Solicitation Information
July 14, 2016

LOI# 7550787

TITLE: Medicaid Managed Care Services

Submission Deadline: September 12, 2016 at 10:00 AM (Eastern Time)

PRE-BID/ PROPOSAL CONFERENCE: No

Questions concerning this solicitation must be received by the Division of Purchases at david.francis@purchasing.ri.gov no later than **August 4, 2016 at 10:00 AM (ET).** Questions should be submitted in a *Microsoft Word attachment.* Please reference the LOI# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

David Francis
Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Note to Applicants:

Offers received without the entire completed three-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

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Section 1: Introduction

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island Executive Office of Health & Human Services (EOHHS), is soliciting proposals from qualified firms to provide health care services to eligible and enrolled Medicaid recipients through a managed care program under a capitation contract in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at www.purchasing.ri.us.

The initial contract period is targeted to begin approximately February 1, 2017 and will continue through June 30, 2022. EOHHS reserves the right per the Purchasing Agents review to defer the start of the initial contract period for one or more contractors to as late as April 1, 2017. Contracts may be renewed for up to five additional 12-month periods based on performance and the availability of funds.

This is a Letter of Interest (LOI), not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to agreement to accept the capitation rates herein in Attachment 2; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1. Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.

2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP will be rejected as being non-responsive.

3. All costs associated with developing or submitting a proposal in response to this RFP, or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for these costs.

4. Proposals are considered to be irrevocable for a period of not less than 60 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent; the state reserves the right to require vendors to hold their proposals for an additional 120 days.

5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.

6. Proposals misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.

7. It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all aspects of the work. Joint venture and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.

8. All proposals should include the vendor's FEIN or Social Security number as evidenced by a W9, downloadable from the Division's website at www.purchasing.ri.gov.

9. The purchase of services under an award made pursuant to this RFP will be contingent on the availability of funds.

10. Vendors are advised that all materials submitted to the State for consideration in response to this RFP will be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island, without exception, and will be released for inspection immediately upon request once an award has been made.

11. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.

12. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation.

13. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).

14. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information visit the website www.mbe.ri.gov

15. Under HIPAA, a "business associate" is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business

associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a Contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement

16. In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSource RI) , the vendor hereby certifies that it is an "eligible entity," as defined by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The vendor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an "eligible entity," as defined by 45 C.F.R. § 155.110.

Section 2: Background

2.1 Overview of Rhode Island Executive Office of Health and Human Services

Under state law, the Executive Office of Health and Human Services (EOHHS) serves as "the principal agency of the executive branch of state government" (R.I.G.L. §42-7.2-2) responsible for managing the departments of: Health (DOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). Last year, these agencies provided direct services to nearly 306,000 Rhode Islanders as well as an array of regulatory, protective and health promotion services to our communities. Health and human services benefits represent $3.1 billion spending per year, or over 40 percent of the entire state budget.

RI EOHHS is the single state agency for Medicaid. This procurement is to secure the services of qualified managed care organizations to arrange for and provide Medicaid covered benefits to eligible beneficiaries in Rite Care, Rite Care for children with special health care needs, Rite Care for children in substitute care, Medicaid Expansion, and Rhody Health Partners. Currently the Medicaid managed care program is served by two contracted managed care organizations. RI EOHHS welcomes potential qualified new entrants with the capabilities to provide high quality and cost effective services to Medicaid eligible populations. Member choice of health plan is an important component of the program. The State reserves the right to contract with two or more health plans at its discretion.

RI EOHHS will conduct a readiness review with all approved Bidders to ensure that Bidder is prepared to meet the requirements of the Medicaid managed care program as presented in its submission. For potential qualified new entrants the readiness review may impact the effective starting date for enrollment in the event a contract is fully executed.

This section provides potential Bidders with background information on the Rhode Island Medicaid Managed Care Programs and the goals of this procurement.

2.2 Overview of the Rhode Island Medicaid Managed Care Program

2.2.1 Evolution of the Managed Care Program

Rhode Island is strongly committed to managed care as a primary vehicle for the organization and delivery of Medicaid covered services to its eligible beneficiaries. Over the years, Rhode Island has steadily

increased the populations and services included in its managed care programs. When Medicaid began in the mid-1960s, the RI Medicaid program was modeled as a traditional indemnity fee-for-service (FFS) health insurance program. Throughout the years, the State has progressively transitioned from a payer to an active purchaser of care. Central to this has been a focus on improved access and quality along with cost management. Contracting with Medicaid managed care organizations (MCOs) provides a structure for measuring and enforcing performance standards. The State has been able to leverage the capabilities of MCOs in such areas as network capacity, member services, care management and coordination while maintaining a strong monitoring and oversight role.

The State's initial Medicaid managed care program, RIte Care, began in 1994, enrolling over 70,000 low-income children and families. A key contractual element was the "mainstreaming" provision, requiring that Health Plans must ensure that if a provider accepted enrollees from commercial lines of business, they must also accept RIte Care enrollees without discrimination. Children in Substitute Care Arrangements were voluntarily enrolled in RIte Care in December 2000 and Children with Special Health Care Needs (CSHCN) were voluntarily enrolled in RIte Care in 2003. Enrollment for CSHCN became mandatory in 2008.

In 2008, voluntary enrollment in Rhody Health Partners was implemented for "Medicaid-only" persons with disabilities. In the fall of 2009, all Medicaid eligible "aged, blind, and disabled" (ABD) adults without third-party coverage (TPL, including Medicare) who resided in the community were required to either enroll in a Health Plan through the Rhody Health Partners program, or in the State's FFS Primary Care Case Management (PCCM) program, Connect Care Choice (CCC). Currently, there are over 14,700 enrolled in the Rhody Health Partners Program and the fee-for-service based Connect Care Choice program has been phased out.

Pursuant to the Affordable Care Act (ACA) Rhode Island elected to extend coverage to the Medicaid Expansion group of low-income adults without dependent children. In January 2014, EOHHS initiated enrollment of this group into managed care.

This progression of expanded enrollment in managed care is characterized by enrollment of populations with increasingly complex health needs. Over this period, the contractual requirements of Health Plans have also expanded in terms of program requirements and in covered benefits, as the State has increased the performance requirements of Health Plans for managing the health care needs of complex populations.

Presently there are two participating health plans in Rhode Island's Medicaid managed care program. These are Neighborhood Health Plan of Rhode Island and United Healthcare of New England. Each of these plans has been participating in the program since inception. The table below shows the distribution of enrollment by product line and by health plan as of the end of March 2016.

