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# UNSCORED SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA INSTRUCTIONS

Instructions to Respondents for the Completion of **Exhibit A-4-V3**

All respondents to this solicitation shall utilize **Exhibit A-4-V3** for submission of its technical response as specified in **Attachment A.**, Instructions and Special Conditions, **Section D.**, Response Evaluation, Negotiations, and Contract Award, **Sub-Section 3.**, Non-Scored Requirements, **Item d.**, Unscored Submission Requirements and Evaluation Criteria. Respondents shall adhere to the instructions below for each Submission Requirement Component (SRC).

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

Order of Contract Selection

The respondent’s submissions for all Submission Requirements and Evaluation Criteria pertaining to prior contract experience will utilize the same three (3) contracts throughout, based on information input by the respondent in **Exhibit A-5-a-V3**, Respondent Information tab, unless otherwise specified in an SRC.  The respondent shall select contracts chosen in the order described below. If the respondent (including the respondent’s parent, affiliate(s), or subsidiary) has multiple contracts within the same numbered category, all contracts in that category, ordered from the greatest to the least number of enrollees, must be chosen before any contracts in the next category can be selected.

1. Florida Medicaid managed care contracts
2. Contracts with another state’s Medicaid managed care program
3. Florida Child Health Insurance Program (CHIP) managed care contracts
4. CHIP managed care contracts with another state
5. Medicare managed care contracts (any state)

Completion of Responses

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

Certain SRCs contain form fields. Population of the form fields with text will allow the form to expand and cross pages. Unless specified in the SRC, there is no character limit. For SRCs with character limits, character counts are inclusive of spaces and exclusive of attachments. Text responses must be formatted for 8-1/2’ x 11” paper, single-spaced, and in a size 11 Arial font. Attachments may be formatted for pages larger than 8.5” x 11” but no longer than 11” by 17” paper.

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

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

The SRCs in **Exhibit A-4-V3,** Unscored Submission Requirements and Evaluation Criteria, may not be retyped and/or modified and must be submitted in the original format.

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

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

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

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**RESPONDENT NAME:**

# INCENTIVIZING VALUE AND QUALITY

## SRC# 1 – Birth Outcomes Narrative:

For the three (3) contracts identified through the Order of Contract Selection (page 3, **Exhibit A-5-V3**), the respondent shall provide descriptive information about the services used to improve birth outcomes, including the following:

1. A description of partnerships the respondent has established with community-based organizations to improve birth outcomes, including but not limited to how the partnership will improve birth outcomes, what services will be provided by the CBO that lead to improved birth outcomes, how disparities in birth outcomes will be addressed by the partnership, how special populations such as people with HIV, serious mental illness, or child welfare history will benefit from the CBO partnership.
2. A description of strategies the respondent has implemented to promote birth spacing and family planning among enrollees along with supporting data. (e.g., utilization of long-acting reversible contraceptives).
3. A description of the respondent’s strategies to increase the number of Medication Assisted Treatment (MAT) prescribers in their network, particularly within the obstetrical field.
4. A description of strategies the respondent has implemented to increase rates of SBIRT utilization among providers in its network, in particular obstetricians.
5. A description of the respondent’s process for identifying, engaging, and coordinating care for high-risk pregnant women.
6. A description of incentives, including dollar amounts given to providers and enrollees, that have been implemented for providers and enrollees aimed at improving maternal health and birth outcomes.
7. A description of the respondent’s commitment to improving postpartum care transitions and overall health outcomes during the 12-month Medicaid postpartum eligibility period.
8. A description of the respondent’s proposed strategies to improve maternal mortality rates, in particular women of color.
9. A description of services the respondent has provided to enrollees to address health-related social needs that improve birth outcomes, including enrollee utilization data for each service.
10. A description of strategy to improve dental care for enrollees during pregnancy and postpartum period.
11. An enumeration and description of services that improve birth outcomes for special populations such as people with HIV, serious mental illness, substance use disorder, or child welfare history.

**Response:**

Limit your written response to a maximum of 22,500 characters, exclusive of attachments (charts, tables, exhibits, etc.).

