

# EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

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# EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

## SCORED SUBMISSION REQUIREMENTS & EVALUATION CRITERIA INSTRUCTIONS

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

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

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

### Order of Contract Selection

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

1. Florida Medicaid managed care contracts
2. Contracts with another state's Medicaid managed care program that serve children
3. Florida Child Health Insurance Program (CHIP) managed care contracts
4. CHIP managed care contracts with another state

### Completion of Responses

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

Each SRC includes response criteria as follows:

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	Yes/No
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	Yes/No
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	Unlimited, N/A, or ###
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	Yes/No
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	Yes/No
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	Yes/No

## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

Each SRC contains form fields to be used when indicated in the Response Criteria. Population of the form fields with text will allow the form to expand and cross pages. Unless specified in the SRC, there is no character limit. For SRCs with character limits, character counts are inclusive of spaces. Character limits exclude SRC attachments, exhibits charts and maps. Text responses must be formatted for 8-1/2" x 11" paper, single-spaced, and in a size 11 Arial font.

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

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

The SRCs in **Exhibit A-5**, **Exhibit A-5-a**, the associated autoscoring procurement intake tool, **Exhibit A-5-b**, MMA SRC# 26 – Provider Network Tool, may not be retyped and/or modified and must be submitted in the original format.

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

<https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>.

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

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

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

### Scoring of the Responses

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

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

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

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

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
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RESPONDENT NAME: \_\_\_\_\_

**A. INCENTIVIZING VALUE AND QUALITY**

**SRC# 16 – Value-Based Purchasing (VBP): AUTOSCORED**

For the three (3) contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall provide its experience in value-based purchasing (VBP). VBP contracts between health plans and providers are intended to maximize high value care, reduce inappropriate care, and reward best-performing providers. Claims-based expenditures include all claim-based expenditures of the attributable enrollees, whether or not the cost is included in the VBP contract. Attributable enrollees are defined as enrollees that attribute to the dental provider(s) and meet the enrollee qualifications under the VBP contract. The respondent shall provide the following information for each state contract:

1. The percentage of in-network providers who were in at least one LAN 2A+ VBP agreement for CY 2021, 2022, and 2023.
2. The percentage of providers in LAN 2A+ VBP agreements who were paid more than **\$10,000** in rewards because of achieving or surpassing VBP outcomes for CY 2021, 2022, and 2023.
3. The percentage of total claim-based expenditures in LAN 3A+ VBP agreements in CY 2021, 2022, and 2023.

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

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>Yes</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### Response:

Respondents shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, Value-Based Purchasing tab, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, to provide its VBP responses.

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

### Evaluation Criteria:

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

### Score:

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria as indicated in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, in the scores table at the bottom of the Value-Based Purchasing tab. *Note:* For any of the three (3) contracts identified through the Order of Contract Selection for which you have no data for CY 2021, 2022, or 2023, enter "0" in the corresponding score field.

#### **The three (3)-year average percentage of providers who were in at least one LAN 2A+ VBP agreement for CY 2021, 2022, and 2023.**

- 20% or higher = 11.1 points
- 10% to 19.99% = 5 points
- 1% to 9.99% = 1 point
- Less than 1% = 0 points

#### **The three (3)-year average percentage of providers in a LAN 2A+ agreement who were paid more than \$10,000 in rewards for achieving or surpassing VBP outcomes for CY 2021, 2022, and 2023.**

- 20% or higher = 11.1 points
- 10% to 19.99% = 5 points
- 1% to 9.99% = 1 point
- Less than 1% = 0 points

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**The three (3)-year average percentage of total claim-based expenditures in LAN 3A+ VBP agreements for CY 2021, 2022, and 2023.**

20% or higher = 11.1 points

10% to 19.99% = 5 points

1% to 9.99% = 1 point

Less than 1% = 0 points

**The total number of points is the sum of all individual weighted points earned for all three states.**

**Weighting will be applied based on geographic area of the VBP arrangements.**

- Florida VBP arrangements will receive 100% of the state points earned.
- Non-Florida VBP arrangements will receive 90% of the state points earned.

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 17 – Expanded Benefits – Medical: AUTOSCORED

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

1. The Respondent shall identify expanded benefits it proposes to offer its enrollees and submit the per member per month (PMPM) cost of each expanded benefit for the following:
  - Home-delivered meals
  - Newborn circumcision
  - Non-medical transportation
  - Over the Counter (OTC) medications and supplies
  
2. The Respondent may propose additional expanded benefits for the following groups:
  - Caregivers
  - Children and their families when transitioning out of institutional settings, including Statewide Inpatient Psychiatric Program (SIPP).
  - Enrollees aging out of foster care.
  - Enrollees in a home or community-based setting, including children receiving private duty nursing, medical foster care, PPEC, therapeutic group care.
  - Enrollees preparing to transition to adulthood.

The proposed additional expanded benefits may include, but are not limited to:

- Adaptive technology to assist with communication.
- Biometric equipment
- Education support (e.g., tutoring, academic summer camp, after-school programs)
- Home modifications
- Housing assistance
- Housecleaning and sanitization (e.g., carpet cleaning, Flu/Pandemic prevention kits, HEPA filter vacuum cleaner, or hypoallergenic bedding)
- Respite (caregiver support), including caregiver behavioral health services for non-Medicaid caregivers and childcare staff.
- Support for wellness (e.g., sports, swimming lessons and other recreational activity fees, health-related camp, cooking classes, art therapy, and music therapy).

#### Response Criteria:

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



**EXHIBIT A-5  
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Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	Yes
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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### Response:

Respondents shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, Expanded Benefits tab, and **Exhibit A-5-a-1**, Expanded Benefits – Medical located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, to provide information on its proposed Expanded Benefits. **Exhibit A-5-a-1** does not generate a score. However, **failure to submit a completed Exhibit A-5-a-1 may result in rejection of the response.**

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

### Evaluation Criteria:

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

### Score:

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

### The identified expanded benefits the respondent proposes to offer its enrollees:

#### Home Delivered Meals

Yes = 15 points

No = 0 points

#### Newborn Circumcision

Yes = 15 points

No = 0 points

#### Non-Medical Transportation

Yes = 15 points

No = 0 points

#### OTC Medication and Supplies

Yes = 15 points

No = 0 points

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The additional expanded benefits the respondent proposes to offer 1) caregivers; 2) children and their families when transitioning out of institutional settings; 3) enrollees aging out of foster care; 4) enrollees in a home or community-based setting, including children receiving private duty nursing, medical foster care, PPEC, therapeutic group care; and 5) enrollees preparing to transition to adulthood.

Adaptive Technology

Yes = 6 points

No = 0 points

Biometric Equipment

Yes = 6 points

No = 0 points

Education Support

Yes = 6 points

No = 0 points

Housecleaning and Sanitization

Yes = 6 points

No = 0 points

Respite

Yes = 10 points

No = 0 points

Support for Wellness

Yes = 6 points

No = 0 points

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **SRC# 18 – Chronic Disease Management (CDM) Program: AUTOSCORED**

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

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

- Cancer
- Asthma
- Anxiety disorders
- Attention deficit hyperactivity disorder (ADHD)
- Autism
- Depression
- Diabetes (type 1 or type 2)
- Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS)
- Bipolar disorder
- Cardiovascular disease
- Chronic Kidney disease
- Sickle cell disease

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

1. Cancer
  - a. Total number of enrollees with cancer.
  - b. Total number of enrollees who participated in a chronic disease management program for cancer.
  - c. Percent of enrollees with cancer who participated in a chronic disease management program for cancer.
2. Asthma
  - a. Total number of enrollees with Asthma.
  - b. Total number of enrollees who participated in a chronic disease management program for Asthma.
  - c. Percent of enrollees with Asthma who participated in a chronic disease management program for Asthma.
3. A behavioral health focus for one of the following: ADHD, anxiety disorder, autism, or depression.
  - a. Total number of enrollees with a behavioral health condition.
  - b. Total number of enrollees who participated in a chronic disease management program for a behavioral health condition.

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- c. Percent of enrollees who participated in a chronic disease management program for a behavioral health condition.

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

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

### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>Yes</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Chr Disease Management tab, to provide information on its proposed Chronic Disease Management Program.

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Evaluation Criteria:**

1. The extent of chronic disease management programs implemented per contract.
2. The extent of enrollees with cancer who participated in a chronic disease management program for cancer.
3. The extent of enrollees with asthma who participated in a chronic disease management program for asthma.
4. The extent of enrollees with a behavioral health condition (i.e., ADHD, anxiety, autism, depression) who participated in a chronic disease management program for the behavioral health condition.

### **Score:**

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

**Each chronic disease management program for cancer, asthma, ADHD, anxiety, or depression = 2 Points**

**Each of the remaining chronic disease programs implemented per contract = 2 Points**

- Diabetes
- HIV/AIDS
- Bipolar disorder
- Cardiovascular disease
- Chronic kidney disease
- Sickle cell disease

**Percent of enrollees with cancer who participated in a chronic disease management program for cancer:**

If greater than 50% = 5.11 Points

25-50% = 3 Points

1-24.99% = 1 Point

If less than 1% = 0 Points

**Percent of enrollees with asthma who participated in a chronic disease management program for asthma:**

If greater than 50% = 5.11 Points

25-50% = 3 Points

1-24.99% = 1 Point

If less than 1% = 0 Points

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**Percent of enrollees with a behavioral health condition (i.e., ADHD, Anxiety, depression) who participated in a chronic disease management program for the behavioral health condition:**

If greater than 50% = 5.11 Points

25-50% = 3 Points

1-24.99% = 1 Point

If less than 1% = 0 Points

**The total number of points is the sum of all individual weighted points earned for all three contracts.**

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 19 – HEDIS Measures: AUTOSCORED

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent (including respondent's parent, affiliate(s), or subsidiary(ies)) shall provide its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include the target population (e.g., TANF children and adolescents, disabled children and adolescents, children and adolescents that receive LTSS), the geographic area of the Contract (statewide vs. not statewide), the respondent's results for the HEDIS measures specified below for each of last three (3) years (measurement/calendar year (MY/CY) 2020, MY/CY 2021, and MY/CY 2022).

The respondent shall provide the data requested in **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, HEDIS tab to provide results for the following HEDIS Health Plan measures:

#### HEDIS Health Plan Measures

- Asthma Medication Ratio – Total
- Child and Adolescent Well-Care Visits – Ages 3-11 (2021 and 2022 only)
- Child and Adolescent Well-Care Visits – Ages 12-17 (2021 and 2022 only)
- Child and Adolescent Well-Care Visits – Ages 18-21 (2021 and 2022 only)
- Childhood Immunization Status – Combo 3
- Follow-up after Hospitalization for Mental Illness – Total – 7-day Follow-up
- Immunizations for Adolescents – Combo 1
- Well-Child Visits in the First 30 Months – Ages 0-15 Mos. (2021 and 2022 only)
- Well-Child Visits in the First 30 Months – Ages 15-30 Mos. (2021 and 2022 only)
- Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase
- Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total – Blood Glucose and Cholesterol Testing

#### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	Yes
Narrative Response Required? <i>If yes, list in form field below.</i>	No
Character Limit? <i>Character limits are inclusive of spaces.</i>	N/A
Attachments Allowed? <i>If yes, list in form field below.</i>	No
SRC Template Required? <i>Original format must be submitted.</i>	No
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	Yes

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Response:**

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, HEDIS tab, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, to provide data on its HEDIS measures.