Managed Care Enrollment as of March 31, 2016				
	NHP	**UHC**	**Total**	***% of Total***
RIte Care	95,554	46,892	142,446	*61.4%*
Children with Special Health Care Needs	5,284	1,711	6,995	*3%*
Children in Substitute Care, including foster care	2,250	0	2,250	*1%*
Medicaid Expansion	35,535	29,312	64,847	*28%*
Rhody Health Partners	7,051	7,709	14,760	*6.4%*
Combined Total	**145,674**	**85,624**	**231,298**	***100%***
% of Total	*63%*	*37%*	*100%*	

This solicitation is for managed care services for all of the populations described above and summarized in the table. Under the provisions of Rhode Island's 1115 waiver, enrollment in managed care is mandatory rather than voluntary for each of these populations with one exception, that being children in legal custody of the State Department of Children, Youth and Families (DCYF) herein referenced as Children in Substitute Care. For all groups other than children in substitute care requirements for freedom of choice are met through the option to select from more than one plan.

Children in substitute care arrangements represent those in foster homes, group homes or in other DCYF designated/approved living arrangements. For this group enrollment in managed care is voluntary rather than mandatory. DCYF, as the legal guardian of these children exercises choice as whether these children are to be enrolled in managed care. Presently all of these children are enrolled in one contracted MCO, Neighborhood Health Plan of Rhode Island. With respect to this LOI, all Bidders are required to include a proposal to serve this population as part of its submission. It is the State's intention to select one or more health plans to enroll this population. Successful Bidders will be able to effect strong communication and coordination among DCYF counselors, parents, the substitute arrangements and the health plan to provide high quality, person centered care coordination and care management.

For these managed care programs, the total managed care capitation expenditures are estimated to be approximately $1.090 billion in SFY 2016. This includes six months of costs for services that were moved in-plan effective January 1, 2016. This total would be somewhat higher had those services been in-plan for the full twelve months.

Rhode Island continues to operate certain programs that are not part of this procurement. These include:

- Rite Share - The RIte Share Program is the State's Premium Assistance Program under Medicaid where the State purchases employer-sponsored health insurance for RIte Care eligible low income working individuals and their families who are eligible for employer sponsored insurance but could not otherwise afford it. Currently, there are approximately 8,000 individuals in the RIte Share Program. Persons eligible for RIte Share are not enrolled in Medicaid managed care.
- PACE - The Program for All-inclusive Care for the Elderly (PACE) was implemented in December 2005. On average, 280 beneficiaries are enrolled in the State's fully integrated program for frail elders who are Medicare and Medicaid Eligible (MME) beneficiaries.
- Rhody Health Options - EOHHS implemented the Rhody Health Options Program in the fall of 2013 to serve the ABD and Medicare and Medicaid Eligible (MME) populations. The program

builds on, improves, and integrates primary care, acute care, specialty care, behavioral health care and long-term services and supports to better meet the needs of the target populations. Approximately 30,000 Rhode Islanders over age 65 and individuals with disabilities/chronic conditions who have Medicaid coverage or Medicare and Medicaid coverage (dual eligibility) are eligible. As of June 2016, almost 22,000 individuals were enrolled in the Rhody Health Options Program in the Neighborhood Health Plan of RI.

In concert with CMS and NHPRI, EOHHS has implemented a three way managed care contract for Medicaid-Medicare eligible or "duals" as part of CMS' Financial Alignment Demonstration (FAD). Enrollment in this program is voluntary.

- Rite Smiles - Rite Smiles is EOHHS' managed dental care program designed to increase access to, and the outcomes of, dental services provided to Medicaid eligible children born on or after May 1, 2000.

Including Rhody Health Options and PACE, over 85% of the Medicaid population is enrolled in a Health Plan and covered services and populations account for just under 65% of Medicaid expenditures in SFY 2016. (In part this is because the vast majority of managed care enrollees are in the RIte Care program, which has a lower PMPM cost, than the elder or adult disabled populations.) Rhode Island's participating Medicaid Managed Care plans have consistently been ranked among the best in the nation by the National Committee for Quality Assurance (NCQA).

2.2.2 Covered Population

Successful Bidders shall be required to cover the following groups: RIte Care, Rhody Health Partners and Affordable Care Act Eligible beneficiaries, with the exception of children in substitute care. All Bidders shall include a proposal to serve children in substitute care in their submission. EOHHS reserves the right to contract with one or more plans for enrollment of children in substitute care.

2.2.3 Enrollment in Managed Care

At the time of initial eligibility determination or re-certification, EOHHS shall make available non-biased enrollment counseling to eligible persons who are not already enrolled in a Health Plan. Responsibilities of the counselors include the following:

- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about managed care in general, including the option to enroll in a Health Plan; the way services typically are accessed under managed care; the role of the Primary Care Provider (PCP); and the responsibilities of the Health Plan member.
- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about benefits available through the Contractor's Health Plan, both in-plan and out-of-plan.
- Informing the Potential Enrollee and his or her family, guardian or adult caregiver of available Health Plans and outlining criteria that might be important when making a choice, e.g., presence or absence of an existing PCP or other providers in a Health Plan's network.
- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about premium and copayment requirements (if applicable).

Bidder will provide updated materials to EOHHS annually to facilitate enrollment counseling. All informational materials related to members and potential members must be written at no higher than a sixth-grade level, in a format and manner that is easily understood.

EOHHS shall have sole authority for determining whether individuals meet the eligibility criteria specified and therefore are eligible to enroll in a managed care plan and for determining the individual's premium rate category. Following ninety (90) days after their initial enrollment into a Health Plan, Members shall be restricted to that Health Plan until the next open enrollment period, unless dis-enrolled by EOHHS.

2.2.4 Enrollment Through HealthSource Rhode Island

Rhode Island's portal for application and enrollment in Medicaid is through Health Source Rhode Island (HSRI). At the time of application or at other times determined in its sole discretion by EOHHS, applicants or beneficiaries are offered the opportunity to select a Health Plan or another program option. Through the HSRI portal eligible individuals are prompted to select a contracted Medicaid managed care organization.

All successful Bidders will be identified in the portal drop down list as a selection option at the point that contracts are executed and readiness determination has been completed. In a small number of cases, an eligible member has not selected a Health Plan and that person will be automatically assigned to a Health Plan. In making automatic assignment EOHHS will employ a formula or algorithm deemed by EOHHS to be in the best interests of the program that may include quality metrics, Health Plan performance of contract requirements, Health Plan financial performance, or other considerations to assign any eligible member that does not make a voluntary selection. For the period from August 2015 through March 2016, the monthly average in auto assignment was 150.

2.2.5 New Enrollment in Medicaid Managed Care

During any period there are persons who both gain and lose Medicaid eligibility. The following provides a frame of reference for the volume of new enrollees entering the system. New enrollment for the period April through June 2015 is shown below by eligibility group.

○ Rite Care Children and Families	7,886
○ Children with Special Health Care Needs	154
○ Children in Substitute Care	119
○ Rhody Health Partners	979
○ Adults without Dependent Children/Medicaid Expansion	4,593
TOTAL	13,371

2.2.6 Lock-in and Open Enrollment

Once an individual selects or is assigned to a health plan they have 90 days during which they can switch to another health plan. Following ninety (90) days after their initial enrollment into a Health Plan, Members shall be restricted to that Health Plan until the next open enrollment period, unless dis-enrolled by EOHHS.