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## SRC# 2 – Organizational Commitment to Quality Narrative:

Section 409.966 (3) (a) 5., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

5.  Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

Section 409.966 (3) (a) 5., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

5.  Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

The respondent shall describe its organizational commitment to quality improvement, including active involvement by the respondent’s medical and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, evaluation design, and a summary of results demonstrating improved health outcomes.

For this SRC, the respondent will be asked to describe all of the following aspects of its QI process:

* Active involvement by the respondent’s medical and administrative leadership.
* The incorporation of quality improvement activities into the culture and operations of the organization.
* Two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle, one of which should be related to improving follow-up after hospitalizations for behavioral health conditions or improving birth outcomes.
* The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.
* A description of the evaluation methods for measuring the success of quality improvement projects.
* Establishment of improved health outcomes as a result of the quality improvement projects.

**Response:**

Limit your written response to a maximum of 15,000 characters, exclusive of attachments (charts, tables, exhibits, etc.).

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## SRC# 3 – Expanded Benefits:

Section 409.966 (3) (a) 6., Florida Statutes (F.S.)

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

6.  Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

Section 409.966 (3) (a) 6., Florida Statutes (F.S.)

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

6.  Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

Expanded benefits are benefits covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency. In **Exhibit A-5-V3**, Scored Submission Requirements and Evaluation Criteria, **SRC# 14** – Expanded Benefits – Medical and Long-Term Care, the respondent will be asked to identify the expanded benefits it proposes to offer.

With consideration to its proposed expanded benefits package, the respondent shall describe an implementation and evaluation plan for its selected expanded benefits.

**Response:**

Limit your written response to a maximum of 2,000 characters, exclusive of attachments (charts, tables, exhibits, etc.).

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# DELIVERY SYSTEM ENHANCEMENTS AND INTEGRATION

## SRC# 4 – Evidence-Based Programs for Children with Intense Behaviors:

Section 409.967(2)(d), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(d) Quality care.—Managed care plans shall provide, or contract for the provision of, care coordination to facilitate the appropriate delivery of behavioral health care services in the least restrictive setting with treatment and recovery capabilities that address the needs of the patient. Services shall be provided in a manner that integrates behavioral health services and primary care. Plans shall be required to achieve specific behavioral health outcome standards, established by the agency in consultation with the department.

Section 409.966 (3) (a) 6., Florida Statutes (F.S.)

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

6.  Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

Evidence-Based Programs for Children with Intense Behaviors are intended to strengthen family relationships, build resiliency in children and parents, and prevent child abuse and neglect. In **Exhibit A-5-V3**, Scored Submission Requirements and Evaluation Criteria, **SRC# 24** – Evidence-Based Programs for Children with Intense Behaviors, the respondent will be asked to identify the Evidence-Based Programs for Children with Intense Behaviors it commits to offering.

With consideration to its proposed benefits for Evidence-Based Programs for Children with Intense Behaviors, the respondent shall describe an implementation and evaluation plan for its selected Evidence-Based Programs.

**Response:**

Limit your written response to a maximum of 5,000 characters, exclusive of attachments (charts, tables, exhibits, etc.).

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SRC# 5 – After Hours Availability**:**

Section 409.967(2)(c)1., F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider’s patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

Section 409.966 (3) (a) 6., Florida Statutes (F.S.)

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

6.  Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

After Hours — The hours between 5:00 p.m. and 8:00 a.m. local time, Monday through Friday inclusive, and all-day Saturday and Sunday. State holidays are included.

For all specialty providers included in **Exhibit A-5-b-V3**, SRC 22 – Provider Network Tool – MMA, the respondent will provide the percentage of

* Non-behavioral health provider specialists who will have available after-hours care, Monday through Friday.
* Behavioral health provider specialists who will have available after-hours care, Monday through Friday.
* Non-behavioral health provider specialists who will have available weekend hours care.
* Behavioral health provider specialists who will have available weekend hours care.

**Response:**

Respondents shall use **Exhibit A-4-a-V3,** SRC# 5 After Hours Availability Tool, located at <https://ahca.myflorida.com/procurements>, to provide the ratios of specific provider types offering appointment availability outside of business hours, including nights and weekends.

