**RESPONDENT NAME:**

1. **RESPONDENT BACKGROUND / EXPERIENCE**

**Criteria #1-Statewide or Regional Reply**

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

**CMS Regional Clusters**

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

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

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

Delivery System Phase in Options

Option I - MCO

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

Option II - Risk Phase In

* **Non-risk Prepaid Inpatient Health Plan** – For the first two years, the CMS Plan will operate as a cost reimbursement Contract for pharmacy (Year 1 only) and Inpatient (Year 1 and Year 2) claims. The Department will make interim non-risk payments to the Department on a quarterly basis and more frequently based on the Respondents satisfactory performance of its duties and responsibilities as set forth in the Contract. Those payments will be settled to actual expenditures, based on utilization, at the Medicaid FFS fee schedule rate for Medicaid and the established rate(s) for CHIP services.
* **Prepaid Ambulatory Health Plan** – For the first two years, the CMS Plan will operate as a Prepaid Ambulatory Health Plan for Outpatient (Year 1 and Year 2) and Pharmacy (Year 2 only) claims. Respondent will be licensed or certified as a fully risk-bearing entity in the State, or qualified as a provider service network pursuant to section 409.962, Florida Statutes that is paid a prospective per-member-per-month capitation payment for covered services provided to eligible enrollees (section 409.968(1), Florida Statutes).

**Reponses:**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PRIORITY 1 REPLY** | |  |  |  |
|  |  | Option I |  | Option II |
|  |  | (MCO) |  | (RISK PHASE IN) |
| Regional Reply | |  |  |  |
|  | Cluster A (1-4) |  | *or* |  |
|  | Cluster B (5-8) |  | *or* |  |
|  | Cluster B (9-11) |  | *or* |  |
|  |  |  |  |  |
| ***OR*** | | | | |
|  |  |  |  |  |
|  |  | Option I |  | Option II |
|  |  | (MCO) |  | (RISK PHASE IN) |
| Statewide Reply | |  | *or* |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **PRIORITY 2 REPLY** | |  |  |  |
|  |  | Option I |  | Option II |
|  |  | (MCO) |  | (RISK PHASE IN) |
| Regional Reply | |  |  |  |
|  | Cluster A (1-4) |  | *or* |  |
|  | Cluster B (5-8) |  | *or* |  |
|  | Cluster B (9-11) |  | *or* |  |
|  |  |  |  |  |
| ***OR*** | | | | |
|  |  |  |  |  |
|  |  | Option I |  | Option II |
|  |  | (MCO) |  | (RISK PHASE IN) |
| Statewide Reply | |  | *or* |  |

**Evaluation Criteria**

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

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

**Score**

This section is worth a maximum of 100 points.

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

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

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

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**Criteria #2 – Managed Care Experience**

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

Respondent will provide the following information for each identified contract:

* 1. The Medicaid population served (such as TANF, ABD, dual eligible, children, persons with disabilities) and the CHIP population served;
  2. The Medicaid population served (such as TANF, ABD, dual eligible, children, persons with disabilities) and the CHIP population served;
  3. The name and address of the client;
  4. The name of the contract;
  5. The specific start and end dates of the contract;
  6. A brief narrative describing the role of the Respondent and scope of the work performed, including covered populations and covered services;
  7. The use of administrative and/or delegated subcontractor(s) and their scope of work;
  8. The annual contract amount (payment to the Respondent) and annual claims payment amount;
  9. The scheduled and actual completion dates for contract implementation;
  10. The barriers encountered that hindered implementation (if applicable) and the resolutions;
  11. Accomplishments and achievements;
  12. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid, CHIP); and
  13. Whether the contract was capitated, FFS or other payment method.

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

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

**Reply:**

**Evaluation Criteria:**

* + 1. The extent of the Respondent’s experience with providing services to children and youth with medical complexity and integrated medical and behavioral health services.
    2. The extent of the Respondent’s subcontractors’ experience in coordinating or providing services to Medicaid and CHIP recipients.
    3. The extent to which the barriers to implementation experienced by the Respondent have clear resolutions outlined.
    4. The extent to which the Respondent has listed accomplishments and achievements that are relevant to this solicitation.
    5. The extent to which the Respondent’s Medicaid and CHIP populations served are similar to the populations served by the Department and includes children with medical complexity.

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

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# Criteria #3 – Florida Experience

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

**Reply:**

**Evaluation Criteria:**

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

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

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

1. 20 points if the Respondent already has a statewide SMMC or CHIP Contract to provide services (MMA, LTC and/or Specialty).
2. 15 points if the Respondent has an SMMC or CHIP Contract in a subset of regions in the State and the Respondent is proposing to cover a statewide contract.
3. 10 points if the Respondent has an SMMC or CHIP Contract in a subset of regions in the State and the Respondent is proposing to cover only those regions covered in the current SMMC or CHIP contracts.
4. 5 additional points will be awarded if the Respondent has a comprehensive (MMA & LTC) SMMC Contract to provide Medicaid services.
5. 5 additional points will be awarded if the Respondent has a Medicare Advantage Plan to provide services.
6. 0 points will be awarded if the Respondent does not have an SMMC Contract in Florida or a Medicare Advantage Plan contract.

# Criteria #4 – Statutorily Required Florida Presence

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

* 1. Specifying the location of where the Respondent’s corporate headquarters will be located (as defined by section 409.966(3)(c)3, Florida Statutes);
  2. Indicating whether the Respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and
  3. Identifying the number of full-time staff, by operational function (as defined in section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

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

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**Reply:**

**Evaluation Criteria:**

* + 1. Whether the Respondent’s corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).
    2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida.

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

**For Item 1:**

1. 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
2. 0 points if no relevant corporate headquarters in Florida.

**For Item 2:**

1. 5 points if all functions will be performed in Florida;
2. 4 points for 6-7 functions to be performed in Florida;
3. 3 points for 4-5 functions to be performed in Florida;
4. 2 points for 2-3 functions to be performed in Florida;
5. 1 point for 1 function to be performed in Florida;
6. 0 points for no functions to be performed in Florida;
7. 0 points if only community outreach, medical director and State administrative functions will be performed in Florida.

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# Criteria #5 – Contract Performance

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

**Reply:**

**Evaluation Criteria:**

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

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

**For Item 1:**

1. 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction and no service area withdrawals;
2. 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

**For Item 2:**

1. 5 points for no involuntary terminations;
2. 0 points for any involuntary termination based on performance.

**For Item 3:**

1. 5 points for no contract terminations related to patient care;
2. 0 points if termination related to patient care.

**For Item 4:**

1. 5 points for no contract terminations related to provider network management, claims processing or solvency concerns;
2. 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.

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1. **CMS Plan GOALS**

**Criteria #6 - Care Coordination and/or Case Management**

Respondent will describe its approach for identifying, assessing, and implementing interventions for enrollees who present with high service utilization and consistently access services at the highest level of care as defined in Attachment A-2, Core Provisions, Section VI., Coverage and Authorization of Services, E. Care Coordination/Case Management.

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

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

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

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

Respondent’s description will include:

1. A description of the overall proposed case management program;
2. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level with at least two percent of the children with high utilization of services in addition to all children receiving nursing facility and private duty nursing services receiving case management;
3. A description of evidence-based guidelines utilized in the care coordination approach, including interventions deployed to improve enrollee engagement and improve treatment adherence;
4. A description of how the case management program is integrated with disease management program to ensure that all children in the CMS Plan are assigned to a Care Coordinator/Case Manager;
5. A description of performance metrics used to evaluate the efficacy of the case management program, including cost-savings, reduction in the use of higher cost services, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics;
6. A description of the process to assess each child and develop a person-centered care plan including the number of anticipated face-to-face contacts for each child per risk level annual. At least one face-to-face visit must be conducted in the home annually. Other acceptable face-to-face visits can be completed in the community, at doctor’s offices, or through another HIPAA compliant mode including video communications technology;
7. A description of minimum contact frequencies and contact type for each severity and/or risk level including a description of the number of face-to-face versus telephonic contacts for each level as well as the assessment tool and care plan development requirements to be used by the Case Management staff. At a minimum, all children should have quarterly face-to-face visits with plan of care reviews, monthly telephone/e-mail contact, and semi-annual assessments and plan of care development;
8. A description of the maximum caseloads for each Care Coordinator/Case Manager (ratio requirements) and case management support staff (note: the caseloads for children in nursing facilities should not exceed 1:15; for children receiving private duty nursing should not exceed 1:40; and for all other high utilizing children should not exceed 1:90);
9. A description of the qualifications of the case management staff who will interact with enrollees in accordance with Exhibit 1, Respondent Staffing Requirements for Children’s Health and Behavioral Health Benefit Administration;
10. A description of the Respondent’s plan to hire qualified current CMS state employees for Care Coordinator/Case Manager positions and how that plan will ensure that the CMS current enrollees do not have a gap in case management prior to implementation (i.e., offering letters of intent to employ with delayed on-boarding for current CMS Care Coordinators/Case Managers); and
11. A description of the Respondent’s plan to co-locate Care Coordinators/Case Managers at large volume children’s hospitals or provider practices/ clinics or to work with existing Care Coordinators/Case Managers at specialty clinics and other locations, i.e. pediatric and specialty practices, to manage enrollees who are high utilizers of care or at high risk of institutionalization or emergency room use.