In order to provide Medicaid eligibles with freedom of choice of health plan, EOHHS will conduct an open enrollment period for all enrollees upon the execution and readiness determinations of successful Bidders. EOHHS will send notices to all eligible members advising them of the open enrollment period and of their health plan options. EOHHS will work closely with HealthSource Rhode Island, with consumer advisory

groups and other stakeholders in order to ensure members are aware of their right to choose and how to be informed about their options.

2.2.7 Health Plan Marketing

Successful Bidders may conduct marketing campaigns for members subject to the restrictions noted in "Guidelines for Marketing and Member Communication Materials for Rhode Island's Medicaid Managed Care Programs" available in the Procurement Library . MCOs are required to submit to EOHHS for review and written approval all materials in any medium that will be distributed to members or potential members (referred to as member and marketing materials) before they are distributed or released. Plan materials developed or distributed by subcontractors or providers also require review and approval before being distributed. Member materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters, newspaper, TV and radio advertisements, call scripts, surveys and other materials as identified by EOHHS. MCOs shall submit marketing plans to EOHHS for its review upon request.

When engaged in marketing its programs or in marketing targeted to potential or current members an MCO: (1) shall not distribute marketing materials to less than the entire service area; (2) shall not distribute marketing materials without the approval of EOHHS; (3) will not seek to influence enrollment in the Health Plan in conjunction with the sale or offering of private insurance; and (4) will not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities.

2.2.8 Quality, Utilization, and Expenditure in Managed Care

Rhode Island has consistently demonstrated strong performance in the delivery of Medicaid managed care services. Most recently, in May 2015, Rhode Island was recognized by the Centers for Medicare & Medicaid Services (CMS) for its performance on the fifteen (15) health care quality measures that comprise the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.

Only six States, including Rhode Island, were considered "higher performing" in the 2015 study by CMS, which looked at 15 measures in five categories: Perinatal and Infant Care, Well Child Care, Adolescent Well Care, Management of Acute and Chronic Conditions, and Dental. Rhode Island achieved scores in the top quartile for 13 of the study's 15 measures, including all the measures related to Perinatal and Infant Care, Well Child Care, Adolescent Well Care, and Management of Acute and Chronic Conditions. No other State achieved top quartile scores in more than nine measures.

Rhode Island's commitment to the provision of high quality care for Medicaid managed care enrollees dates back to the inception of RIte Care. Accreditation by the National Committee for Quality Assurance (NCQA) is a requirement for Medicaid-participating Contractors in Rhode Island.

NCQA accreditation is the most widely recognized accreditation program for managed care in the United States and is based on the results of standardized clinical (Healthcare Effectiveness Data & Information Set/HEDIS®) performance metrics and consumer experience (Consumer Assessment of Healthcare Providers & Systems/CAHPS®) measures. Rhode Island's participating Managed Care Contractors have

consistently demonstrated exceptional performance in the NCQA's annual ranking of Medicaid-participating Health Plans*. During the NCQA's most recent ranking period (2014-2015), both of the State's Medicaid Contractors were ranked within the NCQA's Top 10 for Medicaid.

On an annual basis, Rhode Island's External Quality Review Contractor analyzes the accessibility, timeliness, and quality of services provided by each Medicaid-participating Health Plan, as required by Federal regulations. In addition, Rhode Island has directed its EQR Contractor to produce an aggregate report. In its most recent analytic cycle, the State's External Quality Review Contractor, which is Island Peer Review Organization (IPRO), offered the following summary conclusion:

> IPRO's external quality review concludes that, in 2014, the Rhode Island Medicaid managed care program and both of the participating Health Plans have had a positive impact on the accessibility, timeliness, and quality of services for Rhode Island Medicaid recipients. This is supported by the fact that both Health Plans received an *Excellent* accreditation rating, as well as both being ranked within the top ten (10) of Medicaid Health Plans nationally by the NCQA based on HEDIS® results, CAHPS® scores, and NCQA accreditation results.

Although EOHHS is proud of the accomplishments of its managed care programs over the years, it is clear that there remains considerable opportunity for improvement. This is particularly evident in the area of behavioral health and in the integration of care for persons with co-occurring behavioral and physical health issues.

Note that additional information on the characteristics of the population enrolled in Medicaid managed care is available in the Procurement Library. In particular, included is a report titled: "RI Executive Office of Health and Human Services: Medicaid Managed Care: September 2015 Enrollment SFY15 Cost, Utilization and Provider Expense". This report provides summary information on the size and characteristics of the enrolled population as well as information on patterns of utilization, expenditures, and participating providers.

2.3 Reinventing Medicaid

Rhode Island's Medicaid program is an essential part of the fabric of Rhode Island's health care system serving one out of four Rhode Islanders in a given year and closer to forty percent over a three-year period. It has achieved national recognition for the quality of services provided. These accomplishments come at a cost that needs to be effectively managed in order to balance state economic goals. Rhode Island currently spends more than 30 cents of every state revenue dollar on Medicaid. As the program has expanded, the costs of Medicaid have continued to rise and have crowded out investments for important economic development priorities such as education, skills training and infrastructure.

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* http://www.ncqa.org/ReportCards/HealthPlans/HealthInsurancePlanRankings/MedicareMedicaidHealthPlanRankings20142015.aspx

Maintaining a strong Medicaid system is an economic imperative for the state. Medicaid supports a healthier population, which provides businesses and employers with a healthier workforce and more predictability of publicly funded costs.

In order to address the goals of both setting the foundation for growth in the state's economy and building a sustainable Medicaid program for the future, in March 2015 Governor Gina Raimondo issued Executive Order 15-08, establishing the "Working Group to Reinvent Medicaid" to provide recommendations for a restructuring of the Medicaid program.

Guiding this effort was the understanding that given the crucial role of the Medicaid program to the state, it is of compelling importance that the state conduct a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes for the people of Rhode Island and transforms the health care system to one that pays for outcomes and quality at a sustainable, predictable and affordable cost for Rhode Island taxpayers and employers.

The Governor charged the Working Group to Reinvent Medicaid to:

- Submit a report on or about April 30, 2015, of its findings and recommendations for consideration in the Fiscal Year 2016 budget
- Submit recommendations, no later than July 1, 2015, for a plan for a multi-year transformation of the program and all state publicly financed health care in Rhode Island.

The Reinventing Medicaid Act of 2015 set into law the fundamental recommendations of the Working Group[†]; the Act also reflects the Working Group's FY 2016 budget recommendations for Medicaid.