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# PATHWAYS TO PROSPERITY

## SRC# 6 – Expanded Benefits – Pathways to Prosperity:

Section 409.966(3)(a)6., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

6.  Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

Section 409.966(3)(a)6., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

6.  Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

Expanded benefits are benefits covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency. In **Exhibit A-5-V3**, Scored Submission Requirements and Evaluation Criteria, **SRC# 27** – Expanded Benefits, the respondent will be asked to identify the expanded benefits it proposes to offer. For each of the expanded benefits related to Pathways to Prosperity the respondent proposes to offer its enrollees (i.e., Pathway to Prosperity: Housing assistance, Pathway to Prosperity: Food assistance, Pathway to Prosperity: Non-medical transportation, Pathway to Prosperity: Tutoring, vocational training, and job readiness), the respondent shall describe an implementation and evaluation plan for its expanded benefits.

**Response:**

The respondent shall use the text field below. Limit your written response to a maximum of 2,000 characters.

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# RESPONDENT BACKGROUND AND EXPERIENCE

## SRC# 7 – Managed Care Experience Narrative:

Section 409.966(3)(a)2., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

2. Experience serving similar populations, including the organization’s record in achieving specific quality standards with similar populations.

Section 409.966(3)(a)2., F.S.

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

2. Experience serving similar populations, including the organization’s record in achieving specific quality standards with similar populations.

In **Exhibit A-5-V3**, Scored Submission Requirements and Evaluation Criteria, **SRC# 31** – Managed Care Experience, the respondent will be asked to provide a list of up to twenty (20) of its current and/or recent (within five (5) years of the issue date of this solicitation (since February 1, 2018)) capitated contracts for managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support). The respondent shall describe for each identified contract:

* + - 1. Its experience in delivering managed care services (e.g., medical care, integrated medical and behavioral health services, transportation services and/or long-term services and supports), to Medicaid populations similar to the target population (such as TANF, ABD, dual eligible) identified in this solicitation;
			2. The use of administrative and/or delegated subcontractor(s) and their scope of work. The respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program;
			3. The barriers encountered that hindered implementation of those contracts (if applicable) and the respondent’s solutions; and
			4. The respondent’s accomplishments and achievements under those contracts.

**Response:**

Limit your written response to a maximum of 10,000 characters.

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# RECIPIENT AND PROVIDER EXPERIENCE

## SRC# 8 – Staff-to-Enrollee Ratio Staffing Model:

The respondent shall provide a staff-to-enrollee ratio for the following mandatory staff and any additional proposed staff the respondent includes in the response.

* Claims Resolution Staff
* Provider Relations Staff
* Recipient Relations Staff
* Utilization and Authorization Staff
* Quality Initiative Staff

The respondent must provide a staff-to-enrollee ratio for all mandatory and proposed staffing positions.

The Agency reserves the right to include any or all of the staffing and ratios listed herein, or as negotiated, as part of the resulting contract.

**Response:**

Respondents shall use **Exhibit A-4-b-V3,** Staff to Enrollee Ratio, located at <https://ahca.myflorida.com/procurements>, to provide its mandatory and additional proposed staff with ratios of staff to enrollees.

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## SRC# 9 – Delivery of Services to Children and Families Involved in the Child Welfare System:

The respondent shall describe how it will ensure enrollees, who are children or their parents or guardians, receive medically necessary behavioral health services and have timely access to support services following involvement with the child welfare system under the Florida Department of Children and Families (DCF). The respondent shall describe its approaches to the following in its response:

* Describe how the respondent will coordinate care and ensure delivery of behavioral health services for enrollee(s) in a manner that will prevent utilization of emergency department and inpatient admissions and involvement with the criminal justice system.
* Describe the processes for providing care coordination to the enrollee(s) and ensure the assignment of a mental health or child health services targeted case manager if the enrollee is eligible for that service.
	+ The respondent’s response shall include how care coordination will link the enrollee(s) to Family Support Services and will coordinate with the regional managing entity or Community Based Care Lead Agency to ensure comprehensive access to and delivery of medical and behavioral health services and community supports.
* Describe how the respondent will ensure that the enrollee(s) has access to medically necessary behavioral health services including but not limited to the following:
	+ Community Action Teams (CAT);
	+ Family Intensive Treatment (FIT) teams;
	+ Multisystemic Therapy;
	+ Wraparound; and
	+ Mobile Response Teams.
* Describe the processes for authorizing the delivery of Medicaid-covered behavioral health services recommended by child welfare teams for the enrollee(s).

