December 18, 2020

Interested Bidder(s):

Subject: Addendum No. 1 to Request for Proposal for Non-Emergency Transportation Services

The attached Addendum No. 1 to the Request for Proposal (RFP) for Non-Emergency Transportation Services is being provided for consideration in the preparation of your response to the RFP.

All other terms and conditions of the RFP remain in effect.

ADDENDUM NO. 1 TO THE
RFP FOR NON-EMERGENCY TRANSPORTATION SERVICES

Item # 1

Section 1.3, **RFP Timeline**, is hereby deleted in its entirety and replaced as follows:

1.3 RFP Timeline

The projected timeline for the RFP is shown 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 interested parties will be notified by addenda to the original RFP document.

ACTIVITY	DATE/TIME	DESCRIPTION
RFP Release Date	November 10, 2020	CCP will publish notice of the release of the RFP in the *Florida Administrative Weekly* and it will be available at https://www.ccpcares.org/Newsroom
Acknowledgment Form (Attachment 2) from Interested Bidders due to CCP	November 13, 2020 @ 5:00 p.m.	Interested Bidders should submit Attachment 2 via email to rfp@ccpcares.org
Written Questions (Attachment 3) due to CCP	November 20, 2020 @ 5:00 p.m.	Interested Bidders should submit written questions utilizing Attachment 3 via email to rfp@ccpcares.org
CCP's Response to Written Questions due from CCP (Attachment 3)	December 18, 2020	CCP will submit its Response to Written Questions to Interested Bidders from rfp@ccpcares.org
Responses to RFP due to CCP	January 8, 2021 @ 5:00 p.m.	Bidders should submit response electronically to CCP by email to rfp@ccpcares.org
Oral Presentations	February 1-5, 2021	Community Care Plan 1643 Harrison Parkway Suite H-200 Sunrise, Florida 33323
Notice of Intent to Award	February 26, 2021	Electronically transmitted to Awarded Bidder from rfp@ccpcares.org
Anticipated "Go Live" Date	July 1, 2021	Subject to final contract negotiations

Item # 2

Attachment 7, **Qualifications Checklist**, is hereby amended to add **Section F**, **Additional Information**, as follows:

F. **ADDITIONAL INFORMATION.** Under this Section, Bidder may include any additional information relating to this RFP that Bidder would like CCP to consider in its evaluation of Bidder's response to the RFP.

Item # 3

Attachment 9, **Pricing Proposals**, is hereby deleted in its entirety and replaced with **Attachment 9**, **Pricing Proposals**, attached to this Addendum No. 1.

Item # 4

Attachment 9A, **SMMC MMA Florida Medicaid Dec 2018 – Dec 2019 Transportation Statistics** and **SMMC MMA Florida Medicaid Jan 2020 – Nov 2020 Transportation Statistics**, is hereby added to and incorporated in the RFP, as attached to this Addendum No. 1.

Item # 5

Attachment 11, **Subcontractor Delegation Checklist**, is hereby added to and incorporated in the RFP, as attached to this Addendum No. 1. Responses to the RFP should include a signed attestation of compliance with the requirements in the Checklist to the extent applicable to the services covered by this RFP.

ATTACHMENT 9 – PRICING PROPOSALS

Please complete the following pricing tables as outlined below. The proposal should include both a FFS (per trip) rate proposal and a full risk capitated rate proposal. Bidder may have up to two pages of rationale for the proposed rates.

For the purpose of completing the pricing proposals below, assume the following the utilization data is accurate across CCP's lines of business:

NET Metrics - Jan-Sept 2020 YTD

Utilization	
Eligible Members	59,000
# trips per month	2,674
trips per 1,000 members	45.3
average miles per trip	8.5

Distance Mix (miles)	**Total**
< 6	48.2%
6-10	24.6%
11-25	21.6%
> 25	5.7%

Service Mix	**% Mix**
Ambulatory	84.2%
Wheelchair	12.1%
Mass Transit	2.1%
Stretcher	0.9%
Advanced Life Support	0.4%
Basic Life Support	0.3%

FEE FOR SERVICE PROPOSAL:

NET Services	**Proposed Rates Year 1**	**Proposed Rates Year 2**	**Proposed Rates Year 3**
Per Trip Rate < 6 miles one way			
Per Trip Rate 6-10 miles one way			
Per Trip Rate 11-25 miles one way			
Per Trip Rate > 25 miles one way			
Per Trip Administrative Fee			

FULL RISK CAPITATED PROPOSAL:

NET Services	Proposed Rates Year 1	Proposed Rates Year 2	Proposed Rates Year 3
Capitated (PMPM)			
Additional Services			

ALTERNATIVE FEE PROPOSAL: If Bidder is willing to consider an alternative fee proposal other than FFS (per trip) or 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.

