REQUEST FOR INFORMATION –

OPTOMETRIC AND VISION SERVICES

July 15, 2022

Table of Contents

SECTION 1 – RFI OVERVIEW AND PROPOSAL PROCEDURES ... 1
1.1 Introduction/Background ... 1
1.2 Objective ... 1
1.3 RFI Timeline ... 1
1.4 Restrictions on Communications ... 2
1.5 Written Questions; Additional Information; Addenda ... 2
1.6 Florida Sunshine Act and Public Records Law ... 3
SECTION 2 – INFORMATION TO BE INCLUDED IN THE RFI RESPONSE ... 3
2.1 Format of RFI Responses ... 3
2.2 Minimum Eligibility Criteria ... 4
SECTION 3.0 –EVALUATION OF RFI RESPONSES ... 5
3.1 Evaluation Committee ... 5
3.2 Evaluation Process ... 6
3.3 RFI Postponement/Cancellation ... 6
ATTACHMENT 1 – DEFINITIONS ... 7
ATTACHMENT 2 – ACKNOWLEDGMENT FORM ... 9
ATTACHMENT 3 – QUESTION/ANSWER TEMPLATE ... 10
ATTACHMENT 4 – SERVICE REQUIREMENTS FOR OPTOMETRIC AND VISION SERVICES ... 11
ATTACHMENT 5 – PRICING PROPOSALS ... 18
ATTACHMENT 6 – SUBCONTRACTOR DELEGATION CHECKLIST ... 20

954.622.3200 | www.ccpcares.org | 1643 Harrison Parkway (H-200), Sunrise, FL 33323

SECTION 1 – RFI OVERVIEW AND PROPOSAL PROCEDURES

This Request for Information ("RFI") is issued by South Florida Community Care Network, LLC d/b/a Community Care Plan ("CCP") to solicit information regarding the provision of optometric, ophthalmological, and vision services ("Vision Services").

This RFI should not be construed as a request or authorization to perform work at CCP's expense. Any work performed by a respondent in connection with its evaluation and response to this RFI, will be at the Respondent's own discretion and expense.

1.1 Introduction/Background

CCP is a provider service network ("PSN") owned and operated by the North Broward Hospital District d/b/a Broward Health and the South Broward Hospital District d/b/a Memorial Healthcare System ("Members"). CCP was incorporated as South Florida Community Care Network, LLC in 2014 as a Florida limited liability company, with its principal place of business located at 1643 Harrison Parkway, Suite H-200, Sunrise, Florida 33323.

As part of its operations, CCP has and continues to establish a network of providers to provide health care services to certain payor groups, including Medicaid, Florida Healthy Kids, Marketplace plans, employer groups, including self-insured employer groups, and uncompensated care programs, among others. CCP provides services to its enrollees in Region 10 (Broward County) for the Statewide Medicaid Managed Care ("SMMC") Program and in Regions 9, 10 and 11 (Indian River, Martin, Okeechobee, Palm Beach, St. Lucie, Broward, Miami-Dade, and Monroe Counties) for the Florida Healthy Kids ("FHK") Program.

1.2 Objective

CCP is required by through contracts with the Agency for Health Care Administration ("AHCA Contract") and Florida Healthy Kids Corporation ("FHK Contract") to provide Vision Services to its enrollees as a covered service. CCP is seeking information from entities with direct experience regarding the provision of Vision Services to enrollees enrolled in the SMMC Program and the FHK Program.

1.3 RFI Timeline

The projected timeline for this RFI is provided below. CCP reserves the right to amend the timeline. If CCP finds it necessary to change any of the activities/dates/times listed below, all persons will be notified by addenda to the original RFI.

DATE/TIME	DESCRIPTION
July 15, 2022	CCP will publish notice of the release of the RFI in the *Florida Administrative Register* and it will be available at https://www.ccpcares.org/Newsroom
July 22, 2022 @ 5:00 p.m.	Interested respondents should submit Attachment 2 via email to procurements@ccpcares.org

DATE/TIME	DESCRIPTION
July 29, 2022 @ 5:00 p.m.	Interested respondents should submit written questions utilizing substantially the same form as shown on Attachment 3 via email to procurements@ccpcares.org
August 5, 2022 @ 5:00 p.m.	CCP will submit its Answers to Written Questions to interested respondents via email from procurements@ccpcares.org to each Respondent's designated email contact
August 26, 2022 @ 2:00 p.m.	RFI Responses should be emailed to procurements@ccpcares.org

After CCP has received the RFI Responses, CCP, in its sole discretion, shall determine if a meeting with respondents is necessary to clarify the information received. In the event that CCP decides to hold a meeting, the Respondent(s) will be notified via email.

1.4 Restrictions on Communications

Respondents submitting a response to this RFI or persons acting on their behalf are prohibited from contacting any member of the staff or representative of CCP, Memorial Healthcare System or Broward Health about any aspect of the services related to this RFI beginning on the date on which the RFI is first advertised by CCP and continuing until a recommendation is made to the CCP Members. Any information that amends or supplements any portion of this RFI, which is received by any method other than an Addendum to the RFI should not be considered and is not binding on CCP. Violation of this section, may, at CCP's sole discretion, result in disqualification of the offending respondent from the RFI, as well as suspension or debarment from participating in any future CCP procurements or competitive solicitations. This restriction on communications shall not apply to:

(a) Communications with CCP staff by an existing vendor regarding the vendor's existing contract or other matter clearly outside the scope of this RFI;
(b) Communications to or with the designated point of contact identified in the RFI; or
(c) Presentations before the Selection/Evaluation Committee meetings.

1.5 Written Questions; Additional Information; Addenda

(a) Any questions concerning any portion of this RFI must be submitted, in writing, to CCP via email to Procurements@ccpcares.org no later than 5:00 p.m. on July 29, 2022, as specified in Section 1.3, RFI Timeline, in a format substantially the same as Attachment 3, Question/Answer Template.

(b) Any questions which require a response which amends the RFI in any manner will be answered via Addendum by CCP and provided to all respondents.

(c) It is the sole discretion of CCP to consider questions received after the Written Questions submission deadline.

1.6 Florida Sunshine Act and Public Records Law

Respondent understands that CCP is subject to chapter 119, Florida Statutes, commonly known as Florida's Public Records Law. If any party requests access to or copies of information submitted by a respondent in connection with this RFI, the following terms will apply:

(a) CCP will notify Respondent of any instance in which the disclosure or copies of Respondent's confidential information is requested by any party to be disclosed under chapter 119. If Respondent submitted a redacted copy of its RFI Response with the statutory basis for said redactions, CCP will respond to the public records request with a copy of the redacted response.

(b) If the party requesting the disclosure contests the legal basis for withholding any of the documents Respondent contends should be held as confidential, then Respondent will, at its sole cost, defend its position that the requested documents should not be released. To the extent CCP incurs liability for costs or attorneys' fees (including, without limitation, those awarded to the party requesting the disclosure) in connection with such challenge or appeal, Respondent agrees to indemnify and hold harmless CCP for those costs and fees.

SECTION 2 – INFORMATION TO BE INCLUDED IN THE RFI RESPONSE

2.1 Format of RFI Responses

Each RFI Response shall be written in sufficient detail to permit CCP to conduct a meaningful evaluation of each response. The RFI Responses must include the following information:

(a) **Title Page:** The title page should include the RFI title/subject, Respondent's name, address, telephone number, email address, and the date of submission.