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

### **Evaluation Criteria:**

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

### **Score:**

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

There are eighty-four (84) opportunities for a respondent to report prior experience in meeting quality standards for HEDIS Health Plan measures:

- For six (6) measure rates, three (3) states each, three (3) years each.
- For five (5) measure rates, three (3) states each, two (2) years each.

For the measure rates with three (3) years of reporting, a total of 2.22 points is available per state reported. For the measure rates with two (2) years of reporting, a total of 1.48 points is available per state reported. The respondent will be awarded:

- 2.22 points if their reported plan rate exceeded the national Medicaid mean (HEDIS) for each available year, for each available state.
- An additional 0.74 points for each measure rate where the second year's rate is an improvement over the first year's rate.
- An additional 0.74 points for each measure rate where the third year's rate is an improvement over the second year's rate, for each available state.

### **For Each of the 11 HEDIS Measures:**

#### **2020 (excluding five (5) measures with no reporting in 2020)**

Exceeds National Medicaid Mean = 0.74 Points

Does Not Exceed National Medicaid Mean = 0 Points

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **2021**

Exceeds National Medicaid Mean and increased from 2020 = 1.48 Points  
Exceeds National Medicaid Mean, but did not increase from 2020 = 0.74 Points  
Does Not Exceed National Medicaid Mean, but increased from 2020 = 0.74 Points  
Does Not Exceed National Medicaid Mean and did not increase from 2020 = 0 Points

### **2022**

Exceeds National Medicaid Mean and increased from 2021 = 1.48 Points  
Exceeds National Medicaid Mean, but did not increase from 2021 = 0.74 Points  
Does Not Exceed National Medicaid Mean, but increased from 2021 = 0.74 Points  
Does Not Exceed National Medicaid Mean and did not increase from 2021= 0 Points

Additional weighting will be applied based on geographic area of contract.

- Florida contracts that cover 9-11 of the state's 11 Medicaid regions will receive 100% of the points received based on the methodology above.
- Florida contracts that cover 5-8 regions will receive 90% of the points received.
- Florida contracts that cover 1-4 regions will receive 80% of the points received.
- Non-Florida statewide contracts will receive 90% of the points received based on the methodology above.
- Non-Florida contracts that are **not** statewide will receive 80% of the points received.

**The total number of points is the sum of all individual points earned for the HEDIS measures.**

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 20 – Organizational Commitment to Quality: AUTOSCORED

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

#### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>Yes</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

#### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Commitment to Quality tab, to provide information on its proposed Organizational Commitment to Quality.

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

#### Evaluation Criteria:

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

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Score:**

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

### **% improvement in the key metric:**

20% or higher = 15 points

16-19.99% = 12 points

11-15.99% = 9 points

6-10.99% = 6 points

1-5.99% = 3 points

Less than 1% = 0 points

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

20% or higher = 15 points

16-19.99% = 12 points

11-15.99% = 9 points

6-10.99% = 6 points

1-5.99% = 3 points

Less than 1% = 0 points

### **Project Focus**

Mental Health, Disease Management, Medical Foster Care, or Private Duty Nursing= 3.33 Points

Other Focus = 0 Points

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### **B. DELIVERY SYSTEM ENHANCEMENTS AND INTEGRATION**

#### **SRC# 21 – Person-Centered Care and Patient-Centered Medical Homes: AUTOSCORED**

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

1. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall report the percentage of the following physician specialties who practiced in a certified patient-centered medical home (PCMH) in the most recent complete contract year. A certified PCMH is a PCMH formally certified by the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care (AAAHC), the Joint Commission (TJC), or the Utilization Review Accreditation Commission (URAC).
  - a. **Pediatrics** (including Adolescent Medicine), as defined by the **Provider Network Standards Table 4 in Section VII of Exhibit B-1**.
  - b. Board Certified or Board Eligible **Child Psychiatrists**, as defined by the **Provider Network Standards Table 4 in Section VII of Exhibit B-1**.
  
2. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall report the percentage of enrollees that have had outpatient encounters with the same Primary Care Provider at least two times in the last three years, with at least one outpatient visit in CY2020 and one outpatient visit in CY2022. In this SRC, a Primary Care Provider is defined as a physician specializing in any the following specialties:
  - a. **Pediatrics** (including Adolescent Medicine), as defined by the **Provider Network Standards Table 4 in Section VII of Exhibit B-1**.
  
3. For its proposed provider network, the respondent shall state the percentage of the following physician specialties who practice in a certified PCMH at the time of application submission. A certified PCMH is a PCMH formally certified by the NCQA, the AAAHC, the TJC, or the URAC.
  - a. **Pediatrics** (including Adolescent Medicine), as defined by the **Provider Network Standards Table 4 in Section VII of Exhibit B-1**.
  - b. Board Certified or Board Eligible **Child Psychiatrists**, as defined by the **Provider Network Standards Table 4 in Section VII of Exhibit B-1**.

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

4. The respondent shall indicate at the time of bid submission with which of the Florida hospitals they have a written contract that includes coordination of care in a multidisciplinary clinic for medically complex children with:
- a. One or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments, or
  - b. One life-limiting illness or rare pediatric disease (as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

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

### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	1. & 2. Above - Yes 3. & 4 Above - No
Narrative Response Required? <i>If yes, list in form field below.</i>	No
Character Limit? <i>Character limits are inclusive of spaces.</i>	N/A
Attachments Allowed? <i>If yes, list in form field below.</i>	No
SRC Template Required? <i>Original format must be submitted.</i>	Yes
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	Yes

### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, Person-Centered Care tab, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, to provide its Person-Centered Care.

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

### Evaluation Criteria:

1. The extent of in-network physician specialists who have practiced in a PCMH.
2. The extent of enrollees that have had outpatient encounters with the same PCP.
3. The extent of in-network physician specialists who will practice in a PCMH.



**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

4. The extent of Florida hospitals with contracts for coordinated care of medically complex children.

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Score:**

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

### **Percent of in-network physician specialists who practiced in a certified PCMH in the most recent complete contract year:**

#### **Pediatrics** (including Adolescent Medicine)

Greater than 50% = 8.33 Points

25-50% = 3 Points

1-24.99% = 1 Point

Less than 1% = 0 Points

#### **Child Psychiatrists**

Greater than 50% = 8.33 Points

25-50% = 3 Points

1-24.99% = 1 Point

Less than 1% = 0 Points

### **Percent of enrollees that have had outpatient encounters with the same Primary Care Provider (Pediatrics) at least two times in the last three years, with at least one outpatient visit in CY2020 and one outpatient visit in CY2022:**

Greater than 50% = 8.33 Points

25-50% = 3 Points

1-24.99% = 1 Point

Less than 1% = 0 Points

### **Percent of physician specialists who practiced in a certified PCMH at the time of application submission for the prospective contract:**

#### **Pediatrics** (including Adolescent Medicine)

Greater than 75% = 5 Points

50-75% = 3 Points

20-49.99% = 1 Point

Less than 20% = 0 Points

#### **Child Psychiatrists**

Greater than 75% = 5 Points

50-75% = 3 Points

20-49.99% = 1 Point

Less than 20% = 0 Points

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Each contracted children's hospital at the time of response submission = 1 Point**

1. John's Hopkins All Children's Hospital in St. Petersburg
2. Nemours Children's Hospital in Orlando
3. Nicklaus Children's Hospital in Miami
4. Wolfson Children's Hospital in Jacksonville
5. Arnold Palmer Hospital for Children in Orlando
6. Florida Hospital for Children in Orlando
7. Joe DiMaggio Children's Hospital in Hollywood
8. St. Joseph's Children's Hospital in Tampa
9. UF Health Shands Children's Hospital
10. University of Miami Holtz Children's Hospital of Miami
11. Children's Medical Center at Tampa General Hospital
12. Golisano Children's Hospital of Southwest Florida
13. Palm Beach Children's Hospital at St. Mary's Medical Center
14. Salah Foundation Children's Hospital
15. Studer Family Children's Hospital

**The total number of points is the sum of all individual points earned for all three contracts.**

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **SRC# 22 – Behavioral Health/Primary Care Integration: AUTOSCORED**

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

1. For its proposed provider network, the respondent shall state the numbers and percentages of Pediatricians (including Adolescent Medicine) in network who have a Medicaid-provider-enrolled psychiatrist, psychologist, licensed clinical social worker, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist physically available within the building of their medical practice.
2. For its proposed provider network, the respondent shall state the numbers and percentages of Pediatricians (including Adolescent Medicine) in network whose practice has earned National Committee for Quality Assurance (NCQA) Distinction in Behavioral Health Integration.
3. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall report, the numbers and percentages of Pediatricians (including Adolescent Medicine) in network who submitted at least one claim for screening, brief intervention, referral for treatment (SBIRT, H0049 and H0050, G0396 and G0397, and 99408 and 99409) in the most recent available Calendar Year.
4. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), respondent shall report, the numbers and percentages of providers within their network for the following physician specialties who submitted at least one claim for behavioral health integration (BHI) for three consecutive Calendar Years:
  - a. The number and percentage of Pediatricians (including Adolescent Medicine) in network who submitted at least one claim for BHI CPT code 99484.
  - b. The number and percentage of Child Psychiatrists in network who submitted at least one claim for BHI CPT code 99492.
5. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall report, the numbers and percentages of unutilized, peripheral, standard, and core physicians within their network for the following physician specialties for three consecutive Calendar Years:
  - a. All Providers in network
  - b. All Primary Care Providers in network
  - c. Pediatricians (including Adolescent Medicine) in network
  - d. Child Psychiatrists in network

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

6. The respondent shall indicate at the time of bid submission with which of the Florida Pediatric Mental Health Collaborative (FPMHC) Behavioral Health Hubs they have a written contract that includes, but is not limited to, interprofessional consultation between providers and psychiatrists, technical assistance in coordination of mental and medical health care, case management support for referring people to community-based services, and skills-building training of providers in mental health care. The contract may include enhanced payment for behavioral health integration services, interprofessional consultation, case management services, incentive payments for achieving high quality performance, removal of utilization management controls, or other enablement of integrating high quality mental, emotional, and behavioral health care for people and their families in medical offices and the managed health care environment.
- University of South Florida's Florida Center for Behavioral Health Improvements and Solutions
  - Florida State University's College of Medicine Center for Behavioral Health Integration and their partner the Tallahassee Pediatric Behavioral Health Center
  - University of Florida's Department of Psychiatry, Division of Child & Adolescent Psychiatry
  - University of Miami's Miller School of Medicine Department of Psychiatry and Behavioral Sciences
  - Florida International University's Herbert Wertheim College of Medicine Department of Psychiatry and Behavioral Health
  - Nemours Children's Hospital, Division of Developmental and Behavioral Pediatrics, Orlando Florida

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

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

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

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

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

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

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

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

## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

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

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

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

### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>1 &amp; 2 Above - No 3 - 6 Above - Yes</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Behav Health-Prim Care Integ tab, to provide its Behavioral Health/Primary Care Integration response.