The final report of the Working Group was issued on July 8, 2015. The Executive Summary from that report summarizes:

> *This report builds on the foundation laid by the Reinventing Medicaid Act of 2015 to propose a transformative vision for Rhode Island Medicaid. In this Working Group's first report, we proposed a set of short-term cost-saving measures that were designed to be the first step on a path towards a payment and delivery system that promotes value, quality, health, and efficiency. Working with partners from the health care sector, the advocacy community, the business community at large, and the Executive Office of Health and Human Services, we now lay out a model for a reinvented publicly financed health care system in Rhode Island based on the following principles:*
>
> 1. *Pay for value, not for volume*
> 2. *Coordinate physical, behavioral, and long-term health care*
> 3. *Rebalance the delivery system away from high-cost settings*
> 4. *Promote efficiency, transparency, and flexibility*
>
> *From these principles, we derive ten goals for Rhode Island's Medicaid program:*

† See http://reinventingmedicaid.ri.gov for additional documentation and to review (1) Initial Report of the Working Group to Reinvent Medicaid, May 1, 2015 and (2) Final Report of the Working Group to Reinvent Medicaid, July 8, 2015.

- Goal 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members.
- Goal 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- Goal 3: Maintain and expand on our record of excellence—including our #1 ranking—on delivering care to children.
- Goal 4: Maximize enrollment in integrated care delivery systems.
- Goal 5: Implement coordinated, accountable care for high-cost/high-need populations
- Goal 6: Ensure access to high-quality primary care.
- Goal 7: Leverage health information systems to ensure quality, coordinated care.
- Goal 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings.
- Goal 9: Encourage the development of accountable entities for integrated long-term care
- Goal 10: Improve operational efficiency

Each of these goals is accompanied by specific, measurable objectives that can serve as targets to achieve along the way towards the vision of a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with Accountable Entities, integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population. This will require improved contracts with the MCOs that require them to innovate in value-based purchasing strategies, including enhanced capacity for provider-level quality measurement, risk adjustment, and total cost of care measures; shared savings and bundled payment methodologies; and innovative contracting strategies with hospitals, home care providers, and long term care facilities that align their financial interests and performance metrics with those of the accountable entities—while ensuring access to medically appropriate care. We also envision a system in which case management and other member support resources are coordinated and funded through the Accountable Entity, to ensure that care is focused, aligned, and timely, and that both medical and non-medical needs of our members are met and addressed.

Rhode Island has a strong foundation for reform in Medicaid. Our managed care programs are nationally recognized for their quality and effectiveness, and we have excellent partners in the provider community who have already begun to innovate in meaningful ways.

The vision set forward here is ambitious, as it should be, given the scale, impact, and importance of Medicaid. Rhode Island's leaders, including policy makers, health professionals, providers, community advocates and others, must not lose their passion for reform. Long-term, sustainable reforms must

remain a top priority for the state, with a commitment to implementing those reforms and measuring progress along the way.‡

Through this LOI, EOHHS is seeking partners with the capability and commitment to achieve these critical goals for a sustainable and superior Medicaid program for Rhode Island.

2.4 Programmatic Goals for this LOI – Implementing the Reinventing Medicaid Act of 2015

The Reinventing Medicaid Act of 2015 put in motion a specific set of initiatives impacting the Medicaid managed care program in FY 2016 and set the stage for further changes going forward. This includes a series of amendments to the program beginning in January 2016 that are incorporated into this LOI for the period commencing on or about February 1, 2017. EOHHS reserves the right to defer the start of the initial contract period for one or more contractors to as late as April 1, 2017

2.4.1 Define Medicaid-wide population health targets, and, where possible, tie them to payments

A central goal of Reinventing Medicaid is ensuring a strong focus on population health. Population health is frequently described as the health outcomes of an identified group of individuals, including the distribution of outcomes of subpopulations within the larger population. Over 80% of Medicaid eligible people are enrolled in the Medicaid managed care program. This is a diverse population including many subpopulations of children and adults, persons with complex medical and behavioral health and social needs. A population health approach seeks to maintain and improve the health status of the entire population while systematically identifying those subpopulations with complex needs and implementing strategies to improve their health status and reduce health inequities among population groups. Such approach will include an increased focus on health outcomes as opposed to specific services and inputs. Throughout this LOI, EOHHS has worked to include requirements promotive of a population health approach. This includes the emphasis on transition to value based payment arrangements with Accountable Entities, effective communication, meaningful analytic capacity and metrics, integrations of care across disciplines as appropriate, recognition of and strategies to address social determinants of health, care coordination, care management, and others. The multiple actions and interventions of the successful Bidder will display how these components of their program function within a thoughtful and integrated strategy to impact population health. This will include steps to assess current population health status, define targets and where possible, linking payments to those targets,

2.4.2 Alternative Payment Methodologies (APM) and Accountable Entities

EOHHS seeks to significantly reduce the use of fee-for-service payment as a payment methodology in order to mitigate the fee-for-service volume incentives, which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.

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‡ Report of the Working Group to Reinvent Medicaid: Recommendations for a Plan for a Multi-Year Transformation of the Medicaid Program and All State Publicly Financed Healthcare in Rhode Island, July 8, 2015. http://reinventingmedicaid.ri.gov

The successful Bidder will incorporate value based purchasing initiatives into their provider contracts. EOHHS is committed to creating partnerships or organizations using accountable delivery models that integrate medical care, mental health, substance use disorders, community health, social services and long term services and supports (LTSS), supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability. Pursuant to this commitment, during FY 2016 EOHHS certified Accountable Entity Coordinated Care Pilots and MCOs are expected to execute "total cost of care" payment arrangements with certified Pilots. In FY 2017, EOHHS will move beyond the Pilot phase and certify fully qualified Accountable Entities.

EOHHS' FY 2016 contracts with MCOs include the provision that Bidders will have 20% or more of their total payments to providers in alternative payment arrangements by the last quarter of SFY 2016. This target is increased for the period covered by this procurement.

EOHHS requirements for Alternative Payment Methodologies is included in the Procurement Library for this LOI: "Rhode Island Executive Office of Health and Human Services, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners".

For Contract Period 1 (February 1, 2017 – June 30, 2017)

1. By the final quarter of Contract Period 1, at least 15% of Contractor payments to providers shall be made through an EOHHS approved Alternative Payment Methodology #1: Total Cost of Care Model with EOHHS Certified Accountable Entities.
2. By the final quarter of Contract Period 1, at least 30% of Contractor payments to providers shall be made through an EOHHS approved Alternative Payment Methodology. This total is inclusive of payments made to EOHHS certified Accountable Entities included in number 1 above.
3. The percent of high need, members enrolled in an EOHHS certified and MCO-contracted Accountable Entity that are high need, high cost as defined in Section 6 of "Rhode Island Executive Office of Health and Human Services, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" shall be equal to or greater than the percent of high cost, high need persons in the MCOs entire enrolled membership.