(b) **Table of Contents:** The Table of Contents should outline in sequential order the major areas of the RFI Response. All pages of the RFI Response, including the attachments, must be clearly and consecutively numbered and correspond to the Table of Contents.

(c) **Letter of Transmittal:** The transmittal letter should include Respondent's name, business address, contact person's email address, and federal employer identification number ("FEIN"). The transmittal letter should also include the name of any person authorized to make representations for Respondent, their title, address, telephone number, and email address.

(d) **Instructions:** Respondent should carefully follow the instructions outlined in this RFI, including but not limited to this section 2.1 and its subsections; the attachments to this RFI; the Minimum Eligibility Criteria in Section 2.2; and the Evaluation Criteria in Section 2.3 and its subsections, which will form the substance of Respondent's submission. Respondent must submit a response addressing each of the points in the same order as presented herein. Failure to do so could eliminate Respondent from consideration.

Proposals that do not include the required documents may be deemed non-responsive and may not be considered.

(e) **Exemptions**: If a respondent is asserting any exemption(s) under chapter 119, Florida Statutes, Respondent must submit a redacted copy of its response with the statutory basis for the redactions with the Respondent's name clearly printed on the transmittal letter of the redacted RFI Response.

2.2 Minimum Eligibility Criteria

In order to be considered for contracting with CCP and to be further evaluated, Respondent must meet or exceed the following criteria as of the date of the RFI. Failure to accept the terms below and/or to provide the information requested below may result in disqualification of Respondent for consideration.

(a) Respondent must be licensed as a Third Party Administrator and in good standing to do business in the state of Florida.

(b) Respondent must describe and demonstrate its expertise and experience with similarly situated clients.

(c) Respondent must state under what other or former name(s) Respondent is currently or has previously operated under.

2.3 Evaluation Criteria – (Respondent Qualifications, Scope of Services, and Cost of Services)

This section represents the information that will be utilized in the evaluation of responses received. Respondents are cautioned to read this section carefully and respond with full complete information that will assist the Evaluation Committee in evaluating the RFI Responses submitted. Respondents are requested to respond in the format and organizational structure stated and to refrain from including promotional or advertisement materials in their RFI Responses. Failure to respond or incomplete responses to any evaluation criteria below may result in disqualification of an entire RFI Response. **A complete response to this RFI will include a qualifications summary outline responsive to this section 2.3, including Attachments 4 and 5.**

(a) **Respondent's Qualifications**:

(i) **Executive Summary** – Submit a brief abstract, of approximately three (3) pages, stating Respondent's understanding of the nature and scope of the Vision Services required under the SMMC Program and the FHK Program and Respondent's capability to comply with all terms and conditions of both programs.

(ii) **Litigation** – Provide a statement of any litigation or regulatory action that has been filed by or is pending against Respondent in the last three (3) years. If an action has been filed, state and describe the litigation or regulatory action, and identify the court or agency before which the action was instituted, the applicable case or file number, and the status or disposition for such reported action. If no litigation or regulatory action has been filed against Respondent, provide a statement to that effect. For joint venture or team respondents, submit the requested information for each member of the joint venture or team.

(iii) **Background** – Provide a brief description of Respondent, its services, and its overall qualifications. Information provided in this section should include, but not be limited to: Respondent's mission and vision, number of years providing relevant Medicaid/CHIP or similar services, states serviced as of the date of the response, an organizational chart including immediate and ultimate parent organizations, number of employees, and approximate number of past and current clients, calling out those in the State of Florida.

(iv) **Qualifications and Relevant Experience:** Describe Respondent's experience and qualifications in the provision of Vision Services and any other relevant documentation or information that may be relevant to CCP, including but not limited to experience servicing managed care companies for Medicaid or CHIP programs in Florida and other states.

(v) **Differentiating Factors:** Describe Respondent's unique experience or qualifications that will set it apart from other respondents.

(b) **Scope of Services to be Provided:** Respondent must provide a proposed scope of work including service level agreements and milestones tied to a financial arrangement where possible, ensuring timely submission of all deliverables. The proposed scope of work should include a detailed list of those services that are excluded, i.e., age limits, excluded diagnosis, inpatient services, anesthesia, J-codes, etc. Respondent must also indicate its agreement that Respondent would agree to the service requirements set forth on Attachment 4.

(c) **Cost of Services:** Respondent should submit the worksheet titled Pricing Proposals in Attachment 5 for the provision of Vision Services sought in this RFI. Evaluation of this section will be based on the Respondent's ability to substantiate the proposed pricing levels using similarly sized clients it services, as well as providing estimates for non-recurring or one-time charges, maintenance and support services fees, cost of implementation, training, and other services. Additional consideration will be given to any RFI Responses which include an option for flat fees, maximum/capped fees, or alternative fee arrangements, including putting a portion of the fee at risk in the event of inferior performance, as opposed to uncapped rates.

(d) **Subcontractor Requirements:** Respondent should submit a written certification confirming acknowledgment of and compliance with section 2.2 above, and the requirements outlined in Attachment 6. Respondent agrees that, to the extent applicable, the subcontractor provisions identified in Attachment 6 are required by the AHCA and FHK Contracts and will be incorporated into any agreement with CCP.

SECTION 3 –EVALUATION OF RFI RESPONSES

3.1 Evaluation Committee

The Evaluation Committee ("Committee") shall evaluate all RFI Responses received which meet or exceed Section 2.2, Minimum Eligibility Requirements, and which respond to each criterion

outlined in Section 2.3 and the referenced Attachments. The Committee may recommend the rejection of any response containing material deviations from the RFI. The Committee may recommend waiving any irregularities and technicalities.

3.2 Evaluation Process

The Committee reserves the right to ask questions of a clarifying nature to some or all respondents once the RFI Responses are received, require presentations from select respondents, or make their recommendations based solely on the information contained in the RFI responses submitted. Presentations, if required, will be part of the evaluation process.

3.3 RFI Postponement/Cancellation

CCP reserves the right, in its sole and absolute discretion, to withdraw, postpone or cancel all or part of this RFI at any time. CCP further reserves the right to re-advertise this RFI, which may also be modified to meet the current needs of CCP.

954.622.3200 | www.ccpcares.org | 1643 Harrison Parkway (H-200), Sunrise, FL 33323