MISCELLANEOUS:

Please provide the amount Bidder is willing to contribute toward the implementation of the Contract, in the event the incumbent is not awarded the Contract. $_____

ATTACHMENT 9A --
TRANSPORTATION STATISTICS

SMMC MMA FLORIDA MEDICAID DEC 2018 - DEC 2019 TRANSPORTATION STATISTICS

Enrollee Call Center Phone Stats	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Number of Member Calls Received	1,054	1,141	1,096	1,147	1,178	1,215	1,032	1,348	1,330	1,219	1,370	1,145	1,114
Number of Member Calls Answered	1,049	1,141	1,094	1,147	1,177	1,214	1,032	1,346	1,329	1,216	1,370	1,142	1,114
Number of Member Calls Abandoned	5	0	2	0	1	1	0	2	1	3	0	3	0
Number of Member Calls Answered (<.30 Seconds)	1,013	1,094	988	1,009	1,091	1,047	955	1,251	1,161	1,036	1,307	1,089	1,065
ASA (<0.30 seconds)	00:08	00:08	00:11	00:14	00:11	00:17	00:12	00:12	00:14	15:00	00:13	00:09	00:09
Average Talk Time	06:08	05:56	05:52	06:02	06:03	05:57	06:12	05:52	05:51	56:00	05:51	05:57	05:24
Average Call Hold Time in Queue (<0.60 seconds)	02:39	00:43	00:49	00:40	00:52	00:54	00:53	00:39	00:41	40:00	00:37	00:49	00:35
Abandonment Rate (<3%)	0.47%	0.00%	0.18%	0.00%	0.08%	0.08%	0.00%	0.15%	0.08%	0.25%	0.00%	0.26%	0.00%
Service Level (>90%)	96.57%	95.87%	90.31%	88.00%	92.70%	86.22%	92.56%	92.96%	87.36%	85.84%	95.37%	95.37%	95.58%
First Call Resolution (>80%)	98.00%	97.37%	98.50%	98.43%	98.47%	99.51%	99.61%	99.78%	100.00%	100.00%	100.00%	0.00%	99.91%
Quality Assurance Monitoring (>95%)	95.60%	97.75%	99.00%	98.63%	99.33%	98.67%	95.00%	98.00%	97.00%	96.88%	94.00%	95.82%	93.50%
Telecom Provider Blockage Rate (<0.5%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
ACD Blockage Rate (0.0%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Provider Call Center Phone Stats	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Number of Provider Calls Received	9,687	9,659	9,916	10,389	8,497	10,317	8,954	10,369	10,941	10,006	10,588	8,628	9,213
Number of Provider Calls Answered	9,687	9,554	9,665	10,168	8,288	10,193	8,915	10,285	10,796	6,322	10,507	8,516	9,181
Number of Provider Calls Abandoned	165	105	251	221	209	124	39	84	145	215	81	112	32
Number of Provider Calls Answered (<.30 Seconds)	9,687	8,870	8,186	8,419	6,324	8,645	8,255	9,318	9,013	7,841	9,877	7,277	8,936
ASA (<0.30 seconds)	36:00	00:15	00:27	00:31	00:38	00:29	00:17	00:19	00:28	35:00	00:14	00:25	00:07
Average Talk Time	43:12	04:46	04:53	05:01	01:41	04:54	04:54	04:41	04:14	11:00	04:10	04:04	04:11
Average Call Hold Time in Queue (<0.90 seconds)	00:00	02:15	02:25	02:31	00:35	02:30	02:24	02:13	01:59	52:00	01:51	01:48	01:49
Abandonment Rate (<3%)	1.70%	1.09%	2.53%	2.10%	2.46%	1.20%	0.44%	0.81%	1.33%	2.15%	0.77%	1.30%	0.35%