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

### Evaluation Criteria:

1. The extent of providers who have a Medicaid-provider enrolled behavioral health practitioner (i.e., psychiatrist, psychologist, licensed clinical social workers, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist).
2. The extent of providers whose practice has earned NCQA Distinction in Behavioral Health Integration.
3. The extent of providers who submitted at least one (1) claim for SBIRT in most recent available CY.

## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

4. The extent of providers who submitted at least one (1) claim for BHI.
5. The extent to which core, standard physicians, peripheral, and unutilized physicians were in-network.
6. The extent to which hubs within the FPMHC are engaged in contracts.

### **Score:**

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

### **For Proposed Provider Network**

**Item 1. All Pediatricians (including Adolescent Medicine) who have a Medicaid-provider-enrolled psychiatrist, psychologist, licensed clinical social worker, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist available within the building of their medical practice:**

50% or greater = 6 Points  
33-49.99% = 3 Points  
15-32.99% = 1 Point  
Less than 15% = 0 Points

**Item 2. All Pediatricians (including Adolescent Medicine) whose practice has earned NCQA distinction in Behavioral Health Integration:**

50% or greater = 1 Point  
33-49.99% = 0.5 Points  
15-32.99% = 0.2 Points  
Less than 15% = 0 Points

### **For Three Contracts**

**Item 3. All Pediatricians (including Adolescence Medicine) who submitted at least one claim for SBIRT in the most recent available CY.**

30% or greater = 5 Points  
15-29.99% = 3 Points  
5-14.99% = 1 Point  
Less than 5% = 0 Points

**Item 4a. All Pediatricians (including Adolescence Medicine) who submitted at least one claim for BHI CPT code 99484 for three consecutive CYs.**

30% or greater = 0.5 Points (per year)  
15-29.99% = 0.3 Points (per year)  
5-14.99% = 0.1 Points (per year)  
Less than 5% = 0 Points (per year)

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Item 4b. All Child Psychiatrists who submitted at least one claim for BHI CPT code 99492 for three consecutive CYs.**

30% or greater = 0.5 Points (per year)

15-29.99% = 0.3 Points (per year)

5-14.99% = 0.1 Points (per year)

Less than 5% = 0 Points (per year)

**Item 5. Core, Standard, Peripheral, Unutilized Physicians for three consecutive CYs:**

**All Providers in network – Core and Standard combined**

70% or greater = 2 Points Per Contract Per CY

40-69.99% = 1 Point Per Contract Per CY

20-39.99% = 0.5 Points Per Contract Per CY

Less than 20% = 0 Points Per Contract Per CY

**All PCPs in network – Core and Standard combined**

70% or greater = 2 Points Per Contract Per CY

40-69.99% = 1 Point Per Contract Per CY

20-39.99% = 0.5 Points Per Contract Per CY

Less than 20% = 0 Points Per Contract Per CY

**Pediatricians (including Adolescent Medicine) in network – Core and Standard combined**

50% or greater = 2 Points Per Contract Per CY

30-49.99% = 1 Point Per Contract Per CY

10-29.99% = 0.5 Points Per Contract Per CY

Less than 10% = 0 Points Per Contract Per CY

**Child Psychiatrists in network – Core and Standard combined**

80% or greater = 1 Point Per Contract Per CY

50-79.99% = 0.5 Point Per Contract Per CY

30-49.99% = 0.2 Points Per Contract Per CY

Less than 30% = 0 Points Per Contract Per CY

**At the Time of Bid Submission:**

**Item 6. FPMHC Hubs**

1 point for every contracted FPMHC hub (six total) at the time of bid submission.

**The total number of points is the sum of all individual points earned for all three years of all three contracts.**

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **SRC# 23 – Health Homes for Children with Medically Complex Conditions: AUTOSCORED**

The goal of health homes for children with medically complex conditions (MCC) is to improve the overall wellbeing of this vulnerable population through enhancements and innovations in care coordination, access to teams of specialists that communicate and coordinate amongst each other, data sharing among pediatricians and specialists, comprehensive care planning, preventive services, family-centered care that minimizes number of clinic visits and resolves scheduling conflicts, reduced acute care such as emergency department visits and hospitalizations, educational support for the child's academic advancement, and quality of life services and supports.

In this SRC, children with MCC are defined as having:

- one or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments, or
- one life-limiting illness or rare pediatric disease (as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

1. For its proposed provider network, the respondent shall indicate which of the Florida children's hospitals listed below they have a written contract/agreement, at the time of application submission, that includes specific contracting for health home services for children with MCC. The health home contracts must include the following minimum elements:
  - a. Specific name of the health home clinic for children with MCC.
  - b. Specific name and Medicaid provider ID of the physician director of the health home clinic for children with MCC.
  - c. Specific name of the lead care coordinator of the health home clinic for children with MCC.
  - d. List of reimbursement codes for special services provided by health homes for children with MCC, such as prolonged services, behavioral health integration services, non-face-to-face services, home visits, care plan oversight, team conferences, transition to adult care management, education and training for patient self-management, and complex chronic care management.

Note: General contracts with clinics or hospitals that do not specifically name the health home clinic or lack specific services provided by health homes for children with MCC are not applicable to this SRC item and will not be awarded points.

- John's Hopkins All Children's Hospital in St. Petersburg
- Nemours Children's Hospital in Orlando
- Nicklaus Children's Hospital in Miami
- Wolfson Children's Hospital in Jacksonville
- Arnold Palmer Hospital for Children in Orlando
- Florida Hospital for Children in Orlando
- Joe DiMaggio Children's Hospital in Hollywood
- St. Joseph's Children's Hospital in Tampa

## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

- UF Health Shands Children's Hospital
- University of Miami Holtz Children's Hospital of Miami
- Children's Medical Center at Tampa General Hospital
- Golisano Children's Hospital of Southwest Florida
- Palm Beach Children's Hospital at St. Mary's Medical Center
- Salah Foundation Children's Hospital
- Studer Family Children's Hospital

2. For its proposed provider network, the respondent shall provide recommendations for specific outcome measures of effective health homes for children with MCC and yearly targets. A maximum of four outcome measures may be submitted.
3. For its proposed provider network, the respondent shall propose the percentage of children with MCC who will receive health home services in the health home clinics listed in Item 1.

### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Health Homes tab, to provide its Health Homes for Children with Medically Complex Conditions response.

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

### Evaluation Criteria:

1. The extent of Florida hospitals with contracts for health home services for children with MCC.
2. The extent of specific outcome measures of effective health homes for children with MCC recommended, along with yearly targets.

## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

3. The extent of enrollees with MCC who will receive health home services in the health home clinics.

**Score:**

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

**For Proposed Provider Network**

**Each contracted children's hospital with contracts for health home services at the time of response submission = 4 Points (60 points maximum).**

**Each outcome measure and yearly target:**

- 4 Outcome Measures and Yearly Targets = 12 Points
- 3 Outcome Measures and Yearly Targets = 9 Points
- 2 Outcome Measures and Yearly Targets = 6 Points
- 1 Outcome Measure and Yearly Target = 3 Points
- 0 Outcome Measures and Yearly Targets = 0 Points

**The percentage of children with MCC who will receive health home services in the health home clinics:**

- Greater than 75% = 28 Points
- 50-75% = 14 Points
- 25-49.99% = 7 Points
- 10-24.99% = 3 Points
- 1-9.99% = 1 Point
- Less than 1% = 0 Points

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **SRC# 24 – Vignette – Specialized Case Management: EVALUATOR SCORED**

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

*Robert is a (5) five-year-old who was admitted to a nursing facility (3) weeks ago after being discharged from the hospital after a month with a diagnosis of Meningitis. Robert was a healthy child until contracting Meningitis. Robert's diagnoses include quadriplegia, encephalopathy, G-tube dependent, developmental delay, and seizures which occur at least twice a week and may be accompanied by loss of consciousness requiring medication and oxygen. Robert receives several complex medications which require monitoring. Robert receives most of his nutrition and medications through a G-Tube but is also able to eat small amounts of baby food. He is incontinent of bowel and bladder and is non-ambulatory. Robert receives nursing, physical therapy, occupation therapy, speech therapy, respiratory therapy, and durable medical equipment (DME)/supplies from the nursing facility. He also attends activities. Robert is non-verbal but recognizes and responds to familiar faces and smiles and laughs when he is happy. Robert's condition has been stable. Robert's mother is having a difficult time coping with his illness, often crying during her visits to the nursing facility and not wanting to leave him. Robert's mother resides in a (2)-bedroom first floor apartment with Robert's two siblings ages (3) three and (7) seven who attend day care and school. The (7) seven-year-old is developmentally delayed and receives services at school. Robert's mother works Monday - Friday during the day in the hotel industry. She takes the bus to work and does not have a car. Robert's mother does not have a strong support system and would not have a back-up family member or friend to care for him if she was unavailable or medical staff was not present. Robert's mother has a high school education in her country of origin but speaks limited English. She lacks knowledge of Robert's medical care and is apprehensive about caring for him without medical support staff but would like him home with her and his siblings.*

The respondent shall describe its approach to case management/care coordination for an enrollee with Robert's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- Case Management/Care Coordination
- Transition Planning/ Discharge Planning
- Private Duty Nursing

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

**Response Criteria:**

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>10,000</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>No</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

**Response:**

**Evaluation Criteria:**

1. The extent to which the respondent:
  - a. Describes processes to initiate individualized transition plans for enrollees with complex medical needs requiring 24-hour skilled nursing and for enrollees residing in a skilled nursing facility.
  - b. Describes the sources of data/information that would be utilized in the assessment process, including timeframes for completion.
  - c. Describes the sources of data/information that would be utilized in the decision making for the authorization or denial of services, including timeframes for completion.
  - d. Identifies service needs (covered and non-covered), supports, DME/supplies, and home modifications to facilitate effective transition to the community.
  - e. Describes service referral processes for each service needed to support transition into the community and connect to available social services (e.g., services offered by other state agencies), educational services and medically necessary health services.
  - f. Describes processes for implementing and coordinating 24-hrs. PDN and other services, including addressing gaps in services.
  - g. Identifies strategies that promote adherence to consistent PDN coverage and PDN contractually required case management ratios (see **Attachment B, Exhibit B-1, Section E. Care Coordination/Case Management, Sub-Section 4. Contact Requirements**).
  - h. Applies strategies to integrate enrollee information across the plan and with PDN providers.
  - i. Describes processes for coordinating with utilization management staff and includes strategies to ensure continuity of care.