ATTACHMENT 1 – DEFINITIONS

TERM	DEFINITION
"Agency for Health Care Administration" ("AHCA" or "the Agency")	The State agency responsible for administering the Medicaid Program and the lead agency for Title XXI of the Social Security Act for purposes of receipt of federal funds, reporting and for ensuring compliance with federal and state regulations and rules. Any reference to AHCA or the Agency includes its employees acting in their official capacity, its designee, or its successor agency.
"AHCA Contract"	The contract between CCP and the Agency where CCP provides Covered Services to assigned Enrollees in the Statewide Medicaid Managed Care ("SMMC") Managed Medical Assistance ("MMA") Program in Broward County, Florida. CCP and its Providers are required to remain in compliance with all AHCA Contract requirements at all times in the performance of their obligations.
"Business Day"	Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding legal holidays.
"Community Care Plan" or "CCP"	The fictitious name established in 2016 for South Florida Community Care Network, LLC ("SFCCN") to promote and effectively target the services of SFCCN in the health care marketplace. The naming of CCP does not modify or amend any covenants, Contracts, or other obligations of SFCCN. References to CCP throughout this RFI mean and refer to SFCCN.
"Contract"	All types of CCP agreements, regardless of what they may be called or referred to, for the Procurement or disposal of goods or services of any kind. Contracts also include amendments, modifications, supplemental agreements, addendums, exhibits, and/or attachments with respect to any of the foregoing. Every Contract must be duly authorized and approved.
"Contractor"	Any person or entity having a Contract with CCP to provide goods or services of any kind.
"Enrollee"	An individual who is enrolled in a CCP Program or administered Plan.
"Evaluation Committee"	A group of persons appointed by CCP to evaluate RFI Responses received by CCP.
"FHKC Contract"	The contract between CCP and FHKC where CCP provides Covered Services to assigned Enrollees in the FHKC Program in FHKC Regions 9, 10 and 11. CCP and Provider are required to remain in compliance with all FHKC Contract requirements at all times in the performance of their obligations under this Agreement.
"Florida Healthy Kids Corporation" or "FHKC"	A private, non-profit corporation created by the Legislature in section 624.91, Florida Statutes. FHKC collaborates with public and private partners statewide to ensure access to affordable, high quality health and dental insurance for all Florida children. Children's Medicaid, Florida Healthy Kids, MediKids and Children's Medical Services are marketed as Florida KidCare. The latter three comprise Florida's Title XXI CHIP, created in Florida pursuant to sections 409.810 through 409.821, Florida Statutes.
"Person"	Any business, individual, union, committee, club, other organization, or group of individuals.

TERM	DEFINITION
“Provider”	The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.
“Respondent”	A person who, as determined by CCP, has submitted a response which conforms in all material respects to the RFI.
“RFI Response”	A response submitted by a Respondent in response to this RFI issued by CCP.

ATTACHMENT 2 – ACKNOWLEDGMENT FORM

This form acknowledges receipt of CCP's Request for Information and indicates whether Respondent intends to submit a response.

RFI Responses must be received prior to 2:00 p.m. on August 26, 2022.

Return this form via email no later than 5:00 p.m. on July 22, 2022, to Procurements@ccpcares.org.

Company Name:	______________________________
	______________________________
Contact Name:	______________________________
Street Address	______________________________
City, State, Zip	______________________________
Office Number:	______________________________
Cell Number:	______________________________
Email:	______________________________
Authorized Signature:	______________________________
Print Name	______________________________
Title:	______________________________
Date:	______________________________
Will Respondent be submitting a RFI Response?	☐ Yes ☐ No
Please indicate the reason(s) for not submitting a response.	______________________________ ______________________________ ______________________________ ______________________________

ATTACHMENT 3 – QUESTION/ANSWER TEMPLATE

Question #	Respondent	Section Reference	Subsection Reference	Attachment Reference	Page #	Question	Response

954.622.3200 | www.ccpcares.org | 1643 Harrison Parkway (H-200), Sunrise, FL 33323

ATTACHMENT 4 – SERVICE REQUIREMENTS FOR OPTOMETRIC AND VISION SERVICES

This Attachment shall be completed by all Respondents as it relates to the minimum requirements for all providers of visual aid services and visual care services. *See, Fla. Admin. Code R. 59G-4.210 and 59G.4.340*. If a Respondent indicates "No" on any of the requirements below, a proposed explanation and/or alternative must be included in Respondent's RFI Response.

Number	Service Requirements	*Check one of the following*	
1.	Respondent agrees that providers must comply with the service coverage requirements of *Fla. Admin. Code R. 59G-4.210 and 59G.4.340*, unless otherwise specified in the AHCA Contract or the FHK Contract.	Yes ☐	No ☐
2.	Respondent agrees that an eligible Enrollee must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in the applicable coverage policy. Providers must verify each Enrollee's eligibility each time a service is rendered.	Yes ☐	No ☐
3.	Respondent agrees that Enrollees covered by the AHCA Contract are responsible for the following copayments for services identified in Service Requirement 7 below, unless the Enrollee is exempt from copayment requirements, or the copayment is waived by CCP: • $2.00 per practitioner office visit, per day • $3.00 per federally qualified health center visit, per day • $3.00 per rural health clinic visit, per day	Yes ☐	No ☐
4.	Respondent agrees providers must be enrolled directly or registered with Florida Medicaid to be reimbursed for services rendered to eligible enrollees.	Yes ☐	No ☐
5.	Respondent agrees eligible providers for the services identified in Service Requirement 7 below are: • Practitioners licensed within the scope of practice to perform these services; • County health departments administered by the Department of Health in accordance with chapter 154, Florida Statutes; • Federally qualified health centers approved by the Public Health Service; and • Rural health clinics certified by Medicare.	Yes ☐	No ☐
6.	Respondent agrees Florida Medicaid reimburses for services that meet all of the following criteria: • Are determined medically necessary; • Do not duplicate another service; and • Meet the criteria as specified in *Fla. Admin. Code R. 59G-4.210 and 59G.4.340*.	Yes ☐	No ☐
7.	Respondent agrees that pursuant to Rule 59G-4.210, F.A.C., Medicaid reimburses for visual care services to provide eye examinations, diagnosis, treatment, and management related to ocular and adnexal pathology. Medicaid reimburses for visual care services including: • Blepharoplasty when the drooping or sagging of the eyelid(s) interferes with the enrollee's vision; • Up to four (4) computerized corneal topography per year; • Up to four (4) intravitreal implants per year; • Lacrimal punctum plugs;	Yes ☐	No ☐

Number	Service Requirements	Check one of the following	
	• One (1) initial consultation visit per year; • Pathology and laboratory services (the laboratory must hold a CLIA license); • Special ophthalmological services when performed in addition to a general ophthalmological, or evaluation and management visit; • Up to twelve (12) temporary lacrimal punctum plugs per year when a more permanent conservative treatment will cause discomfort; • Up to two (2) evaluation and management visits per month; • Up to two (2) refractions every 365 days; and • Visual examination services performed when there is a reported vision problem, illness, disease, or injury.		
8.	Respondent agrees Florida Medicaid provides services to eligible recipients under the age of twenty-one (21) years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of twenty-one (21) years exceeding the coverage described in the applicable policies or the associated fee schedules may be approved, if medically necessary.	Yes ☐	No ☐
9.	Respondent agrees that eligible providers for the services identified in Service Requirements 11 through 15 below are an: • Optometrist and certified optometrist licensed in accordance with chapter 463, Florida Statutes; • Ophthalmologist licensed in accordance with chapter 458, Florida Statutes; • Optician licensed in accordance with chapter 484, Florida Statutes.	Yes ☐	No ☐
10.	Respondent agrees that Medicaid reimburses for visual aid services to provide visual aids to enrollees to alleviate visual impairments.	Yes ☐	No ☐
11.	Respondent agrees that Medicaid reimburses for eyeglasses: • For two (2) pairs per 365 days for enrollees under the age of twenty-one (21) years. • For recipients age twenty-one (21) years and older, Florida Medicaid reimburses for the following: o One (1) frame every two (2) years; and o Two (2) lenses every 365 days. o Polycarbonate or thermoplastic lens materials for a recipient's safety or documented medical condition (when necessary); and o Metal frames when plastic frames are medically inappropriate. Florida Medicaid may reimburse for additional frames, lenses, pairs of glasses, and special order frames with prior authorization.	Yes ☐	No ☐
12.	**Fitting, Dispensing, and Adjustment of Eyeglasses Services:** Respondent agrees that Florida Medicaid reimburses for services for new Medicaid-provided glasses and after factory repairs.	Yes ☐	No ☐
13.	**Eyeglass Repair Services:** Respondent agrees that Florida Medicaid reimburses for repairs when performed in an office or by a licensed authorized dealer. Only elements of the frames or lenses that are damaged beyond repair may be replaced.	Yes ☐	No ☐