For Contract Period 2 (July 1, 2017 – June 30, 2018)

1. By the final quarter of Contract Period 2, at least 35% of Contractor payments to providers shall be made through an EOHHS approved Alternative Payment Methodology #1: Total Cost of Care Model with EOHHS Certified Accountable Entities.
2. By the final quarter of Contract Period 2, at least 60% of Contractor payments to providers shall be made through an EOHHS approved Alternative Payment Methodology. This total is inclusive of payments made to EOHHS certified Accountable Entities included in number 1 above.
3. The percent of high need, members enrolled in an EOHHS certified and MCO-contracted Accountable Entity that are high need, high cost as defined in Section 6 of "Rhode Island Executive Office of Health and Human Services, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" shall be equal to or

greater than the percent of high cost, high need persons in the MCOs entire enrolled membership.

For Contract Period 3 (July 1, 2018 – June 30, 2019)

1. By the final quarter of Contract Period, at least 50% of Contractor payments to providers shall be made through an EOHHS approved Alternative Payment Methodology #1: Total Cost of Care Model with EOHHS Certified Accountable Entities.
2. By the final quarter of Contract Period 3, at least 80% of Contractor payments to providers shall be made through an EOHHS approved Alternative Payment Methodology. This total is inclusive of payments made to EOHHS certified Accountable Entities included in number 1 above.
3. The percent of high need, members enrolled in an EOHHS certified and MCO-contracted Accountable Entity that are high need, high cost as defined in Section 6 of "Rhode Island Executive Office of Health and Human Services, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" shall be equal to or greater than the percent of high cost, high need persons in the MCOs entire enrolled membership

For Contract Periods 4 and 5 (July 1, 2019 – June 30, 2020; July 1, 2020 – June 30, 2021)

1. At least 65% of Contractor payments to providers shall be made through an EOHHS approved Alternative Payment Methodology #1: Total Cost of Care Model with EOHHS Certified Accountable Entities
2. At least 80% of Contractor payments to providers shall be made through an EOHHS approved Alternative Payment Methodology. This total is inclusive of payments made to EOHHS certified Accountable Entities included in number 1 above.
3. The percent of high need, members enrolled in an EOHHS certified and MCO-contracted Accountable Entity that are high need, high cost as defined in Section 6 of "Rhode Island Executive Office of Health and Human Services, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" shall be equal to or greater than the percent of high cost, high need persons in the MCOs entire enrolled membership.

2.4.3 Rhode Island Health System Transformation Program

RI is presently in discussions with CMS in anticipation of CMS' approval and support for the Rhode Island Medicaid Health System Transformation Program. This Program will build on the core strengths and capacities that already exist in RI's health care landscape – including:

- The state's long history of commitment to health care reform and access to coverage;
- A strong history of high quality Medicaid managed care;
- Statewide health information exchange (CurrentCare) and high penetration of electronic medical records;
- A robust Medical Home initiative; and
- A strong state university and college system providing valuable health professional training needed for the health workforce of a transformed system of care.

Rhode Island will leverage these strengths to tackle the most significant challenges of the current program, including the six percent of Medicaid users with the most complex needs and highest costs that account for almost two-thirds (65%) of Medicaid claims expenditure.

The Rhode Island Medicaid Health System Transformation Program will focus on two priorities:

1. **Long-term services and supports (LTSS).** Nearly half of claims expenditures on high cost users is on nursing facilities and residential services for persons with developmental disabilities;
2. **Physical and behavioral health integration.** Forty percent of claims expenditure on high cost users is on high utilizers "in the community", most of whom have multiple comorbidities, with both physical and behavioral health needs that require an integrated approach.

RI envisions that by the completion of the Program (by 2021), all Medicaid enrollees will be enrolled in fully capitated MCOs, who contract on a risk-basis with certified provider-based Accountable Entities, with payment based on value, not volume. These Accountable Entities will build on the existing strengths of the current MCO model and enhance its capacity to serve high-risk populations by increasing delivery system integration and improving information exchange and clinical integration across the continuum of care.

As a result of this transformation of the Rhode Island Medicaid program (and in partnership with other efforts such as the Rhode Island State Innovation Model (SIM), RI anticipates that by 2022 readmission rates, preventable hospitalizations and ED visits will be significantly decreased; and the balance of long-term care expenditures will shift from institutional to eighty percent (80%) community-based.

The Medicaid Health System Transformation Program proposes to support and incentivize this critical transformation of RI's system of care with two interlaced components, each critical to RI's success:

1. Infrastructure Funding for Accountable Entities

   Accountable Entities become mature, multi-provider organizations, capable of coordinating, communicating, and being accountable for each patient's care without significant infrastructure investment. Medicaid is proposing to award performance-based infrastructure funding over the next five years through Health Plans to Medicaid Certified Accountable Entities. Medicaid-participating Health Plans will be full partners with the state and provider community in this transition, as the ultimate intent of this effort is to support the development of effective, value-based contracts between Health Plans and AEs for the delivery of Medicaid services.

2. Health Workforce for RI's Future

   To be more effective, health care must transform at the level of the patient and provider. The health care delivery system at this level of care will require a significant infusion of new health professionals as well as retraining of the current workforce. Medicaid will develop a new Health Workforce partnership with RI's three public higher education institutions, the University of Rhode Island (URI), Rhode Island College (RIC), and the Community College of Rhode Island (CCRI), as well as with the Department of Labor and Training (DLT) and other critical organizations.

Most pertinent to this LOI and described here is the proposed infrastructure funding for accountable entities.

The RI Medicaid Health System Transformation Program will support and incentivize the critical transformation of RI's system of care through its incentive payment program. Pending CMS and EOHHS approval, Incentive Payments will be made to MCOs to support investment in performance-based infrastructure development by EOHHS/Medicaid certified Accountable Entities (AEs).

Accountable Entities that meet state defined certification standards will initially apply for incentive-based awards for infrastructure funding to develop the governance, technology, skills and capacity to enter into risk-based contracts with Medicaid MCOs; manage enrollees' care across AE providers; and decrease out-year cost trend rates. Qualified AEs must meet one of three levels of readiness demonstrating that they either have or are developing the capacity to integrate and manage the full continuum of health care and to address members' social determinants (e.g., housing, food), in a way that is acceptable to CMS and the State.

A portion of each year's award to AEs will be at risk for performance, with measures shifting over time from structural to Medicaid-specific clinical/utilization, and ultimately to cross-population improvements in health and health behaviors.

Through this program short term Planning Awards will be made available to Certified Accountable Entity Partnerships to support planning for infrastructure development and to enable recipients to develop applications for infrastructure funds. Based on those applications entities will be eligible for multi-year Infrastructure Incentives. The program will be implemented in collaboration with contracted MCOs, building on the current Pay for Performance arrangements to operationalize the program. Payments to AEs will be made via the MCOs. Continued eligibility for the AEs for the funding will depend on identified performance measures. A portion of funds will be set aside to support enhanced MCO performance awards and for MCO administrative costs associated with the operation, oversight and monitoring of infrastructure payments to Accountable Entities.