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- j. Ensures state mandated reporting of data is accurate, timely, and comprehensive.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care coordination/case management process, which include the following:
- a. Process of identification and assignment of enhanced/specialized care coordination.
  - b. Process describing the transition of an enrollee from the hospital to a skilled nursing facility and with the transition plan completed within 30 days of the admission.
  - c. Describes its strategies for promoting the enrollee's successful transition into the community, including timeframes for the following case management/care coordination activities for enrollee transition planning:
    - (1) Assignment of case manager and initiating and updating the transition plan.
    - (2) Educating the parent(s)/legal guardian(s) on the SNF transition planning process, including identification of barriers, and addressing those barriers, and documentation of the parent(s)/legal guardian(s) choice.
    - (3) Identifying medically necessary Medicaid services and community support with linkage to providers.
    - (4) Attending Children's Multidisciplinary Assessment Team (CMAT) meetings for skilled nursing facility referrals
    - (5) Following up with the facility for updates to the proposed discharge date
    - (6) Communicating with the enrollee/parent(s)/legal guardian(s) to follow up on contacting providers (including PDN providers), assistance with making appointments, to discuss any barriers and service delivery outcomes.
  - d. Describes its strategies for promoting the enrollee's successful transition into the community.
  - e. Strategies to establish and maintain a robust quantity of PDN providers.
  - f. Demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers (including PDN providers) and subcontractors (for delegated functions).
  - g. Describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary inpatient or emergency department use.
  - h. Demonstrates experience in providing services to enrollees with complex social and medical needs (both physical and behavioral) and provides evidence of strategies utilized that resulted in improved health outcomes.

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- i. Describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.
- j. Processes to inform parent(s)/legal guardian(s) on reporting complaints in care coordination, including reporting individual care coordinators and provider failure in real time to the State designated personnel.

**Score:**

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

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

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### **SRC# 25 – Vignette – Quality of Care and Outcomes for Transplant Patients: EVALUATOR SCORED**

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

*Juan is a 13-year-old boy in the 7th grade who has chronic kidney failure and has been on peritoneal dialysis for 1 year. Juan's parents are divorced, his mother has primary custody and is the person who administers his peritoneal dialysis at home. Juan has congenital anomalies that have required access to multiple healthcare providers including his pediatrician, cardiologist, nephrologist, and psychologist. The decision has been made for Juan to receive a kidney transplant, however the work-up for the transplant has taken more time than anticipated, which Juan's mother attributes to the providers not all 'working together'. She has indicated that sometimes she feels like they don't know what tests have already been done or what questions she has already answered, and she identified that she had to follow up on a 'lost' referral during the process. She has indicated that it is difficult to know who to call first when she has a concern about Juan's health. She is worried about how his providers will plan and work together to monitor him for any problems including rejection and she would like support to coordinate his appointments and care pre- and post-transplant. Her preference would be to have real-time electronic access to the plan of care, status of referrals/requests, test results and provider notes.*

*Juan's mother will be his living donor, he did initially resist this option out of concern for her health and routinely asks about her risks and recovery. Juan's mother does have concerns about how she will manage while she is recovering from the surgery, this includes managing meals, laundry and driving along with Juan's post-transplant care. One of her major concerns is that she has used up almost all her leave time from work while managing his current care needs. Juan has expressed feelings of having 'no control' over his life and is focused on hearing about when he can resume participation in sports, go back to being a "normal" kid, and not think about his kidneys all the time. Juan's mother has some concerns about his long-term adherence to the post-transplant regimen. He does currently have a 504 plan at school to accommodate his medical care/appointments and meet his medical needs while at school. Juan's mother has indicated that it has been difficult to negotiate the terms of the 504 plan and she wants it to remain in place and be updated to address his post-transplant needs.*

The respondent shall describe its approach to addressing the needs of an enrollee with Juan's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

1. Case Management leading up to and after the transplant.
2. Discharge Planning
3. Supporting the enrollee and family with home and community services
4. Long-term monitoring for enrollee health outcomes



## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

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

### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>5,000</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>No</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

### Response:

### Evaluation Criteria:

1. The extent to which the respondent:
  - a. Describes innovative solutions to support enrollees and living donors with navigating financial and other challenges.
  - b. Describes effective processes to support enrollees and their families pre-transplant.
  - c. Describes processes to initiate individualized discharge plans for enrollees leaving the hospital.
  - d. Describes the sources of data/information that would be utilized in the decision making for the authorization or denial of home-based services, including timeframes for completion.
  - e. Identifies service needs (covered and non-covered), supports, DME/supplies, specialty pharmacy, drug-level monitoring, and other resources to facilitate effective transition to the community.
  - f. Describes service referral processes for each service needed to support transition into the community and connect to available social services (e.g., services offered by other State agencies) and medically necessary health services.
  - g. Applies strategies to integrate enrollee information across the plan and with providers.
  - h. Describes processes for coordinating with utilization management staff and includes strategies to ensure continuity of care.

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
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**EXHIBIT A-5  
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AND EVALUATION CRITERIA**

**Score:**

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

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

<b>STANDARD EVALUATION CRITERIA SCALE</b>	
<b>Point Score</b>	<b>Evaluation</b>
0	The component was <u>not addressed</u> anywhere in the response submission.
.932	The component is <u>unsatisfactory</u> . It contained significant deficiencies and omissions and lacked meaningful detail.
2.262	The component is <u>poor</u> . It met some of the minimum requirements, but did not address all elements requested.
3.432	The component is <u>adequate</u> . It met the minimum requirements with minimal content and detail.
4.4602	The component is <u>good</u> . It exceeded the minimum requirements and contained good content and detail.
5.88	The component is <u>excellent</u> . It exceeded the minimum requirements and contained exceptional content and detail.

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 26 – Provider Network Agreements/Contracts: AUTOSCORED

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

#### MMA Providers

Allergy	Ophthalmology
Cardiology	Optometry
Cardiology (Pediatric)	Orthopedic Surgery
Cardiovascular Surgery	Otolaryngology
Chiropractic	Pediatrics (Including Adolescent Medicine)
Dermatology	Pharmacy
Endocrinology	Podiatry
Endocrinology (Pediatric)	Pulmonology
Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Units (CSUs)/Freestanding Psychiatric Specialty Hospital	Rheumatology
Fully Accredited Psychiatric Community Hospital (Child) or CSUs/Freestanding Psychiatric Specialty Hospital	Statewide Inpatient Psychiatric Program Providers (Inpatient Psychiatric Under 21 State Plan Benefit)
Gastroenterology	Therapist (Occupational)
General Surgery	Therapist, Pediatric (Occupational)
Infectious Disease	Therapist (Speech)
Internal Medicine Specialist	Therapist, Pediatric (Speech)
Midwife	Therapist (Physical)
Nephrology	Therapist, Pediatric (Physical)
Nephrology (Pediatric)	Therapist (Respiratory)
Neurology	Therapist, Pediatric (Respiratory)
Neurology (Pediatric)	Urology
Neurosurgery	Board Certified/Eligible Psychiatrist (Child)
Obstetrics/Gynecology	Licensed Practitioners of the Healing Arts
Oncology	

#### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### Response:

The respondents shall use **Exhibit A-5-b, SRC# 26** – Provider Network Tool located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, to provide its Provider Network information.

### Evaluation Criteria:

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

### Score:

This SRC is worth a maximum of 100 points. The final score with points earned for each evaluation criteria is indicated in **Exhibit A-5-b, SRC# 26** – Provider Network Tool, in the Scores table at the top of the Scoring tab.

Each Region tab in the tool shows how many contracts/agreements for each type are in place in that region. The respondent shall enter the number of contracts/agreements of each specialty type in that region with which the respondent has an active agreement.

**The ratio of contracts/agreements to the total regional population for each type in the region will be displayed, then points assigned to tiers as follows:**

- Less than 1% = 0 points
- 1-25% = 9 points
- 25.1-50% = 14 points
- 50.1-75% = 19 points
- 75.1-100% = 24 points

The sum total of those points will appear at the top of each Region tab within the tool and will be displayed on the Scoring tab of the tool. Each region has a maximum score of 1,032 points, totaling 9,288 possible points across all 9 regions. The Total Points Earned will be divided by the Total Points Possible to produce a percentage, which will be multiplied by 100 to determine the Provider Network Final Score.

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 27 – Telemedicine: AUTOSCORED

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

1. For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall report the percentage of the following physician specialties who made claim for at least one telemedicine encounter in the most recent complete contract year: Family Practice, Internal Medicine, Pediatrics, Infectious Disease, Child Psychiatrists, Emergency Medicine Physicians, and Mental Health Therapists. A telemedicine encounter is defined as a two-way, synchronous audio and visual connection between patient and provider.
2. For its proposed provider network as provided by the respondent in **Exhibit A-5-b, SRC# 26** – Provider Network Tool, the respondent shall state the percentage of the following physician specialties who will offer telemedicine visits: Family Practice, Internal Medicine, Pediatrics, Infectious Disease, Child Psychiatrists, Emergency Medicine Physicians, and Mental Health Therapists. A telemedicine encounter is defined as a two-way, synchronous audio and visual connection between patient and provider.

#### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	For 1 above – Yes For 2 above – No
Narrative Response Required? <i>If yes, list in form field below.</i>	No
Character Limit? <i>Character limits are inclusive of spaces.</i>	N/A
Attachments Allowed? <i>If yes, list in form field below.</i>	No
SRC Template Required? <i>Original format must be submitted.</i>	Yes
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	Yes

#### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Telemedicine tab, to provide its Telemedicine information.