**Reply:**

**Evaluation Criteria:**

1. The extent of experience (e.g., number of contracts, enrollees or years) in providing care coordination/case management to similar target populations, including disease or special condition management.
2. The extent to which the described experience demonstrates the ability to effectively provide care coordination/case management to the population proposed.
3. The extent to which the care coordination/case management activities proposed by the Respondent are relevant to the specialty population proposed and include community specific resources such as an on-line search capability for community resources available to Care Coordinators/Case Managers and enrollees. The resource should include contacts for Medicaid and CHIP financial eligibility, SNAP, WIC, utility payment assistance, referral to Legal Aid and local parenting classes or wellness classes available in each community.
4. The extent to which the Respondent proposes an innovative and evidence-based approach to case management for at least the following conditions:
   * + 1. Cancer;
       2. Diabetes;
       3. Asthma;
       4. Sickle Cell Anemia;
       5. Phenylketonuria (PKU) and other metabolic conditions;
       6. Developmental disabilities including Autism;
       7. Rare congenital conditions including cleft lip/palate, spina bifida, congenital heart disease;
       8. Mental health including ADHD and Severe Emotional Disturbance;
       9. Substance abuse;
       10. Hemophilia;
       11. HIV/AIDS; and
       12. “Children with special health care needs” which means those children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children. This includes: arthritis, cerebral palsy, epilepsy, hearing impairments, liver diseases, multiple sclerosis, paralysis of extremities (complete or partial), speech impairments, and visual impairments.
5. The adequacy of the Respondent’s description of how its respective disease management program will be incorporated into its overall Case Management approach to advance the CMS Plan’s goals.
6. The extent to which the Respondent’s algorithm and risk stratification approach is well defined and describes the data sources that will be utilized and ensures that all children will receive Disease/Case Management.
7. The extent to which the Respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.
8. The extent to which the Respondent’s approach includes the use of predictive modeling.
9. The extent to which the Respondent’s approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.
10. The adequacy of the Respondent’s description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.
11. The efficacy of the Respondent’s approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, transitioning children out of institutional settings, and diverting institutionalization, etc.
12. The extent to which the Respondent’s case management programs include at least the following components:

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

1. The extent to which the Respondent has described a methodology for evaluating the impact of the case management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.
2. The extent to which the frequency and intensity of the case management services (i.e., maximum caseload and minimum contact requirements) are aligned with the Respondent’s risk stratification process and proportional to the clinical and psychosocial needs of the target population.
3. A description of how the Respondent will hire current State Employee Care Coordinators/Case Managers experienced with coordinating care for children with medical complexity (e.g., job fairs, language for Care Coordinator/Case Manager employment transition without gaps, etc.).
4. A description of how the Respondent will work with high volume children’s hospitals and clinics to co-locate Care Coordinators/Case Managers and to leverage existing specialty clinic Care Coordinator/Case Manager staff to avert institutionalization, emergency room utilization and readmissions.

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

1. 10 points if the component is excellent;
2. 8 points if the component is above average;
3. 6 points if the component is average;
4. 4 points if the component is below average;
5. 2 points if the component contained significant deficiencies;
6. 0 points if the component was not addressed.

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**Criteria #7 – Disease Management (DM) Program**

Respondent will describe its proposed approach to implementation of specific disease management programs and how they will be used to advance the CMS Plan’s goals as defined in Attachment A-2, Core Provisions, Section VI., Coverage and Authorization of Services, E. 13 Disease Management Program.

Respondent’s description will include:

1. A description of the overall proposed disease management program and each targeted disease;
2. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;
3. A description of the evidence-based guidelines utilized in the approach;
4. A description of how the disease management program is integrated with case management/care coordination programs to ensure that all children in the CMS Plan are assigned to either a Care Coordinator/Case Manager;
5. A description of performance metrics used to evaluate the efficacy of the disease management program, including cost-savings, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics;
6. A description of the process to assess each child and develop a person-centered care plan including the number of anticipated contacts for each child per risk level annual;
7. A description of the number of face-to-face versus telephonic contacts for each level as well as the assessment tool and care plan development requirements to be used by the Care Coordinators/Case Managers performing Disease Management. At least one face-to-face visit must be conducted in the home annually. Other acceptable face-to-face visits can be completed in the community, at doctor’s offices, or through another HIPAA compliant mode including video communications technology;
8. A description of the qualifications of the disease management staff who will interact with enrollees, in accordance with Exhibit 1, Respondent Staffing Requirements for Children’s Health and Behavioral Health Benefit Administration, and
9. A description of the Respondent’s plan to hire qualified current CMS state employees for Care Coordinator/Case Manager positions performing disease management and how that plan will ensure that the CMS current enrollees do not have a gap in care management prior to implementation (i.e., offering letters of intent to employ with delayed on-boarding for current CMS Care Coordinators/Case Managers). Respondent’s plan should include an exception process for current CMS staff not meeting the minimum professional qualifications established.

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent proposes an innovative and evidence-based approach to disease management for at least the following conditions:
2. Cancer;
3. Diabetes;
4. Asthma;
5. Sickle Cell Anemia;
6. Phenylketonuria (PKU) and other metabolic conditions;
7. Developmental disabilities including Autism;
8. Rare congenital conditions including cleft lip/palate, spina bifida, congenital heart disease;
9. Mental health including ADHD and Severe Emotional Disturbance;
10. Substance abuse;
11. Hemophilia;
12. HIV/AIDS; and
13. “Children with special health care needs” which means those children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children. This includes: arthritis, cerebral palsy, epilepsy, hearing impairments, liver diseases, multiple sclerosis, paralysis of extremities (complete or partial), speech impairments, and visual impairments.
14. The adequacy of the Respondent’s description of how its respective disease management program will be incorporated into its overall Case Management approach to advance the CMS Plan’s goals.
15. The extent to which the Respondent’s algorithm and risk stratification approach is well defined and describes the data sources that will be utilized and ensures that all children will receive disease management.
16. The adequacy of the Respondent’s description of how its disease management programs will be integrated into case management/care coordination programs.
17. The extent to which the Respondent’s disease management programs include at least the following components:
18. Assessment;
19. Plan of Care development;
20. Diversion from or transition from institutional care as needed;
21. Solution-oriented follow-up after emergency room or institutional care to identify opportunities for care improvement to prevent re-institutionalization;
22. Identification of gaps in care including accessibility issues;
23. Identification of service needs to support children in their homes;
24. Symptom management;
25. Medication support;
26. Emotional support;
27. Behavior change;
28. Parent training regarding diagnoses, medications, symptoms;
29. Arranging transportation;
30. Communication with schools in the development of an Individual Education Plan, 504 plan or other education plan; and
31. Communication/education with providers, including the PCP/specialists.
32. The extent to which the Respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

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

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**Criteria #8 – Transitions of Care:**

Respondent will describe how it will address the transition of care between service settings as defined in Attachment A-2, Core Provisions, Section VI., Coverage and Authorization of Services, E. 12 Transition of Care, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home. Identify specific methodologies for ensuring that transition planning ensures appropriate primary care and behavioral health follow up, where appropriate. Provide an example of an effective transition plan.

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

1. Experience and strategies pertaining to deploying transitional care coordinators and using evidence-based practices with support from other clinical resources and community- based organizations.
2. Experience and strategies pertaining to individuals who reside in an institutional setting, or have otherwise resided in a facility for less than one year.
3. Experience and strategies pertaining to individuals who have resided in an institutional setting for more than one year.
   1. Respondent will also describe how it will address the transitions of care for each child in Case Management and Disease Management between the children’s and adult service systems. Description should include:
4. Identification of specific milestones that would trigger need for or that should be addressed in transition plan.
5. Process for ensuring that transition planning includes the child and his/her family, children’s providers and adult providers.
6. An example of an effective transition plan.

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent’s process and example address all three transition circumstances (A-C) and the following transition of care requirements:
   1. Assessment criteria for ensuring the enrollee can be served safely in the community;
   2. The extent to which the Respondent identifies how it will coordinate care with all individuals and/or entities necessary including collaboration with providers’ (e.g., hospitals, institutional settings, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;
   3. The extent to which the Respondent assesses potential caregiver willingness and availability in supporting the transition;
   4. The extent to which the Respondent’s description addresses transitioning enrollees with special circumstances or medical conditions (e.g., complex needs); enrollees with ongoing needs; and enrollees who at the time of their transition have existing prior authorization or approval for ancillary services;
   5. The extent to which the Respondent demonstrates through data its success rate at transitioning individuals from institutional to community settings;
   6. The extent to which the Respondent addresses referral and scheduling assistance coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred;
   7. The extent to which the Respondent describes processes to prevent unnecessary hospital or nursing facility readmissions;
   8. The extent to which the Respondent demonstrates through data its success rate at maintaining individuals who have transitioned from an institutional placement to community placements;
   9. The child to adult transition process incorporates the following principles at a minimum:
      * A systematic and formalized transition process.
      * Early preparation with milestones identified.
      * Identification of a transition coordinator.
      * A communication plan.
      * An individual transition plan identifying:
        + The child’s housing, education and employment goals.
        + The child’s need to change from pediatric to adult specialists and the transfer of any medical records necessary.
        + Guardianship or health proxy documents, if needed.
        + The need to address physical, mental or social barriers or risk factors.
        + Teaching self-knowledge of diagnoses, medication, and medical professionals in order to empower, engage, and enable the young person to self-manage to the extent developmentally appropriate.
        + Follow-up and evaluation.
2. The extent to which the Respondent’s process and example ensures the protection of the enrollee’s privacy consistent with confidentiality requirements.