Service Level (>90%)	93.41%	92.84%	83.57%	86.80%	95.55%	84.81%	92.60%	90.60%	83.48%	79.09%	94.01%	85.45%	97.33%
First Call Resolution (>75%)	100.00%	92.84%	99.80%	98.55%	98.66%	99.33%	99.41%	99.84%	99.84%	100.00%	100.00%	100.00%	100.00%
Quality Assurance Monitoring (>95%)	98.00%	99.90%	98.30%	97.69%	97.25%	86.00%	90.18%	89.00%	91.00%	89.00%	93.90%	93.00%	92.11%
Telecom Provider Blockage Rate (<5%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
ACD Blockage Rate (0.0%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Claims Processing	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Total Number of Claims Processed	2911	3118	2808	2344	2847	3534	2812	3964	3501	3384	3976	3976	2800
>50% of Claims Processed within 7 Days	81.7%	51.9%	73.5%	76.8%	72.4%	66.6%	72.6%	49.7%	67.5%	65.3%	89.4%	89.4%	85.0%
>70% of Claims Processed within 10 Days	100.0%	99.6%	99.9%	97.6%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%
>90% of Claims Processed within 20 Days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Number of Adjustments	0	0	0	0	0	0	0	0	0	0	0	0	0
Claim Denial Rate	0.14%	0.00%	0.64%	0.04%	0.35%	0.62%	0.36%	3.73%	4.23%	0.33%	0.08%	0.18%	0.21%
Total Number of Pended Claims	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Backlog Claims	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage on Paper Claims Within 20 Calendar Days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage on Electronic Claims within 15 Calendar Days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Top 5 monthly claims denial reasons	1. No Signature Provided 2. Billed cost was not provided	None	1. No Signature Provided 2. Invalid Vehicle Number 3. Claim submitted more than the contracted # of days 4. Billed cost was not provided 5. Invalid DL Number	1. Member No Show	1. Invalid Vehicle Number 2. No Signature Provided 3. No PU/DO Time Provided	1. Invalid Vehicle Number 2. Claim was submitted more than the contracted number of days after the trip date. 3. Insufficient information provided to approve charge 4. No PU/DO Time Provided	1. Invalid Vehicle Number 2. No Signature Provided 3. No PU/DO Time Provided	1. Invalid Driver Name 2. Invalid Vehicle Number 3. No Signature Provided 4. Billed Cost was not Provided 5. No PU/DO Time Provided	1. Invalid Vehicle Number 2. Invalid Driver Name 3. No Signature Provided 4. Billed Cost was not Provided 5. No PU/DO Time Provided	1. Claim was submitted more than the contracted number of days after the trip date. 2. No Signature Provided	1. No Signature Provided	1. Invalid Vehicle Number 2. No Signature Provided	1. Claim was submitted more than the contracted number of days after the trip date. 2. No Signature Provided