Number	Service Requirements	*Check one of the following*	
14.	**Contact Lenses:** Respondent agrees that Florida Medicaid reimburses for the following when the recipient has a documented medical condition where eyeglasses would not provide any benefit for their visual impairment: • Rigid or soft contact lenses; and • Extended wear (if the recipient cannot wear normal soft lenses). Contact lens services include all of the following: • Fitting; • The contact lens and required care kits; • Instructions on insertion, removal, and proper care of the lenses; and • A ninety (90) day follow-up visit period that includes acuities, assessment of corneal physiology, biomicroscopy examination, and other procedures required (as necessary).	Yes ☐	No ☐
15.	**Prosthetic Eyes:** Respondent agrees that Florida Medicaid reimburses for evaluating, measuring, fitting, and dispensing of the prosthetic eye(s). The evaluation must be completed no more than three (3) months prior to the provision of the prosthetic eye. Florida Medicaid reimburses for replacement of prosthetic eyes when the eye(s) are damaged or no longer the appropriate size. Prosthetic eyes may also be reimbursed through Florida Medicaid's durable medical equipment and medical supply services benefit.	Yes ☐	No ☐
16.	Respondent agrees that there is no coinsurance, copayment, or deductible for the services identified in Service Requirements 11 through 15 above.	Yes ☐	No ☐
17.	Respondent agrees that CCP's contract with the Agency includes an expanded benefit that cover a six (6) month supply of contact lenses for ages 21+.	Yes ☐	No ☐
18.	Respondent agrees that Enrollees covered by the FHK Contract are responsible for the following copayments for services identified in Service Requirement 19 below, unless the Enrollee is exempt from copayment requirements, or the copayment is waived by CCP: • $5.00 per visit; and • $10.00 for corrective lenses.	Yes ☐	No ☐
19.	Respondent agrees that Florida Healthy Kids reimburses for the following covered services: • Examination to determine the need for and to prescribe corrective lenses as medically necessary; and • Corrective lenses and frames are limited to one (1) pair every two (2) years unless the Enrollee's head size or prescription changes. CCP follows the Florida Medicaid Visual Aid Services fee schedule laid out in Rule 59G-4.340, Florida Administrative Code, and its successors, insofar as it relates to the criteria for covered eyeglasses and contact lenses. In the event rule 59G-4.340 conflicts with the FHK benefit schedule or Contract, the FHK benefit schedule or Contract will prevail.	Yes ☐	No ☐
20.	Has Respondent been involved in bankruptcy as a debtor, or in a reorganization, liquidation, or dissolution proceeding, or has a trustee or receiver has been appointed	Yes ☐	No ☐

Number	Service Requirements	*Check one of the following*	
	over all or a substantial portion of the property of the Respondent under federal bankruptcy law or any state insolvency law?		
21.	Respondent represents and warrants that Respondent and none of its employees or subcontractors are and at no time have been excluded from participation in any federally funded health care program under sections 1128 and 1128A of the Social Security Act, or any other federally funded program or federal contract, including Medicare and Medicaid, and that neither it nor any affiliate is currently included in or listed on the List of Excluded Individuals/Entities maintained by the Department of Health and Human Services Office of Inspector General pursuant to 42 U.S.C. §§ 1320a-7, 1320c-5, 1395cc, and regulation promulgated thereunder, which can be searched at http://exclusions.oig.hhs.gov/ ("OIG List"), or is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in 42 C.F.R. § 438.610(a)(1), or is on the Convicted Vendor List or Discriminatory Vendor List maintained pursuant to section 287.133 or 287.134, Florida Statutes.	Yes ☐	No ☐
22.	Respondent agrees to observe and comply with the applicable requirements of CCP's compliance program and code of conduct, including those related to compliance with HIPAA rules and regulations.	Yes ☐	No ☐
23.	Respondent agrees to maintain the confidentiality of all enrollee information which it or any of them receives or has access to in connection with any such activities and shall treat all patient PHI and PII in the same manner.	Yes ☐	No ☐
24.	Respondent agrees that any contracts entered into as a result of this RFI shall be governed by and interpreted in accordance with the laws of Broward County in the state of Florida.	Yes ☐	No ☐
25.	Respondent agrees that it will indemnify CCP against any legal action that may occur as a result of performance of any obligation under any contract resulting from this RFI.	Yes ☐	No ☐
26.	Respondent agrees that Respondent is located and shall conduct all obligations under an awarded Contract within the United States. Additionally, Respondent agrees that it shall not send, store, or allow access to data outside the United States. A violation of this requirement may result in the termination of the awarded Contract or liquidated damages assessed under the AHCA Contract or the FHK Contract, other provisions of the Agreement notwithstanding.	Yes ☐	No ☐
27.	Respondent agrees to notify CCP immediately should any regulatory or other government agency requests a review of any Optometric and Vision Services related to any CCP engagement.	Yes ☐	No ☐
28.	Respondent agrees that other than the compensation to be paid under a contract, CCP shall not be liable or responsible to Respondent beyond the monetary limits specified in section 768.28, Florida Statutes, regardless of whether said liability be based in tort, contract, indemnity or otherwise; and in no event shall CCP be liable to Respondent for punitive or exemplary damages or for lost profits or consequential damages.	Yes ☐	No ☐
29.	During performance of any contract, Respondent and any subcontractor and/or joint-venturer shall not discriminate on the basis of race, color, gender, national origin, sexual orientation, age, disability, sex, pregnancy, religion, veteran status, military service, marital status, genetic information or any other status specifically protected by all applicable laws, in the provision of services and goods to CCP, the solicitation for or	Yes ☐	No ☐

Number	Service Requirements	*Check one of the following*	
	purchase of goods and/or services, or the subcontracting of work in the performance of a contract.		
30.	Respondent agrees that it and any subcontractor shall establish and maintain a written harassment policy and shall inform their employees and/or agents of the policy. The Respondent and/or any subcontractor understands its obligation to abide by CCP policies during the performance of a contract.	Yes ☐	No ☐
31.	Respondent understands and acknowledges that CCP is subject to the public records provisions of chapter 119, Florida Statutes. Respondent agrees that any provision in this Agreement that conflicts with the public records disclosure requirements of chapter 119, will be held null and void to allow CCP to comply with its statutory disclosure requirements.	Yes ☐	No ☐
32.	Respondent understands that AHCA and Florida Healthy Kids encourage supplier diversity and the participation of small and minority business enterprises in contracting, both as vendors and subcontractors. AHCA supports diversity in its Procurement Program and requests that all subcontracting opportunities afforded by the AHCA Contract enthusiastically embrace diversity.	Yes ☐	No ☐
33.	Respondent agrees to comply with Section 274A(e) of the Immigration and Nationality Act. The Agency and FHKC will consider the employment by CCP of unauthorized aliens a violation of this Act. If CCP or Respondent knowingly employs unauthorized aliens, such a violation shall be cause for unilateral cancellation of the Prime Contracts. Respondent shall be responsible for including this provision in all subcontracts with private organizations for work related to the AHCA Contract and FHK Contract.	Yes ☐	No ☐
34.	Respondent agrees to comply with the Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. Respondent shall only employ individuals who may legally work in the United States – either U.S. citizens or foreign citizens who are authorized to work in the United States. Respondent shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility system to verify the employment status of all new employees employed by Respondent during the term of the Agreement and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees contracted by the subcontractor performing work or providing services.	Yes ☐	No ☐
35.	Respondent agrees that it may not seek payment from Medicaid or FHKC on behalf of CCP.	Yes ☐	No ☐
36.	Respondent agrees to comply with all applicable federal and state laws and regulations, including: A. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d et seq.; B. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794; C. Title IX of the Education Amendments of 1972, as amended 20 U.S.C. § 1681 et seq.; D. The Age Discrimination Act of 1975, as amended, 42 U.S.C. § 6101 et seq.; E. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. § 9849; F. The American Disabilities Act of 1990, P.L. 101-336; G. Section 274A (e) of the Immigration and Nationalization Act; H. Title XXI of the federal Social Security Act;	Yes ☐	No ☐