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

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Evaluation Criteria:**

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

### **Score:**

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

### **Percent of Physician Specialties who submitted a claim for at least one telemedicine encounter in the most recent complete calendar year:**

#### **Family Practice**

10% or greater = 3.09 Points

3-9.99% = 2 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

#### **Internal Medicine**

10% or greater = 3.09 Points

3-9.99% = 2 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

#### **Pediatrics**

10% or greater = 3.09 Points

3-9.99% = 2 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

#### **Infectious Diseases**

10% or greater = 3.09 Points

3-9.99% = 2 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

#### **Child Psychiatrists**

10% or greater = 3.09 Points

3-9.99% = 2 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

Less than 1% = 0 Points

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**EXHIBIT A-5  
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**Emergency Medicine Physicians**

10% or greater = 3.09 Points

3-9.99% = 2 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

**Mental Health Therapists**

10% or greater = 3.09 Points

3-9.99% = 2 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

**Percent of Physician Specialties in the respondent's proposed provider network who will offer telemedicine visits:**

**Family Practice**

10% or greater = 5 Points

3-9.99% = 3 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

**Internal Medicine**

10% or greater = 5 Points

3-9.99% = 3 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

**Pediatrics**

10% or greater = 5 Points

3-9.99% = 3 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

**Infectious Diseases**

10% or greater = 5 Points

3-9.99% = 3 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

**Child Psychiatrists**

10% or greater = 5 Points

3-9.99% = 3 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
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**Emergency Medicine Physicians**

10% or greater = 5 Points

3-9.99% = 3 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

**Mental Health Therapists**

10% or greater = 5 Points

3-9.99% = 3 Points

1-2.99% = 1 Point

Less than 1% = 0 Points

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### **SRC# 28 – Evidence-Based Programs for Children with Intense Behaviors: AUTOSCORED**

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

1. The respondent shall identify Evidence-Based Programs for Children with Intense Behaviors it proposes to offer its enrollees, and the proposed billing services codes, from the following:
  - a. **Homebuilders:** This program is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning and by enlisting them as partners in assessment, goal setting and treatment planning. (Target population is families with children under eighteen (18) years of age.)
  - b. **Motivational Interviewing:** This program is a person-centered, directive method designed to enhance a person's internal motivation for behavior change, to reinforce this motivation and develop a plan to achieve change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. Motivational Interviewing can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate individuals for other treatment modalities. Motivational Interviewing can be used to promote behavior change with a range of target populations and for a variety of problem areas. (Target population is all age groups and individuals.)
  - c. **Multisystemic Therapy:** This program is an intensive treatment for troubled youth. The program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, substance use and out-of-home placements. Multisystemic Therapy addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, school, and community. The intervention strategies are personalized to address the identified drivers. (Target population is families with children ages two (2) to seven (7) years of age.)
  - d. **Parent-Child Interaction Therapy:** This program is a dyadic behavioral intervention for children and their parents or caregivers. Parent-Child Interaction Therapy focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcement of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skill and

## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

master them rapidly. (Target population is families with children ages two (2) to seven (7) years of age.)

- e. **Functional Family Therapy:** This program is a family intervention program for at-risk youth and their families. The programming is delivered by master's level therapists, meeting weekly with families. (Target population is children eleven (11) to eighteen (18) years of age with behavioral or emotional challenges).
- f. **Parents as Teachers:** This program is an early childhood parent education, family support, family well-being, and school readiness home visiting model. It teaches parents skills intended to promote positive child development and prevent child maltreatment. The Parents as Teachers model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings and community resource networks. (Target population is expectant parents and parents with children up to five (5) years of age that in high-risk environments such as teen parents, low income, parental low educational attainment, history of substance use in the family, and chronic health conditions.)
- g. **Brief Strategic Family Therapy:** This program is a brief intervention used to treat adolescent drug use, conduct problems, oppositional behavior, delinquency, aggressive and violent behavior, and risky sexual behavior. Brief Strategic Family Therapy is a family systems approach which recognizes that patterns of interaction in the family influence the behavior of each family member. Brief Strategic Family Therapy directly provides services to parents/caregivers and addresses lack of parental leadership, unhealthy parental collaboration, lack of guidance and nurturance to adolescents in their care. (Target population is families with children under eighteen (18) years of age who display or are at risk for developing problem behaviors including: drug use and dependency, antisocial peer associations, bullying, or truancy.)
- h. **Healthy Families:** This program is a multi-year, intensive, home visiting program. The program best serves families who are high-risk, including those families who may have histories of trauma, intimate partner violence, mental health issues and/or substance use issues. Services focus on promoting healthy parent-child interaction and attachment, increasing knowledge of child development, improving access to and use of services, and reducing social isolation. (Target population is parents of children under five (5) years of age.)
- i. **Nurse Family Partnership:** This program provides home visits by registered nurses to first-time, low -income mothers beginning. The program promotes women's health, pregnancy outcomes, early childhood development, and parenting capacity. It also enhances relationships and economic well-being of mothers and their children. Nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. (Target population is first-time mothers who are pregnant or have a child under two (2) years of age.)

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

- j. **Community Action Teams (CAT):** This program strives to help children and young adults with behavioral health concerns to recover at home safely. These teams also assist families in building and maintaining a support system within their community. CAT is a safe and effective alternative to out-of-home treatment or residential care for children with serious behavioral health conditions. CAT Teams use a multidisciplinary team and in-home/on-site approach to make sure youth and their families receive the appropriate services to improve functioning and manage their behavioral health concerns. Services include care coordination, case management, crisis management, mental health and substance use treatments, psychoeducation, and respite care. (Target population is children and young adults with serious behavioral conditions or complex needs that contribute to family disruption.)
- k. **Hi-Fidelity Wrap-Around Services:** This program is a team-based approach to “wrap” a team around families to help those families work toward family and team identified goals. Team members can include service providers, extended family members, friends, neighbors, and other natural supports. The process is guided by a trained individual and individualized to each family’s culture, values, strengths, and needs. Four phases comprise the wraparound process: initial engagement and assessment, plan development, implementation and plan evolution, and transition to established support systems. (Target population is families at risk due to mental health, substance abuse, trauma, or serious behavioral conditions.)

### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	No
Narrative Response Required? <i>If yes, list in form field below.</i>	No
Character Limit? <i>Character limits are inclusive of spaces.</i>	N/A
Attachments Allowed? <i>If yes, list in form field below.</i>	Yes
SRC Template Required? <i>Original format must be submitted.</i>	Yes
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	Yes

### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, EBP Child Intense Behav tab, to provide information on its proposed Evidence-Based Programs for Children with Intense Behaviors.

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

## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Evaluation Criteria:**

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

### **Score:**

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

### **Evidence-Based Programs for Children with Intense Behaviors Proposed to Offer:**

#### **Homebuilders**

Yes = 8.33 points

No = 0 points

#### **Motivational Interviewing**

Yes = 8.33 points

No = 0 points

#### **Multisystemic Therapy**

Yes = 8.33 points

No = 0 points

#### **Parent-Child Interaction Therapy**

Yes = 8.33 points

No = 0 points

#### **Functional Family Therapy**

Yes = 8.33 points

No = 0 points

#### **Parents as Teachers**

Yes = 8.33 points

No = 0 points

#### **Brief Strategic Family Therapy**

Yes = 8.33 points

No = 0 points

#### **Healthy Families**

Yes = 8.33 points

No = 0 points

#### **Nurse Family Partnership**

Yes = 8.33 points

No = 0 points



**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Community Action Teams**

Yes = 8.33 points

No = 0 points

**Hi-Fidelity Wrap-Around Services**

Yes = 8.33 points

No = 0 points

**Recipient Selected “Yes” to All of the Above Services**

Yes = 8.33 points

No = 0 points

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 29 – Essential Provider Networks: AUTOSCORED

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

#### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

#### Response:

The respondents shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Essential Providers tab, to provide its Statewide Essential Providers. Respondents shall only include those Statewide Essential Providers with which it has a fully executed agreement/contract.

#### Evaluation Criteria:

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

#### Score:

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

#### Percentage of Fully Executed Agreements/Contracts

100% = 100 points  
 90-99.99% = 80 points  
 75-89.99% = 60 points  
 60-74.99% = 40 points  
 40-59.99% = 20 points  
 0-39.99% = 0 points

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 30 – Autism Spectrum Disorder Services: AUTOSCORED

Evidence-Based Practices for Children diagnosed with Autism Spectrum Disorder (ASD) are intended to strengthen and build family relationships, build resiliency, and build skill sets in both children and parents, while reducing maladaptive symptoms of the disorder.

In this SRC, the respondent shall detail its experience in coordinating services and supports for children with autism spectrum disorder. For the purposes of this SRC, the **ICD-10-CM code F84.0** should be used to identify individuals diagnosed with ASD.

#### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>Yes</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

#### Response:

The respondents shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, ASD Services tab, to provide its experience.

#### Evaluation Criteria:

The respondent shall provide the following data:

1. Average time from comprehensive Autism assessment to the start of intervention services.
2. Percentage of individuals with Autism that are utilizing case management services from the respondent.
3. Percentage of children who have received a comprehensive Autism assessment.
4. Identification of social support services for adolescents with autism.
5. Percentage of individuals with Autism who were seen by a primary care physician (PCP) for well visits annually for two years or more.

## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Score:**

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

Points are awarded as follows:

#### **Average time from assessment to start services**

0 – 10 days = 30 points  
11 – 20 days = 26 points  
21 – 30 days = 22 points  
31 – 40 days = 18 points  
> 40 days = 0

#### **Individuals utilizing case management services**

0 – 59% = 0 points  
60% - 64% = 10 points  
65% - 74% = 15 points  
75% - 84% = 20 points  
85% - 100% = 25 points

#### **Children receiving comprehensive autism assessments**

0 – 59% = 0 points  
60% - 64% = 10 points  
65% - 74% = 15 points  
75% - 84% = 20 points  
85% - 100% = 25 points

#### **Individuals receiving annual well-child visits with PCP for 2 or more years**

0 – 59% = 0 points  
60% - 64% = 8 points  
65% - 74% = 12 points  
75% - 84% = 16 points  
85% - 100% = 20 points

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**C. PATHWAYS TO PROSPERITY**

**SRC# 31 – Community Partnerships: AUTOSCORED**

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

The respondent shall provide a list of CBOs with which the respondent has executed a formal contract for health-related services and supports in the upcoming contract period. In **Exhibit A-5-a**, the respondent shall list the CBO name, the CBO’s federal employer identification number (FEIN), the CBO’s Florida Division of Corporations (FDOC) document number, the CBO principal address, the CBO mailing address, the respondent’s contract identification number with the CBO, the contract execution date, a description of the enrollee population(s) being served, a description of the health-related services and supports for said enrollees, whether the CBO contract was designed to directly support living in the least restrictive setting and improve community integration, including supporting educational advancement, whether the CBO contract was designed to directly improve mental health of child or adolescent enrollees, whether the CBO contract was designed to directly improve access to health-related social needs (e.g., childcare, transportation, nutrition, housing and home modifications), regions where the CBO will provide services and supports, counties where the CBO will provide services and supports, whether there will be a closed-loop software system of referrals and service verification between the respondent and CBO, annualized financial investment into the CBO, annualized in-kind investment into the CBO, and whether the CBO has a representative on the respondent’s committees or advisory boards.

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

**Response:**

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Community Partnerships tab, to provide information on Community Partnerships.

## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### Evaluation Criteria:

1. The extent of unique, contracted CBOs with principal address in Florida for the upcoming contract period.
2. The extent to which each CBO provides services or supports in at least one of the following areas:
  - Supporting living in the least restrictive setting and improving community integration, including supporting educational advancement,
  - Improving mental health of children or adolescents, OR
  - Improving access to health-related social needs (e.g., childcare, transportation, nutrition, housing and home modifications).
3. The extent to which at least one CBO provides services or supports in each AHCA region.
4. The extent of Florida counties with at least one CBO providing services and supports to enrollees.
5. The extent to which each CBO uses a closed-loop software system to receive enrollee referrals from health care providers and verify with the respondent that services or supports were provided to enrollees.
6. The extent to which each CBO receives a financial investment from the respondent.
7. The extent to which each CBO receives in-kind support from the respondent.
8. The extent to which each CBO has a representative who serves on a respondent committee or advisory board.

