, completeness, and integrity of encounter data by comparing Agency encounter data with the health plan's administrative data. In addition, the Vendor shall develop systems to validate provider-reported encounter data against medical records;
- 3) Conduct the EDV study based on a sample of Medicaid encounter data which shall include medical and clinical record reviews and may include a review of NCQA's Baseline Assessment Tool (BAT) findings and/or other sources of data that may be required by Federal CMS. The Vendor shall review encounter types for

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validation as requested and specified by the Agency. Validation of encounter data shall include only those encounters that are submitted to Florida's Medicaid Fiscal Agent;

- 4) Develop an EDV study methodology document that includes, but is not limited to, the number of medical and clinical records for review and submit to the Agency for review and approval; and
- 5) Develop a data submission requirements document to include submission requirements for the Agency and its health plans, including technical assistance in the form of conference calls. The Vendor shall review Agency requirements for collecting and submitting encounter data, review the health plans' capacity to produce accurate and complete encounter data, and analyze the electronic encounter data for accuracy and completeness. These activities are standard components of the encounter data validation study. The fourth activity required by the protocol is the review of medical records for confirmation of findings of analysis of encounter data. The Agency shall direct the Vendor to conduct a medical review for a maximum number of medical record reviews specific to a subset of services (for example, dental record reviews submitted within a certain timeframe).

#### **7. Category F: Annual Technical Report**

##### **a. Background**

State Medicaid agencies are required to provide for an annual external, independent evaluation of quality outcomes, timeliness of and access to services. (See the Social Security Act, section 1932(c).) The Balanced Budget Act (BBA) of 1997 requires state agencies contracting with health plans to provide, for each contracted plan, an annual external, independent evaluation of aggregate information on the timeliness, access to and quality outcomes for the services covered under each health plan contract.

##### **b. The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:**

- 1) Produce a detailed technical report that describes the manner in which the data from all EQR-related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness and access to care furnished to Medicaid managed care enrollees. The report must include the following for each activity conducted:
  - a) Objectives and background information;
  - b) Technical methods of data collection and analysis;
  - c) Description of data obtained, including validated performance measurement data in accordance with 42 C.F.R § 438.358(b)(1)(i) and (ii); and

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- d) Conclusions drawn from the data, including important trends and implications, results, limitations and improvement opportunities.
- 2) An assessment of each health plan's strengths and weaknesses with respect to the quality, timeliness of, and access to health care services furnished to Medicaid enrollees.
- 3) Prospective recommendations to identify patterns of inappropriate utilization or poor standards of care. The Vendor shall provide recommendations on how to effectively incorporate findings into performance and/or quality improvement projects. Recommendations shall be specific and applicable to the Florida Medicaid delivery system.
- 4) Wherever methodologically appropriate, comparative information for each quality measure relative to industry benchmarks, including national Medicaid averages, commercial plan averages, Healthy People 2020 target rates, and statewide health plan performance averages. Where feasible, the analysis of plan data shall include comparisons with previous plan performance.
- 5) The Vendor shall use data obtained from the mandatory (and optional activities as requested by the Agency) External Quality Review (EQR)-related activities for the annual EQR. (See 42 CFR 438.350)
- 6) Wherever possible, the data and results from all EQR-related activities shall be analyzed and reported separately for individuals with and without special health care needs.
- 7) An assessment of the extent to which each health plan has addressed the recommendations for quality improvement made by the EQRO during the previous year's review.
- 8) A strategic executive summary anchored to Agency goals (as defined in Section B.3., Services Provided by the Vendor, Sub-Section E., Category I., Quality Initiatives) and priorities and aligned with 42 CFR, Part 438, Section D (438.200 – 438.242).
- 9) Findings that the Vendor shall use to produce the technical report evaluating the health plan's performance include, but are not limited to:
  - a) Agency's annual compliance reviews of the health plans;
  - b) Agency quality indicators (e.g., HEDIS® measures, Child Core Set measures, etc.) results, including findings from validation of Agency-defined performance measures, and findings from any strategic reports produced using HEDIS® results;
  - c) Validation of the Agency-required health plan's performance improvement projects;

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- d) Validation of encounter data to ensure the accuracy, completeness and integrity of encounter data;
- e) Annual child and adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) and other consumer surveys studies, including findings from any strategic report produced on consumer survey data;
- f) Child Health Check Up participation rates; and
- g) Clinical and nonclinical focused studies conducted by the EQRO during the preceding year.

**8. Category G: Dissemination and Meetings**

**a. Required Activities for Communication and Dissemination**

Communication with the health plans and Agency identified key stakeholders ensures that information and best practices are available and accessible. At a minimum, the Vendor shall:

- 1) Develop and maintain a secure web portal for the purposes of storing and sharing documents with health plans and key stakeholders. The Agency, health plans and other Agency approved key stakeholders shall have access to the web portal and all documents;
- 2) Ensure that the web portal is operational no later than forty-five (45) calendar days after contract execution;
- 3) Ensure that the web portal is available twenty-four (24) hours per day, seven (7) days per week. The web portal shall have no more than forty-eight (48) cumulative hours per month of system downtime.
- 4) Conduct a telephone conference call that shall occur up to thirty (30) calendar days before beginning external quality review activities to provide staff introductions, orientation, and training to the health plans regarding the Vendor's EQR process.

**b. Medicaid Quality Meeting**

The Vendor shall provide the following at a minimum, in meeting the requirements of this Contract:

- 1) Assist the Agency in facilitating and coordinating Medicaid Quality meetings with the health plans as requested by the Agency. There shall be no more than four (4) meetings per year, in line with the state fiscal year (July 1 - June 30). At the Agency's discretion, the meetings may be held in a webinar format or face-to-face in Tallahassee or in a central location approved by the Agency;
- 2) Provide recommendations for topics and speakers based on Medicaid Quality goals and objectives, health plan training needs, and any innovative topics that support quality improvement;

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- 3) Create a draft agenda on the Vendor's template;
- 4) Create registration information, meeting notifications, and meeting reminders to be submitted to the health plans and key stakeholders;
- 5) Manage the registration for each meeting;
- 6) Facilitate the webinar format using its own webinar software, approved by the Agency;
- 7) Create the meeting evaluations for distribution to the participants at each meeting;
- 8) Compile and analyze evaluation results for incorporation into the Strategic Summary Report;
- 9) Compile meeting materials and speaker presentations, in coordination with the Agency; and
- 10) Present on findings from reports such as the EDV, Quality Initiatives or Provider Satisfaction reports, as requested by the Agency.

**c. Medicaid Quality Strategic Summary Report**

Each meeting will culminate with the completion of the Medicaid Quality Meeting Strategic Summary Report. The Vendor shall create a Medicaid Quality Meeting Strategic Summary Report for submission to the Agency within thirty (30) calendar days following the meeting. The Vendor shall include the following components in the Medicaid Quality Meeting Strategic Summary Report:

- 1) A brief and concise summary of each meeting presentation;
- 2) Analysis of how the presentations support the goals and objectives of Medicaid Quality, including those goals and objectives described in the Agency's Medicaid Comprehensive Quality Strategy;
- 3) A summary of the results of the evaluations, with particular attention to the needs of the health plans and their suggested topics for future Medicaid Quality meetings;
- 4) A section of recommendations for future Medicaid Quality meetings, including suggested topics and areas where follow up may be needed; and
- 5) In general, a page limitation shall not be required; however, this report should generally not exceed five (5) pages in length and

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should include only concise summaries, implications and emphasize strategic and actionable recommendations.

#### **9. Category H: Administration of Provider Satisfaction Surveys**

##### **a. Background**

Provider Satisfaction Surveys can be a source of valuable information to assess provider's overall satisfaction with the health plans. The surveys also provide the health plans with an opportunity to receive valuable feedback from providers. An independently administered survey has the potential to increase transparency and the provider response rate. The administration of Provider Satisfaction Surveys is an optional EQR-activity. (See 42 CFR §438.358(c)(2))

##### **b. Upon request by the Agency, the Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:**

- 1)** Develop a detailed description of the proposed survey administration process including methodology that should be used (i.e. mail, online, etc.);
- 2)** Initially, the Agency will provide the Vendor with the provider survey instruments that should be utilized; however, the Agency may require the Vendor to assist in updating existing provider survey tools or to create new survey instruments;
- 3)** Collaborate with the Agency to develop a sample of Medicaid managed care providers;
- 4)** Administer provider satisfaction surveys to a maximum number of Medicaid managed care providers as agreed upon by the Agency and compile and analyze survey results;
- 5)** Develop plan-specific recommendations for the health plans to address the results of the Provider Satisfaction Survey by July 1<sup>st</sup> of each Contract year;
- 6)** Produce a plan-specific report which includes a targeted improvement plan that categorizes actionable recommendations by level of priority; and
- 7)** Incorporate any best practices, procedures, guidelines, or toolkits issued by Federal CMS for administration of surveys.