954.622.3200 | www.ccpcares.org | 1643 Harrison Parkway (H-200), Sunrise, FL 33323

Number	Service Requirements	Check one of the following	
	I. HIPAA, and any other federal or state laws regarding disclosure of protected health information; J. The Immigration Reform and Control Act of 1986; and K. All applicable federal and state laws regarding advertising, marketing and promotional activities of health care services or otherwise related to the offering of health care services and items and services including: L. The Federal Anti-Kickback Law, 42 U.S.C. § 1320a-7b; (i) the Civil Monetary Penalty Law, 42 U.S.C. § 1320a-7a; (ii) the Civil and Criminal False Claims Acts, 31 U.S.C. §§ 3729-3733; (iii) the Stark Law, 42 U.S.C. § 1395nn; (iv) the Health Care Fraud Statute, 18 U.S.C. § 1347, Federal; and (v) to the extent applicable, the respective state law counterparts of any of the federal laws described in (i) through (v) above.		
37.	Respondent agrees that all contractors, subcontractors, sub-grantees, or others with whom it arranges to provide goods, services, or benefits in connection with any of its programs and activities are not discriminating against either those whom they employ nor those to whom they provide goods, services, or benefits in violation of the above statutes, regulations, guidelines, and standards. It is expressly understood that evidence of Respondent's refusal or failure to substantially comply with a contract or such failure by Respondent's subcontractors or anyone with whom Respondent affiliates in performing under a contract shall constitute a material breach and render any awarded contract subject to unilateral termination.	Yes ☐	No ☐
38.	Does Respondent anticipate a merger or acquisition taking place within the next twelve (12) months?	Yes ☐	No ☐
39.	Respondent agrees that, to the extent applicable, the subcontractor requirements identified on Attachment 6 and required by the AHCA Contract will be incorporated into any agreement between the Respondent and CCP. These requirements will apply to Respondent and any subcontractor Respondent contracts with to carry out any aspect of an agreement between Respondent and CCP.	Yes ☐	No ☐
40.	Respondent agrees that any liability, including any sanctions or liquidated damages, imposed upon CCP by AHCA or FHKC resulting from the failure of Respondent to provide timely and accurate services or information, or reporting shall be subject to Respondent's indemnification obligations set forth in the Contract.	Yes ☐	No ☐
41.	Respondent agrees to provide its staff with all specific training, equipment and supplies, and in-depth knowledge of regulations and procedures required for the performance of Vision Services.	Yes ☐	No ☐
42.	Respondent agrees to provide experienced supervisory personnel to oversee, manage and assist in providing Vision Services.	Yes ☐	No ☐
43.	Respondent agrees to have the capability of providing electronic reports to CCP as requested.	Yes ☐	No ☐
44.	Respondent agrees to promptly address any Enrollee complaints and/or concerns and coordinate its response with CCP.	Yes ☐	No ☐

Number	Service Requirements	*Check one of the following*	
45.	Respondent agrees to provide reasonable but prompt availability to senior supervisory personnel, and/or others within its business having technical expertise relevant to its qualifications and involvement in the engagement.	Yes ☐	No ☐
46.	Respondent agrees to provide immediate phone contact with a designated emergency coordinator 24/7/365 to resolve issues.	Yes ☐	No ☐
47.	Respondent agrees to provide on-going quality assurance activities to meet state, federal, and professional requirements.	Yes ☐	No ☐
48.	Respondent agrees to submit periodic updates during the performance of Vision Services to CCP. It will be the responsibility of Respondent to promptly communicate any difficulties encountered or potential difficulties in its ability to provide the services in accordance with agreed upon timetables and contract terms with such advance notice so as to afford CCP the ability to address such and maintain timetables and contract terms.	Yes ☐	No ☐
49.	Respondent understands and is committed to meeting CCP's timetable.	Yes ☐	No ☐
50.	Respondent agrees that its vision network is of sufficient size to ensure the provision of the services required under the AHCA Contract and the FHKC Contract. Respondent agrees to provide documentation of network adequacy upon request from CCP, which will meet AHCA and FHKC contract time and distance and adequacy standards.	Yes ☐	No ☐
51.	Respondent agrees to provide CCP with all information needed to comply with reporting requirements imposed by the Prime Contracts with respect to Vision Services.	Yes ☐	No ☐
52.	Respondent agrees to comply with the minimum liability insurance requirement of two hundred thousand dollars ($200,000.00) per person and three hundred thousand dollars ($300,000.00) per incident for all vision services purchased or provided through the Managed Care Plan. § 768.28(5), Fla. Stat. Respondent agrees to indemnify and hold harmless the local, state, and federal governments and their entities and the Agency from any liabilities arising out of or due to an accident or negligence on the part of the Respondent and/or all employees.	Yes ☐	No ☐
53.	Respondent agrees that its advance notification policies shall comport with the timely access to medical care requirements as specified in the AHCA Contract and the FHKC Contract.	Yes ☐	No ☐
54.	Confirm that Respondent uses a screening process for all employees, including all contract employees that includes Level II background checks, as required by the Prime Contracts.	Yes ☐	No ☐
55.	Respondent will ensure that providers must have an active FL Medicaid ID.	Yes ☐	No ☐

ATTACHMENT 5 – PRICING PROPOSALS

Please complete the following pricing tables as outlined below. The RFI Response should include full risk capitated rate proposals based on the assumptions provided below of the eligible enrollees in the SMMC Program and the FHK Program.