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

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# Criteria #9 – HEDIS Measures

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

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

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

For members ages 18-21

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

**Reply:**

**Evaluation Criteria:**

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar medically complex children’s populations, for the HEDIS performance measures included in this submission requirement.
2. The extent to which the Respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

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

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

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

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

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**INSTRUCTIONS:**

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

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

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

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

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

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

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| **RESPONDENT NAME:** |  | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Group A** | | | | | | |
|  | **State #1:** | **Florida** | **State #2:** | **Hawaii** | **State #3:** | **Georgia** |
| **HEDIS Performance Metric** | **CY 2015 Rate** | **CY 2016 Rate** | **CY 2015 Rate** | **CY 2016 Rate** | **CY 2015 Rate** | **CY 2016 Rate** |
| Adolescent Well-Care Visits - (AWC) |  |  |  |  |  |  |
| Antidepressant Medication Management - (AMM) |  |  |  |  |  |  |
| Adult BMI Assessment |  |  |  |  |  |  |
| Childhood Immunization Status – (CIS) – Combo 2 and 3 |  |  |  |  |  |  |
| Comprehensive Diabetes Care – (CDC)  Hemoglobin A1c (HbA1c) testing  HbA1c poor control  HbA1c control (<8%)  Eye exam (retinal) performed  Medical attention for nephropathy |  |  |  |  |  |  |
| Follow-up Care for Children Prescribed ADHD Medication – (ADD) |  |  |  |  |  |  |
| Immunizations for Adolescents – (IMA) |  |  |  |  |  |  |
| Chlamydia Screening in Women – (CHL) |  |  |  |  |  |  |
| Prenatal and Postpartum Care – (PPC) |  |  |  |  |  |  |
| Medication Management for People with Asthma – (MMA) |  |  |  |  |  |  |
| Well-Child Visits in the First 15 Months of Life – (W15) |  |  |  |  |  |  |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34) |  |  |  |  |  |  |
| Children and Adolescents’ Access to Primary Care Practitioners - (CAP) |  |  |  |  |  |  |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - (IET) |  |  |  |  |  |  |
| Ambulatory Care - (AMB) |  |  |  |  |  |  |
| Lead Screening in Children – (LSC) |  |  |  |  |  |  |
| Annual Monitoring for Patients on Persistent Medications - (MPM) |  |  |  |  |  |  |
| Frequency of Ongoing Prenatal Care - (FPC) |  |  |  |  |  |  |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics – (APM) |  |  |  |  |  |  |
| Use of Multiple Concurrent Antipsychotics in Children and Adolescents - (APC) |  |  |  |  |  |  |
| Follow-Up After Emergency Department Visit for Mental Illness  – (FUM) |  |  |  |  |  |  |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Treatment – (FUA) |  |  |  |  |  |  |
| Diabetes Screening for People with Schizophrenia or Bipolar Who are Using Antipsychotic Medications SSD |  |  |  |  |  |  |
| ED visits per 1,000-member months |  |  |  |  |  |  |
| Follow-Up after Hospitalization for Mental Illness – (FHM) |  |  |  |  |  |  |
| Inpatient Utilization Discharges/1,000 Member Months/Years |  |  |  |  |  |  |
|  | | | | | | |
| **Total Points** | **0** |

**Criteria #10 – HEDIS Measures - Standards**

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

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

For Members 18-21

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

**Reply:**

**Evaluation Criteria:**

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

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

**Criteria #11 – HEDIS (Data Sources)**

Respondent will describe:

* 1. The extent to which it has used the following standard supplemental data sources for its HEDIS and other performance measures:
* Laboratory result files;
* Immunization data in State or county registries;
* Transactional data from behavioral healthcare Respondents; and
* Current or historic State transactional files in a standard electronic format.
  1. The extent to which it has used supplemental data from electronic health record Respondent systems and data from certified eMeasure Respondents for HEDIS and other performance measures.
  2. The extent to which it has experience reporting HEDIS measures collected using Electronic Clinical Data Systems.

**Reply:**

**Evaluation Criteria:**

1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare Respondents; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures.
2. The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) Respondent systems and data from certified eMeasure Respondents for HEDIS and other performance measures.
3. The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS).

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

**Criteria #12 – Potentially Preventable Events**

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

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

**Reply:**

**Evaluation Criteria:**

* 1. The extent to which the Respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the Respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health).
  2. The extent to which the Respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers.
  3. The extent to which the Respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples.
  4. The extent to which the Respondent plans to include the use of AHCA’s Event Notification System as a means to extract relevant data from hospitals.
  5. The adequacy of the Respondent’s description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.
  6. The extent to which the Respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid and CHIP patients).
  7. The extent to which the Respondent proposed local performance benchmarks for:
     1. Reducing potentially preventable hospital admissions and readmissions;
     2. Reducing use of the emergency department for non-emergent/urgent visits; and
     3. Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

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

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**Criteria #13 – Patient Centered Medical Homes**

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

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent’s description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:
   1. Enhanced access;
   2. Coordinated and/or integrated care; and
   3. Achievement of improved quality outcomes.
2. The extent to which the Respondent’s description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH as their PCP.
3. The extent to which the Respondent’s description of recognizing PCMHs addresses methodologies and processes to improve child health outcomes for enrollees assigned to a PCMH as their PCP.
4. The extent to which the Respondent’s description of recognizing PCMHs that focus on improving enrollee/family satisfaction.

**Score:** This section is worth a maximum of 25 raw points with the first component being worth 10 points and each of the remaining components (2-4) being worth a maximum of 5 points each.

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**Criteria #14 – Telemedicine**

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

1. Pediatric Primary Care Physicians (including General Practitioners and Family Practitioners)
2. Board Certified Pediatric Cardiologists
3. Board Certified Pediatric Endocrinologists
4. Board Certified Pediatric Nephrologists
5. Board Certified Pediatric Neurologists
6. Board Certified Pediatric Psychiatrists
7. Board Certified Rheumatologists
8. Licensed mental health clinicians

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

**Reply:**

**Evaluation Criteria:**

* 1. The extent to which the Respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the service delivery to medically complex children in order to improve access to:
* Pediatric Primary Care Physicians (including General Practitioners and Family Practitioners)
* Board Certified Pediatric Cardiologists
* Board Certified Pediatric Endocrinologists
* Board Certified Pediatric Nephrologists
* Board Certified Pediatric Neurologists
* Board Certified Pediatric Psychiatrists
* Board Certified Rheumatologists
* Licensed mental health clinicians

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

* 1. The extent to which the Respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.
  2. The extent to which the Respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:
     + The percentage of providers authorized to provide telemedicine services for the provider types referenced; and
     + The percentage and type of authorized providers that provided telemedicine services during the 2016 and 2017 calendar year.

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

**Criteria #15 – Quality Measures:**

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

**Reply:**

**Evaluation Criteria:**

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, including HEDIS or Contract required measures.
2. The extent to which the quality measures proposed are relevant to the specialty population(s) being proposed for this solicitation.
3. The extent to which the quality management activities proposed demonstrates the ability to improve quality for the population(s) proposed in a meaningful way including a performance improvement project on improving transition of care as outlined in the Prime Contract.
4. The extent to which the Respondent met quality measure targets, successfully remediated all failures, or achieved improvement to overall performance.

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

# Criteria #16 – CMS Physician Incentive Program (PIP)

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

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent’s reply to improve quality can be tied to redirecting costs to pay higher physician rates.
2. The extent to which the Respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.
3. The extent to which the Respondent incorporates quality initiatives goals or incentives for improvement of child health outcomes.
4. The extent to which the Respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.

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

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1. **Recipient Experience**

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

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

**Reply:** Respondent will select the following benefits it will offer, as listed in

**Attachment A-1-b**, Expanded/ILS Benefits Tool (Respondent will check all that apply):

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

In Lieu of Services

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

Note: the following are suggested ILS

* Nursing Facility in lieu of hospital services
* Detoxification or addictions receiving facilities in lieu of inpatient detoxification hospital care
* Partial hospitalization in a hospital in lieu of inpatient psychiatric hospital care
* Mobile crisis assessment and intervention for enrollees in the community in lieu of emergency behavioral health care
* Ambulatory detoxification services in lieu of inpatient detoxification hospital care
* The following in lieu of community behavioral health services:
  + - Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services.
    - Respite Care Services in lieu of Specialized Therapeutic Foster Care services.
    - Drop-In Center in lieu of Clubhouse services.
    - Infant Mental Health Pre-and Post Testing Services in lieu of Psychological Testing services.
    - Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services.
    - Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.