#### **10. Category I: Quality Initiatives**

##### **a. Background**

All health plans are required to have an ongoing quality improvement program that objectively and systematically monitors, evaluates, and improves the quality and appropriateness of care and service delivery (or



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the failure to provide care or deliver services) to enrollees, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. (See 42 CFR 438.330(a)(1) and (3); 42 CFR 438.330(b)(4); 42 CFR 438.340.) All health plans are also required to develop specific strategies to address the Agency's goals.

**b.** The Agency has established the following goals to build on the success of the SMMC program and to ensure continued quality improvement:

**1)** Reduce Potentially Preventable Events:

- a)** Admissions;
- b)** Readmissions; and
- c)** Emergency department visits.

**2)** Improve Birth Outcomes

- a)** Reduce Primary Cesarean Section (C-section) Rate;
- b)** Reduce Pre-term Birth Rate; and
- c)** Reduce Rate of Neonatal Abstinence Syndrome (NAS).

**3)** Improve Care Transitions

Increase the percentage of enrollees receiving long-term care services in their own home or in the community instead of a nursing facility.

**4)** Improve Access to Dental Care

- a)** Increase the percentage of children receiving preventive dental services; and
- b)** Reduce potentially preventable dental related emergency department visits.

**c.** The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:

**1)** The Vendor shall provide recommendations for quality improvement initiatives for Agency contracted entities, stakeholders, and/or the health plans as requested by the Agency based on an identified area in need of improvement that support the Agency's goals;

**2)** Upon Agency approval of the Vendor's recommendation, the Vendor shall incorporate any best practices, procedures, guidelines, or toolkits issued by Federal CMS for implementation into the quality initiative project;

**3)** Review the health plan's quality improvement programs annually and provide recommendations for quality initiatives. Recommendations must support Agency goals and have the

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ability to be implemented as a quality initiative for the SMMC program;

- 4) Upon Agency approval of the Vendor's recommended quality improvement project, the Vendor shall provide a summary of the process to implement and support the project within a timeframe approved by the Agency. The summary must, at a minimum, include the following:
  - a) Description of the goals to be accomplished through the initiative and why it is important;
  - b) Description of how the initiative shall be implemented, including identifying the activities/services that will be provided by the Agency, Vendor and the health plans;
  - c) Description of how change shall be measured and assessed for improvement;
  - d) Description of how the Vendor will identify, test and communicate ideas for changes that may need to be implemented during the initiative to improve results;
  - e) Timeline of the quality initiative from implementation to completion of the project; and
  - f) Estimate of the number of hours required from implementation to completion of the project.
- 5) Produce a summary report, summarizing the findings, implications and a roadmap for improvement for the quality initiative.

#### **11. Category J: Technical Assistance on EQR-Related Activities**

##### **a. Background**

The Agency may request technical assistance on EQR-related projects and tasks.

- ##### **b. The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:**
- 1) A quarterly report in accordance with the description provided in **Attachment B**, Scope of Services, **Section II.**, Manner of Service(s) Provision, **Sub-Section B.**, Services Provided by the Vendor, **Item D.**, Reporting, **Sub-Item 2.**, Quarterly Reporting;
  - 2) A description of the responsibilities, proposed number of hours, and activities requested by the Agency and a description of the scope of the project;
  - 3) A description of the required deliverables and the performance evaluation requirements to determine satisfactory completion of a deliverable;
  - 4) A timeline and due dates for the deliverables;

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- 5) Specifications regarding the medium or format of the requested deliverables;
- 6) Any Vendor project requirements; and
- 7) Requirements regarding the submission of timesheets and applicable documentation to support the invoice.

#### **12. Category K: Managed Medical Assistance (MMA) Program Waiver**

##### **a. Background**

The Statewide Medicaid Managed Care (SMMC) program has two key components: the Managed Medical Assistance (MMA) program and the Long-Term Care (LTC) program. The Agency completed an 1115 demonstration waiver application with Federal CMS and received authority to operate the MMA waiver on July 31, 2014. The Special Terms and Conditions (STCs) set forth conditions and limitations on the waiver and expenditure authorities, and describe in detail the nature, character and extent of Federal involvement in the Demonstration and the State's obligations to Federal CMS during the life of the Demonstration. The STCs require the evaluation design to be approved by Federal CMS and an independent evaluator to complete an evaluation of the demonstration. The Vendor shall complete independent assessment projects to ensure Agency compliance with MMA waiver requirements.

Federal CMS approved a second extension of the MMA 1115 waiver demonstration for a period of five (5) years beginning August 3, 2017 through June 30, 2022. The current MMA waiver evaluation will not be an activity for this Contract; however, a future MMA evaluation may be included as an activity in this Contract. The STCs for the demonstration stipulate that an evaluation design that describes how the evaluation will be conducted, including goals and objectives of the demonstration, hypotheses related to the demonstration, and methodologies for the evaluation, must be submitted to Federal CMS for approval within one-hundred twenty (120) calendar days of the approval of the waiver extension.

The following are the nine (9) evaluation components, approved by Federal CMS, for the MMA Program Waiver:

- 1) The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
- 2) The effect of expanded benefits on enrollees' utilization of services, access to care, and quality of care;
- 3) Participation in the Healthy Behaviors programs and its effect on participant behavior or health status;
- 4) The impact of low income pool (LIP) funding on hospital charity care programs. The Vendor may find information related to the

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LIP at the following link:

<https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/background.shtml>;

- 5) The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals;
  - 6) The effectiveness of enrolling individuals into a health plan upon eligibility determination in connecting beneficiaries with care in a timely manner;
  - 7) The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services;
  - 8) The impact of the waiver of retroactive eligibility on beneficiaries and providers; and
  - 9) The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are twenty-one (21) and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability.
- b. The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:
- 1) Conduct an evaluation of the MMA program, to ensure Agency compliance with the most current STCs approved by Federal CMS. The most recently approved STCs are located at the below link:  
provide: [https://ahca.myflorida.com/medicaid/Policy\\_and\\_Quality/Policy/federal\\_authorities/federal\\_waivers/docs/FL\\_MMA\\_Technical\\_Edit\\_STCs\\_07201902.pdf](https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_MMA_Technical_Edit_STCs_07201902.pdf)
  - 2) Design a future evaluation plan and/or implement and conduct a future evaluation plan, upon Agency request and approval;
  - 3) Conduct the evaluation based on the evaluation questions, analytic methods, and data sources in the evaluation design as agreed to by the Agency and the Vendor and approved by Federal CMS;
  - 4) During the period when Federal CMS is reviewing and approving the most recently updated and submitted MMA evaluation design, the Vendor will proceed with conducting the MMA waiver evaluation in accordance with the most recently submitted evaluation design;

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- 5) Respond to any inquiries or directives by Federal CMS and/or the Agency related to any reports submitted to Federal CMS, including revising any reports at no cost to the Agency during the term of this Contract;
- 6) Ensure that deliverables produced from the evaluation, enable the Agency to further develop clinically appropriate, fiscally responsible and effective health care policies to build on the success of the MMA program; and
- 7) If applicable, for all projects that require approval from the Vendor's Institutional Review Board (IRB), the Vendor shall submit the application for review to the IRB within thirty (30) calendar days of execution of this Contract, unless otherwise authorized in writing by the Agency's Contract Manager.

#### **13. Category L: Long-Term Care (LTC) Program Waiver**

##### **a. Background**

The SMMC program has two key components: the MMA program and the Long-term Care (LTC) program. The Agency, under the authority provided in Sections 409.978 – 409.985, F.S., received Legislative authority in 2011 and approval from Federal CMS on February 1, 2013, under Section 1915 (b) and (c) waivers, to administer the LTC program. Federal CMS requires that an independent assessment be completed and submitted for the first two (2) approval periods of a Section 1915 (b) waiver. Federal CMS approved a five (5) year renewal of the LTC waiver for a period beginning on December 28, 2016 through December 27, 2021.

The LTC program is mandatory for Florida Medicaid aged or disabled enrollees ages eighteen (18) and older who are residing in a nursing facility, or who are not currently residing in a nursing facility but need nursing facility level of care. Under the LTC program, LTC plans are required to provide additional benefits to LTC enrollees, such as an increased emphasis on Home and Community-Based Services (HCBS), facilitation of nursing facility transition, increased care coordination and case management across care settings and enhanced community integration and personal goal setting. In addition, LTC enrollees will have increased access to quality providers and quality services with the expansion of services available in rural areas.

At a minimum, the Agency intends to achieve the following goals through the LTC program:

- 1) Shift service delivery away from nursing facilities to less restrictive home and community-based settings while at the same time controlling costs without restricting recipients' access to services or reducing quality of care.

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- 2) Ensure those enrollees in a HCBS have timely and adequate access to services to ensure they can remain safely in the community for as long as possible.
- 3) Promote the health, safety and well-being of enrollees receiving services in the community.