MMA MEDICAID POPULATION ASSUMPTIONS:

Region	10
Eligible Enrollees	50,000
Children	75%
Adults	25%

Rate Cell Membership Mix		
TANF	43,000	86%
SSI	4,000	8%
Duals	2,000	4%
Other	1,000	2%
MMA Total	**50,000**	**100%**

FHK POPULATION ASSUMPTIONS:

Regions	9, 10, 11
Eligible Enrollees	10,000
Children – Ages	5 to 18

Membership Mix (Distributed across 3 regions)	
Region 9	34%
Region 10	36%
Region 11	30%
FHK Total	**100%**

I. FULL RISK CAPITATED PROPOSAL (Per Benefit Type):

OPHTHALMOLOGY	Proposed Rates Year 1	Proposed Rates Year 2	Proposed Rates Year 3
SMMC Program			
Capitated (PMPM)			
Additional Services (identified below)			
FHK Program			
Capitated (PMPM)			
Additional Services (identify each additional service below):			

954.622.3200 | www.ccpcares.org | 1643 Harrison Parkway (H-200), Sunrise, FL 33323

OPTOMETRY	**Proposed Rates Year 1**	**Proposed Rates Year 2**	**Proposed Rates Year 3**
SMMC Program			
Capitated (PMPM)			
Additional Services (identified below)			
FHK Program			
Capitated (PMPM)			
Additional Services (identified below)			

EXPANDED BENEFITS	**Proposed Rates Year 1**	**Proposed Rates Year 2**	**Proposed Rates Year 3**
SMMC Program			
Capitated (PMPM)			
Additional Services (identified below)			
FHK Program			
Capitated (PMPM)			
Additional Services (identified below)			

II. **ALTERNATIVE FEE PROPOSAL:** If Respondent is willing to consider an alternative fee proposal other than a full risk capitated rate, please fully describe in detail the alternative fee proposal (i.e. shared savings, expanded benefits, etc.) with proposed rates for Year 1 through Year 3.

III. **QUALITY BASED INITIATIVES:** If Respondent is willing to submit a proposal based on its HEDIS and quality metric improvement initiatives, provide a detailed summary of any existing or proposed arrangements for value-based care initiatives Respondent would be willing to include in any contract with CCP, covering the relevant population provided above. Any such proposal would subject to negotiation and additional data regarding the actual membership. Additional consideration will be given to responses which include a risk based or value-based purchasing component tied to quality metrics, though other quality focused programs are responsive to this section.

IV. **MISCELLANEOUS**: Please provide the amount Respondent is willing to contribute toward the implementation of any contract. $__________________

ATTACHMENT 6 – SUBCONTRACTOR DELEGATION CHECKLIST

SMMC Contract Section	Subcontract Requirements
42 CFR 438.230(b)(1) Attachment II, X.C.1.a. X.C.1.e.	The Managed Care Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract, including performance of duties. All tasks related to the subcontract are to be performed in accordance with the terms of the SMMC Contract.
Attachment II, X.C.1.a	The plan's right to promptly revise the subcontract into compliance if the Agency determines, at any time, that a subcontract is not in compliance with an SMMC Contract requirement.
42 CFR 438.230, 438.3(k), 455.104-.106 Attachment II, X.C.1.b	The subcontractor shall comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and SMMC Contract provisions, and any other applicable State or federal law.
Attachment II, X.C.1.c.	The Managed Care Plan shall identify the service(s) and/or goods covered by the subcontract, as applicable.
42 CFR 438.230(c)(1)(i) & (ii) Attachment II, X.C.1.a.(1) & X.C.1.d.	Contains provisions wherein the subcontractor is agreeing to perform the delegated activities and reporting responsibilities specified in the SMMC Contract Reporting Requirements and the SMMC Report Guide.
Attachment II, X.C.3.a.	The Managed Care Plan agrees to make payment to all subcontractors pursuant to all State and federal laws, rules, and regulations, including s. 409.967, F.S., s. 409.975(6), F.S., s. 409.982, F.S., s. 641.3155, F.S., 42 CFR 238.230, 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (5) and (6), in addition to sub regulatory guidance and the provisions of this Contract.
Attachment II, X.C.3.a.(1).(a).	Identifies the conditions and method of payment.
Attachment II, X.C.3.a.(1).(b).	Provide for a prompt submission of information needed to make payments.
Attachment II, X.C.3.a.(1).(c).	Provide for full disclosure of the method and amount of compensation or other consideration to be received from the Managed Care Plan.
Attachment II, X.C.3.a.(1).(d).	Requires that any claims processing vendors maintain accurate enrollee and provider information, including provider agreements reflecting the correct reimbursement rate and provider specialty, to ensure the correct adjudication of claims and proper payment to providers.
Attachment II, X.C.3.a.(1).(e).	Requires that any payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Managed Care Plan.

SMMC Contract Section	Subcontract Requirements
Attachment II, X.C.3.a.(1).(f).	Requires that an adequate record system be maintained for recording services, charges, dates, and all other commonly accepted information elements for services rendered to the Managed Care Plan.
Attachment II, X.C.3.a.(1).(g).	Specifies that the Managed Care Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with the Financial Requirements section of the SMMC Contract.
42 CFR 438.230(c)(3)(i) 42 CFR 438.230(c)(3)(iv) Attachment II, X.C.3.b.(1)	Provide that the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate, or inspect the subcontractor's premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's subcontractor, pertaining to any aspect of services and activities performed, determination of amounts payable under the Managed Care Plan's SMMC Contract with the State, or if there is a reasonable possibility of fraud or similar risk.
42 CFR 438.230(c)(3)(iii) 42 CFR 438.3(h) Attachment II, X.C.3.b.(1)	The subcontractor shall agree that the right to audit exists through ten (10) years from the final date of the Managed Care Plan's SMMC Contract period or from the date of completion of any audit, whichever is later.
42 CFR 438.230(c)(3)(ii) 42 CFR 438.3(h) SSA 1903(m)(2)(A)(iv) Attachment II, X.C.3.b.(2)	Provide that the subcontractor shall make available, at any time, for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Medicaid enrollees pertinent to the Managed Care Plan's SMMC Contract by the Agency, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS.
Attachment II, X.C.3.b.(3)	Require full cooperation in any investigation by the Agency, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, DOEA, or other State or federal entity or any subsequent legal action that may result from such an investigation.
Attachment II, X.C.3.b.(6)	Provide for monitoring of services rendered to Managed Care Plan enrollees through the subcontractor.
42 CFR 438.224 Attachment II, X.C.3.c.(1)	Ensuring medical records and other health and enrollment information that identifies a particular enrollee is safeguarded.
Attachment II, X.C.3.c.(2)	An exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that enrollees or the Agency will not be held liable for any debts of the subcontractor;

SMMC Contract Section	Subcontract Requirements
768.28, F.S. Attachment II, X.C.3.c.(3)	A clause indemnifying, defending, and holding the Agency, its designees, and the Managed Care Plan's enrollees harmless from and against all claims, damages, causes of action, costs, or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency. The Agency may waive this requirement for itself, but not Managed Care Plan enrollees, for damages in excess of the statutory cap on damages for public entities if the subcontractor is a State agency or subdivision or a public health entity with statutory immunity.
Attachment II,X.C.3.c.(4)	Require that the subcontractor secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under the SMMC Contract unless such employees are covered by the protection afforded by the Managed Care Plan. Such insurance shall comply with Florida's Workers' Compensation Law.
Attachment II, X.C.3.c.(5)	Specify that if the subcontractor delegates or subcontracts any functions of its contract with the Managed Care Plan, that the subcontract or delegation shall include all the requirements of the SMMC Contract, unless otherwise exempted by the SMMC Contract or its Exhibits.
Attachment II, X.C.3.c.(6)	Waiver provisions of those terms of the subcontract, which, as they pertain to Medicaid recipients, are in conflict with the specifications of the SMMC Contract.
42 CFR 438.230(c)(1)(iii) Attachment II, X.C.3.b.& X.C.3.c.(7)	Provide for revoking delegation, or imposing other sanctions, if the subcontractor's performance is inadequate.
42 CFR 438.210 Attachment II, X.C.3.c.(8)	Provide that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.
Attachment II, X.C.3.c.(9)	The subcontractor shall establish, enforce, and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.
Attachment II, X.C.3.c.(10)	Require that the subcontractor timely notify the Managed Care Plan of changes in directory information.
Attachment II, X.C.3.c.(11).(a)	Details about the False Claims Act.
Attachment II, X.C.3.c.(11).(b)	Details about the penalties for submitted false claims and statements.
Attachment II, X.C.3.c.(11).(c)	Details about the Whistleblower protections.
42 CFR 438.608(a) Attachment II, X.C.3.c.(11).(d)	Arrangements or procedures for the subcontractor's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention that are in accordance with 42 CFR 438.608(a).
Attachment II, X.C.3.c.(12)	Providers are obligated to cooperate with recovery efforts, including participating in audits and repay overpayments.