Expanded Benefits:

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

**Evaluation Criteria:**

**Score:** This section is worth a maximum of 315 raw points as outlined below.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. a) | Respondent will implement a Value-Added Services tool for Care Coordinators/Case Managers to determine if a child should receive a cost-effective benefit. (55 pts) |  | |
| 1. b) | **In Lieu of Services**   * Emergency Respite to divert or shorten an institutional stay (25 pts) * Crisis Stabilization unit and freestanding psychiatric hospitals in lieu of inpatient psychiatric hospital care (25 pts) * Housing-related supports/modifications to divert or shorten an institutional stay (e.g., bed bug treatment to prevent hospitalization or building a ramp or modifying a vehicle to allow a child in a wheel chair to shorten an institutional stay) or to provide safety for a child (e.g., interior door locks for a child with Autism who wanders) (25 pts) * Nursing Facility in lieu of hospital services (10 pts) * Detoxification or addictions receiving facilities in lieu of inpatient detoxification hospital care (10 pts) * Partial hospitalization in a hospital in lieu of inpatient psychiatric hospital care (10 pts) * Mobile crisis assessment and intervention for enrollees in the community in lieu of emergency behavioral health care (10 pts) * Ambulatory detoxification services in lieu of inpatient detoxification hospital care (10 pts) * The following in lieu of community behavioral health services: * Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services. (10 pts) * Respite Care Services in lieu of Specialized Therapeutic Foster Care services. (10 pts) * Drop-In Center in lieu of Clubhouse services. (10 pts) * Infant Mental Health Pre and Post Testing Services in lieu of Psychological Testing services. (10 pts) * Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services. (10 pts) * Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services. (10 pts) |  | |
| 1. c) | **Expanded Benefits**   * Planned Respite (25 pts) * Home maintenance and minor home or environmental adaptations that contribute to community integration or wellness of a child such as In-Home Pest Control for homeowners up to $500 per calendar year (10 pts) * Non-medical transport (10 pts) * Financial coaching/benefits counseling (10 pts) * Parenting classes (10 pts) * Education/supports for Wellness including but not limited to (10 pts): * Gym memberships * Cooking classes * Free Healthy Living Coaching for families with kids ages 7-13 who qualify * Hypoallergenic bedding for people with asthma, allergies, and chronic respiratory or pulmonary conditions up to a $100 one-time credit * Healthy Behavior Reward program – members can earn points for healthy activities like going to the doctor and eating healthy * Specialized recreational opportunities for Wellness and community integration (e.g., adaptive baseball, basketball, fees for physical activities)   Attachment A-1-b is available for Respondents to download at:  <http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/cms-plan-invitation-to-negotiate/index.html> | |  | |

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| **Category** | **Sub-category** | **Procedure Code Description** | **Procedure/CPT**  **Code** | **Min Age** | **Max Age** | **Current Florida Medicaid Coverage** | **Expanded Benefit**  **Coverage (Units)** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Emergency and Planned Respite | Respite | Respite Care-in home  Respite Care-out of home | S9125-in-home  H0045-out of home | 0 | 21 yrs | For model and DD waiver enrollees, this is covered via FFS | For non-model and DD waiver enrollees, 200 hours a year for in home.  10 days of out of home. |
| Behavioral Health |  | Crisis Stabilization | 0910 | 2 yrs | 21 yrs |  | As needed to divert hospitalization, emergency room visits, or prevent out-of-home placement |
| Modifications to divert institutional stay or home maintenance and minor home or environmental modifications including vehicle modifications |  | Home maintenance and minor home/environmental modifications | s5165 | 0 | 21 yrs | Only in MMC-LTC program-no limit | $5,000 every 3 years. |
| Housing related supports/supplemental adaptive device or equipment |  | Home helper catalog item |  | 0 | 21 yrs | Not covered | 1 item a year. |
| Housing related supports/supplemental adaptive device or equipment |  | hypoallergenic bedding |  | 0 | 21 yrs | $100 1x credit | $100 1x credit |
| Community Behavioral Health |  | Self-Help/Peer | H0038 | 0 | 21 yrs |  | In lieu of Psychosocial Rehabilitation |
| Mobile Crisis |  | Crisis Intervention | S9485; H2011 | 0 | 21 yrs |  | As needed to divert hospitalization, emergency room visits, or prevent out-of-home placement |
| Healthy Behavior Reward Program |  | healthy community reward  program |  | 0 | 21 yrs |  | As outlined in health plan literature submitted in ITN reply |
| Professional consultation between primary care provider and specialist or medical team conference without patient/family present |  | case consultation | 99367 or 99368 | 0 | 21 yrs |  | Limited to 2 per year for team |
| Family Training |  | family support and education | S5110 | 0 | 21 yrs |  | 12 visits a year. |
| social determinant of health |  | benefits counseling | H2014 SE | 0 | 21 yrs | Not covered | 3 sessions annually. |
| Partial hospitalization |  | Partial hospitalization | H0035 or S9480 (Mental Health), H0015 (Substance Use Disorder), Use of Revenue codes (0172, 0173, 0175, 0176), | 0 | 21 yrs |  | Covered as needed in lieu of inpatient hospitalization |
| Detoxification or withdrawal management in an ambulatory or non-hospital residential setting |  | Withdrawal management | H0010, H0011, H0012, H0014, | 0 | 21 yrs |  | Covered as needed in lieu of inpatient hospital detoxification |
| Drop-in Center |  | Drop-in Center | H2030 or H2031 | 16 | 21 yrs |  | Covered as needed in lieu of clubhouses |
| Non-medical transport |  | Transportation | A0090, A0100, A0110, A0120, A0130, A0170, T2003 | 0 | 21 yrs |  | Covered as needed for community integration |
| Nutritional Counseling |  | Nutritional Counseling, diet | S9470 | 0 | 21 yrs | Covered as medically necessary for children with diabetes, Phenylketonuria (PKU) and other metabolic conditions, eating disorders, Obesity, and children at risk of metabolic disorders under EPSDT | For wellness counseling for at-risk children |
| Supports for Wellness |  | healthy living coaching |  | 7 yrs | 13 yrs |  | 12 visits a year. |
| Education/Supports for Wellness |  | Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in “remarks” | T1999 |  |  |  | Covered up to $200 per year |
| Housing Supports | Pest control | Pest Control (in-home) | S5121 | 0 | 21 yrs | Only available on Project Aids Care Waiver $25 a job/$150 a year. | $500 max annually. |
| Social Determinant of Health | Financial Counseling | Financial counseling | T2013 SE | 0 | 21 yrs | Not covered | 6 sessions annually. |

# Criteria #18 – Additional Expanded Benefits

Respondent will identify each additional expanded benefit that it proposes to offer its enrollees by eligible population (TANF, ABD, CHIP, dual eligible). For the purposes of this Criteria, the Respondent must not select expanded benefits that are included in **Attachment A-1-b**,Expanded Benefits Tool described in Criteria #17. Respondent will include the name of the benefit, procedure code descriptions, procedure codes and any limitations (frequency/duration, etc.).

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

**Reply:**

**Evaluation Criteria:**

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

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

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

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

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

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| Category | Sub-category | Procedure Code Description | Procedure/CPT  Code | Min Age | Max Age | Current Florida Medicaid Coverage | Expanded Benefit  Coverage (Units) |
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**Criteria #19 Quality Enhancements**

Respondent will describe in detail its approach for providing quality enhancements as defined in Attachment A-2, Core Provisions, Section VI., Coverage and Authorization of Services, F. Quality Enhancements, including how it will educate enrollee’s and their families on the availability of quality enhancements:

* 1. **Database of information for Families**

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

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

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

Respondent will offer QEs in community settings accessible to enrollees.

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

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

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

* 1. **Children's Programs** 
     1. Respondent will provide regular general wellness programs targeted specifically toward enrollees from birth to the age of five years, or the Respondent will make a good faith effort to involve enrollees in existing community children's programs.
     2. Children's programs will promote increased use of prevention and early intervention services for at-risk enrollees. Respondent will authorize covered services recommended by the Early Intervention Program when medically necessary. Respondent will collaborate with the Local Early Intervention Program Office to negotiate and maintain agreements that establish methods of communication and procedures for the timely approval of services covered by Medicaid pursuant to s. 391.308, Florida Statutes.
     3. Respondent will provide education to families regarding the “Help Me Grow”

which is the Florida Department of Education-funded programs that connects children birth-8 years of age with community resources (including Early Steps and Part B services).

* 1. **Domestic Violence**

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

* 1. **Pregnancy Prevention**

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

* 1. **Healthy Start Services**
  2. Respondent will develop agreements with local Healthy Start Coalitions as necessary to provide risk-appropriate care coordination/case management for pregnant women and infants.
  3. The program for pregnant women and infants must be aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes.
  4. Respondent will collaborate with the Healthy Start care coordinator within the enrollee's county of residence to assure delivery of risk-appropriate care.
  5. Respondent will submit a completed Practitioner Disease Report Form (DH Form 2136) to the Perinatal Hepatitis B Prevention Coordinator at the local CHD for all prenatal or postpartum enrollees and their infants who test HBsAg-positive.
  6. **Nutritional Assessment/Counseling**

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

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

c. Respondent will:

1. Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes.
2. Offer a mid-level nutrition assessment.
3. Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or physician following the nutrition assessment.
4. Refer all enrollees under the age of five and pregnant, breast-feeding and postpartum enrollees to the local WIC program office using the Florida WIC Program Medical Referral Form (DH 3075).

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

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

* 1. **Behavioral Health Programs**

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

**Reply:**

Evaluation Criteria:

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

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

* + 1. 20 points for providing a description in 1 and all of the quality enhancements in 2.
    2. 15 points for providing a description in 1 and some but not all of the quality enhancement in 2, including at a minimum 2a.
    3. 10 points for providing a description in 1 and some but not all of the quality enhancement in 2, but not including 2a.
    4. 5 points for providing a description in 1 and including quality enhancements not on the State’s suggested list.
    5. 0 points for proposing no quality enhancements or not including a description in 1.