The LTC program evaluation may be included as an activity in this Contract.

b. The Vendor shall provide the following, at a minimum, in meeting the requirements of this Contract:

- 1) Conduct an independent assessment of the LTC program. The Vendor shall collaborate with the Agency to identify areas of focus for the independent assessment. Additionally, the goal is to integrate the LTC review with an evaluation of the MMA program for Medicaid recipients in both programs to show the effectiveness of both programs in achieving program goals. The most recently approved LTC waiver can be found at the below link:

[http://ahca.myflorida.com/medicaid/Policy\\_and\\_Quality/Policy/federal\\_authorities/federal\\_waivers/docs/Final\\_1915\(b\)\\_LTC\\_Waiver.pdf](http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/Final_1915(b)_LTC_Waiver.pdf)

- 2) Respond to any inquiries or directives by Federal CMS and/or the Agency related to any reports submitted to Federal CMS, including revising any reports at no cost to the Agency during the term of this Contract;
- 3) Ensure that deliverables produced from the evaluation, enable the Agency to further develop clinically appropriate, fiscally responsible and effective health care policies to build on the success of the LTC program;
- 4) Identify differences in access to care, quality of care and cost-effectiveness as a result of the LTC program over time; and
- 5) If applicable, for all projects that require approval from the Vendor's Institutional Review Board (IRB), the Vendor shall submit the application for review to the IRB within thirty (30) calendar days of execution of this Contract, unless otherwise authorized in writing by the Agency's Contract Manager.

#### **14. Vendor Qualifications**

The Vendor shall:

- a. Be a Federally designated Quality Improvement Organization (QIO) as established in Title XI, Part B of the Social Security Act and must maintain this designation for the life of this Contract; and

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- b. Not contract with any provider that is intended to be monitored by the Vendor under the entire term of this Contract.

**15. Implementation Plan**

- a. The Vendor shall prepare a draft implementation plan outlining the steps necessary for the Vendor to be fully operational by the start date of this Contract. The Agency shall meet with the selected Vendor after the award notification to discuss the Vendor's proposed implementation plan and anticipated time-frames and to determine information and other resources needed to complete the final implementation plan.
- b. The Vendor shall develop and deliver a comprehensive final implementation plan no later than fifteen (15) calendar days following execution of this Contract.
- c. The final implementation plan shall detail the specific timeframes, tasks, responsibilities, and key milestones to ensure a successful implementation. The final implementation plan shall describe any upgrades or additions to the Vendor's current system(s), if applicable, that are necessary to meet the requirements of this Contract.
- d. At a minimum, the final implementation plan shall include the following:
  - 1) Tasks associated with the Vendor's establishment of a "project office" or similar organization with which the Vendor shall manage implementation activities and the Vendor shall have staff available during normal business hours. Normal business hours are defined as 8:00 AM to 5:00 PM, ET, Monday through Friday, excluding State of Florida observed holidays ;
  - 2) An itemization of activities that the Vendor shall undertake during the period between the successful award and the start date of this Contract. These activities shall have established deadlines and timeframes;
  - 3) Staff responsible for each activity/step;
  - 4) Identification of interdependencies between activities in the implementation plan;
  - 5) Identification of Vendor expectations regarding participation by the Agency and/or its agent(s) in the activities in the implementation plan and dependencies between these activities and implementation activities for which the Agency and/or its agent(s) shall be responsible;
  - 6) Draft templates and tools to assist the Agency and health plans in ensuring that approved PIP projects are valid; and
  - 7) Draft tool(s) for evaluating the PIP projects.

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- e. The Vendor shall implement the final implementation plan only after Agency approval.
- f. Any deviation by the Vendor from the Agency approved final implementation plan shall be regarded by the Agency as a material breach and all remedies provided for in this Contract, shall become available to the Agency, except as due to reasons beyond the control of the Vendor and prior Agency approval has been provided in writing.
- g. The Vendor shall participate in both face-to-face meetings and conference calls with the Agency and relevant parties for purposes of coordinating implementation activities.

**16. Training, Education, and Outreach**

- a. The Vendor shall develop and implement an outreach plan which, at a minimum, includes written communication; telephonic, text messaging, or electronic application support; webinars; and face-to face training for all aspects of this Contract.
- b. The outreach plan must address all aspects of this Contract.
- c. The Vendor shall finalize, and submit to the Agency, the outreach plan no later than fifteen (15) calendar days following execution of this Contract.
- d. The Agency reserves the right to direct the Vendor to amend or update its outreach plan in accordance with the best interests of the State and at no additional cost to the Agency.

**17. Vendor Staffing**

- a. General Staffing Requirements
  - 1) The Vendor shall conduct all aspects of this Contract in a timely, efficient, productive, consistent, courteous, and professional manner as representatives of the State. The Vendor shall recruit highly qualified staff to provide all aspects of the services required by this Contract.
  - 2) The Vendor shall maintain staffing levels sufficient to complete the services and meet the requirements specified in this Contract. The Vendor shall be prepared at all times to recruit qualified staff, as required by applicable State and Federal laws and/or regulations, including 45 CFR Part 75, to implement all aspects of the services required in this Contract within the stated timeframes.
  - 3) The Vendor shall maintain copies of qualifications, including current licenses and board certifications if applicable, for staff and sub-contracted personnel in a centralized administrative file.



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- 4) In the event the Agency determines the Vendor's staff or staffing levels are not sufficient to properly complete the services specified in this Contract, it shall advise the Vendor in writing. The Vendor shall have thirty (30) calendar days to remedy the identified staffing deficiencies.
- 5) The Vendor shall make its staff available to meet with Agency staff on a schedule, as agreed to by the Agency and the Vendor, to review reports and all other obligations under this Contract as requested by the Agency. The Vendor shall meet in person or by telephone at the request of the Agency, at least monthly, to discuss the status of this Contract, Vendor performance, benefits to the Agency, necessary revisions, reviews, reports, and planning.
- 6) The Vendor shall notify the Agency in writing of any key staff resignations, dismissals, or personnel changes within one (1) business day of the occurrence. Should the Contract Manager position become vacant, the Vendor shall notify the Agency immediately and provide information on the replacement within ten (10) business days.
- 7) The Vendor shall have staff available during normal business hours. Normal business hours are defined as 8:00 AM to 5:00 PM, ET, Monday through Friday, excluding State of Florida observed holidays.
- 8) The Vendor shall provide staff with demonstrated experience and knowledge of the EQR-related projects and services, Medicaid program rules, regulations, policies, data systems, and processes; managed care delivery systems; quality assessment and improvement methods; and research and methodology design, including statistical analysis.
- 9) The Vendor shall ensure no conflict of interest exists for its staff, including its subcontractors. The Vendor staff, including subcontractor staff, shall not review any health plan entity for which it is conducting or has conducted an accreditation review within the previous three (3) years. (See 42 CFR 438.350.)
- 10) The Vendor shall comply with Equal Employment Opportunity Provisions. (45 CFR 75 Appendix II(C), 48 CFR Subpart 22.8.)
- 11) The Vendor shall not enter into any subcontract for services to be provided under this Contract without the express written prior consent of the Agency. The Vendor shall maintain full responsibility for all work to be performed under this Contract. Each approved subcontractor shall be subject to the same terms and conditions as the Vendor.

**b. Key Staff**

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For purposes of this Contract, the following positions are considered key staffing positions:

- 1) Contract Manager
  - a) The Vendor shall employ one (1) Contract Manager. The Contract Manager shall be responsible for coordinating all activities between the Agency and the Vendor. The Contract Manager shall be a full-time employee dedicated solely to this Contract for no less than forty (40) hours per week and may be located in or outside of the State of Florida;
  - b) The Contract Manager shall possess, at a minimum, a bachelor's degree from an accredited college or university and at least two (2) years of medical utilization review and/or quality assurance experience; and
  - c) The Contract Manager shall have the ability to recruit, select, and maintain experienced and qualified staff. The Contract Manager shall possess the authority to revise processes or procedures and assign additional resources as needed to maximize the efficiency and effectiveness of services required under this Contract.
  
- 2) Medical Records Review Staff Coordinator
  - a) The Vendor shall provide a Medical Records Review Staff Coordinator to oversee all medical record reviews described in this Contract; and
  - b) The Medical Records Review Staff Coordinator must have experience in managing a program similar in size and scope as the EQR program described herein within the last five (5) years and shall be a full-time employee of the Vendor with the authority to revise processes and procedures and assign additional resources, as needed.
  
- 3) Medical records Review Staff
  - a) Possess at least three (3) years of medical or clinical experience; and
  - b) Possess at least two (2) years of medical utilization review and/or quality assurance experience.

#### **18. System Functionality**

- a. The Vendor shall have facsimile and scanning capability, email capability, and provide the Agency on-line access to the Vendor databases, reports, and other information related to the Program at no cost to the Agency.
- b. Any instances of system down time shall be reported to the Agency immediately.