SMMC Contract Section	Subcontract Requirements
Attachment II, X.C.3.d	Subcontractors will co-brand all communications with enrollees and providers to ensure it is clear that the Managed Care Plan is aware of and endorses the content contained within the communication.
Attachment II, X.C.3.f & h.	Includes detailed termination procedures, which should include a requirement for subcontractors to submit notice of termination at least ninety days before the effective date of such withdrawal.
Attachment II, X.C.3.g	Subcontract specifies that the subcontractor shall comply with the marketing requirements specified in the Marketing Section of the SMMC Contract.
Attachment II, X.C.3.i	Require subcontractors to submit timely, complete, and accurate encounter data to the Managed Care Plan in accordance with the requirements of the Information Management Systems Section of the SMMC Contract.
408.809, F.S. Attachment II, X.C.4	Subcontractors are subject to background checks. The Managed Care Plan shall consider the nature of the work a subcontractor or agent shall perform in determining the level and scope of the background checks and include language of such in the subcontractor agreement.
For Claims Processing and Payment and/or Risk-bearing Subcontracts Only:	
Attachment II, X.C.3.a.(2)(a)	Requires the subcontractor to submit quarterly unaudited and annual audited financial statements to the Managed Care Plan. The quarterly unaudited financial statements shall be submitted to the Managed Care Plan within sixty (60) days of the end of the quarter and annual audited financial statements shall be submitted within one hundred twenty (120) days of the end of the year.
Attachment II, X.C.3.a.(2)(b)	The Managed Care Plan will provide to the Agency, upon request, copies of the financial statements, including documentation of the Managed Care Plan's financial review.
Attachment II, X.C.3.a.(2)(c)	The Managed Care Plan will notify the Agency within two (2) days of discovery, if based on the Managed Care Plan's review of financial statements or other information, the Managed Care Plan has reason to believe that the subcontracted vendor is insolvent or becoming insolvent.
Attachment II, X.C.3.a.(2)(d)	The Managed Care Plan will include one or both of the following in the subcontractor agreement for subcontractors delegating claims processing and payment: An insolvency account to meet its obligations. The insolvency account shall be funded in an amount equal to two percent (2%) of the annual contract value. In the event that the subcontractor has filed for bankruptcy or has otherwise been determined to be insolvent by a regulating entity, the insolvency account may be drawn upon solely by the Managed Care Plan to disburse funds to meet Medicaid financial obligations incurred by the subcontractor under the contract between the Managed Care Plan and subcontractor. Documentation of the insolvency account, including account balances and governing agreements, shall be provided to the Agency upon request -AND/OR- An Irrevocable Standby Letter of Credit, with the Managed Care Plan as the beneficiary. The issuing bank shall be a federally guaranteed financial institution, licensed to do business in Florida and shall be an entity that is acceptable to the Agency. The value of the Irrevocable Standby Letter of Credit shall be at least two percent (2%) of the annual subcontract value and shall allow the Managed Care Plan to draw upon the Irrevocable Standby Letter of Credit to disburse funds to meet Medicaid financial obligations incurred by the subcontractor under the contract between the Managed Care Plan and the subcontractor. Copies of the Irrevocable Standby Letter of Credit shall be provided to the Agency.

SMMC Contract Section	Subcontract Requirements
Attachment II,X.C.3.a.(2).b.	For subcontractors delegated claims processing and payment, the subcontractor shall maintain a surplus account to meet its obligations if the subcontractor is at financial risk and/or is delegated to process and pay claims.
42 CFR 438.8(k)(3) Attachment II, X.C.3.e	All subcontracts for claims adjudication activities shall provide all underlying data associated with MLR reporting to the Managed Care Plan within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Managed Care Plan, whichever is sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.
Retainment Requirements:	
42 CFR 438.3(u) Attachment II, X.C.3.b.(4)	Require subcontractors to retain, as applicable, the following information for no less than 10 years from the close of the SMMC Contract and further if the records are under review or audit until the review or audit is complete:
42 CFR 438.416 Attachment II, X.C.3.b.(4)	Enrollee grievance and appeal records, including, at a minimum, a general description of the reason for the appeal or grievance, data received, date of each review or review meeting, resolution at each level of the appeal or grievance, date of resolution at each level, name of enrollee for whom it was filed.
42 CFR 438.5(c) Attachment II, X.C.3.b.(4)	Base data (example - encounter data)
42 CFR 438.8(k) Attachment II, X.C.3.b.(4)	MLR Reports that include total incurred claims; expenditures on quality improving activities; expenditures related to the compliance program as outlined in 42 CFR 438.608(a) & (b); taxes, licensing, and regulatory fees; methodology for allocation of expenditures; any credibility adjustment applied; the calculated MLR; any remittance owed to the State; a comparison report with the audited financial report required under 438.3(m); a description of the aggregation method used; and the number of member months.
42 CFR 438.604 Attachment II, X.C.3.b.(4)	Data, information, and documentation, such as encounter data, ownership and control information, overpayment recoveries annual reporting, or any other data, documentation, or information relating to the performance of the subcontractor’s obligations required by the Managed Care Plan or State.
For Credentialing Subcontracts Only:	
Attachment II, X.C.3.b.(5)	The monitoring and oversight plan to provide assurance that all licensed medical professionals are credentialed in accordance with the Managed Care Plan’s and the Agency’s credentialing requirements as found in the SMMC Contract, which should include, at a minimum:
42 CFR 455.100-.106, 455.400-.470 Attachment II, VIII.C.2.a	All providers are eligible for participation in the Medicaid program.
Attachment II,VIII.C.2.b	Use the CAQH app ProView® application throughout the life of the agreement to collect data from providers as necessary to complete the credentialing process.