ATTACHMENT 9A --
TRANSPORTATION STATISTICS

Credentialing/Network	December	January	February	March	April	May	June	July	August	September	October	November	December
Total Number of Initial Credentialed Providers	0	4	6	6	0	0	0	0	0	0	12	9	7
Total Number of Initial Credentialing Providers NOT Approved	0	0	0	0	0	0	0	0	0	0	1	0	0
Total Number of Initial Credentialing Performed Timely	0	0	0	0	0	0	0	0	0	0	12	12	7
Total Number of Recredentialed Providers	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Recredentialed Providers NOT Approved	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Recredentialing Performed Timely	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Providers Credentialed within 45 days of full application receipt	0	2	0	6	0	0	0	0	0	0	0	0	0
Total Number of Providers Board Certified from Above Numbers	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Facilities Accredited from Above Numbers	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Terminated Providers	2	1	0	2	0	0	0	0	0	0	1	0	1
Total Number of Providers Re-Instated	0	0	0	0	0	0	0	0	0	0	0	0	0
Network Gaps (List Specialty and County of Gap)	0	0	0	0	0	0	0	0	0	0	0	0	0
Actual Date Monthly Credentialed Providers were Submitted in Roster File to CCP	0	0	0	0	0	0	0	0	0	0	0	0	0
Quality Improvement	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
Total Number of Reported QI Incidents	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Confirmed QI Incidents	0	0	0	0	0	0	0	0	0	0	0	0	0
Enrollee Complaints	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
Total Number of Member Complaints	1	3	2	0	3	3	4	4	22	5	4	9	1
Total Number of Member Complaints referred to the plan	1	1	2	0	3	2	2	2	16	5	3	4	1
Provider Complaint, Grievances & Appeals	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
Total Number of Provider Complaints	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Provider Grievances	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Provider Appeals	0	0	0	0	0	0	0	0	0	0	0	0	0
Fraud, Waste & Abuse	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
Total Number of Fraud Waste and Abuse Issues Suspected	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Fraud Waste and Abuse Issues Under Investigation	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Fraud Waste and Abuse Issues Confirmed	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Amount Paid (FWA)	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Amount of Dollars Recovered (FWA)	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Incidents Referred to Plan	0	0	0	0	0	0	0	0	0	0	0	0	0
Compliance	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
Monthly Review of OIG/GSA Exclusions Database for all employees (Y/N)	y	y	y	y	y	y	y	y	y	y	y	y	y
If yes, Total Number of Excluded/Ruled-out employees	0	0	0	0	0	0	0	0	0	0	0	0	0
All Compliance Documents/Materials updated Annually (Y/N)	y	y	y	y	y	y	y	y	y	y	y	y	y
Annual Compliance Training - FWA, HIPAA, conducted for all employees (Y/N)	y	y	y	y	y	y	y	y	y	y	y	y	y
Total Number of HIPAA Disclosures	0	0	0	0	0	0	0	0	0	0	0	0	0
Standards of Conduct/Code of Ethics/Compliance P&Ps distributed to all employees Annually (Y/N)	y	y	y	y	y	y	y	y	y	y	y	y	y
Annual Screening of Employees, Governing Bodies and Senior Leadership for Conflicts of Interest (Y/N)	y	y	y	y	y	y	y	y	y	y	y	y	y
Notify Plan Immediately (Y/N) Date	n	n	n	n	n	n	n	n	n	n	n	n	n
Utilization Management	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
Requests													
Total Enrollment	40,085	39,682	38,089	39,431	37,812	37,829	39,172	39,172	37,631	37,220	37,769	37,585	37,342
Total # Requests Received	4,353	4,586	4,123	4,719	4,714	5,162	4,940	5,516	5,405	4,947	5,205	4,761	4,526
# Approved	4,339	4,581	4,121	4,715	4,709	5,158	4,933	5,513	5,398	4,939	5,204	4,757	4,518
% of Total Requests Approved	99.7%	99.9%	100.0%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.8%	100.0%	99.9%	99.8%
Requests / 1000 Enrollees	109	116	108	120	125	136	126	141	144	133	138	127	121
Standard (Non-urgent Preservice)													
# of Standard Requests	4,270	4,489	4,055	4,650	4,654	5,076	4,852	5,425	5,353	4,903	5,148	4,681	4,458
% of Total Requests	98.1%	97.9%	98.4%	98.5%	98.7%	98.3%	98.2%	98.4%	99.0%	99.1%	98.9%	98.3%	98.5%
Average TAT (In calendar days) (7 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
% Completed within 7 calendar days (100%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
% with Extension completed within 11 calendar days (100%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Expedited													
Urgent Concurrent Requests	20	9	9	16	6	11	12	24	5	4	11	17	11
Urgent Preservice Requests	63	88	59	53	54	75	76	67	47	40	46	63	57
# of Expedited Requests	0	0	0	0	0	0	0	0	0	0	0	0	0
% of Total Requests	1.9%	2.1%	1.6%	1.5%	1.3%	1.7%	1.8%	1.6%	1.0%	0.9%	1.1%	1.7%	1.5%
Average TAT (In calendar days) (2 days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
% Completed within 2 calendar days (100%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