#### **19. System Modifications**

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- a. When the Vendor needs to upgrade or make changes to any part of its web-based system, the changes must be scheduled to occur after 10:00 PM, ET and before 6:00 AM, ET, unless a different time is approved by the Agency. Agency staff shall be notified by email twelve (12) hours prior to any scheduled maintenance.
- b. The Agency reserves the right to request system changes or modifications not otherwise specified or required in this Contract on an as needed basis. In the event that changes or modifications requested by the Agency would require additional staff commitment beyond that which is proposed by the Vendor, the Agency will allow the Vendor thirty (30) calendar days to provide a cost analysis of the changes and a timeline for completing the changes. If the Vendor's response is accepted by the Agency, the change or modification shall be reduced to writing in an amendment to this Contract.

#### **20. Database Creation**

- a. The Vendor shall develop and maintain HIPAA compliant database(s) necessary to support the requirements of this Contract. The database and data developed as a result of this Contract are the property of the Agency.
- b. The Vendor shall provide the Agency with direct read-only access to its database(s). The Vendor shall provide training in the use of the database(s) and the equipment required for Agency on-line access to the database(s). Agency staff shall be given access to the Vendor's database for the purpose of monitoring at no additional cost to the Agency.
- c. The Vendor's database shall store processed claim data, provided by the Agency for the purposes of encounter data validation studies, MMA evaluations and LTC evaluations, against which a variety of analytic tools can be run. Based on the information stored in the database, the Vendor shall analyze historical data, recommend program changes, and provide customized reports upon request.
- d. The Agency is modernizing its current Medicaid technology using a modular approach to simultaneously improve overall Agency functionality and connections to other data sources and programs (Florida Health Care Connections). The process will involve development of an Integration Services and Integration Platform (IS/IP), an Enterprise Data Warehouse (EDW), and subsequent integration and consolidation of existing data and systems. Use of the IS/IP will enable existing systems to securely share data and processing services across system boundaries. Use of the EDW will enable systems to securely contribute, update, access, and analyze data from the single, authoritative source. The Agency is currently procuring and implementing the IS/IP and EDW components. The proposed solution must have the capability to integrate with the new IS/IP and EDW platforms once it is implemented to enable continued efficiencies. The Vendor shall adapt, as needed, to any changes in the Agency's data sharing environment as directed by the Agency.

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**21. Data Exchange**

- a. The Vendor shall be able to receive data and other information, from the Agency or its designee, on a daily basis.
- b. The Vendor shall become knowledgeable of the field definitions related to the data being sent from the Agency and/or its agents.
- c. Upon the Agency's request, the Vendor shall make data samples available to the Agency or its designee. Criteria for inclusion in any data sample requested will be provided by the Agency. The data sample may include elements previously sent from the Agency or its designee and data collected by the Vendor. This data may be used for ad hoc reporting, program monitoring and quality assurance activities by the Agency. The Vendor shall provide the data in a format prescribed by the Agency.

**22. Quality Assurance/ Internal Quality Control (IQC) Program**

- a. The Vendor shall develop and provide a complete internal quality control (IQC) plan to ensure appropriate administration of all responsibilities specified in this Contract. The Vendor shall specify all components of its internal quality control plan. The Vendor shall submit its IQC plan in accordance with the Agency approved implementation plan.
- b. The administrative requirements of the IQC program shall include, at a minimum:
  - 1) How the Vendor shall ensure that all functions are performed timely in accordance with this Contract; and
  - 2) Staff who shall be responsible for the IQC activities and the staff's qualifications.
- c. The Agency reserves the right to direct the Vendor to make modifications and/or additions to the Vendor's IQC program/plan, as needed.
- d. The Vendor shall submit to the Agency a quarterly report of its IQC activities and findings in accordance with this Section.
- e. The Vendor shall have a written policy for escalation of technical problems or manpower problems or shortages that threaten to, or actually prevent, the meeting of the Vendor's quality and/or timeliness requirements. The policy shall require escalation of the problem within the Vendor's organization if not resolved in a timely manner and shall call for disciplinary action for any staff who do not perform according to the escalation policy.
- f. The Vendor's IQC program, as approved by the Agency and based on the IQC plan, shall become effective no later than thirty (30) calendar days following execution of this Contract.

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#### **C. Deliverables**

The Vendor shall provide the deliverables described in **Exhibit B-1**, Deliverables, Associated Payment and Financial Consequences, to the Agency's Contract Manager by the dates indicated. The Agency reserves the right to request modification of the deliverables, as deemed necessary by the Agency, prior to their approval. Deliverable due dates may be modified, if approved in writing, in advance by the Agency.

The Agency reserves the right to include additional deliverables based on the Agency's review of the Vendor's response to this solicitation.

#### **D. Reporting**

##### **1. General Reporting Requirements**

The Vendor shall adhere to reporting requirements included in this Item. The Agency reserves the right to direct the Vendor to amend or update its reports and/or report formats in accordance with the best interests of the Agency and at no cost to the Agency. The Agency will notify the Vendor of such modification, in writing.

All electronic transmission of reports and supporting documentation containing Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA) must be encrypted to meet the HIPAA privacy standards. Unless otherwise directed by the Agency, all electronic reports shall be formatted utilizing Microsoft Word or Excel, version 2016. Supporting documentation may be submitted in Adobe PDF format. The Vendor shall maintain the capability to upgrade its electronic report format as directed by the Agency.

Report formats shall be finalized and approved by the Agency no later than thirty (30) calendar days after execution of this Contract, unless otherwise agreed to by the Agency.

The Vendor shall develop reports, using formats approved in advance by the Agency, complying with the requirements established by the Agency. When reporting requirements are not established in this Contract, the Agency shall provide the Vendor with instructions and submission timetables. The Agency reserves the right to modify reporting formats and submission timetables resulting from changing priorities or management direction.

All reports shall be developed and produced at no cost to the Agency.

##### **2. Quarterly Reporting**

a. The Vendor shall submit quarterly reports. For purposes of this Contract, quarterly reporting will be based on Contract year quarters. At a minimum, quarterly reports shall include the following:

- 1) Brief summary of current activities;

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- 2) Changes in tasks and responsibilities of both the Vendor and the Agency in accordance with the Agency approved timeline;
  - 3) Activities planned for the upcoming quarter;
  - 4) Progress made on tasks from the previous quarter;
  - 5) Discussion of issues, barriers, or obstacles that may impact the timely submission of accurate deliverables;
  - 6) Notice of staff changes and introductions of new staff members; and
  - 7) Updates to Internal Quality Control Plan.
- b. Quarterly reports shall be due the fifteenth (15<sup>th</sup>) day of the month following the end of the preceding fiscal quarter (July 1 – June 30).

**E. Monitoring**

1. The Vendor shall comply with all reporting requirements as specified in this Contract. These reports shall be used for monitoring progress or performance of the contractual services as specified in **Attachment B**, Scope of Services.
2. The Vendor shall permit persons duly authorized by the Agency to inspect any records, papers, documents, facilities, goods and services of the Vendor which are relevant to this Contract.
3. The Agency's Contract Manager shall monitor this Contract quarterly via desk review of the Scope of Services for this Contract.

**III. Method of Payment**

This is a fixed price, unit cost Contract. The Agency shall pay the Vendor, in arrears, upon the completion and acceptance of deliverables in accordance with the deliverable schedule specified in **Exhibit B-1**, Deliverables, Associated Payment and Financial Consequences.

**A. Invoicing**

1. Invoices and all supporting documents shall be submitted on the Vendor's letterhead to the Agency's designated Contract Manager within fifteen (15) calendar days of completion and Agency approval of deliverable(s).

Invoice(s) shall include, at a minimum:

- a. Invoice date;
- b. Invoice number;
- c. Agency's Contract number;
- d. Description of the services rendered;

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- e. Date(s) on which services were rendered;
  - f. Payment remittance address; and
  - g. Other supporting documentation as requested by the Agency.
2. The Vendor shall not charge the State for any travel expenses related to any portion of this Contract without the Agency's prior written approval. Upon obtaining the Agency's written approval, the Vendor shall be authorized to incur travel expenses payable by the Agency to the extent provided by Section 112.061, Florida Statutes (F.S.).
  3. Payments will be authorized only for services that are in accordance with the terms and conditions of this Contract.
  4. Appropriate documentation as determined by the Agency shall be submitted to support invoices.
  5. Invoices shall not be approved for payment by the Agency until reports and deliverables from the Vendor are received as specified in this Contract.

### **B. Late Invoicing**

Unless written approval is obtained from the Agency, and at the discretion of the Agency, correct invoices with documentation received forty-six (46) to sixty (60) calendar days after the Agency's acceptance of the deliverable(s) will be paid at ninety percent (90%) of the amount of the invoice. Correct invoices with documentation received sixty-one (61) to ninety (90) calendar days after the Agency's acceptance of the deliverable(s) will be paid at seventy-five percent (75%) of the invoice. Invoices received ninety-one (91) calendar days or more after the Agency's acceptance of the deliverable(s) will **not** be paid.