### Score:

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

### **Number of unique, contracted CBOs\* with principal address in Florida for the upcoming contract period.**

Greater than 19 CBOs = 13 Points

10-19 CBOs = 10 Points

5-9 CBOs = 5 Points

1-4 CBOs = 1 Point

0 CBOs = 0 Points

**\*Note:** A CBO with more than one contract with the Respondent for community-based services and supports shall be considered one CBO.

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

**1 Point for each unique, contracted CBOs (up to 20) that provides services or supports in at least one of the following areas (maximum of 13 points):**

- **supporting living in the least restrictive setting and improving community integration, including supporting educational advancement**
- **improving mental health of children or adolescents, or**
- **improving access to health-related social needs (e.g., childcare, transportation, nutrition, housing and home modifications).**

**Number of AHCA regions (up to 9) where at least one of these unique, contracted CBOs provides services or supports.**

8-9 Regions = 9 Points

7 Regions = 7 Points

6 Regions = 6 Points

5 Regions = 5 Points

4 Regions = 4 Points

3 Regions = 3 Regions

2 Regions = 2 Points

1 Region = 1 Point

0 Regions = 0 Points

**Percentage of Florida counties with at least one of these unique, contracted CBOs providing services and supports to enrollees.**

100% of Florida counties = 13 Points

50-99.99% of Florida counties = 10 Points

25-49.99% of Florida counties = 5 Points

1-24.99% of Florida counties = 1 Point

Less than 1% of Florida counties = 0 Points

**Number of these unique, contracted CBOs (up to 13) that uses a closed-loop software system to receive enrollee referrals from health care providers and verify with the Respondent that services or supports were provided to enrollees.**

Greater than 13 CBOs = 13 Points

Each CBO up to 13 = 1 Point each

0 CBOs = 0 Points

**Number of these unique, contracted CBOs (up to 13) that receives a financial investment from the Respondent.**

Greater than 13 CBOs = 13 Points

Each CBO up to 13 = 1 Point each

0 CBOs = 0 Points

**Number of these unique, contracted CBOs (up to 13) that receives in-kind support from the Respondent.**

Greater than 13 CBOs = 13 Points

Each CBO up to 19 = 1 Point each

0 CBOs = 0 Points



**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Number of these unique, contracted CBOs (up to 13) that has a representative who serves on a Respondent committee or advisory board.**

Greater than 13 CBOs = 13 Points

Each CBO up to 13 = 1 Point each

0 CBOs = 0 Points

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 32 – Expanded Benefits – Pathways to Prosperity: AUTOSCORED

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

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

#### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	No
Narrative Response Required? <i>If yes, list in form field below.</i>	No
Character Limit? <i>Character limits are inclusive of spaces.</i>	N/A
Attachments Allowed? <i>If yes, list in form field below.</i>	Yes
SRC Template Required? <i>Original format must be submitted.</i>	Yes
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	Yes

#### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Exp. Benefits-Pathways tab, to provide information on its proposed Expanded Benefits for Pathways to Prosperity.

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

## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Evaluation Criteria:**

- The extent of the respondent's commitment to offering expanded benefits that advance the goals for Pathways to Prosperity

### **Score:**

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

### **Expanded Benefits Proposed to Offer**

#### **Housing assistance**

Yes = 25 points total for one or more complete entry rows (columns B through H)

No = 0 points total for one or more complete entry rows (columns B through H)

#### **Food assistance**

Yes = 25 points total for one or more complete entry rows (columns B through H)

No = 0 points total for one or more complete entry rows (columns B through H)

#### **Non-medical transportation**

Yes = 25 points total for one or more complete entry rows (columns B through H)

No = 0 points total for one or more complete entry rows (columns B through H)

#### **Tutoring, educational support, vocational training, and job readiness**

Yes = 25 points total for one or more complete entry rows (columns B through H)

No = 0 points total for one or more complete entry rows (columns B through H)

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### **SRC# 33 – Vignette – Support Continuous Age-Appropriate Education for Kids: EVALUATOR SCORED**

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

*Isabella is a 10-year-old girl in fifth grade who presents to her pediatric primary care clinic for her annual wellness visit. She has a complex medical history and special healthcare needs due to her diagnosis of cerebral palsy, which was diagnosed shortly after her birth. Isabella was born prematurely at 29 weeks, weighing 3 pounds, 7 ounces. She spent the first few months of her life in the neonatal intensive care unit, where she received intensive medical care and interventions.*

*Since her diagnosis, Isabella has been under the care of multiple healthcare teams, including pediatrician primary care provider, a pediatric neurologist, a pediatric orthopedic surgeon, physical therapists, and occupational therapists. She also receives support from early intervention and special education services at her school.*

*Isabella's cerebral palsy affects her both physically and intellectually. She has spastic diplegia, which primarily affects her legs. She is non-ambulatory and relies on a motorized wheelchair for mobility. Isabella also has difficulty with fine motor skills, which challenges her activities of daily living. She requires assistance with dressing, grooming, and feeding.*

*Isabella's speech is affected by cerebral palsy. She communicates primarily using a communication device that generates speech based on her eye movements. Despite these challenges, she is a bright and motivated young girl who attends a mainstream school with the support of an individualized education program (IEP) plan. She is passionate about sports and computers, and dreams of working on a sports team staff as a manager of websites, smartphone applications, or social media.*

*During this clinic visit, Isabella's mother and father expressed concerns about their daughter's recent difficulty in swallowing, which has led to recurrent respiratory infections. On examination, Isabella's weight appears to have plateaued. The primary care pediatrician ordered a swallowing study and referred her to a pediatric gastroenterologist for further evaluation.*

*Given the increased complexity of Isabella's needs, a nurse in the primary care office recommended the Pediatric Prescribed Pediatric Extended Care (PPEC) program, but wasn't sure what kind of specialized nursing care, therapy, or education was available to children with complex medical conditions.*

*Isabella's mother and father were also concerned about Isabella matriculating into sixth grade. The public school district IEP team is ready to make adaptations that support Isabella's grade promotion, but they need to understand her health needs*

## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

*better. Isabella's current elementary school and upcoming middle school both have school nurses with the capability to provide school-based services, but need assistance in how those services articulate with managed care health plan covered services and expanded benefits.*

The respondent shall describe its approach to case management/care coordination for an enrollee with Isabella's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- Case Management/Care Coordination
- Transition of Care
- Private Duty Nursing
- Patient-Centered Health-Home

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

### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>10,000</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>No</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

### Response:

### Evaluation Criteria:

1. The adequacy of the respondent's approach in case management/care coordination requirements, including but not limited to the following:
  - a. Prior Authorization for the enrollee's service(s) and support(s).
  - b. The provision of information regarding the PPEC program to the enrollee's parents.
  - c. Communication with the enrollee's IEP Team to foster grade promotion.

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

- d. Inclusion of the enrollee's school schedule and IEP plan in the enrollee's healthcare scheduling and care plan, such that the enrollee's health needs and education needs are maximally addressed.
2. The adequacy of the respondent's approach in addressing case management for services not covered by managed care and outside the requirements of this contract.
    - a. Continuity of Care for the enrollee.
    - b. Communication with the IEP team and coordination of the development of an updated IEP plan for the enrollee.
    - c. Education Supports for the enrollee.
    - d. Transportation for the enrollee.
  3. The adequacy of the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care coordination/case management process.
    - a. Process of identification and assignment of enhanced/specialized care coordination.
    - b. Process of leading the coordination of the enrollee's care among multiple healthcare offices and multiple clinic-based care coordinator(s).
    - c. Process of establishing and maintaining clear and reliable communication with the enrollee's patient-centered health-home.
  4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids preventable inpatient or emergency department use.
  5. The adequacy of the respondent's demonstrated experience in providing services to enrollees with complex social and medical needs (both physical and mental) and provides evidence of strategies utilized that resulted in improved health outcomes, grade promotion, and school completion.
  6. The adequacy of the respondent's inclusion of innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

**Score:**

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

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

<b>STANDARD EVALUATION CRITERIA SCALE</b>	
<b>Point Score</b>	<b>Evaluation</b>
0	The component was <u>not addressed</u> anywhere in the response submission.
1.43	The component is <u>unsatisfactory</u> . It contained significant deficiencies and omissions and lacked meaningful detail.
2.86	The component is <u>poor</u> . It met some of the minimum requirements but did not address all elements requested.
4.28	The component is <u>adequate</u> . It met the minimum requirements with minimal content and detail.
5.71	The component is <u>good</u> . It exceeded the minimum requirements and contained good content and detail.
7.14	The component is <u>excellent</u> . It exceeded the minimum requirements and contained exceptional content and detail.

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**SRC# 34 – Commercial Insurance Premium Assistance Program: EVALUATOR SCORED**

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

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>10,000</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>No</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

**Response:**

**Evaluation Criteria:**

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

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

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

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

<b>STANDARD EVALUATION CRITERIA SCALE</b>	
<b>Point Score</b>	<b>Evaluation</b>
0	The component was <u>not addressed</u> anywhere in the response submission.
5	The component is <u>unsatisfactory</u> . It contained significant deficiencies and omissions and lacked meaningful detail.
10	The component is <u>poor</u> . It met some of the minimum requirements but did not address all elements requested.
15	The component is <u>adequate</u> . It met the minimum requirements with minimal content and detail.
20	The component is <u>good</u> . It exceeded the minimum requirements and contained good content and detail.
25	The component is <u>excellent</u> . It exceeded the minimum requirements and contained exceptional content and detail.

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**D. RESPONDENT BACKGROUND AND EXPERIENCE**

**SRC# 35 – Managed Care Experience: AUTOSCORED**

The respondent, including respondent’s parent, affiliate(s), and subsidiary(ies), shall provide a list of up to twenty (20) of its current and/or recent (within five (5) years of the issue date of this solicitation (since October 1, 2019) capitated contracts for managed care services (e.g., medical care, integrated medical and behavioral health services, and transportation services). For purposes of identifying the respondent’s parent, affiliate(s), and subsidiary(ies), see “business relationship” as defined in Section 409.966(3)(b), F.S.

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

1. The line of business (Medicaid or CHIP).
2. The state in which the contract is held.
3. The specific contract implementation date (first date of services provided) and end date of the contract. *Note:* The respondent will enter the contract end date as it appears in the applicable contract. However, dates after October 1, 2019, will not be counted toward the actual length of contract in years.
4. Whether the contract is statewide or not statewide.
5. Total unduplicated population served under the contract.
6. Premium revenue for latest contract year.

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

**Response:**

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Managed Care Experience tab, to provide its managed care experience.

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Evaluation Criteria:**

1. The relevance of the line of business to this Solicitation.
2. The extent of the respondent's ability to maintain contracts. Note: Dates after October 1, 2019, will not be counted toward the actual length of contract in years.
3. The extent of the respondent's experience with statewide versus not statewide contracts.
4. The extent of the respondent's experience with population.