ATTACHMENT 9A --
TRANSPORTATION STATISTICS

Transportation Stats	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Advance Notice													
Same Day Trips	83	97	68	69	60	86	88	91	52	44	57	80	68
Excessive Mileage													
Trips over 50 miles	15	0	0	2	4	1	0	3	2	0	0	1	0
Utilization													
Gross Reservations	4353	4586	4123	4719	4714	5162	4940	5516	5405	4947	5205	4761	4526
Cancellations	732	772	646	810	739	1019	781	927	863	850	634	744	724
Member No-Shows	112	114	107	116	107	115	96	150	144	91	104	100	134
Total Trips	3621	3814	3477	3909	3975	4143	4159	4589	4542	4097	4571	4017	3802
Utilization Rate	9.0%	9.6%	9.1%	9.9%	10.5%	11.0%	10.6%	11.7%	12.1%	11.0%	12.1%	10.7%	10.2%
Trip Mode													
Ambulatory	2976	3425	3103	3535	3604	3566	3555	3959	3923	3587	3951	3539	3297
Stretcher	76	5	18	6	7	13	30	35	36	24	34	30	38
ALS	17	12	12	10	4	8	12	12	0	3	4	8	11
BLS	0	3	4	6	3	7	3	5	15	4	19	2	2
Public Transit	92	118	70	92	72	60	52	62	58	48	74	60	42
Commercial Air	0	0	0	0	0	0	0	0	0	0	0	0	0
Wheelchair	460	251	270	260	285	489	507	516	510	431	489	378	412
Quality Mgmt													
Complaints - Total	1	1	2	0	3	2	2	2	16	5	0	9	1
Provider Late	0	0	0	0	1	0	1	1	9	3	0	3	1
Provider No Show	1	0	1	0	1	1	1	1	5	1	0	5	0
Rider (Member) No Show	0	0	0	0	0	0	0	0	0	0	0	0	0
Provider Issue	0	0	1	0	1	1	0	0	2	1	0	1	0
Other	0	1	0	0	0	0	0	0	0	0	0	0	0
Trip Measures													
Percent of trips that resulted in the enrollee arriving to their scheduled appointment on time. (90% or >)	89.85%	89.21%	91.84%	93.33%	90.02%	90.15%	89.87%	87.92%	89.35%	88.79%	89.36%	89.52%	91.97%
Percentage of transportation requests that resulted in a missed trip. (0.2% of <)	0.67%	0.48%	0.27%	0.25%	0.06%	0.58%	0.22%	0.47%	0.56%	0.20%	0.21%	0.23%	0.24%
Percent (85%) of unscheduled trips fulfilled within three (3) hours of the request. (85%)	65.12%	59.38%	62.50%	72.73%	56.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Percent of the total scheduled Leg A trip requests were fulfilled within fifteen (15) minutes of the scheduled time for pick-up. (90% or >)	81.36%	82.22%	81.25%	84.47%	89.79%	89.45%	90.84%	90.57%	89.78%	90.95%	91.59%	91.44%	94.39%
Percent of the total scheduled Leg B trip requests fulfilled within thirty (30) minutes of the scheduled time for pick-up. (90 or >)	83.38%	83.17%	75.29%	85.35%	89.24%	88.08%	91.28%	90.22%	88.94%	87.87%	88.14%	89.86%	88.60%