If the Vendor is unable to meet the invoice submission deadlines specified in this Contract, the Vendor shall notify the Agency in writing prior to the deadline explaining the circumstances and requesting an extension to the deadline.

### **C. Financial Consequences as Liquidated Damages**

1. **Performance Standards and Liquidated Damages**
  - a. The Vendor shall comply with all requirements and performance standards set forth in this Contract.
  - b. The Agency's Contract Manager will monitor the Vendor's performance in accordance with the monitoring requirements of this Contract. Failure by the Vendor to meet the established minimum performance standards may result in the Agency, in its sole discretion, finding the Vendor to be out of compliance, and all remedies provided in this Contract and under law, shall become available to the Agency.

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- c. The Agency reserves the right to impose liquidated damages upon the Vendor for failure to comply with the performance standard requirements set forth in **Table 1**, Performance Standards and Liquidated Damages, below.

<b>TABLE 1</b>	
<b>PERFORMANCE STANDARDS AND LIQUIDATED DAMAGES</b>	
<b>Performance Standard Requirement</b>	<b>Liquidated Damages to be Imposed</b>
<b>Performance Bond</b>	
A performance bond in the amount of ten percent (10%) of the total annual amount of this Contract shall be furnished to the Agency by the Vendor within thirty (30) calendar days after execution of this Contract and prior to commencement of any work under this Contract.	<b>\$500.00</b> per calendar day for each calendar day after the due date until an acceptable performance bond is furnished to the Agency.
A performance bond shall be furnished on an annual basis, thirty (30) calendar days prior to the new Contract year and be in the amount of ten percent (10%) of the current annual Contract amount.	<b>\$500.00</b> per calendar day for each calendar day after the due date until an acceptable performance bond is furnished to the Agency.
<b>HIPAA</b>	
The Vendor shall comply with provisions of the Health Insurance Portability and Accountability Act (HIPAA)/Health Information Technology for Economic and Clinical Health (HITECH).	<b>\$500.00 to \$5,000.00</b> , per incident, per occurrence, depending upon the severity. In addition, Federal penalties may apply in accordance with the HIPAA Act of 1996.
The Vendor shall not inappropriately release PHI.	<b>\$500.00 to \$5,000.00</b> , per incident, per occurrence, depending upon the severity.
<b>Records</b>	
The Vendor shall comply with public records laws, in accordance with Section 119.0701, F.S.	<b>\$5,000.00</b> for each incident in which the Vendor does not comply with a public records request.
<b>Background Screening</b>	
Complete initial and renewal background screenings within required timeframes.	<b>\$250.00</b> per occurrence.
Submit policies and procedures within thirty (30) calendar days of Contract execution.	<b>\$250.00</b> per calendar day beyond the due date.
<b>Security Rating Score</b>	
Annually maintain a top tier security rating score from the Agency's selected information security rating service.	<b>\$5,000.00</b> per occurrence and <b>\$250.00</b> per calendar day, if the Vendor does not improve to a top tier security rating score within three (3) months after its initial failure notification by the Agency, to annually obtain a top tier security rating score.



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<b>TABLE 1</b>	
<b>PERFORMANCE STANDARDS AND LIQUIDATED DAMAGES</b>	
<b>Performance Standard Requirement</b>	<b>Liquidated Damages to be Imposed</b>
<b>Service Organization Controls (SOC) 2 Type II Audit</b>	
Annually submit the SOC 2 Type II audit report by date agreed upon by with the Agency for each Contract year.	<b>\$1,000.00</b> per calendar day for each calendar day beyond the due date.
<b>Services</b>	
Implement the approved Corrective Action Plan (CAP) by the Agency specified date.	<b>\$500.00</b> per calendar day for each calendar day that the approved CAP is not implemented to the satisfaction of the Agency.
The Vendor shall comply with the requirements as outlined in <b>Attachment B.</b> , Scope of Services, Section II. Manner of Service(s) Provision, Sub-Section B., Services Provided by the Vendor, Item 11., Category J: Technical Assistance on EQR-Related Activities.	<b>\$100.00</b> per calendar day for each calendar day beyond the due date.
The Vendor shall comply with the requirements as outlined in <b>Attachment B.</b> , Scope of Services, Section II. Manner of Service(s) Provision, Sub-Section B., Services Provided by the Vendor, Item 15., Implementation Plan.	<b>\$100.00</b> per calendar day for each calendar day beyond the due date.
The Vendor shall comply with the requirements as outlined in <b>Attachment B.</b> , Scope of Services, Section II. Manner of Service(s) Provision, Sub-Section B., Services Provided by the Vendor, Item 16., Training, Education and Outreach.	<b>\$100.00</b> per calendar day for each calendar day beyond the due date.
The Vendor shall comply with the requirements as outlined in <b>Attachment B.</b> , Scope of Services, Section II. Manner of Service(s) Provision, Sub-Section B., Services Provided by the Vendor, Item 17., Vendor Staffing.	<b>\$100.00</b> per calendar day for each calendar day beyond the due date.
<b>Secure Web Portal</b>	
The Vendor shall comply with the secure web portal requirements as outlined in <b>Attachment B.</b> , Scope of Services, Section II. Manner of Service(s) Provision, Sub-Section B., Services Provided by the Vendor, Item 8, Category G: Dissemination and Meetings.	<b>\$500.00</b> for each time the web portal is unavailable and cannot be accessed by the Agency or health plans for more than forty-eight (48) hours of downtime per month.

**2. Program Performance Standards and Liquidated Damages**

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- a. The Agency may impose liquidated damages as identified in **Exhibit B-1**, Deliverables, Associated Payment and Financial Consequences, when the Vendor has failed to meet the performance standard requirements.
- b. In the event the Agency identifies a violation of this Contract, or other non-compliance with this Contract, the Agency shall notify the Vendor of the occurrence in writing. The Agency shall provide the Vendor with a timeframe for corrections to be made.

**3. Sanctions**

- a. In the event the Agency identifies a violation of or other non-compliance with this Contract (to include the failure to meet performance standards), the Agency may sanction the Vendor pursuant to Section 409.912(4), F.S. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to this Contract.
- b. For purposes of this Item, violations involving individual, unrelated acts shall not be considered arising out of the same action.
- c. If the Agency imposes monetary sanctions, the Vendor must pay the monetary sanctions to the Agency within thirty (30) calendar days from receipt of the notice of sanction, regardless of any dispute in the monetary amount or interpretation of policy which led to the notice. If the Vendor fails to pay, the Agency, at its discretion, reserves the right to recover the money by any legal means, including but not limited to the withholding of any payments due to the Vendor. If the Deputy Secretary determines that the Agency should reduce or eliminate the amount imposed, the Agency will return the appropriate amount to the Vendor within sixty (60) calendar days from the date of a final decision rendered.

**4. Disputes**

- a. To dispute liquidated damages, sanctions and/or contract interpretations, the Vendor must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute.
- b. The Vendor must submit a written dispute directly to the Deputy Secretary, listed below, or designee by U.S. mail and/or commercial courier service (hand delivery will not be accepted). This submission must be received by the Agency within twenty-one (21) calendar days after the issuance of liquidated damages, sanctions and/or contract interpretations and shall include all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation and exhibits). The Vendor submitting such written requests for appeal or dispute as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such appeal or dispute to the following mailing address:

**Deputy Secretary for Medicaid**  
**Agency for Health Care Administration**  
**2727 Mahan Drive, Mail Stop 70**

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### **Tallahassee, FL 32308**

Regardless of whether delivered by U.S. mail or commercial courier service, appeals or disputes not delivered to the address above will be denied.

- c. The Vendor waives any dispute not raised within twenty-one (21) calendar days of issuance of liquidated damages, sanctions and/or contract interpretations. It also waives any arguments it fails to raise in writing within twenty-one (21) calendar days of receiving the liquidated damages, sanctions and/or contract interpretations, and waives the right to use any materials, data, and/or information not contained in or accompanying the Vendor's submission submitted within the twenty-one (21) calendar days following its receipt of the liquidated damages, sanctions and/or contract interpretations in any subsequent legal, equitable, or administrative proceeding (to include Circuit Court, Federal court and any possible administrative venue).
- d. The Deputy Secretary or his/her designee will decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the Vendor. This written decision will be final.
- e. The exclusive venue of any legal or equitable action that arises out of or relating to this Contract, including an appeal of the final decision of the Deputy Secretary or his/her designee, will be Circuit Court in Leon County, Florida. In any such action, the Vendor agrees to waive its right to a jury trial, and that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this Contract, the Agency will notice the Vendor of the appropriate administrative remedy.

#### **IV. Attorney's Fees**

In the event of a dispute, each party to this Contract shall be responsible for its own attorneys' fees, except as otherwise provided by law.