The Rhode Island Health System Transformation Program is in the early stages of its development with much yet to be fully defined. It is described here because if implementation is to be achieved as envisioned by building on the Medicaid managed care program, successful Bidders will need to be committed partners with demonstrable ability to engage effectively with Accountable Entities. In their submission, Bidders will need to affirm their commitment to positive collaboration in this program. §

2.4.4 Primary Care Practice Transformation

Fundamental to health care system transformation is a strong foundation of high performing primary care practices. EOHHS is committed to continued support for primary care practice transformation.

By the final quarter of the second contract period (by June 30, 2018) Contractor shall take such actions as are necessary so that 65% of members are assigned to a primary care practice contracting with Contractor that functions as a Patient-Centered Medical Home as recognized by the Rhode Island Office of the Health Insurance Commissioner and as defined in the following document that is included in the Procurement Library for this LOI: "Rhode Island Executive Office of Health and Human Services, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners".

§ For a high level overview of this program see the Document Procurement Library for the power point presentation "Rhode Island Health System Transformation Program, Update for Health Care Provider, March 16, 2016

By the final quarter of Contract Period 3 and throughout Contract Periods 4 and 5 Contractor shall take such actions as are necessary so that 80% of members are assigned to a primary care practice contracting with Contractor that functions as a Patient-Centered Medical Home as recognized by the Rhode Island Office of the Health Insurance Commissioner.

2.4.5 Alignment with Rhode Island State Innovation Model (SIM)

In 2014, CMS awarded Rhode Island a State Innovation Model (SIM) grant titled "Healthy Rhode Island". Through this program, Rhode Island is focusing on population health goals, multi-payer delivery system reform, and enhancements in information technology infrastructure to support payment and delivery system reform. With the support of stakeholders from across the state, the SIM program aims to achieve measurable improvement in health and productivity of all Rhode Islanders, and achieve better care while decreasing the overall cost of care. Fundamental is transitioning from a disparate and health care provider and payer-centric environment to an organized delivery and payment system that is outcomes-oriented and person-centric. This work is further closely aligned with the Affordability Standards established by the Rhode Island Office of the Health Insurance commissioner (OHIC). Success in these efforts requires the active engagement of key participants in the health care system. Successful Bidders are expected to serve as engaged and positive participants in this work.

2.4.6 CurrentCare

CurrentCare is a secure electronic network that gives authorized medical professionals access to their enrolled patients' most up-to-date protected health information from multiple sources in one place. Through this program, providers have timely access to critical information at the point in time when it can support high quality, informed, and coordinated care. It is a free service for patients and providers that can help reduce fragmentation and duplicate testing while supporting medication management and proper follow-up. The State's goal is to maximize the effectiveness in part by maximizing patient participation of CurrentCare. The broader the covered population the better it works in support of high quality care. Signing up for CurrentCare is voluntary on the part of the patient. Almost 50% of all Rhode Islanders have enrolled as of April 2016. However, enrollment of Medicaid members in CurrentCare lags behind that of the states, Rhode Island's population more generally. Successful Bidders will work to actively ensure that members are fully informed of the potential benefits to them and to their families through participation in CurrentCare.

2.4.7 Movement of Additional Services into Managed Care Contracts

A central goal of Reinventing Medicaid and this procurement is to improve the coordination and effectiveness of care for persons with complex needs, notably people with co-occurring behavioral and medical health conditions. Until recently, specialized services for two such groups of individuals remained in fee-for-service. Effective January 1, 2016 contracts with MCOs were amended to move certain specialized services from fee-for-service Medicaid into managed care. These pertain to (a) specialized programs for adults with serious mental illness and (b) certain specialized home and community based services for individuals less than twenty-one (21) years of age.

2.4.7.1 Specialized Programs for Adults with Serious Mental Illness

Adults with serious mental illness require specialized programs that deliver recovery-oriented care addressing all clinical needs both behavioral and medical. These specialized programs are responsible for

ensuring integration of care that includes coordinating the recipient's comprehensive health care needs including physical health, mental health, substance use and social supports.

The specialized programs are for adults with a range of serious mental health illness identified based on diagnostic characteristics. The specialized programs will be carried out by the Community Mental Health Organizations (CMHOs), licensed by BHDDH, and referred to as: Assertive Community Treatment (ACT) and Integrated Health Homes (IHH). Program monitoring and evaluation by the Bidder is required to ensure validity to the model and the effective implementation of responsibilities and functions by the MCO and the CMHOs. The program is supported by BHDDH regulations. Prior to moving "in plan" on January 1, 2016 related services were reimbursed through Medicaid fee-for-service. Additionally, effective 7/1/2016 Opioid Treatment Program Health Home (OTP) moved from Medicaid fee-for-service to an "in plan" service.

2.4.7.2 Home and Community Based Services for Individuals under Age 21

Home Based Treatment Services (HBTS), Personal Assistance Services and Supports (PASS), Respite, Evidence Based Practices (EBP) and Adolescent Residential Substance Use Treatment are designed for children with complex health needs. These services for children with complex health needs have historically been paid for through Medicaid fee-for-service and have been outside of the MCO's scope of covered services. Effective January 1, 2016, as part of its effort to better integrate comprehensive services for the whole child, EOHHS amended the MCO contracts to include these services within the MCO covered benefit package. It is intended that the Contractors will further expand the service array available to enrolled children and fully manage the health care of the whole child within the context of their families. Provision of these services must be in compliance with Federal EPSDT regulations. These services are not specific to any particular product line or Medicaid eligibility group but are intended to meet the needs of children with serious or chronic health needs to attain their fullest potential and to remain in the least restrictive and most community based setting possible . Contractor will ensure that Cedar Family Center services, provided under Medicaid fee-for-service arrangements are utilized as a community care management resource, if necessary to augment the MCO care management program.

Section 3: Scope of Work

3.1 General Scope of Work

The goal of the Medicaid managed care program is to promote the overall health of the enrolled populations and to do so in the most cost effective manner possible. Enrolled populations are diverse, including people with existing complex medical and social needs, people at high and rising risk, and a larger population requiring more routine but high quality, accessible, responsive health services. This is a low income and culturally diverse population whose health status will be impacted by a range of social factors that must be recognized within effective plans of care. The Medicaid managed care program shall have a clear focus on outcomes.

The Bidder must meet all State general requirements as described in Section One.

Section Three describes the scope of work and technical requirements for the successful Bidder. In this procurement, Rhode Island seeks partners that will continue on the path to building the "Next Generation" of high performing Medicaid managed care organizations . Core requirements and competencies that have long been a part of the managed care program will continue in the next period.

Section Four of this LOI provides the guidelines for submission of a Bidder's proposal and is organized in relation to the requirements set forth in Section Three.