SMMC MMA FLORIDA MEDICAID JAN 2020 - NOV 2020 TRANSPORTATION STATISTICS

Enrollee Call Center Phone Stats	January	February	March	April	May	June	July	August	September	October	November	December
Number of Member Calls Received	1,237	2,079	1,780	384	423	642	601	537	661	769	656	
Number of Member Calls Answered	1,233	2,074	1,779	384	423	639	598	535	648	756	644	
Number of Member Calls Abandoned	4	5	1	-	-	3	3	2	2	-	-	
Number of Member Calls Answered (<.30 Seconds)	1,176	1,894	1,712	378	407	580	486	419	588	745	628	
ASA (<0.30 seconds)	00:09	00:13	00:08	00:08	00:10	00:11	00:18	00:20	00:12	00:08	00:08	
Average Talk Time	05:43	05:19	04:13	04:50	05:10	05:14	05:31	05:44	05:09	05:51	05:27	
Average Call Hold Time in Queue (<0.60 seconds)	00:38	00:49	01:08	00:33	00:14	00:12	00:09	00:22	00:25	00:34	00:23	
Abandonment Rate (<3%)	0.32%	0.24%	0.06%	0.00%	0.00%	0.47%	0.50%	0.37%	0.30%	0.00%	0.00%	
Service Level (>90%)	95.34%	91.33%	96.26%	98.43%	96.21%	90.78%	81.27%	78.30%	89.36%	96.87%	95.73%	
First Call Resolution (>80%)	100.00%	100.00%	99.88%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%	100.00%	
Quality Assurance Monitoring (>95%)	93.73%	91.94%	90.00%	93.50%	93.39%	95.09%	96.60%	97.09%	98.06%	98.28%	98.16%	
Telecom Provider Blockage Rate (<0.5%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
ACD Blockage Rate (0.0%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Provider Call Center Phone Stats	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	
Number of Provider Calls Received	9,478	8,896	7,636	3,311	4,245	6,044	6,436	8,003	8,832	9,922	9,004	
Number of Provider Calls Answered	9,435	8,760	7,597	3,310	4,232	5,997	6,348	7,813	8,362	9,588	8,305	
Number of Provider Calls Abandoned	43	136	39	1	13	47	88	190	157	37	38	
Number of Provider Calls Answered (<.30 Seconds)	9,180	7,619	7,270	3,253	4,094	5,358	5,453	6,301	6,193	9,604	8,277	
ASA (<0.30 seconds)	00:09	00:19	00:10	00:06	00:09	00:17	00:26	00:08	00:25	00:11	00:07	
Average Talk Time	03:54	03:44	02:06	02:17	02:23	02:33	02:38	02:54	02:55	02:52	02:45	
Average Call Hold Time in Queue (<0.90 seconds)	01:38	01:28	01:32	01:17	00:59	01:07	01:04	01:05	01:10	01:07	01:06	
Abandonment Rate (<3%)	0.45%	1.53%	0.51%	0.03%	0.31%	0.78%	1.37%	2.45%	1.83%	0.38%	0.43%	
Service Level (>90%)	97.30%	86.97%	95.70%	98.27%	96.75%	89.34%	85.90%	80.65%	87.52%	96.79%	91.93%	
First Call Resolution (>75%)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Quality Assurance Monitoring (>95%)	87.65%	87.62%	81.29%	84.98%	93.39%	95.09%	96.60%	97.09%	98.06%	98.28%	98.16%	
Telecom Provider Blockage Rate (<5%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
ACD Blockage Rate (0.0%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Claims Processing	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	
Total Number of Claims Processed	4716	3604	3339	2565	1695	1929	2476	1889	2560	2558	2119	
>50% of Claims Processed within 7 Days	78.6%	82.7%	83.1%	80.2%	88.1%	95.9%	72.9%	60.5%	78.7%	78.7%	89.9%	
>70% of Claims Processed within 10 Days	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	
>90% of Claims Processed within 20 Days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Total Number of Adjustments	0	0	0	0	0	0	0	0	0	0	0	
Claim Denial Rate	0.64%	0.19%	3.56%	1.36%	0.77%	0.00%	0.20%	0.11%	0.74%	0.59%	2.03%	
Total Number of Pended Claims	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Backlog Claims	0	0	0	0	0	0	0	0	0	0	0	
Percentage on Paper Claims Within 20 Calendar Days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Percentage on Electronic Claims within 15 Calendar Days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	