**Criteria #20 – Online Provider Directory**

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

1. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether or not the online provider directory is mobile friendly.
2. Screen shots for each mouse click required from the start of the Respondent’s home page to actual search results for a provider, using durable medical equipment providers and zip code as the search elements.
3. A list of performance indicators the Respondent will include for each provider type listed in its provider directory.
4. A description of the Respondent’s process for verification of provider information in the online provider directory, including delegated subcontractor provider information, and the method(s) the Respondent uses to ensure the weekly network file submission to the Department is accurate.

**Reply:**

**Evaluation Criteria:**

* 1. The extent of the Respondent’s search functions for the Respondent’s online directory and ease of access for enrollees’ navigation of the online provider directory, including whether or not the online directory is mobile friendly.
  2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five.
  3. The extent and relevance of the performance indicators available in the Respondent’s provider directory for each provider type listed.
  4. The extent of the Respondent’s efforts to ensure information in the Respondent’s online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.
  5. The extent to which the Respondent’s online provider directory updates are performed daily and the extent to which the updates are communicated to the Department as required ensuring the information the Respondent displays on its website align with the Department’s information.

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

**Criteria #21 – Enrollee Grievance and Appeal System:**

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

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent’s grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages.
2. The extent to which the Respondent’s timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements.
3. The extent to which the Respondent’s complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.
4. The extent to which the Respondent’s complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.
5. The extent to which the Respondent is able to ensure all complaints (including those submitted to the Respondent by the Department or Respondent’s subcontractors) are tracked and resolved as part of the Respondent’s established complaint, grievance and appeal process.
6. The extent to which the Respondent’s grievance and appeal system data resulted in operational improvements of the Respondent.

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

# Criteria #22 – CAHPS Results:

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

1. Health Plan Rating;
2. Health Care Rating;
3. Getting Needed Care (composite);
4. Getting Care Quickly (composite); and
5. Getting Help for Customer Service (composite).

**Reply:**

**Evaluation Criteria:**

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

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

**Attachment A-1-d**, Standard CAHPS Measurement Tool, provides for 30 opportunities for a Respondent to report prior experience in providing desirable experiences with health care (five measures, three states each, adult population for each, and child population for each). For each of the five measures, a total of six points are available.

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

**INSTRUCTIONS:**

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

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

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

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

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

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

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| **RESPONDENT NAME:** |  | | | | | |
| **Group A** | | | | | | |
|  | **State #1:** | **Florida** | **State #2:** | **Hawaii** | **State #3:** | **Delaware** |
| **CAHPS Item/Composite** | **2017 Adult** | **2017 Child** | **2017 Adult** | **2017 Child** | **2017 Adult** | **2017 Child** |
| Rating of Health Plan (the percentage of Respondents rating their plan an 8, 9, or 10 out of 10) |  |  |  |  |  |  |
| Rating of Health Care (the percentage of Respondents rating their health care an 8, 9, or 10 out of 10) |  |  |  |  |  |  |
| Getting Needed Care Composite (the percentage of Respondents reporting it is usually or always easy to get needed care) |  |  |  |  |  |  |
| Getting Care Quickly Composite (the percentage of Respondents reporting it is usually or always easy to get care quickly) |  |  |  |  |  |  |
| Getting Help from Customer Service  Composite (the percentage of Respondents reporting it is usually or always easy to get help needed from customer service |  |  |  |  |  |  |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life |  |  |  |  |  |  |
|  | | | | | | |
| **Total Points** | **0** |

# Criteria #23 – PCP Timely Access Standards:

Respondent will describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in **Attachment A-2,** Core Provisions, Section VIII. Provider Services, A. Network Adequacy Standards. Respondent will also describe the process and methodology it uses for determining whether a PCP has the capacity to accept new patients.

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent’s process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in **Attachment A-2,** Core Provisions, Section VIII. Provider Services, A. Network Adequacy Standards.
2. The extent to which the Respondent’s monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.
3. The extent to which the Respondent’s process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.

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

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# Criteria #24 – Provider Network Development

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

1. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);
2. Strategies that will be deployed to address identified gaps, increase provider capacity and meet the needs of enrollees where network gaps have been identified;
3. Strategies (including a description of data sources utilized) for measuring timely access to appointments, including but not limited to, the following provider types:
   1. Cardiologists (pediatric);
   2. Neurologists (pediatric);
   3. Pulmonologists (pediatric);
   4. Endocrinologists (pediatric);
   5. Internists (adult);
   6. Psychiatrists (pediatric and adult);
   7. Nutritionists;
   8. Private Duty Nursing (pediatric and adult);
   9. Licensed mental health clinicians (pediatric);
   10. Pediatric Primary Care Physicians (including General Practitioners and Family Practitioners);
   11. Board Certified Pediatric Nephrologists; and
   12. Board Certified Rheumatologists.
4. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider’s success in making progress towards the CMS Plan goals.
5. Strategies for inclusion of specialties who historically received CMS Plan clinic or supplemental funding (see procurement library for a listing).
6. Procedures for ensuring that child specialties for the following conditions are included in the network:
   1. Cancer
   2. Diabetes
   3. Asthma;
   4. Sickle Cell Anemia
   5. Phenylketonuria (PKU) and other metabolic conditions
   6. Developmental disabilities including Autism;
   7. Rare congenital conditions including cleft lip/palate, spina bifida, congenital heart disease;
   8. Mental health including ADHD and Severe Emotional Disturbance;
   9. Substance abuse; and
   10. “Children with special health care needs” which means those children younger than 21 years of age who have serious and chronic physical, developmental, behavioral, or emotional conditions and who require health care and related services of a type or amount beyond that which is generally required by children.” This includes: arthritis, cerebral palsy, epilepsy, hearing impairments, liver diseases, multiple sclerosis, paralysis of extremities (complete or partial), speech impairments, and visual impairments.

**Reply:**

**Evaluation Criteria:**

1. The adequacy of the Respondent’s methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.
2. The adequacy of the Respondent’s plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long- term interventions.
3. The adequacy of the Respondent’s approach for measuring timely access for the specified provider types and the extent to which the Respondent’s approach includes clear methodology for determining the following:
   1. Average wait time for an urgent appointment; and
   2. Average wait time for a routine appointment.
4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.
5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the Respondent.
6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the CMS Plan goals are transparent to providers, including the frequency with which providers will be able to access their progress.

**Score:** This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 10 points each.

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

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# Criteria #25 – Provider Network – Network Development Plan

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

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

Respondent’s approach will include at a minimum:

1. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);
2. Strategies that will be deployed to increase provider capacity where network gaps have been identified;
3. Strategies that will be deployed to ensure retention of CMS Plan legacy providers to ensure access is maintained to physicians and specialists in the CMS Provider Network File as of January 2018, with initial contracting targets of 12 months retention for these physician providers;
4. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received;
5. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services;
6. Strategies for how the Respondent will analyze provider accessibility standards and will maintain these based on future population changes;
7. Strategies for considering enhanced reimbursement for providers not accepting Medicaid (i.e. difference between the private and Medicaid participation rates);
8. Strategies for implementing telemedicine in rural areas with access issues;
9. Strategies for working with regional providers to ensure access to unique network challenges; and
10. Strategies for working with the Department’s medical director to ensure that children are receiving appropriate referrals to the correct specialists (regionally based such as neurologists versus developmental pediatricians/psychiatrists).

**Reply:**

**Evaluation Criteria:**

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

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

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

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

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

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

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

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

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

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent’s description includes how quality and/or performance metrics are defined and utilized in the assignment process.
2. The extent to which the Respondent’s algorithm includes assignment of enrollees to high quality PCPs.
3. The extent to which the Respondent can process requests for PCP changes within three business days.

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

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1. **Provider Experience**

# Criteria #27 – Provider Engagement Model

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

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

Minimum staffing requirements for Provider Engagement are described in in Attachment A-2-a, Respondent Staffing Requirements, B. Organizational Governance. Staff qualifications are described in Exhibit 1, Respondent Staffing Requirements for Children’s Health and Behavioral Health Benefit Administration.

**Reply:**

**Evaluation Criteria:**

1. The extent to which Respondent leadership are involved in provider engagement.
2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.
3. The extent to which the method the Respondent uses to track interactions with providers is capable of producing meaningful data the Respondent will use to address both clinical and administrative problem areas.
4. The extent to which the method the Respondent uses to track interactions with providers addresses potential provider field representative training needs.
5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.
6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and Respondent’s dispute resolution process and timeframes, including corresponding requirements in scope of services.

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

# Criteria #28 – Dispute Resolution

Respondent will describe in detail its provider dispute resolution process as defined in **Attachment A-2**, Core Provisions, Section VII. Grievance and Appeal System. Respondent must address dispute resolution for both Title XIX and Title XXI enrollees.

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

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent’s process identifies claims related dispute trends and initiates process improvement activities/system enhancements.
2. The extent to which the Respondent’s process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes resolved within required timeframes.
3. The extent to which the Respondent’s process incorporates timely reply to Department requests related to complaint resolution in accordance with the Prime Contract and CMS Plan requirements.
4. The extent to which the Respondent integrates all complaints, regardless of the complaint referral source (e.g., Department, third party).
5. The extent to which the Respondent’s resolution process includes the Respondent’s participation in the Department claims dispute resolution program authorized in section 408.7057, Florida Statutes, as well as includes the following:
   1. Responding to requests for information from the State contracted independent dispute resolution organization;
   2. A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and
   3. Prompt payment of final orders issued by the Department related to claims arbitration case determinations.