The successful Bidder(s) must demonstrate the capacity to provide high quality services in a cost-effective manner to eligible Medicaid populations throughout the State of Rhode Island. The selected Bidder(s) must be properly licensed and have the capability to meet a defined set of program and technical standards including but not limited to the following:

- Enroll the covered population and provide the covered benefits that represent a full continuum of health care services,
- Maintain a robust provider network that meets Federal and State accessibility standards,
- Provide in-plan benefits and to coordinate out-of-plan benefits that meet individual member needs,
- Capacity to provide care management to a diverse population with complex needs,
- Capacity to provide responsive member and provider services,
- Capacity to operate under a risk bearing contract and to meet financial standards,
- Maintain a viable information technology capacity and meet Federal and State reporting requirements,
- Attend and preside at meetings with stakeholders on a regular basis, and
- Maintain a grievance and appeals process that meets Federal and State requirements.
- Implement alternative payment methodologies with defined quality metrics.

The successful Bidder(s) will also be required to meet specific terms and conditions related to contract amendments and potential contract disputes; personnel and performance standards; confidentiality of information; and other terms and conditions related to administering its contract with EOHHS.

3.2 Core Requirements

3.2.1 Experience and Understanding

3.2.1.1 Health Plan Licensure and Organizational Requirements

The Bidder must meet all State general requirements as described in Section One.

The Bidder certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 2741, "the HMO Act", or that it shall become licensed as a Health Maintenance Organization (HMO) or Health Plan (HP) in the State of Rhode Island by the Rhode Island Department of Health and the Rhode Island Department of Business Regulation prior to signing an Agreement with State. If Bidder is not a licensed HMO in Rhode Island, Bidder certifies that it is either a nonprofit hospital service corporation that is licensed by the Rhode Island Department of Business Regulation ("DBR") under Chapter 27-19 of the Rhode Island General Laws, a nonprofit medical service corporation that is licensed by DBR under Chapter 27-20 of the Rhode Island General Laws, or another health insurance entity licensed by DBR,; and that it meets the following requirements:

- Is certified by the Rhode Island Department of Health as a Health Plan under R23-17.13- CHP; and
- Meets the requirements of Sections 3.4, 5.2, 6.1.4, and 6.4.7 under R23-17.13-CHP; and

- Meets the requirements under R23-17.12: *Rules and Regulations for the Utilization Review of Health Care Services*

The Bidder agrees to forward to EOHHS any complaints received from the DBR or the Rhode Island Department of Health concerning its licensure, certification, and/or accreditation within thirty (30) days of Contractor's receipt of a complaint.

The Bidder agrees to provide to the State, or its designees, any information requested pertaining to its licensure and/or certification including communication to and from DBR and the Rhode Island Department of Health. This provision shall apply to any subsidiary of Bidder or any subcontractor with delegated authority for administration or oversight of covered benefits or adjudication of covered benefit claims under this Agreement. Bidder also agrees to forward to the State a copy of any correspondence sent by the Bidder to the Rhode Island Department of Business Regulation or the Rhode Island Department of Health, which pertains to the Bidder's licensure or its contract status with any institution or provider group.

The Contractor shall be accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid managed care organization or otherwise for a newly entering plan:

- The Contractor must submit a PDF copy of its current NCQA accreditation certificate for a Medicaid managed care organization in another State; and
- The Contractor must specify timeline outlining the Contractor's plan to achieve full accreditation within twelve months of the execution of a contract; and
- For all Bidders, achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the Final Report of the NCQA and may result in termination of the State's Agreement with the Contractor. In the event that NCQA were to deny accreditation to the Bidder, EOHHS shall consider this to be sufficient cause for termination of the Agreement.

The Bidder will attest that it is in good standing with and has not been debarred from participation in any Federal or Federal/State health care programs, including Medicare, CHIP, and any state Medicaid program

The Bidder is financially solvent, has the capital, and has the financial resources and management capability to operate under this procurement's risk-based contract that reimburses the successful Bidder with capitation rates.

The Bidder is required to have the staffing capacity with the appropriate expertise. The Bidder is required to have a Medical Director, as well as adequate staffing, to complete the administrative procedures, develop an organization structure, maintain a management information system; and to perform all the functions required under this contract (e.g. program and service development, member enrollment, member services, claims processing, accounting and finance, quality assurance, medical management and utilization review, provider network development and continuing relations, care management, grievance and appeals systems, etc.).

The Bidder is required to have an office in the Greater Providence area of Rhode Island. The Bidder may perform some administrative functions out-of-state, with the approval of EOHHS, as long as it does not affect the quality, effectiveness, and efficiency of the services or functions performed by the Bidder in the judgment of EOHHS. The Bidder is expected to have an in-state presence to conduct outreach and approved marketing activities within all the communities throughout the State.

3.2.2 Contract Goals for this Procurement - Special Initiatives Requirements

The Bidder must demonstrate the ability to successfully advance the Contract Goals for this LOI – Implementing the Reinventing Medicaid Act of 2015, as noted in Section 2.4 of this LOI. These Special Initiatives are:

1. Defined, integrated programmatic focus on population health
2. Alternative Payment Methodologies (APM) and Accountable Entities
3. Rhode Island Medicaid Health System Transformation Program
4. Primary Care Practice Transformation
5. Alignment with Rhode Island State Innovation Model (SIM)
6. Movement of Additional Services into Managed Care Contracts
7. CurrentCare

Contractors must meet requirements as described in Section 2.4 of this LOI. In the Bidder's Technical Proposal (submission guidelines are provided in Section 4) the Bidder shall specifically address 1 - 5 of these initiatives. Number 6, Movement of Additional Services into Managed Care Contracts will be addressed in pertinent sections of the submittal.

3.2.3 Member Enrollment and Dis-enrollment

The Bidder must adhere to all enrollment and dis-enrollment policies, as defined by the State.

All eligible populations will be enrolled by the State. Following their initial enrollment into the MCO, members will be restricted to that managed care plan after the first 90 days unless dis-enrolled by EOHHS for an acceptable reason.

3.2.3.1 Enrollment

The Bidder must have State approved written policies, procedures, systems and practices that meet the requirements. The State supplies the Contractor on a monthly basis with a list of members.

The Bidder must notify, by mail, members of their enrollment that indicates the effective date and how to access care within 10 calendar days after receiving notification from the State of their enrollment. The Bidder agrees to report any changes in the status of individual member within (5) five calendar days of their becoming known, including but not limited to changes in address or telephone number, out-of-State residence, deaths, household composition (e.g. birth of a child or change in legal guardianship of a minor) and sources of third-party liability. The Bidder must have a process for performing outreach calls and an approach for determining a member's most recent and accurate address and telephone number.

The Bidder agrees to enroll, in the order in which he or she applies or is assigned, any eligible individual who selects it or is assigned to it, regardless of the individual's age, sex, sexual orientation, ethnicity, language needs, health status, or need for health services. At the same time, the Bidder also must agree to enroll any eligible siblings and/or dependents. The only exceptions will be if the member was previously dis-enrolled from the MCO as the result of a grievance filed by the Bidder.