ATTACHMENT 9A --
TRANSPORTATION STATISTICS

Top 5 monthly claims denial reasons	1. Invalid Vehicle Number 2. Billed cost was not provided 3. Claim was submitted more than the contracted number of days after the trip date	1. No Signature Provided 2. Insufficient Information provided to approve charge	1. Invalid Vehicle Number 2. No Signature Provided 3. Insufficient Information provided to approve charge 4. Invalid Driver Licencse Number	1. Invalid Driver Name 2. Invalid Vehicle Number 3. No Signature Provided 4. Claim was submitted more than the contracted number of days after trip date 5. Invalid Driver License Number	1. No Signature Provided	0	1. Invalid Vehicle Number 2. Invalid Driver License Number	1. No Signature Provided 2. Insufficient information provided to approve charge	1. No Signature Provided 2. No PU/DO Time Provided	1. Invalid Vehicle Number 2. No Signature Provided	1. Invalid Vehicle Number 2. Invalid Driver License Number	
Credentialing/Network	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	
Total Number of Initial Credentialed Providers	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Initial Credentialing Providers NOT Approved	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Initial Credentialing Performed Timely	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Recredentialed Providers	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Recredentialed Providers NOT Approved	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Recredentialing Performed Timely	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Providers Credentialed within 45 days of full application receipt	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Providers Board Certified from Above Numbers	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Facilities Accredited from Above Numbers	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Terminated Providers	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Providers Re-Instated	0	0	0	0	0	0	0	0	0	0	0	
Network Gaps (List Specialty and County of Gap)	0	0	0	0	0	0	0	0	0	0	0	
Actual Date Monthly Credentialed Providers were Submitted in Roster File to CCP	0	0	0	0	0	0	0	0	0	0	0	
Quality Improvement	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	
Total Number of Reported QI Incidents	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Confirmed QI Incidents	0	0	0	0	0	0	0	0	0	0	0	
Enrollee Complaints	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	
Total Number of Member Complaints	7	6	1	1	5	4	4	4	7	5	4	
Total Number of Member Complaints referred to the plan	6	1	1	0	3	2	1	2	2	1	3	
Provider Complaint, Grievances & Appeals	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	
Total Number of Provider Complaints	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Provider Grievances	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Provider Appeals	0	0	0	0	0	0	0	0	0	0	0	
Fraud, Waste & Abuse	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	
Total Number of Fraud Waste and Abuse Issues Suspected	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Fraud Waste and Abuse Issues Under Investigation	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Fraud Waste and Abuse Issues Confirmed	0	0	0	0	0	0	0	0	0	0	0	
Total Amount Paid (FWA)	0	0	0	0	0	0	0	0	0	0	0	
Total Amount of Dollars Recovered (FWA)	0	0	0	0	0	0	0	0	0	0	0	
Total Number of Incidents Referred to Plan	0	0	0	0	0	0	0	0	0	0	0	
Utilization Management	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	
Requests												
Total Enrollment	36,894	36,931	36,945	39,479	42,007	43,447	37,644	44,862	45,808	43,542	47,193	
Total # Requests Received	5,121	4,893	4,603	3,029	3,050	3,503	3,704	3,438	3,664	3,937	3,603	
# Approved	5,108	4,877	4,576	3,007	3,030	3,474	3,688	3,413	3,647	3,895	3,588	
% of Total Requests Approved	99.7%	99.7%	99.4%	99.3%	99.3%	99.2%	99.6%	99.3%	99.5%	98.9%	99.6%	
Requests / 1000 Enrollees	139	132	125	77	73	81	98	77	80	90	76	

ATTACHMENT 9A --
TRANSPORTATION STATISTICS

Standard (Non-urgent Preservice)												
# of Standard Requests	5,035	4,838	4,576	3,004	3,023	3,459	3,674	3,424	3,624	3,899	3,561	
% of Total Requests	98.3%	98.9%	99.4%	99.2%	99.1%	98.7%	99.2%	99.6%	98.9%	99.0%	98.8%	
Average TAT (In calendar days) **(7 days)**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
% Completed within 7 calendar days **(100%)**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
% with Extension completed within 11 calendar days **(100%)**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Expedited												
Urgent Concurrent Requests	16	11	2	2	3	15	9	4	4	4	4	
Urgent Preservice Requests	70	44	25	23	24	29	21	10	36	34	38	
# of Expedited Requests	0	0	0	0	0	0	0	0	0	0	0	
% of Total Requests	1.7%	1.1%	0.6%	0.8%	0.9%	1.3%	0.8%	0.4%	1.1%	1.0%	1.2%	
Average TAT (In calendar days) **(2 days)**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
% Completed within 2 calendar days **(100%)**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
% with Extension completed within 3 calendar days **(100%)**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