### **Score:**

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

### **Length of Contract:**

Greater than 5 years = 1.75 Points  
3 years to 5 years = 1.0 Point  
1 year to less than 3 years = 0.5 Points  
Less than 1 year = 0 Points

### **State Coverage**

Statewide = 1.50 Points  
Not Statewide = 1.0 Point

### **Total Unduplicated Population Under Contract**

Greater than or equal to 500,000 enrollees = 1.75 Points  
250,000 to 499,999 enrollees = 0.75Points  
Less than 250,000 enrollees = 0 Points

**Total Contract amount is for information only and is unscored.**

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 36 – Compliance History: AUTOSCORED

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

1. The respondent shall provide all the following information:
  - **Liquidated damages, fines, and penalties** - The respondent shall disclose whether any monetary amounts were charged to it due to non-compliance for the previous three (3) full calendar years.
  - **Sanctions** - The respondent shall disclose whether any monetary or non-monetary penalty was imposed upon it for the previous three (3) full calendar years.
  - **Corrective Action Plans (CAPs)** - The respondent shall disclose whether it developed any written plan of action to correct cited deficiencies in compliance with federal or state regulations, rules, or policies for the previous three (3) full calendar years.
  
2. The respondent shall also disclose, for the past five (5) years since October 1, 2019, whether it:
  - Voluntarily terminated a managed care contract, in whole or in part, under which health care services were provided as the insurer.
  - Had a managed care contract partially or fully terminated before the contract end date (with or without cause).
  - Withdrew from a contracted service area of a managed care contract.
  - Requested a reduction of enrollment levels of a managed care contract.

#### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	1. Above - Yes 2. Above - No
Narrative Response Required? <i>If yes, list in form field below.</i>	No
Character Limit? <i>Character limits are inclusive of spaces.</i>	N/A
Attachments Allowed? <i>If yes, list in form field below.</i>	No
SRC Template Required? <i>Original format must be submitted.</i>	Yes
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	Yes

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Compliance tab and Compliance-Terminations tab, to provide its Compliance History response.

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

### Evaluation Criteria:

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

### Score:

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

#### **Liquidated Damages – % Total Revenue Imposed**

0-0.099% = 1 point

0.1-0.199% = 0.5 points

0.2% or greater = 0 points

#### **Number of Sanctions**

0 Sanctions = 5.3 points

1+ Sanctions = 0 points

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Number of CAPs**

0 CAPs = 2 points

1+ CAPs = 0 points

**Number of Terminations**

0 Terminations = 25 points

1+ Terminations = 0 points

**The total number of points is the sum of all individual points earned for all three contracts.**

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**SRC# 37 – Florida Presence: AUTOSCORED**

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

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

**Response:**

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Florida Presence tab, to provide its Florida Presence information.

**Evaluation Criteria:**

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

**Score:**

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

**Presence in Florida**

**Corporate Headquarters**

Yes = 10 Points  
No = 0 Points

**Claims Processing**

Yes = 15 Points  
No = 0 Points

**Member Services**

Yes = 15 Points

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

No = 0 Points

**Provider Services**

Yes = 15 Points

No = 0 Points

**Utilization Management**

Yes = 5 Points

No = 0 Points

**Prior Authorization**

Yes = 5 Points

No = 0 Points

**Case Management**

Yes = 15 Points

No = 0 Points

**Disease Management**

Yes = 5 Points

No = 0 Points

**Quality**

Yes = 15 Points

No = 0 Points

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 38 – Managed Care Plan Accreditation: AUTOSCORED

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

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

#### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

#### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Accreditation tab, to provide its accreditation information.

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

#### Evaluation Criteria:

1. Evidence that the respondent has:
  - (a) Full Managed Care Plan accreditation by a nationally recognized accrediting body (e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAHC)); or
  - (b) Partial/conditional Managed Care Plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAHC); or
  - (c) No Managed Care Plan accreditation or denied accreditation.

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

2. Evidence that the respondent has additive accreditations from one or more of the following programs:
- (a) NCQA Population Health Program Accreditation.
  - (b) URAC Integrated Behavioral Health Designation.

**Score:**

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

**Health Plan Accreditation**

Full 3-Year Accreditation = 50 points

Partial/Conditional Accreditation = 25 points

No Accreditation/Denied Accreditation = 0 points

**Additive Accreditation**

NCQA Population Health Program Accreditation = 25 Points

URAC Integrated Behavioral Health Designation = 25 Points

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

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**E. RECIPIENT AND PROVIDER EXPERIENCE**

**SRC# 39 – Grievances: AUTOSCORED**

The respondent shall provide data and information relevant to its highest-ranking contract identified through the Order of Contract Selection For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), on the performance of its enrollee grievance and appeal system, including providing sufficient staffing to support the grievance and appeal system, and identifying, tracking, trending, and resolving enrollee grievances, appeals, and Medicaid fair hearings for calendar year 2023.

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>Yes – Highest-Ranking Contract</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

**Response:**

Respondents shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Grievances tab, to provide performance metrics for its Grievances.

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

**Evaluation Criteria:**

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

## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

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**Score:**

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

**% Grievances Not Resolved within 90 days**

0-5.99% = 20 Points  
6-10.99% = 15 Points  
11-25.99% = 10 Points  
26% or higher = 0 Points

**% Grievances Per Total Population**

0-5.99% = 20 Points  
6-10.99% = 15 Points  
11-25.99% = 10 Points  
26% or higher = 0 Points

**% Appeals Not Resolved Within 30 days**

0-5.99% = 20 Points  
6-10.99% = 15 Points  
11-25.99% = 10 Points  
26% or higher = 0 Points

**% Appeals Per Total Population**

0-5.99% = 20 Points  
6-10.99% = 15 Points  
11-25.99% = 10 Points  
26% or higher = 0 Points

**% Medicaid Fair Hearings Overturned**

0-5.99% = 20 Points  
6-10.99% = 15 Points  
11-25.99% = 10 Points  
26% or higher = 0 Points

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 40 – Claims Processing and Payment: AUTOSCORED

For the respondent's highest-ranking contract identified through the Order of Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall provide data and information for the time period of the most recent calendar year.

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

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

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

#### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	Yes – Highest-Ranking Contract
Narrative Response Required? <i>If yes, list in form field below.</i>	No
Character Limit? <i>Character limits are inclusive of spaces.</i>	N/A
Attachments Allowed? <i>If yes, list in form field below.</i>	No
SRC Template Required? <i>Original format must be submitted.</i>	Yes
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	Yes

#### Response:

Respondents shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html> Processing and Payment tab, to provide its Claims Processing and Payment Process responses.

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

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Evaluation Criteria:**

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

### **Score:**

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

### **Timeliness of Electronically Submitted Clean Claims:**

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

90-100% = 7.5 Points

80-89.99% = 4.5 Points

79% and below = 0 Points

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**% Paid/Denied within 10 calendar days for Nursing Facility**

95-100% = 7.5 Points

94% and below = 0 Points

**% Paid/Denied within 10 calendar days for Hospice**

95-100% = 7.5 Points

94% and below = 0 Points

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

95-100% = 7.5 Points

94% and below = 0 Points

**% Paid/Denied within 15 calendar days for Durable Medical Equipment (DME)**

95-100% = 7.5 Points

94% and below = 0 Points

**% Paid/Denied within 15 calendar days for County Health Department**

95-100% = 7.5 Points

94% and below = 0 Points

**% Paid/Denied 15 days for All Other Providers:**

95-100% = 7.5 Points

94% and below = 0 Points

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

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

90-100% = 10 Points

80-89.99% = 5 Points

79% and below = 0 Points

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

95-100% = 7.5 Points

94% and below = 0 Points

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

95-100% = 7.5 Points

94% and below = 0 Points

**Accuracy:**

**% Electronically Submitted Claims Accurately processed**

98-100% = 7.5 Points

95-97.99% = 5 Points

90-94.99% = 3 Points

89% and below = 0 Points.

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

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

98-100% = 7.5 Points

95-97.99% = 5 Points

90-94.99% = 3 Points

89% and below = 0 Points.

**Claim Appeals/Grievances:**

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

0-5.99 % Overturned = 7.5 Points

6-10.99% Overturned = 5 Points

11-20.99% Overturned = 3 Points

21% or more Overturned = 0 Points.

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 41 – Provider Engagement Model: AUTOSCORED

For the respondent's highest-ranking contract identified through the Order of Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall provide data and information detailing its experience implementing its provider engagement model with a contract. The respondent must provide three (3) years' worth of data. The respondent shall include the following elements in its response:

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

#### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	<b>Yes – Highest Ranking Contract</b>
Narrative Response Required? <i>If yes, list in form field below.</i>	<b>No</b>
Character Limit? <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
Attachments Allowed? <i>If yes, list in form field below.</i>	<b>No</b>
SRC Template Required? <i>Original format must be submitted.</i>	<b>Yes</b>
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

#### Response:

Respondents shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Provider Engagement tab, to provide the data and details concerning its prior experience operating a provider engagement model.

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

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Evaluation Criteria:**

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

### **Score:**

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

#### **Responsiveness to Provider-Initiated Interactions**

Less than 24 hours = 9.3 Points

24 to 48 hours = 5 Points

More than 48 hours = 0 Points

#### **Frequency of Reviews of Provider Complaint Reasons to Identify Training Needs**

Daily = 3 Points

Weekly = 2 Points

Monthly = 1 Point

Less frequently than monthly = 0 Points

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

Daily = 3 Points

Weekly = 2 Points

Monthly = 1 Point

Less frequently than monthly = 0 Points

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Regularity of Meetings with Provider Associations**

Met regularly = 3 Points

Met irregularly or not at all = 0 Points

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

Met with 5 or more = 3 Points

Met with 1 to 4 = 1 Point

Did not meet = 0 Points

**Frequency of Provider Association Meetings**

Monthly = 3 Points

Quarterly = 2 Points

Less than quarterly = 1 Point

**Coverage of Provider Training Topics:**

- 1. Service Coverage Guidelines**
- 2. Service Authorization Requirements**
- 3. Billing Procedures**
- 4. Claims Processing**
- 5. Payment Timeframes**
- 6. Dispute Resolution Process and Timeframes**
- 7. Department Contract Requirements**

All 7 topics indicated = 3 Points

At least 5 topics indicated = 1 Point

Less than five (5) topics indicated = 0 Points

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

At least 75% = 6.03 Points

50 to 74.99% = 3 Points

Less than 50% = 0 Points

**Frequency of Routine Training Provided**

Unscored

**The total number of points is the sum of all individual points earned for all three years.**

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### **SRC# 42 – Non-Emergency Transportation Performance: AUTOSCORED**

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall provide data reporting its non-emergency transportation (NET) services delivered between January 2023 and January 2024:

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

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

## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

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

### Response Criteria:

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>Yes</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

### Response:

Respondents shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Non-Emergency Transportation tab, to provide performance metrics for its Non-Emergency Transportation Performance.