#### **V. Legal Action Notification**

The Vendor shall give the Agency, by certified mail, immediate written notification (no later than thirty (30) calendar days after service of process) of any action or suit filed or of any claim made against the Vendor by any subcontractor, vendor, or other party that results in litigation related to this Contract for disputes or damages exceeding the amount of **\$50,000.00**. In addition, the Vendor shall immediately advise the Agency of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor.

#### **VI. Damages for Failure to Meet Contract Requirements**

In addition to remedies available through this Contract, in law or equity, the Vendor shall reimburse the Agency for any Federal disallowances or sanctions imposed on the Agency as a result of the Vendor's failure.

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**VII. Corrective Action Plan (CAP)**

- A. If the Agency determines that the Vendor is out of compliance with any of the provisions of this Contract, the Agency may require the Vendor to submit a Corrective Action Plan (CAP) within a specified timeframe. The CAP shall provide an opportunity for the Vendor to resolve deficiencies without the Agency invoking more serious remedies, up to and including contract termination.
- B. The Vendor shall respond by providing a CAP to the Agency within the timeframe specified by the Agency.
- C. The Vendor shall implement the CAP only after Agency approval.
- D. The Agency may require changes or a complete rewrite of the CAP and provide a specific deadline.
- E. If the Vendor does not meet the standards established in the CAP within the agreed upon timeframe, the Vendor shall be in violation of the provisions of this Contract and shall be subject to liquidated damages.

**VIII. Performance Bond**

- A. A performance bond in the amount specified in **Table 2**, Performance Bond Requirements, and paragraph B below, shall be furnished to the Agency by the Vendor for the specified Contract term.

<b>TABLE 2</b>		
<b>PERFORMANCE BOND REQUIREMENTS</b>		
<b>Contract Term</b>	<b>“Estimated” Annual Contract Amount</b>	<b>Performance Bond Amount (10%)</b>
<b>Operations Year 1</b>	<b>TBD</b>	<b>Ten (10%) of Operations Year 1 Contract Amount</b>
<b>Operations Year 2</b>	<b>TBD</b>	<b>Ten (10%) of Operations Year 2 Contract Amount</b>
<b>Operations Year 3</b>	<b>TBD</b>	<b>Ten (10%) of Operations Year 3 Contract Amount</b>

**B. Performance Bond Requirements**

- 1. The initial performance bond shall be furnished to the Agency’s Procurement Office within thirty (30) calendar days after execution of this Contract and prior to commencement of any work under this Contract.
- 2. Thereafter, the performance bond shall be furnished on an annual basis, thirty (30) calendar days prior to the new Contract year.

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3. The initial performance bond shall be in the amount of ten percent (10%) of the current annual Contract amount and shall be submitted to the Agency's Procurement Office at:

**Procurement Office**  
**Agency for Health Care Administration**  
**2727 Mahan Drive, Mail Stop 15**  
**Tallahassee, FL 32308**

4. A copy of all performance bonds shall be submitted to the Agency's Contract Manager.
5. The performance bond must not contain any provisions that shorten the time for bringing an action to a time less than that provided by the applicable Florida Statute of Limitations. (See Section 95.03, F.S.)
6. No payments will be made to the Vendor until an acceptable performance bond is furnished to the Agency. The performance bond shall remain in effect for the full term of this Contract, including any renewal period. The Agency shall be named as the beneficiary of the Vendor's bond. The bond shall provide that the insurer(s) or bonding company(ies) pay losses suffered by the Agency directly to the Agency.
7. The cost of the performance bond will be borne by the Vendor.
8. Should the Vendor terminate this Contract prior to the end of this Contract period, an assessment against the bond will be made by the Agency to cover the costs of selecting a new Vendor. The Vendor agrees that the Agency's damages in the event of termination by the Vendor shall be considered to be for the full amount of the bond. The Agency need not prove the damage amount in exercising its right of recourse against the bond.

**IX. Contract Transition**

- A. At the time of this Contract's completion, the Vendor shall cooperate with the Agency in transitioning responsibilities of this Contract to the Agency or another vendor.
- B. The Vendor shall deliver to the Agency, or its authorized representative, all Contract-related records and data in a format specified by the Agency, within sixty (60) calendar days from the expiration or termination of this Contract. This obligation survives termination of this Contract.
- C. Prior to the ending or termination of this Contract, the Vendor shall meet with the new vendor or the Agency's designated representative(s) to develop a HIPAA compliant, written agreement that sets forth how the entities will cooperate to ensure an effortless transition. The agreement must be approved by the Agency prior to execution and shall include at a minimum, the following:
1. Designated point of contact for both entities;
  2. A calendar of regularly scheduled meetings;

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3. A detailed list of data that will be shared;
4. A mechanism and timeframe for transmitting records and data from the Vendor's system;
5. A mechanism and timeframe for transmitting documents produced under this Contract, as requested by the Agency;
6. A clear description of the mutual needs and expectations of both entities; and
7. Identification of risks and barriers associated with the transition of services to a new vendor and solutions for overcoming them.

#### **X. System Functionality**

- A. The Vendor shall have the capacity (hardware, software, and personnel) sufficient to access and generate all data and reports needed for this Contract.
- B. The Vendor shall comply with HIPAA and the HITECH Act.
- C. The Vendor shall have protocols and internal procedures for ensuring system security and the confidentiality of recipient identifiable data.
- D. The Vendor shall ensure an annual SOC 2 Type II audit is performed on the application hosting center. The Vendor shall provide a copy of the most recent audit report to the Agency.

#### **XI. Information Technology**

- A. The Vendor shall have the necessary information technology (IT) resources needed to fully manage the product required in this Contract.
- B. Agency Contract Managers shall be responsible for submitting and managing Vendor staff requests or needs for access connectivity to the Agency's data communications network, and the relevant information systems attached to this network, in accordance with all applicable Agency policies, standards and guidelines. The Vendor shall notify the Agency of termination of any staff with access to the Agency's network within twenty-four (24) hours of the termination.
- C. Vendor staff that have access connectivity to the Agency's data communications network shall be required to complete Agency Security Awareness Training and Agency HIPAA Training. The Vendor shall also be required to sign an Acceptable Use Acknowledgement Form and submit the completed form to the Agency's Information Security Manager (ISM). The requirements described in this **Item** must be completed before access to the Agency's network is provided.
- D. **Development Requirements**

**This Sub-Section is applicable if the Vendor solution or service includes interoperability with the Agency's information technology enterprise.**

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1. The Vendor shall provide the Agency, providers, and others as identified in this Contract, with the necessary software to execute the requested system.
2. The Vendor's software when implemented, shall meet the implementation day's industry's best practices and standards NIST (National Institute for Standards and Technology), and W3C (World Wide Web Consortium) which includes development tools.
3. The Vendor shall develop a system that allows Agency staff to access the system from the Agency network and mobile devices.
4. The Vendor shall allow Agency access to the data for reporting purposes. Data exports shall comply with the National Information Exchange Model (NIEM) format.
5. The Vendor's architecture and design document will be reviewed by the Agency's Division of IT before coding starts. This will require a personal presentation by the Vendor's architect(s).
6. Comments will be used in the code to help other developers to understand the coding methodology/logic that was used.
7. Proper exception handling is required.
8. Logging and Auditing may be required for some systems.
9. Usage of Session and Cache should be limited.
10. Hard coded values are not allowed for referencing the shared resource address and name. This includes: URL (Uniform Resource Locator) name, file path, email address, database connection string, etc.
11. The website shall be Section 508 compliant and follow W3C industry standards and best practices.
12. The website shall contain the Agency header and footer that are currently on [ahca.myflorida.com](http://ahca.myflorida.com).
13. Chrome, Firefox, Safari and Internet Explorer are the most commonly used browsers. Internet applications must be compatible with all internet browsers recognized by the World Wide Web Consortium, <http://www.w3.org/>. The Vendor shall deploy the system to be browser agnostic while keeping up with the most current versions of Internet browser releases in coordination with the Agency's Division of IT standards. Compatibility is required by the Vendor with all supported versions within six (6) months of the browser's official release.
14. All code shall be submitted to the Agency by the Vendor for standards review prior to user testing. This code review requires a personal presentation by the Vendor's coder(s).

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15. The Vendor's test plan shall be prior-approved by the Agency's Division of IT. The system will be tested on and off site using different browsers and different devices.
16. The documents listed below are required as part of the Vendor's application development:
  - a. Architecture design;
  - b. Security model;
  - c. Technical specifications;
  - d. Database entity relationship diagram;
  - e. Data Dictionary;
  - f. User documentation;
  - g. Test plan;
  - h. Deployment plan; and
  - i. Maintenance requirements.