Transportation Stats	January	February	March	April	May	June	July	August	September	October	November	
Advance Notice												
Same Day Trips	86	55	27	25	27	44	30	14	40	38	42	
Excessive Mileage												
Trips over 50 miles	1	0	1	0	0	2	0	1	0	0	2	
Utilization												
Gross Reservations	5121	4893	4603	3029	3050	3503	3704	3438	3664	3937	3603	
Cancellations	706	566	936	592	471	535	680	524	769	830	758	
Member No-Shows	132	104	123	40	42	90	89	84	212	187	167	
Total Trips	4415	4327	3667	2437	2579	2968	3024	2914	2895	3107	2845	
Utilization Rate	12.0%	11.7%	9.9%	6.2%	6.1%	6.8%	8.0%	6.5%	6.3%	7.1%	6.0%	
Trip Mode												
Ambulatory	3809	3731	3164	2101	2233	2622	2671	2498	2491	2700	2465	
Stretcher	56	61	30	30	7	6	7	21	11	1	23	
ALS	8	5	7	0	0	1	3	4	0	3	4	
BLS	13	7	0	2	0	1	1	0	0	2	0	
Public Transit	76	76	78	26	26	26	26	26	26	28	24	
Commercial Air	0	0	0	0	0	0	0	0	0	0	0	
Wheelchair	453	447	388	278	313	312	316	365	367	373	329	
Quality Mgmt												
Complaints - Total	6	1	1	0	3	2	1	2	2	1	3	
Provider Late	2	0	1	0	1	0	0	1	1	1	1	
Provider No Show	2	1	0	0	2	0	1	1	1	0	1	
Rider (Member) No Show	0	0	0	0	0	0	0	0	0	0	0	
Provider Issue	0	0	0	0	0	1	0	0	0	0	1	
Other	2	0	0	0	0	1	0	0	0	0	0	
Trip Measures												
Percent of trips that resulted in the enrollee arriving to their scheduled appointment on time. (90% or >)	93.14%	90.45%	88.06%	91.00%	94.52%	91.78%	95.94%	93.45%	92.68%	95.19%	94.15%	
Percentage of transportation requests that resulted in a missed trip. (0.2% of <)	0.31%	0.48%	0.17%	0.33%	0.13%	0.11%	0.03%	0.17%	0.22%	0.13%	0.14%	
Percent (85%) of unscheduled trips fulfilled within three (3) hours of the request. (85%)	100.00%	100.00%	100.00%	91.67%	100.00%	94.74%	100.00%	100.00%	84.62%	100.00%	100.00%	
Percent of the total scheduled Leg A trip requests were fulfilled within fifteen (15) minutes of the scheduled time for pick-up. (90% or >)	94.29%	89.75%	85.69%	86.46%	90.24%	83.88%	96.84%	92.06%	91.02%	91.53%	93.03%	
Percent of the total scheduled Leg B trip requests fulfilled within thirty (30) minutes of the scheduled time for pick-up. (90 or >)	92.09%	88.75%	92.57%	97.10%	94.99%	91.53%	94.07%	95.75%	93.82%	96.03%	94.44%	

ATTACHMENT 11 – 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.

SMMC Contract Section	Subcontract Requirements
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.
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 anytime, 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

SMMC Contract Section	Subcontract Requirements
	the contract between the Managed Care Plan and the subcontractor. Copies of the Irrevocable Standby Letter of Credit shall be provided to the Agency.
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.

SMMC Contract Section	Subcontract Requirements
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.
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:	

SMMC Contract Section	Subcontract Requirements
Attachment II,VIII.C.2.o.(1)	Process for drug and alcohol testing, safety standards, driver accountability, and driver conduct compliance.
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 a 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.
For Plans Who Have a MMA LOB Physician Incentive Plan Only:	

SMMC Contract Section	Subcontract Requirements
42 CFR 422.208(c)(1) 42 CFR 438.3(i) Exhibit II-A, X.C.2.	Includes a statement that the Managed Care Plan shall make no specific payment directly or indirectly under a physician incentive plan to a subcontractor as an inducement to reduce or limit medically necessary services to an enrollee, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care. If the physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the Managed Care Plan shall assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with 42 CFR 422.208(c)(2).
For LTC LOB Fiscal/Employer Agent Contract Only:	
Exhibit II-A, X.C.2.	The Managed Care Plan or its subcontractor shall perform all F/EA responsibilities as specified in the Participant Direction Option Manual, as provided by the Agency.
Other Requirements:	
Section 119.0701, F.S. Attachment II, XV.K.1.	To include the following audit and record keeping requirements in all approved subcontracts and assignments: To comply with public record laws as outlined in Section 119.0701, Florida Statutes. **Note**: Other requirements as mentioned in C.1., 2., 3., & 5., are covered in Attachment II Section VIII.B. (see applicable checklist items).
Section 274A [8 U.S.C. 1324a], Immigration and Nationality Act Attachment II, XV.O.	To comply with Section 274A (e) of the Immigration and Nationality Act, the Agency will consider the employment of any contractor of unauthorized aliens a violation of this Act. If the Vendor knowingly employs unauthorized aliens, such a violation shall be cause for unilateral cancellation of this Contract. The Vendor shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Contract.
8 CFR 274a.2 XV.P.	The Immigration Reform and Control Act of 1986 prohibits employers from knowingly hiring illegal workers. The Vendor shall only employ individuals who may legally work in the United States (U.S.) - either U.S. citizens or foreign citizens who are authorized to work in the U.S. The Vendor shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired by the Vendor during the term of this Contract 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 hired by the subcontractor performing work or providing services pursuant to this Contract.