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

# Criteria #29 – Claims Processing and Payment Process

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

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

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

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

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**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.
2. The extent to which the Respondent has included detailed metrics to be employed by the Respondent to track timeliness and accuracy of the claims processing and payment process.
3. The extent to which the Respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.
4. The extent to which the Respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Department and that the described process provides sufficient opportunity for the Department to access this data.
5. The extent to which the Respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.
6. The extent to which the Respondent has included its applicable proposed subcontractors in its reply, with each component addressed for each applicable proposed subcontractor.

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

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# Criteria #30 – Provider Credentialing

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

**Reply:**

**Evaluation Criteria:**

1. The adequacy of the Respondent’s description of its credentialing and re-credentialing criteria, certified credential verification organization processes, and utilization of a third-party credentialing vendor.
2. The extent to which the Respondent’s timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of 120 days.
3. The adequacy of the Respondent’s approach to providing transparency to providers throughout the credentialing and re-credentialing processes, including how providers will be informed at each step of the application process. The proposed method for educating and assisting providers through the credentialing process including a description of specific tools, websites or specially assigned staff to help support this process. This includes any tools, websites, special staffing, special processes for atypical providers, etc.
4. The extent to which the Respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its re-credentialing process.
5. The extent to which the Respondent and its subcontractors incorporate the Agency for Health Care Administration’s streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and re-credentialing processes.
6. The extent to which the Respondent outlines steps the Respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the Respondent in-between credentialing cycles.

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

# Criteria #31 – Value Based Purchasing

1. Respondent will include a strategy outlining its plans for value based purchasing as defined in **Attachment A-2**, Core Provisions, Section XI. Method of Payment, L. Value Based Purchasing.
2. Designation and contact information for the individual in the Respondent’s organization responsible for development and execution of the Respondent’s VBP implementation and development strategy;
3. Discussion of target areas including the specific models and VBP arrangements proposed for implementation of the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated at least by topic area within primary care, specialty care and hospital-based care;
4. Description of the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five Contract years, delineated by primary care, specialty care and hospital-based care;
5. Description of the specific VBP arrangements it intends to implement and/or maintain in an effort to promote the CMS Plan’s goals, delineated by topic area within primary care, specialty care and hospital-based care;
6. Discussion of plans and strategies to develop provider readiness for VBP and evolution along the VBP continuum;
7. Discussion of Respondent’s approach to and experiences (if applicable) with episodic payment arrangements and the challenges and opportunities they present for implementation among providers serving the member population;
8. Specific health outcomes and efficiency goals that will be tracked and evaluated for performance as part of each model and the specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by topic area within primary care, specialty care and hospital-based care;
9. Description of how proposed or developing VBP arrangements align with Medicare initiatives or other Florida books of business. To the extent such alignment is relevant, the strategy should address how provider performance measurement and incentives align or will align across books of business in a way that maximizes the impact of such incentives while minimizing provider confusion caused by multiple, differing VBP arrangements;
10. Discussion of how Respondent systems are designed to identify providers operating under VBP arrangements and track its performance;
11. Discussion of how Respondent will share data with providers and support providers in using the data to improve performance;
12. Methods and frequency for collecting and providing performance data to providers (please provide an example or template of a relevant, current data sharing report issued to providers);
13. Specific objectives for VBP arrangement implementation, including scope, provider performance, and a timeline for implementation related to each of the proposed VBP approaches; and
14. Plans for the provision of provider support to facilitate successful implementation and development of VBP arrangements, such as technical support, establishment of new data feedback systems, and financial support for provider infrastructure necessary to execute select model concepts.

**Reply:**

**Evaluation Criteria:**

1. The extent the Respondent has prior experience implementing VBP arrangements among its provider network and included a table indicating all of its current VBP arrangements across all lines of business and states. The table separately and explicitly identifies any applicable VBP arrangements across lines of business for children with medical complexity. Entries included the specific model type (e.g. Accountable Care Organizations). Respondent’s tables addressed the following:
2. Name of the VBP program
3. Line(s) of business to which the program applies
4. State(s) in which the program applies
5. Description of the VBP program
6. Whether the VBP program was required by the state
7. Applicable HCP-LAN APM category/sub-category (e.g. Category 2c) in which the arrangement best fits
8. Provider types governed under the arrangement
9. Service types governed under the arrangement
10. Quality requirements under the VBP program
11. Percent of total medical spending (including drug spending) governed under the arrangement for the relevant line of business in for the most recent fiscal year
12. Percent of total projected medical spending (including drug spending) governed under the arrangement for the relevant line of business for the most recent fiscal year
13. The extent to which the Respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.
14. The extent to which the Respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five Contract years, including a rationale for the intended percentages. Respondent is proposing an increase in the volume of contracts implemented or maintained through a VBP arrangement each year by at least 5 percent annually (from the submitted baseline in the ITN reply) for the first three years of the contract.
15. The extent to which the Respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum.
16. The extent to which the Respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.
17. The extent to which the Respondent describes how its VBP arrangements incorporate goals or incentives for improvement of child health outcomes.
18. The extent to which the Respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.
19. The extent to which the Respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of Respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

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

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1. **Delivery System Coordination**

# Criteria #32 – Utilization Management

1. Respondent will describe the following related to its utilization management (UM) approach:
2. A description of the process used to determine whether a service should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid and CHIP benefit.
3. A description of how the Respondent will ensure consistent application of the review criteria for authorization decisions.
4. A description of how the Respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.
5. A description of the approach used to determine whether a service will be needed short- term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the Respondent’s service authorization approach (if any exists) based on the length of time that the service will be needed.
6. To the extent that a service is needed long-term, a description of the strategies that the Respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.
7. A description and example of how the Respondent will detect, monitor and evaluate under- utilization, over-utilization and inappropriate utilization as well as processes to identify and address opportunities for improvement.
8. A description of the utilization guidelines adopted by the Respondent including national criteria and adapted for Florida Medicaid benefit design.
9. A description of how the UM staff employed by the Respondent will coordinate with the Department employed CMS Plan Medical Director and clinical oversight staff.

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**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.
2. The adequacy of the processes used by the Respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.
3. The adequacy of the Respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for Respondent staff and network providers).
4. The adequacy of the review processes (data collection and analysis) deployed by the Respondent to ensure services are not arbitrarily being denied or reduced.
5. The adequacy of the review processes (data collection and analysis) deployed by the Respondent to identify aberrant utilization patterns (under and over utilization).
6. The adequacy of the Respondent’s approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long- term (ongoing maintenance services/therapies).
7. The adequacy of the Respondent’s approach at ensuring continuity of care, particularly as it relates to special needs populations.
8. The extent to which the Respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.
9. The extent to which the Respondent utilizes national utilization review criteria adapted for Florida Medicaid and CHIP benefit design including ASAM for SUD treatment.

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

# Criteria #33 – Utilization Management – Ease of Use

1. Respondent will describe the following related to its utilization management systems:
2. A description of how the Respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;
3. A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, subcontractors and the Respondent (to the extent any UM functions are delegated);
4. A description of the Respondent’s experience meeting timeliness standards for service authorization requests;
5. A description of the approach that the Respondent will use to educate enrollees and providers about the process for seeking authorization;
6. A detailed workflow of how “special service” requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the Respondent to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbooks/coverage policy or the associated fee schedule. This includes 1905(a) services regularly utilized by children with medical complexity including but not limited to:
   * + OTC medical supplies including vitamins, acetaminophen, etc.
     + Additional dental services including medically necessary sedatives,
     + Nutritional supplements and supports including low protein foods,
     + In-home skilled nursing and therapies for chronic conditions, additional personal care beyond covered benefits,
     + Incontinence supplies,
     + A specially adapted car seat needed by a child because of a medical problem,
     + Nutritional counseling necessary for addressing obesity; and
7. A detailed workflow of how Medicaid and CHIP covered benefits under the contract including Value Added services and In-lieu of services necessary to maintain a child in the community and divert institutionalization and emergency room utilization will have expedited approval when necessary to ensure the health and welfare of a child.

**Reply:**

**Evaluation Criteria:**

* 1. The extent to which the Respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the Respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the Respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.
  2. The extent to which the Respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.
  3. The extent to which the Respondent has demonstrated experience with meeting timeliness standards for service authorization requests.
  4. The adequacy of the Respondent’s education and training plan providers on the service authorization processes.
  5. The extent to which the Respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).
  6. The extent to which the workflow describing the Respondent’s process for handling “special service” requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

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

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# Criteria #34 – Coordination of Benefits:

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

* + - * 1. Florida Medicaid and/or CHIP does not cover the service, but it is available through the third-party payer;
        2. Florida Medicaid and/or CHIP and the third-party payer cover the service, but Medicaid/CHIP is only liable for the coinsurance/copayment expenses. In this scenario, the Respondent will identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid;
        3. The third-party carrier benefit limit is exhausted and the service is now a Medicaid and/or CHIP expense. In this scenario, the Respondent will identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid/CHIP; and
        4. The service is not covered by the third party but is available through Florida Medicaid and/or CHIP.

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**Reply:**

**Evaluation Criteria:**

The adequacy of the Respondent’s approach when:

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

Florida Medicaid/CHIP and the third-party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.

The third-party carrier benefit limit is exhausted and the service is now a Medicaid expense.