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

### Evaluation Criteria:

1. The extent of NET trips that resulted in an enrollee arriving on time for an appointment.
2. The extent of NET trips that resulted in an enrollee arriving late for an established, standing order appointment.
3. The extent of NET Leg A trips that resulted in pick-up of an enrollee within fifteen (15) minutes of the scheduled time.
4. The percentage of NET Leg B trips that resulted in pick-up of an enrollee within thirty (30) minutes of the scheduled time.
5. The extent of NET service requests for transporting an enrollee to an urgent care center.
6. The percentage of NET service requests for transporting enrollee following discharge from a hospital fulfilled within three (3) hours of receiving the request.
7. The extent of missed NET trips due to the fault of the NET provider.

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

8. Whether the respondent identifies that it currently uses technological capabilities to track NET trips in real-time utilizing geo-mapping to locate providers at any time during service delivery.
9. Tracking Capability to track and assess completed or missed trips prior to adjudicating claims for those trips.

### Score:

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

#### **Percentage of non-emergency transportation trips that resulted in an enrollee arriving on time for an appointment.**

95% or greater = 5 Points  
90-94.99% = 3 Points  
89.99% or less = 0 Points

#### **Percentage of non-emergency transportation trips that resulted in an enrollee arriving late for an established, standing order appointment.**

3% or less = 2.1 Points  
3.01% or greater = 0 Points

#### **Percentage of non-emergency transportation Leg A trips that resulted in pick-up of an enrollee within fifteen (15) minutes of the scheduled time**

95% or greater = 5 Points  
90-94.99% = 3 Points  
89.99% or less = 0 Points

#### **Percentage of non-emergency transportation Leg B trips that resulted in pick-up of an enrollee within thirty minutes of the scheduled time.**

95% or greater = 5 Points  
90-94.99% = 3 Points  
89.99% or less = 0 Points

#### **Percent of non-emergency transportation service requests for transporting an enrollee to an urgent care center fulfilled within three (3) hours of receiving the request.**

95% or greater = 5 Points  
85-94.99% = 3 Points  
84.99% or less = 0 Points

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Percentage of non-emergency transportation service requests for transporting enrollee following discharge from a hospital fulfilled within three (3) hours of receiving the request.**

95% or greater = 5 Points

85-94.99% = 3 Points

84.99% or less = 0 Points

**Percentage of missed non-emergency transportation trips due to fault of the non-emergency transportation provider.**

0.2% or less = 2.1 Points

0.21% or greater = 0 Points

**Tracking Capability-Real-Time**

Yes = 2.1 Points

No = 0 Points

**Racking Capability-Assessing Missed Trips**

Yes = 2.1 Points

No = 0 Points

**The total number of points is the sum of all individual points earned for all three states.**

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 43 – Consumer Assessment of Healthcare Providers and Systems Results: AUTOSCORED

For the three contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent (including respondent’s parent, affiliate(s), or subsidiary(ies)) shall include the target population (TANF children and adolescents, disabled children and adolescents, children and adolescents that receive LTSS), and the respondent’s results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2022 survey for its child populations. Respondents shall provide the data requested in **Exhibit A-5-a**, CAHPS Measurement Tool, to provide results for the following CAHPS items/composites.

**Health Plan CAHPS:**

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

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

**Response Criteria:**

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>Yes</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>No</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>Yes</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

**Response:**

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, CAHPS tab, to provide CAHPS results.

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

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## **EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA**

### **Evaluation Criteria:**

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

### **Score:**

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

There are fifteen (15) opportunities for a respondent to report prior experience in providing desirable experiences with health care:

- Five (5) health plan measures, three (3) states each, child population for each

For Health Plan CAHPS, the respondent will be awarded:

- 6.67 points if their reported plan rate exceeded the national Medicaid mean, for each available state, for children.

### **Health Plan CAHPS**

#### **Health Plan Rating - Child**

Exceeds National Medicaid Mean = 6.67 Points

Does Not Exceed National Medicaid Mean = 0 Points

#### **Health Care Rating - Child**

Exceeds National Medicaid Mean = 6.67 Points

Does Not Exceed National Medicaid Mean = 0 Points

#### **Getting Needed Care - Child**

Exceeds National Medicaid Mean = 6.67 Points

Does Not Exceed National Medicaid Mean = 0 Points

#### **Getting Needed Care Quickly - Child**

Exceeds National Medicaid Mean = 6.67 Points

Does Not Exceed National Medicaid Mean = 0 Points

#### **Information and Customer Service - Child**

Exceeds National Medicaid Mean = 6.67 Points

Does Not Exceed National Medicaid Mean = 0 Points

**The total number of points is the sum of all individual points earned for all three states.**

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### F. BUSINESS OPERATIONS AND ADMINISTRATION

**SRC# 44 – Encounter Data Submission Compliance: EVALUATOR SCORED**

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

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

**Response Criteria:**

RESPONSE CRITERIA	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>Yes</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>50,000</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>No</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

**Response:**

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

**Evaluation Criteria:**

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

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

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

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

<b>STANDARD EVALUATION CRITERIA SCALE</b>	
<b>Point Score</b>	<b>Evaluation</b>
0	The component was <u>not addressed</u> anywhere in the response submission.
3.33	The component is <u>unsatisfactory</u> . It contained significant deficiencies and omissions and lacked meaningful detail.
6.67	The component is <u>poor</u> . It met some of the minimum requirements but did not address all elements requested.
10.02	The component is <u>adequate</u> . It met the minimum requirements with minimal content and detail.
13.35	The component is <u>good</u> . It exceeded the minimum requirements and contained good content and detail.
16.67	The component is <u>excellent</u> . It exceeded the minimum requirements and contained exceptional content and detail.

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## EXHIBIT A-5 SCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

### SRC# 45 – Management Experience and Retention: AUTOSCORED

For the respondent's highest-ranking contract identified through the Order of Selection (page 3, **Exhibit A-5**, and input into the Respondent Information tab in **Exhibit A-5-a**), the respondent shall describe the extent to which executive managers (e.g., CEO, COO, CFO, CMO, vice presidents, senior managers) have expertise and experience in serving children and adolescents with special health care needs and document such expertise and experience.

#### Response Criteria:

RESPONSE CRITERIA	
Order of Contract Selection Required? <i>See page 2.</i>	<b>Yes – Highest Ranking Contract</b>
Narrative Response Required? <i>If yes, list in form field below.</i>	<b>No</b>
Character Limit? <i>Character limits are inclusive of spaces.</i>	<b>N/A</b>
Attachments Allowed? <i>If yes, list in form field below.</i>	<b>No</b>
SRC Template Required? <i>Original format must be submitted.</i>	<b>Yes</b>
Internal Reports Required? <i>See Attachment A, Section C.1.a.2).</i>	<b>Yes</b>

#### Response:

The respondent shall use **Exhibit A-5-a**, Submission Requirements and Evaluation Response Template, located at <https://www.floridahealth.gov/about/administrative-functions/purchasing/index.html>, Mgmt Exp & Retention tab, to provide its Management Experience information.

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

#### Evaluation Criteria:

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

#### Score:

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

#### Years of experience at senior manager level or above at managed care organizations

5.0 or more = 33.33 Points

3.0-4.99 = 20 Points

1.0-2.99 = 10 Points

Less than 1.0 = 0 Points

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Years of Employment with Respondent**

5.0 or more = 33.33 Points

3.0-4.99 = 20 Points

1.0-2.99 = 10 Points

Less than 1.0 = 0 Points

**Total years of experience serving children and adolescents with special health care needs.**

5.0 or more = 33.33 Points

3.0-4.99 = 20 Points

1.0-2.99 = 10 Points

Less than 1.0 = 0 Points

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

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**SRC# 46 – Fraud and Abuse Compliance Program: EVALUATOR SCORED**

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

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>3,500</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>No</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

**Response:**

**Evaluation Criteria:**

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

**Score:**

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

**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

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

<b>STANDARD EVALUATION CRITERIA SCALE</b>	
<b>Point Score</b>	<b>Evaluation</b>
0	The component was <u>not addressed</u> anywhere in the response submission.
5	The component is <u>unsatisfactory</u> . It contained significant deficiencies and omissions and lacked meaningful detail.
10	The component is <u>poor</u> . It met some of the minimum requirements but did not address all elements requested.
15	The component is <u>adequate</u> . It met the minimum requirements with minimal content and detail.
20	The component is <u>good</u> . It exceeded the minimum requirements and contained good content and detail.
25	The component is <u>excellent</u> . It exceeded the minimum requirements and contained exceptional content and detail.

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**SRC# 47 – Fraud and Abuse Special Investigations Unit (SIU) Manager: EVALUATOR SCORED**

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

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>3,500</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>No</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

**Response:**

**Evaluation Criteria:**

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

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Score:**

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

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

<b>STANDARD EVALUATION CRITERIA SCALE</b>	
<b>Point Score</b>	<b>Evaluation</b>
0	The component was <u>not addressed</u> anywhere in the response submission.
5	The component is <u>unsatisfactory</u> . It contained significant deficiencies and omissions and lacked meaningful detail.
10	The component is <u>poor</u> . It met some of the minimum requirements but did not address all elements requested.
15	The component is <u>adequate</u> . It met the minimum requirements with minimal content and detail.
20	The component is <u>good</u> . It exceeded the minimum requirements and contained good content and detail.
25	The component is <u>excellent</u> . It exceeded the minimum requirements and contained exceptional content and detail.

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**SRC# 48 – Fraud and Abuse Special Investigations Unit (SIU): EVALUATOR SCORED**

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

**Response Criteria:**

<b>RESPONSE CRITERIA</b>	
<b>Order of Contract Selection Required?</b> <i>See page 2.</i>	<b>No</b>
<b>Narrative Response Required?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>Character Limit?</b> <i>Character limits are inclusive of spaces.</i>	<b>3,500</b>
<b>Attachments Allowed?</b> <i>If yes, list in form field below.</i>	<b>Yes</b>
<b>SRC Template Required?</b> <i>Original format must be submitted.</i>	<b>No</b>
<b>Internal Reports Required?</b> <i>See Attachment A, Section C.1.a.2).</i>	<b>No</b>

**Response:**

**Evaluation Criteria:**

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

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**EXHIBIT A-5  
SCORED SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA**

**Score:**

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

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

<b>STANDARD EVALUATION CRITERIA SCALE</b>	
<b>Point Score</b>	<b>Evaluation</b>
0	The component was <u>not addressed</u> anywhere in the response submission.
5	The component is <u>unsatisfactory</u> . It contained significant deficiencies and omissions and lacked meaningful detail.
10	The component is <u>poor</u> . It met some of the minimum requirements but did not address all elements requested.
15	The component is <u>adequate</u> . It met the minimum requirements with minimal content and detail.
20	The component is <u>good</u> . It exceeded the minimum requirements and contained good content and detail.
25	The component is <u>excellent</u> . It exceeded the minimum requirements and contained exceptional content and detail.

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