SMMC Contract Section	Subcontract Requirements
Attachment II, VIII.C.2.c	Process for ensuring all providers have a current provider agreement.
Attachment II, VIII.C.2.d	All providers are fully enrolled/on-boarded within 60 days and the date the full and complete provider application is received is indicated on the PNV file when requested.
42 CFR 438.602(b)(2) Attachment II, VIII.C.2.e	Process for terminating a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of the 60 day period without enrollment of the provider and notifying enrollees of such.
1173(b), SSA Attachment II, VIII.C.2.f	Process for ensuring all providers have a NPI and providing such as part of the PNV submission.
409.907, F.S. Attachment II, VIII.C.2.g	Ensuring providers with a valid Limited Enrolled or Fully Enrolled agreement with the Agency are deemed as having met the following requirements: (1) Proof of provider's current license or authority to do business (2) No revocation, moratorium, or suspension of provider's license (3) No sanctions imposed by Medicare or Medicaid (4) Disclosure of ownership and management, business transactions, and conviction of crimes (5) Level II background check
Attachment II, VIII.C.2.h	To receive payment for covered services, non-participating providers have a Medicaid ID in FMMIS.
Attachment II, VIII.C.2.i	If a provider does not successfully complete onboarding within 60 days and the delay is not caused by the plan or its subcontractor, payments may be recouped.
Attachment II, VIII.C.2.j	Credentialing and recredentialing procedure are in writing and include: (1) Formal delegations and approvals of the process (2) Designated credentialing committee (3) Identification of providers under its scope of authority (4) Process that verifies credentialing and recredentialing criteria in the SMMC contract (5) Approval of new providers and imposition of sanctions, termination, suspension, and restrictions on existing providers (6) Identify quality deficiencies that result in sanctions, termination, suspension and restrictions of a provider
Attachment II, VIII.C.2.k	Process for establishing and verifying additional credentialing and recredentialing criteria.
Attachment II, VIII.C.2.l	If a provider is currently suspended or terminated from Medicaid other than for purposes of inactivity, that provider is not eligible.
Attachment II, VIII.C.2.m	Provide for provider disclosures and notifications to the federal DHHS OIG and MPI.
Attachment II, VIII.C.2.n	Process for reporting suspected unlicensed ALFs and AFCH to the Agency and requiring provider do the same.
Additional Requirements for Transportation Subcontractors Who Credential:	
Attachment II,VIII.C.2.o.(1)	Process for drug and alcohol testing, safety standards, driver accountability, and driver conduct compliance.

SMMC Contract Section	Subcontract Requirements
Attachment II, VIII.C.2.o.(2)	Maintain vehicles and equipment in accordance with State and federal safety standards and the manufacturers' mechanical operating and maintenance standards for all vehicles used for transporting Medicaid enrollees.
Attachment II, VIII.C.2.o.(3)	Complies with applicable State and federal laws, including ADA and FTA regulations.
Attachment II, VIII.C.2.o.(4)	Process to immediately remove any vehicle that does not meet FDHSMV licensing requirements, safety standards, ADA regulations, or SMMC Contract requirements and re-inspect the vehicle before it is eligible to provide transportation services for Medicaid enrollees.
Attachment II, VIII.C.2.o.(4)	Vehicles are not to carry more passengers than the vehicle was designed to carry.
Attachment II, VIII.C.2.o.(4)	All lift-equipped vehicles must comply with ADA regulations.
Attachment II, VIII.C.2.o.(5)	Maintain sufficient liability insurance to meet requirements of Florida law.
Attachment II, VIII.C.2.o.(6)	Ensuring adequate seating for paratransit services for each enrollee and escort, child, or personal care attendant.
Attachment II, VIII.C.2.o.(6)	Ensuring personal property that can be stowed safely is transported with enrollee at no additional charge. This includes wheelchairs, child seats, stretchers, secured oxygen, personal assistive devices, and/or intravenous devices, within the capabilities of the vehicle.
Attachment II, VIII.C.2.o.(6)	Requires that each vehicle have posted the plan's toll-free number for complaints.
Attachment II, VIII.C.2.o.(6)	Requires the interior of all vehicles be free from dirt, grime, oil, trash, torn upholstery, damaged or broken seats, protruding metal, or other objects or materials which could soil items placed in the vehicle or cause discomfort to the enrollee.
Attachment II, VIII.C.2.o.(6)	Prohibits smoking, eating, and drinking unless medical necessity requires enrollee to have fluids or sustenance during transport.
Attachment II, VIII.C.2.o.(6)	Requires all vehicles be equipped with two-way communications that are in good working order and audible to the driver at all times.
Attachment II, VIII.C.2.o.(6)	All vehicles have working air conditioners and heaters.
Attachment II, VIII.C.2.o.(7)	Complies with the minimum liability insurance requirement of $200,000 per person and $300,000 per incident for all services. The plan indemnifies and holds harmless the local, state, and federal governments and their entities and the Agency from any liabilities arising out of or due to an accident or negligence on the part of the plan or transportation providers.
Attachment II, VIII.C.2.o.(8)	Maintains a passenger/trip database that includes information for each enrollee it transports.
Attachment II, VIII.C.2.o.(9)	Requires boarding assistance, if necessary or requested, to the seating portion of the vehicle, including opening the door, fastening the seat belt or wheelchair securing devices, storing mobility assistive devices, and closing doors.
Attachment II, VIII.C.2.o.(10)	Requires providers provide shelter, security, and safety of enrollees at vehicle transfer points.
Attachment II,VIII.C.2.o.(11)	Requires providers provide pick up from and return to a mutually agreed-upon location for the enrollee and associated attendant/escort.

SMMC Contract Section	Subcontract Requirements
Attachment II, VIII.C.2.p	All vehicles used for transportation services receive annual safety inspections, and all drivers have passed background checks and meet all qualifications specified in law and rule.
For Plans Who Have an MMA LOB, Additional Requirements for Credentialing Subcontracts Only:	
Exhibit II-A, VII.C.2.a.(1)	Process to verify physicians have good standing of privileges at the hospital designated as the primary admitting facility by the physician or, if the physician does not have admitting privileges, good standing of privileges at the hospital by another physician with whom the physician has entered into an arrangement for hospital coverage.
Exhibit II-A, VII.C.2.a.(2)	Process to verify physicians have Valid Drug Enforcement Administration certificates, where applicable.
Exhibit II-A, VII.C.2.a.(3)	Process to verify physicians have an attestation that the total active patient load (all populations, including but not limited to Medicaid FFS, Children's Medical Services, SMMC plans, Medicare, KidCare, and commercial coverage) is no more than three thousand (3,000) patients per physician. An active patient is one that is seen by the provider a minimum of two (2) times per year.
Exhibit II-A, VII.C.2.a.(4)	Process to verify physicians have a good standing report on a site visit survey. For each provider, documentation in the credentialing files regarding the site survey that include: (a) Evidence that the Managed Care Plan has evaluated the provider's facilities using the Managed Care Plan's organizational standards; (b) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; and (c) Evidence that the Managed Care Plan has evaluated the provider's enrollee record keeping practices at each site to ensure conformity with the Managed Care Plan's organizational standards.
Exhibit II-A, VII.C.2.a.(5)	Process to verify physicians have an attestation to the correctness/completeness of the provider's application.
Exhibit II-A, VII.C.2.a.(6)	Process to verify physicians have Statement regarding any history of loss or limitation of privileges or disciplinary activity as described in s. 456.039, F.S.
Exhibit II-A, VII.C.2.a.(7)	Process to verify physicians have a statement from each provider applicant regarding any physical or behavioral health problems that may affect the provider's ability to provide health care and any history of chemical dependency/substance abuse.
Exhibit II-A, VII.C.2.a.(8)	Process to verify physicians have current curriculum vitae or completed credentialing application, which includes at least five (5) years of work history.
Exhibit II-A, VII.C.2.a.(9)	Process to verify physicians have proof of the provider's medical school graduation, completion of residency or other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training, if applicable.
Exhibit II-A, VII.C.2.a.(10)	Process to verify providers are recredentialed at least every three (3) years using information from ongoing provider monitoring.
Exhibit II-A,VII.C.2.b.	Process to verify physicians have evidence of specialty board certification, if applicable.
Exhibit II-A, VII.C.2.c.	Process to verify hospital ancillary providers are not required to be independently credentialed if those providers serve Managed Care Plan enrollees only through the hospital.