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

The extent to which the Respondent’s approach includes:

Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials).

Processes used to identify non-covered services by the primary insurer for individual enrollees.

Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third-party insurer has been exhausted.

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

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

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

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

1. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.
2. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the Respondent (case management, utilization management, provider relations, etc.) as well as subcontractors.
3. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the Respondent and with subcontractors.
4. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the Respondent’s approach towards coverage of the EPSDT benefit.

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**Reply:**

**Evaluation Criteria:**

* 1. The adequacy of the Respondent’s approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.
  2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.
  3. The adequacy of the Respondent’s training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the Respondent/subcontractors. Respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.
  4. The adequacy of the Respondent’s monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the Respondent and with subcontractors.
  5. The extent to which the Respondent’s overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

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

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# Criteria# 36 – Behavioral Health/Primary Care Integration:

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

* + 1. Identification of integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness.
    2. Identification of opportunities for improvement across the Respondent’s system of care (e.g., care management, provider network, utilization management, enrollee services) with the goal of advancing to more integrated care models.
    3. Description of strategies the Respondent will deploy to overcome the barriers/gaps identified to increase its capacity for providing integrated care models, including use of alternative payment models/financing strategies.
    4. Description of strategies the Respondent will deploy to specifically address pediatric behavioral health/primary care integration (e.g., child psychiatrist’s consultation with pediatricians, addressing complex behavioral health/ mental illness cases, etc.).

**Reply:**

**Evaluation Criteria:**

* + - 1. The extent with which the Respondent thoroughly describes its current approach to and readiness for promoting/incentivizing and removing barriers to, integrating behavioral health and primary care throughout its system of care with an emphasis on pediatric practices and child behavioral health providers.
      2. The extent to which the Respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. Respondent must also describe the data sources that focus on pediatric outcomes.
      3. The extent to which the Respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the Respondent will implement across its systems to increase capacity for providing integrated pediatric care.

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

# Criteria# 37 – Transportation

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

* + - * 1. A description of the software capabilities utilized to facilitate ease in scheduling and tracking of enrollee pickup adherence;
        2. Strategies for determining the most appropriate mode of transportation; and
        3. Providing data on the following performance metrics for calendar year 2016:

Percentage of trips where the enrollee arrived to their scheduled appointment on- time;

Percentage of missed trip requests (failed to pick up the enrollee regardless of reason);

Percentage of hospital discharge requests fulfilled within three hours of the request;

Percentage of urgent care requests fulfilled within three hours of the request; and

Number of transportation related complaints and grievances per 1,000 enrollees.

* + - * 1. A description of how the Respondent uses the performance metric data above to identify areas in need of improvement and implements successful strategies that improve the provision of service.
        2. Provider network by level of service and region.

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**Reply:**

**Evaluation Criteria:**

1. The adequacy of the Respondent’s software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence.
2. The extent to which the Respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee’s individual needs.
3. The extent to which the Respondent’s approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.
4. The adequacy of the Respondent’s performance related to:
   1. Percentage of trips where the enrollee arrived at their scheduled appointment on-time;
   2. Percentage of missed trip requests;
   3. Percentage of hospital discharge requests fulfilled within three hours of the request;
   4. Percentage of urgent care requests fulfilled within three hours of the request; and
   5. Number of transportation related complaints and grievances per 1,000 enrollees.
5. The extent to which the Respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.
6. Respondent describes its capacity to serve individuals with a wide spectrum of needs, including individual needs for physical accommodations or adult/support staff accompaniment. Respondent describes capacity to provide transportation services in a manner that furthers participant’s community integration and independence. In addition, the Respondent describes its capacity to effectively serve individuals with complex conditions, including those with behavioral challenges, or those who may have exhausted a typical panel of providers.
7. Respondent outlines public transportation parameters appropriate to the CMS population.
8. Respondent outlines when adapted transportation may be required if a physically disabled child is enrolled in the program. Adapted transportation may be transportation provided in modified vehicles (such as vehicles with wheelchair or stretcher safe travel systems or lifts) that meet the participant’s medical needs that cannot be met with the use of a standard passenger vehicle.

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

# Criteria# 38 – Coordination of Carved Out Services

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

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent describes effective and efficient processes for reciprocal referral for needed services.
2. The adequacy of the Respondent’s approach to engage and educate enrollees in understanding the difference in benefits covered by the Respondent and those that are available through other Medicaid/CHIP delivery systems.
3. The extent to which the Respondent’s description includes a process for ensuring Respondent’s staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid/CHIP delivery systems.

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

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# Criteria# 39 - Vignette:

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

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

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

1. New Enrollee Identification;
2. Health Risk Assessment;
3. Care Coordination/Case Management;
4. Service Planning;
5. Discharge/Transition Planning;
6. Disease Management;
7. Utilization Management; and
8. Grievance and Appeals.

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

**Reply:**

**Evaluation Criteria:**

* 1. The adequacy of the Respondent’s approach in addressing the following:
     1. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
     2. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
     3. Application of the Respondent’s case management risk stratification protocol;
     4. Identification of service needs (covered and non-covered) and a description for service referral processes that the Respondent has in place;
     5. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
     6. Application of discharge and aftercare planning protocols that facilitate a successful transition;
     7. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
     8. Description of the assessment of provider capacity to meet the specific needs of enrollees;
     9. Identification of strategies that promote enrollee self-management and treatment adherence;
     10. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
     11. Application of strategies to integrate information about the enrollee across the Respondent and various subcontractors when the Respondent has delegated functions.
  2. The extent to which the Respondent’s workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
  3. The extent to which the Respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
  4. The extent to which the Respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
  5. The extent to which the Respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
  6. The extent to which the Respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
  7. The extent to which the Respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

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

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# Criteria #40 – Vignette:

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

*Emma is 4 years old. She currently lives in a pediatric nursing facility. At the age of 2 she was admitted to PICU following a respiratory arrest during an acute illness. A further complication of her condition led to her requiring a tracheostomy to support her breathing. Following an acute exacerbation of her condition, she is now unable to breathe without the support of her ventilator when she is tired, asleep, or unwell. She is fully ventilated overnight. Her difficulties are compounded by complex seizures. Emma’s doctor says Emma needs to have nurses or health care assistants with her at all times to monitor her ventilation. Emma’s most recent developmental screening indicates the presence of an intellectual disability. Emma’s condition has stabilized, but her mother is concerned about agreeing to bring her home permanently. Her mother is the sole income for their home, which includes three older siblings and Emma’s maternal grandmother. Emma’s grandmother is retired, and her ability to help the family is limited by severe rheumatoid arthritis.*

*To be discharged to her home, Emma’s physician has ordered a custom wheelchair that must be individually fabricated and assembled. Her physician also ordered an electronic tablet to provide cognition exercises for Emma. The tablet has a cognition exercise application that reduces the likelihood for any seizure activity that may occur with other similar tablets. Florida Medicaid does not cover the tablet nor the wheelchair, which includes a part that will make it easier for Emma to hold the tablet. Her mother is unable to bear the costs for these special service items. Further orders for Emma’s transition to home care are:*

* *Continuous pulse oximetry monitoring.*
* *Apnea monitor when she is not on the ventilator.*
* *A backup generator for the ventilator if the power goes out in the home.*

*Emma is a new enrollee. Prior to her enrollment, all services were provided through the Medicaid FFS delivery system.*

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

1. New Enrollee Identification;
2. Health Risk Assessment;
3. Care Coordination/Case Management;
4. Service Planning;
5. Discharge/Transition Planning;
6. Disease Management;
7. Utilization Management; and
8. Grievance and Appeals.

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

**Reply:**

**Evaluation Criteria:**

* 1. The adequacy of the Respondent’s approach in addressing the following:
     1. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
     2. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
     3. Application of the Respondent’s case management risk stratification protocol;
     4. Identification of service needs (covered and non-covered) and a description for service referral processes that the Respondent has in place;
     5. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
     6. Application of discharge and aftercare planning protocols that facilitate a successful transition;
     7. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
     8. Description of the assessment of provider capacity to meet the specific needs of enrollees;
     9. Identification of strategies that promote enrollee self-management and treatment adherence;
     10. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
     11. Application of strategies to integrate information about the enrollee across the Respondent and various subcontractors when the Respondent has delegated functions.
  2. The extent to which the Respondents’ workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
  3. The extent to which the Respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
  4. The extent to which the Respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoid unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
  5. The extent to which the Respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
  6. The extent to which the Respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
  7. The extent to which the Respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

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

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# Criteria #41 – Provider Network Standards

Respondent will propose provider network standards that meet the needs of the specialty population(s) being proposed for this solicitation, including specific provider access ratios that exceed standards described in **Attachment A-2**, Core Provisions, Section VIII. Provider Services, A. Network Adequacy Standards for provider types relevant to the specialty population(s). Respondent (including Respondents’ parent, affiliate(s) or subsidiary(ies)) will describe its experience in managing provider networks for population(s) similar to the specialty population(s) being proposed for this solicitation, including experience with provider contracting and performance measurement relevant to the specialty population(s) proposed. Identify specific requirements for provider contracts, credentialing, provider handbooks, etc., the Respondent proposes for network providers serving the specialty population(s) proposed. Describe any additional provider services the Respondent proposes to make available to the provider network serving the specialty population(s).