**Response:**

Limit your written response to a maximum of 10,000 characters.

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# BUSINESS OPERATIONS AND ADMINISTRATION

## SRC# 10 – Encounter Data Submission Processes:

Section 409.967(2)(e), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(e) Encounter data.—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

Section 409.967(2)(e), F.S.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(e) Encounter data.—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.
2. The respondent shall describe how it will work with providers, particularly sub capitated providers, subcontractors, atypical providers, and non-participating providers to ensure the accuracy, timeliness, and completeness of encounter data.
3. The respondent shall demonstrate policies and procedures that are in place to ensure its providers submit all claims to the respondent for submission as an encounter. The respondent should include its approach to ensuring providers submit claims using the correct claim form (UB-04 and/or CMS1500) to the plan every time a service is rendered.
4. The description should include processes in place for monitoring encounter submissions, adjustments, and resubmissions, including tools and methodologies used to determine compliance with encounter data submission requirements.
5. The description should include the respondent’s approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.
6. The description should include the respondent’s approach to educating and supporting providers who submit paper claims.
7. The description should include the respondent’s approach to encouraging providers, particularly sub capitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.
8. The description should include the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.
9. The description should include the respondent’s approach to work with providers to comply with correct coding.
10. The description should include the respondent’s approach to ensure that all encounters are included in submissions.

**Response:**

Limit your written response to a maximum of 50,000 characters, exclusive of attachments (charts, tables, exhibits, etc.).

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## SRC# 11 – Management Experience and Retention:

Section 409.981(3)(a), F.S.

(3) In addition to the criteria established in Section 409.966, the agency shall consider the following factors in the selection of eligible plans:

(a) Evidence of the employment of executive managers with expertise and experience in serving aged and disabled persons who require long-term care.

For the respondent’s highest-ranking contract identified through the Order of Selection, the respondent shall describe its approach to the hiring and promoting retention, throughout the Contract term, of executive managers (e.g., CEO, COO, CFO, CMO, vice presidents, senior managers) who have expertise and experience in serving elders and adults with disabilities who require long-term services and supports. The respondent shall describe the relevant experience of their current management team [See Section 409.981(3)(a), Florida Statutes].

The respondent must describe its approaches and the effectiveness of its approaches to staff retention, including staff tenure. If the respondent acquired or merged with another managed care entity during the term of the highest-ranking contract, the respondent shall not include the corporate experience of the acquired or merged entity prior to the respondent’s ownership.

**Response:**

Limit your written response to a maximum of 4,000 characters.

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## SRC# 12 – Proposed Subcontractors:

The respondent shall list any proposed subcontractors to which it will delegate the management of Managed Care Plan responsibilities, as permitted in **Attachment B**, Scope of Services – Core Provisions,and its Exhibits,for the following functions:

* **Coverage of Services**
	+ Care Coordination/Case Management
	+ Utilization Management
	+ Service Authorization
	+ Participant Direction Option (PDO) (e.g., fiscal/employer agent)
* **Grievance and Appeal System**
	+ Notice of Adverse Benefit Determination Issuance & Completion
* **Provider** **Services**
	+ Network Management
	+ Provider Contracting
	+ Provider Complaint System
	+ Claims & Provider Payment
	+ Physician Incentive Program
* **Quality**
	+ Performance Measures
	+ Performance Improvement Projects
* **Administration and Management Services**
* Electronic Visit Verification
* Fraud, Abuse, & Waste Recoveries
* Pharmacy Benefits Manager

**Response:**

Respondents shall use **Exhibit A-4-c-V2,** Proposed Subcontractor Tool, located at <https://ahca.myflorida.com/procurements>, to provide its list of proposed subcontractors.

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