**E. Below is the Agency's current environment:**

1. HIPAA and CJIS (Criminal Justice Information System) compliance;
2. Microsoft office;
3. SQL (Structured Query Language) server;
4. Microsoft Azure and Office 365;
5. SFTP (Secure File Transfer Protocol);
6. WEB Services;
7. MVC (Model View Controller);
8. C#;
9. TFS (Team Foundation Server);
10. WEB Applications;
11. Laserfiche;
12. SharePoint;



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13. SSL (Secure Sockets Layer) and TLS (Transport Layer Security); Mobile devices; and
  14. SSRS (SQL Server Report Services) and Tableau.
- F. The Vendor must adhere and comply with the Agency's Division of IT standards regarding SSL Web interface(s) and TLS.
  - G. The Vendor must adhere to the Driver Privacy Protection Act (DPPA) rules that address a memorandum of understanding and security requirements as well as other requirements contained in Rule.
  - H. The Vendor, its employees, subcontractors and agents shall provide immediate notice to the Agency Information Security Manager ("ISM") in the event it becomes aware of any security breach and any unauthorized transmission or loss of any or all of the data collected or created for or provided by the Agency ("State Data") or, to the extent the Vendor is allowed any access to the Agency's information technology ("IT") resources, provide immediate notice to the ISM, of any allegation or suspected violation of security procedures of the Agency. Except as required by law and after notice to the Agency, the Vendor shall not divulge to third parties any confidential information obtained by the Vendor or its agents, distributors, resellers, subcontractors, officers or employees in the course of performing this Contract work according to applicable rules, including, but not limited to, Rule 60GG-2, Florida Administrative Code (FAC) and its successor regulation, security procedures, business operations information, or commercial proprietary information in the possession of the State or the Agency. After the conclusion of this Contract unless otherwise provided herein, the Vendor shall not be required to keep confidential information that is publicly available through no fault of the Vendor, material that the Vendor developed independently without relying on the State's confidential information, or information that is otherwise obtainable under State law as a public record.
  - I. In the event of loss of any State Data or record where such loss is due to the negligence of the Vendor or any of its subcontractors or agents, the Vendor shall be responsible for recreating such lost data in the manner and on the schedule set by the Agency at the Vendor's sole expense, in addition to any other damages the Agency may be entitled to by law or this Contract. In the event lost or damaged data is suspected, the Vendor will perform due diligence and report findings to the Agency and perform efforts to recover the data. If it is unrecoverable, the Vendor shall pay all the related costs associated with the remediation and correction of the problems engendered by any given specific loss. Further, failure to maintain security that results in certain data release will subject the Vendor to the administrative sanctions for failure to comply with Section 501.171, F.S., together with any costs to the Agency of such breach of security caused by the Vendor. If State Data will reside in the Vendor's system, the Agency may conduct, or request the Vendor conduct at the Vendor's expense, an annual network penetration test or security audit of the Vendor's system(s) on which State Data resides. All Vendor personnel who will have access to State-owned Data will undergo the background checks and screenings described in this Contract.
  - J. The Vendor shall ensure that call centers, Information Technology (IT) help desks or any other type of customer support provided directly under this Contract, shall be located only in the forty-eight (48) contiguous United States.

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- K.** The Vendor must conform to current and updated publications of the principles, standards, and guidelines of the Federal Information Processing Standards (FIPS), the National Institute of Standards and Technology (NIST) publications, including but not limited to [Cybersecurity-Framework](#) and [NIST.SP.800-53r4](#).
- L.** The Vendor must employ traffic and network monitoring software and tools on a continuous basis to identify obstacles to optimum performance.
- M.** The Vendor must employ traffic and network monitoring software and tools on a continuous basis to identify email and Internet spam and scams and restrict or track user access to appropriate websites.
- N.** The Vendor must employ traffic and network monitoring software and tools on a continuous basis to identify obstacles to detect and prevent hacking, intrusion and other unauthorized use of the Vendor's resources.
- O.** The Vendor must employ traffic and network monitoring software and tools on a continuous basis to prevent adware or spyware from deteriorating system performance.
- P.** The Vendor must employ traffic and network monitoring software and tools on a continuous basis to update virus blocking software daily and aggressively monitor for and protect against viruses.
- Q.** The Vendor must employ traffic and network monitoring software and tools on a continuous basis to monitor bandwidth usage and identify bottlenecks that impede performance.
- R.** The Vendor must employ traffic and network monitoring software and tools on a continuous basis to provide methods to flag recipient data to exclude Protected Health Information (PHI) from data exchanges as approved by the State, and to comply with recipient rights under the HIPAA privacy law for: 1) Requests for restriction of the uses and disclosures on PHI (45 Code of Federal Regulations (CFR) 164.522(a)); 2) Requests for confidential communications (45 CFR 164.522(b)); and 3) Requests for amendment of PHI (45 CFR 164.526). The Vendor must also enter into a Business Associate Agreement ("BAA") with the Agency. The provisions of the BAA apply to HIPAA requirements and in the event of a conflict between the BAA and the provisions of this **Sub-Section**, the BAA shall control. (See **Attachment A**, Instructions and Special Conditions, **Exhibit A-8**, Standard Contract, Business Associate Agreement).
- S.** The Vendor shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or Federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with Federal Information Processing Standards (FIPS), and/or the National Institute of Standards and Technology (NIST) publications regarding cryptographic standards.
- T.** In order to enable the Agency to effectively measure and mitigate the Vendor's security risks the Agency may conduct an initial IT security risk score scan on the Vendor, as well as periodic or continuous security monitoring through an information security rating service, at the Agency's expense, to enable the Agency to effectively measure and mitigate the Vendor's security risks. The Vendor will work with the Agency's Security

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Rating Score Provider to define the relevant Vendor assets providing Agency services. If the Vendor does not maintain a top tier security rating score, the Agency will impose liquidated damage(s) and/or other applicable sanction(s).

#### **XII. Disaster Recovery**

- A.** The Vendor shall 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. The disaster recovery plan shall limit service interruption to a period of twenty-four (24) clock hours and shall ensure compliance with all requirements under this Contract. The records backup standards and a comprehensive disaster recovery plan shall be developed and maintained by the Vendor for the entire period of this Contract and submitted for review annually by the anniversary date of this Contract.
- B.** The Vendor shall maintain a disaster recovery plan for restoring day-to-day operations including alternative locations for the Vendor to conduct the requirements of this Contract. The disaster recovery plan shall limit service interruption to a period of twenty-four (24) clock hours and shall ensure compliance with all requirements of this Contract.
- C.** The Vendor shall maintain database backups in a manner that shall eliminate disruption of service or loss of data due to system or program failures or destruction.
- D.** The disaster recovery plan shall be finalized no later than thirty (30) calendar days prior to this Contract effective date. The Agency shall review the Vendor's disaster recovery plan during the readiness review.
- E.** The Agency, at its discretion, reserves the right to direct the Vendor to amend or update its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.
- F.** The Vendor shall make all aspects of the disaster recovery plan available to the Agency at all times.
- G.** The Vendor shall conduct an annual Disaster Recovery Plan test and submit results for review to the Agency in the annual plan submitted in compliance with **Section XII.**, Disaster Recovery, **Sub-Section A.**

#### **XIII. Smartphone Applications**

The Vendor shall receive written approval from the Agency Division of Information Technology before implementation of a smartphone application. If the Vendor uses smartphone applications (apps) to allow providers direct access to Agency-approved documents and/or content, the Vendor shall comply with the following:

- A.** The smartphone application shall disclaim that the application being used is not private and that no PHI or Personally Identifiable Information (PII) should be published on this application by the Vendor or provider; and
- B.** The Vendor shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines; for example:

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1. OWASP [Open Web Application Security Project] Secure Coding Principles – [http://www.owasp.org/index.php/Secure\\_Coding\\_Principles](http://www.owasp.org/index.php/Secure_Coding_Principles);
2. CERT Security Coding - <http://www.cert.org/secure-coding/>; and
3. Top10SecuritycodingPractices – <https://www.securecoding.cert.org/confluence/display/seccode/Top+10+Secure+Coding+Practices>

#### **XIV. Social Networking**

- A. All social networking applications, tools or media interactions and communications must be approved in writing by the Agency, prior to use. Any vendor using social networking applications is responsible and accountable for the safeguarding of PHI and all HIPAA Privacy Rule related information must be maintained and monitored.
- B. In addition to all other review and monitoring aspects of this Contract, the Agency, at its discretion, reserves the right to monitor or review the Vendor's monitoring of all social networking activity without notice.
- C. The Vendor shall not conduct business relating to this Contract that involves the exchange of personally identifying, confidential or sensitive information on the Vendor's social network application. The Vendor shall not post information, photos, links/URLs or other items online that would reflect negatively on any individual(s), its enrollees, the Agency or the State.
- D. Any violations of this provision shall subject the Vendor to administrative action by the Agency as determined by the Agency.

#### **XV. Definitions and Acronyms**

##### **A. Definitions**

**Ad Hoc** – A report designed for a specific purpose, case, or situation.

**Agency** — State of Florida, Agency for Health Care Administration (AHCA), its employees acting in their official capacity, or its designee.

**Agency Information Technology (IT) Enterprise** – Any interconnected system(s) or subsystem(s) or equipment that is used in the automatic acquisition, storage, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information by the Agency.