**Reply:**

**Evaluation Criteria:**

1. The extent of experience (e.g., number of Contracts, enrollees or years) managing a provider network serving the proposed population(s).
2. The extent to which the described experience demonstrates the ability to manage a provider network relevant to the specialty population(s) proposed.
3. The extent to which the provider capacity ratios proposed ensure the adequacy of a provider network relevant to the specialty population(s) proposed.
4. The extent to which the provider requirements proposed are relevant to the provider network serving the specialty population(s) proposed.
5. The extent to which the additional provider services proposed are relevant to the provider network serving the specialty population(s) proposed.

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

1. **Oversight and Accountability**

# Criteria #42 – Subcontractor Oversight

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

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent provides a list of subcontractors it proposes to use under the CMS Plan for the delegation of work as described above.
2. The adequacy of the Respondent’s oversight structure, including the extent of executive level staff participation.
3. The extent to which the Respondent uses and monitors for service level agreements consistent with the CMS Plan Scope of Services.
4. The adequacy of the Respondent’s approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.
5. The adequacy of the Respondent’s processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.
6. The extent to which the Respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

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

# Criteria #43 – Subcontractor Oversight – Disaster Contingency Plan

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

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent has outlined the data sources it would use to trigger the Respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.
2. The extent to which the Respondent outlines a communications strategy in the contingency plan.
3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.
4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

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

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# Criteria #44 – System Modification Protocol

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

* 1. How the Respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems;
  2. How the Respondent will accommodate Department -directed IT modifications; and
  3. How the Respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

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

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**Reply:**

**Evaluation Criteria:**

* + 1. The adequacy of the Respondent’s IT processes addressing internal modifications for its core systems and subcontractor’s systems.
    2. The extent to which the Respondent’s IT processes documented for implementing the CMS Plan directed modifications is less than 90 days.
    3. The adequacy of the Respondent’s processes documented for handling production IT system issues.
    4. The adequacy of the Respondent's communication process used when system issues/updates are identified and resolved by the Respondent and/or its subcontractors throughout the change control process.
    5. The adequacy of the Respondent’s approach to internal testing of the system in order to ensure the Respondent’s and/or subcontractors’ system changes/updates is accurate.
    6. The adequacy of the Respondent's approach to integration testing to ensure the Respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.
    7. The adequacy of the Respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

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

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# Criteria #45 – Encounter Data Submission

* + - 1. Respondent will submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.
      2. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. Respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.
      3. Respondent will demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.
      4. Respondent will include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.
      5. Respondent will include documentation of the most recent three years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.
      6. Respondent will submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

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**Reply:**

**Evaluation Criteria:**

* + - * 1. The adequacy of the Respondent’s process to ensure accurate, timely, and complete encounter data.
        2. Demonstrated knowledge of the combination of key fields needed to identify services.
        3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.
        4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.
        5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.
        6. The completeness of the Respondent’s flowcharts describing its encounter data submission process.
        7. The adequacy of the Respondent’s mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.
        8. The adequacy of the Respondent’s encounter data submission historical compliance ratings.
        9. The adequacy of the Respondent’s ability to implement timely corrective actions to compliance ratings, if indicated.
        10. The adequacy of the tools and methodologies used to determine compliance.
        11. The adequacy of the Respondent’s process for converting paper claims to electronic encounter data.
        12. The adequacy of the Respondent’s approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.
        13. The adequacy of the tool to ensure that all encounters are submitted.

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

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

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

**Reply:**

**Evaluation Criteria:**

1. The adequacy of the Respondent’s approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.
2. The adequacy of the Respondent’s approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.
3. The adequacy of the Respondent’s approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the Respondent’s approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.
4. The adequacy of the Respondent’s approach to educating and supporting providers who submit paper claims.
5. The adequacy of the Respondent’s approach to encouraging providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.
6. The adequacy of the Respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.
7. The adequacy of the Respondent’s approach to work with providers to comply with correct coding.
8. The adequacy of the Respondent’s approach to ensure that all encounters are included in submissions.

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

# Criteria #47 – Fraud and Abuse/Compliance Office

Respondent will describe its compliance program as defined in **Attachment A-2**, Core Provisions, Section X. Administration and Management, F. Fraud and Abuse Prevention, including the compliance officer’s level of authority and reporting relationships. Respondent will describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. Respondent will include a résumé or curriculum vitae for the compliance officer. Respondent will also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

**Reply:**

**Evaluation Criteria:**

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

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

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

Respondent will describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, including electronic verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.
2. The extent to which the Respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.
3. The extent to which the Respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.
4. The extent to which the Respondent uses innovative technology for the purposes of verifying home-based visits and services.

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

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# Criteria #49 – Disaster Recovery Requirements

Respondent will demonstrate its capability and approach to meet the requirements described in **Attachment A-2**, Core Provisions, Section X. Administration and Management, D.4.i. Business Continuity-Disaster Recovery (BC-DR) Plan.

**Reply:**

**Evaluation Criteria:**

1. The adequacy of the Respondent’s proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.
2. The adequacy of the Respondent’s proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of 24 hours and ensures compliance with all requirements under the Contract.
3. The adequacy of the Respondent’s proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the Respondent for the entire period of the Contract and submitted for review annually by the anniversary date of the Contract.
4. The adequacy of the Respondent’s proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the Respondent to conduct the requirements of the Contract.
5. The adequacy of the Respondent’s proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.
6. The adequacy of the Respondent’s proposed approach and capability to ensure the disaster recovery plan is finalized no later than 30 calendar days prior to the Contract effective date.
7. The adequacy of the Respondent’s proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Department and at no additional cost to the Department.
8. The adequacy of the Respondent’s proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Department at all times.
9. The adequacy of the Respondent’s proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Department.

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

# Criteria #50 – Management Experience and Retention:

Respondent will describe its approach to hiring, promoting and retention, throughout the Contract term, of executive managers (e.g., CEO, COO, CFO, CMO, vice presidents, and senior managers) who have expertise and experience in serving children with medical complexity, and document such expertise and experience. Respondent will describe the relevant experience of their current management team.

**Reply:**

**Evaluation Criteria:**

* 1. The extent to which executive managers have expertise and experience in implementing innovative care delivery systems serving children with medical complexity who require specialized services.
  2. The extent to which executive managers have expertise and experience for their respective positions.
  3. The degree to which the Respondent provides evidence, data, or metrics to demonstrate the effectiveness of its approaches to staff retention, including staff tenure, by contract, for the Respondent’s two most recent contracts.

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

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1. **Statutory Requirements**

# Criteria #51 – Statutory Community Partnerships

Respondent will describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees, including:

* 1. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.
  2. Partnerships with local community organizations focused on addressing the following social determinants of health:

1. Access to food;
2. Employment and community inclusion;
3. Housing stability and utility payment assistance;
4. Education; and
5. Exposure to crime/violence.
   1. Participation in both grass-roots and grass-tops provider initiatives.

**Reply:**

**Evaluation Criteria:**

* + 1. The extent to which the Respondent provides details on how their local community partnerships, activities and initiatives support the local system of care.
    2. The extent to which the Respondent has senior executive leadership staff who will be assigned to the resulting Contract who also participate on local health and human service related boards, councils, and commissions.
    3. The extent to which the Respondent has partnerships with local agencies that focus on addressing social determinants of health.
    4. The extent to which the Respondent jointly develops and incorporates change from grassroots and grass-tops provider initiatives.

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

# Criteria #52 – Organization Commitment to Quality (See section 409.966, Florida Statutes):

Respondent will describe its organizational commitment to quality improvement, including active involvement by the Respondent’s medical and administrative leadership, and document its achievements with two examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

**Reply:**

**Evaluation Criteria:**

1. The extent to which the Respondent’s description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.
2. The adequacy of the Respondent’s approach to incorporating quality improvement activities into the culture and operations of the organization.
3. The extent to which the Respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.
4. The extent to which the Respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.
5. The extent to which the Respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.
6. The extent to which one of the quality improvement projects described by the Respondent is related to reducing potentially preventable events or improving birth outcomes.

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

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# Criteria #53 – Health Plan Accreditation (See section 409.966, Florida Statutes)

Respondent will specify its current accreditation status by a nationally recognized accrediting body. This will include the name of the accrediting body, the most recent date of certification, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (i.e., provisional, conditional, etc.). Respondent will attach documentation that supports this information.

**Reply:**

**Evaluation Criteria:**

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

**Score:** This section is worth a maximum of five raw points as outlined below:

1. 5 points for full health plan accreditation.
2. 3 points for partial/conditional health plan accreditation.
3. 0 points if health plan accreditation denied or no accreditation.

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# Criteria #54 – Provider Network Agreements/Contracts

The Department has identified some of the key network service provider types that will be critical in order for the Respondent to promote the CMS Plan’s goals.

Respondent will demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting **Attachment A-1-e**, Provider Network Agreements/Contracts:

**Reply:**

**Evaluation Criteria:**

For each service provider type the Respondent may receive up to 20 points as described below. Points for each service provider type will be awarded as outlined in the table below:

|  |  |
| --- | --- |
| **Percentage of agreements/contracts for each service provider type** | **Points** |
| 0.0% | 0 |
| 1.0% - 25% | 5 |
| 25.1%- 50% | 10 |
| 50.1%- 75% | 15 |
| 75.1% or greater | 20 |

**Score:** This section is worth a maximum of 240 raw points based on the above point scale.

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

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