**Business Day** – Traditional workday, including Monday, Tuesday, Wednesday, Thursday, and Friday. State holidays are excluded.

**Calendar Day** – All seven days of the week. A twenty-four (24) hour period between midnight and midnight, regardless of whether or not it occurs on a weekend or holiday.

**Calendar Year** — A twelve (12) month period of time beginning on January 1 and ending on December 31.

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**Centers for Medicare & Medicaid Services** — The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act.

**Contract** – The written agreement between the Agency and the Vendor comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

**Contract Amendment** – Any written alteration in the specifications, delivery point, rate of delivery, Contract period, price, quantity, or other Contract provisions of any existing Contract.

**Contract Manager** – An individual designated to act as liaison between the Agency and the Vendor and is responsible for the management of this Contract.

**Encounter Data** — A record of diagnostic or treatment procedures or other medical, allied, or long-term care provided to the health plan's Medicaid enrollees, excluding services paid by the Agency on a fee-for-service basis.

**Enrollee** — A Medicaid recipient enrolled in a Managed Care Plan.

**External Quality Review** — The analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a health plan.

**External Quality Review Organization** — An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other related activities as set forth in federal regulations, or both.

**Healthcare Effectiveness Data and Information Set** – The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

**Health Information Technology for Economic and Clinical Health Act** – Legislation that addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

**Health Insurance Portability and Accountability Act** - A US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

**Interoperability** – The ability of a system to work with or use the parts or equipment of another system, and characterized by seamless coordination and integration with other systems.

**Managed Care Plan** — An eligible plan under Contract with the Agency to provide services in the LTC or MMA Statewide Medicaid Managed Care Program.

**Medicaid** — The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency under s. 409.901, F.S., et seq.

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**Performance Standards** - The criteria by which Vendor performance is measured.

**Protected Health Information** – For purposes of this Contract, protected health information shall have the same meaning and effect as defined in 45 CFR and 164, limited to the information created, received, maintained or transmitted by the Recipient from, or on behalf of the Agency.

**Protocols** — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

**State Fiscal Year** — The State of Florida government’s fiscal year, which starts July 1 and ends on June 30.

**Statewide Medicaid Managed Care Program** — A program authorized by the 2011 Florida Legislature through House Bill 7107, creating Part IV of Chapter 409, F.S., to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC) and includes two programs: Managed Medical Assistance (MMA) and Long-term Care (LTC).

**Subcontract** — An agreement entered into by the health plan for the delegation of some of its functions, services or responsibilities for providing services under this Contract.

**Subcontractor** — Any person or entity with which the health plan has contracted or delegated some of its functions, services or responsibilities for providing services under this Contract.

**System Downtime** — The measurement of the system’s reliability, expressed as the percentage of time the system is unavailable.

**Vendor** – The entity that contracts directly with the Agency for the work specified within this Contract.

#### **B. Acronyms**

<b>Apps</b>	Applications
<b>BAA</b>	Business Associate Agreement
<b>CAP</b>	Corrective Action Plan
<b>CFR</b>	Code of Federal Regulations
<b>CJIS</b>	Criminal Justice Information System
<b>DPPA</b>	Driver Privacy Protection Act
<b>EEO</b>	Equal Employment Opportunity
<b>FAC</b>	Florida Administrative Code

**ATTACHMENT B**  
**SCOPE OF SERVICES (February 17, 2020)**

<b>FIPS</b>	Federal Information Processing Standards
<b>FS</b>	Florida Statutes
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HITECH</b>	Health Information Technology for Economic and Clinical Health
<b>ISM</b>	Information Security Manager ( )
<b>IT</b>	Information Technology
<b>LIP</b>	Low Income Pool
<b>MVC</b>	Model View Controller
<b>NIEM</b>	National Information Exchange Model
<b>NIST</b>	National Institute for Standards and Technology
<b>PHI</b>	Protected Health Information
<b>PII</b>	Personally Identifiable Information
<b>PL</b>	Public Law
<b>SFTP</b>	Secure File Transfer Protocol
<b>SOC</b>	Service Organization Controls
<b>SQL</b>	Structured Query Language
<b>SSL</b>	Secure Sockets Layer
<b>SSRS</b>	SQL Server Report Services
<b>TFS</b>	Team Foundation Server
<b>TLS</b>	Transport Layer Security
<b>URL</b>	Uniform Resource Locator
<b>US</b>	United States
<b>USC</b>	United States Code
<b>W3C</b>	World Wide Web Consortium

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**ATTACHMENT B  
EXHIBIT B-1  
DELIVERABLES, ASSOCIATED PAYMENT AND FINANCIAL CONSEQUENCES**

<b>1.</b>	<b><u>DELIVERABLE</u></b>
	Performance Improvement Project (PIP) Validation Forms
	<b><u>SUPPORTING DOCUMENTATION</u></b>
	The Vendor shall submit a final PIP validation form for each PIP that is validated by the Vendor for this Contract.
	<b><u>EVALUATION CRITERIA</u></b>
	The Agency Contract Manager reviews for minimum quality standards. The deliverable shall meet "minimum quality standards" upon it being submitted in accordance with the deliverable description provided in <b>Attachment B</b> , Scope of Services, <b>Section II.</b> , Manner of Service(s) Provision, <b>Sub-Section B.</b> , Services Provided by the Vendor, <b>Item 2.</b> , Category A: Validation of Performance Improvement Projects, <b>Sub-Item b.</b>
	<b><u>DUE DATE(S)</u></b>
	Annually per Contract year.
	<b><u>AMOUNT</u></b>
	Unit cost per documented completion of validation of PIP per health plan.
	<b><u>PERFORMANCE STANDARDS</u></b>
The Vendor shall submit the deliverable in accordance with the description provided in <b>Attachment B</b> , Scope of Services, <b>Section II.</b> , Manner of Service(s) Provision, <b>Sub-Section B.</b> , Services Provided by the Vendor, <b>Item 2.</b> , Category A: Validation of Performance Improvement Projects, <b>Sub-Item b.</b>	
<b><u>FINANCIAL CONSEQUENCES</u></b>	
<b>\$500.00</b> per business day for each business day beyond the due date.	

<b>2.</b>	<b><u>DELIVERABLE</u></b>
	Performance Improvement Project (PIP) Pseudo-Validation Forms
	<b><u>SUPPORTING DOCUMENTATION</u></b>
	The Vendor shall submit a pseudo-validation form for each PIP that has a high-level review completed by the Vendor for this Contract.
	<b><u>EVALUATION CRITERIA</u></b>
	The Agency Contract Manager reviews for minimum quality standards.
	<b><u>DUE DATE(S)</u></b>
	Annually per Contract year.
	<b><u>AMOUNT</u></b>
	Unit cost per documented completion of a PIP pseudo-validation per health plan.
	<b><u>PERFORMANCE STANDARDS</u></b>
The Vendor shall submit the deliverable in accordance with the description provided in <b>Attachment B</b> , Scope of Services, <b>Section II.</b> , Manner of Service(s) Provision, <b>Sub-Section B.</b> , Services Provided by the Vendor, <b>Item 2.</b> , Category A: Validation of Performance Improvement Projects, <b>Sub-Item b.</b>	
<b><u>FINANCIAL CONSEQUENCES</u></b>	
<b>\$500.00</b> per business day for each business day beyond the due date.	

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**ATTACHMENT B  
EXHIBIT B-1  
DELIVERABLES, ASSOCIATED PAYMENT AND FINANCIAL CONSEQUENCES**

<b>3.</b>	<b><u>DELIVERABLE</u></b>
	Performance Measure Validation (PMV) Report
	<b><u>SUPPORTING DOCUMENTATION</u></b>
	The Vendor shall submit a final report that evaluates the accuracy of Medicaid performance measures reported by or on behalf of each health plan and determine the extent to which Medicaid-specific performance measure calculations followed State specifications.
	<b><u>EVALUATION CRITERIA</u></b>
	One hundred percent (100%) of quality criteria checked as “accepted” on the Minimum Quality Standards rubric, commentary grid(s) or other documentation indicating on hundred percent (100%) of requested edits required for deliverable approval were completed.
	<b><u>DUE DATE(S)</u></b>
	Annually per Contract year.
	<b><u>AMOUNT</u></b>
	Unit cost per documented completion of validation of performance measures per health plan.
	<b><u>PERFORMANCE STANDARDS</u></b>
	The Vendor shall submit the deliverable in accordance with the description provided in <b>Attachment B</b> , Scope of Services, <b>Section II.</b> , Manner of Service(s) Provision, <b>Sub-Section B.</b> , Services Provided by the Vendor, <b>Item 3.</b> , Category B: Validation of Performance Improvement Projects, <b>Sub-Item b.</b>
<b><u>FINANCIAL CONSEQUENCES</u></b>	
<b>\$500.00</b> per business day for each business day beyond the due date.	