The Bidder shall have written policies and procedures for orienting new members to their benefits, how to utilize services in other circumstances, how to register a complaint or file a grievance, conduct a Health Risk Assessment, conduct required orientation for children with special health care needs. These policies and procedures shall take into account the multi-lingual, multi-cultural nature of the population. All enrollment notices, informational materials and instructional materials relating to members should be written at no higher than a sixth-grade level, presented in a manner and format that may be easily understood. All written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All members must be informed that information is available in alternative formats and how to access those formats.

3.2.3.2 Dis-enrollment

The State has sole authority for dis-enrolling members. The Bidder may not dis-enroll a member. The Bidder refers requests for dis-enrollment to EOHHS for determination.

3.2.3.3 Materials

The Bidder issues all members an identification card within ten (10) calendar days after receiving notification from the State of their enrollment. The card includes at least the following information: (1) Bidder's name; (2) Twenty-four (24) hour telephone number for the Bidder (for use in urgent or emergent medical situation; and (3) telephone number for Member Services function if different from number 2; (4) Telephone number for Behavioral Health Services; and (5) PCP or PCP practice, with name and office telephone number (PCP-related information can be affixed by a sticker to the card).

The Bidder provides a Member Handbook or new member packet to all members within ten (10) calendar days of being notified of their enrollment and updates the Member Handbook when material changes occur as determined by EOHHS. The Bidder also agrees to make available Member Handbooks in languages other than English consistent with the interpreter requirements.

The Bidder submits all member materials to EOHHS for approval prior to its use. This includes any changes made to language previously approved by the State. Contractor also agrees to make modifications in member materials, if required by the State.

The Bidder must assure that all materials are written at no higher than a sixth-grade level and are culturally appropriate.

3.2.3.4 Marketing

The Bidder may conduct marketing campaigns for members, subject to the restrictions noted in the "Guidelines for Marketing and Member Communication Materials for Rhode Island's Medicaid Managed Care Programs" issued by the State. Bidder may not display or distribute marketing materials, nor solicit members in any other manner, within 50 feet of eligibility and enrollment offices, unless it has received permission to do so from the State.

The Bidder submits all marketing materials to the EOHHS for approval prior to use. All marketing materials are written at no higher than a sixth-grade level, in a format and a manner that is easily understood, and are culturally appropriate for the population. EOHHS determines whether Bidder's marketing plans,

procedures, and materials are accurate, and do not mislead, confuse, or defraud either recipients or the State, pursuant to 42 CFR 438.104. When engaged in marketing targeted to members the Bidder (1) does not distribute marketing materials to less than the entire service area; (2) does not distribute marketing materials without the approval of the EOHHS; (3) does not seek to influence enrollment in the MCO in conjunction with the sale or offering of private insurance; and (4) does not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities.

3.2.4 Provider Network and Access to Services

3.2.4.1 Provider Network

The Bidder maintains a robust multi-disciplinary provider network (1) to provide members with the full range of covered services; (2) that maintains providers in sufficient number, mix and geographic area; and (3) makes available all services in a timely manner.

The Bidder agrees to establish and maintain a network that is supported by written agreements that meet both State and Federal requirements and can sufficiently demonstrate to EOHHS' satisfaction the Bidder's ability to provide covered services under this Agreement. Members must have access to services that are at least equal to, or better than community norms.

In establishing and maintaining the network, the Bidder considers the following:

- Anticipated enrollment
- Sufficient number of PCPs who accept new members
- Sufficient number of specialized providers to address the needs of those members who require access to specialized behavioral health and substance use disorder services such as Integrated Health Home (IHH), Assertive Community Treatment (ACT), Opioid Treatment Program (OTP), Home Based Therapeutic Services (HBTS), Personal Assistance Services and Supports (PASS), HBTS, PASS, Respite and Evidence Based Practices/Applied Behavioral Analysis (ABA).
- Selective contracting
- Expected utilization of services taking into consideration the characteristics and health care needs of specific populations for which the Bidder will be responsible
- Numbers and types (in terms of training, experience, and specialization) of providers, specifically specialty providers, required to furnish the services contracted for herein
- Numbers of providers who are not accepting new patients
- Geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities
- "Cultural Competency" of providers and office staff. "Cultural Competency" is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.
- "Disability competency" of providers and the physical accessibility of their offices as it relates to the capacity of health professionals and health educators to support the health and wellness of people with disabilities through their knowledge, experience and expertise providing services to children with disabilities.

The provider network consists of a continuum of care required to meet the diverse and often complex needs of members.

The Bidder includes in its network the traditional providers of health care services for RI Medicaid population. These providers include but are not limited to FQHC/RHCs, hospital and school based clinics, Community Mental Health Centers, Home Based Therapeutic Service, as well as private practice practitioners and multi-specialty providers to meet the diverse needs of the population. Bidder ensures that each member has an assigned PCP and offers each member the ability to change this/her PCP. The Bidder makes available to every member a primary care provider, whose office is located within twenty (20) minutes or less travel distance from the member's home.

Bidder understands that those members may transition between network and non-network providers for all covered services. Bidder has policies and procedures to ensure continuity of care when transitions occur.

Bidder maintains a comprehensive network of multi-specialty providers to meet the needs of all members. The network includes but is not limited to primary care, specialists, FQHC/RHC, adult and children's behavioral health, Title X providers, hospital and school based clinics.

Bidder agrees that all of its network providers will accept Medicaid members for treatment and will have policies and procedures for mainstreaming.

The Bidder provides the State quarterly with a list of all its participating providers, including those whose practices are open to additional members. The Bidder notifies the State monthly of any changes in its network's composition and will have procedures to address changes in its network that negatively affect the ability of members to access services.

The Bidder may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

3.2.4.2 Access to Services – Service Accessibility Standards

The Bidder will establish and implement mechanisms to ensure that network providers comply with access and timely appointment availability requirements. Contractor will monitor access and availability standards of the network to determine compliance and take corrective action if there is a failure to comply. Bidder must assure that service accessibility standards are fully in place for persons with special needs. Service accessibility standards include:

- Twenty-Four Hour Coverage

  Bidder shall provide access to medical and behavioral health services either directly or through its PCPs, to Members on a twenty-four (24) hours per day, seven (7) days per week basis. If PCPs are to provide such coverage, Bidder must have a back-up plan for instances where the PCP is not available. Bidder must also have written policies and procedures describing how Members and providers can contact the Bidder to receive instructions for treatment of an emergent or urgent medical problem.

- Travel Time

Bidder shall develop, maintain and monitor a network that is geographically accessible on a timely basis to the population to be served including a PCP, whose office is located within twenty (20) minutes or less travel time from the member's home. Members may, at their discretion, select PCPs located farther from their homes.

- Emergency Medical Services

Pursuant to 42 CFR 438.114, Bidder shall provide or ensure access to Emergency Services which are available twenty-four (24) hours a day and seven (7) days a week, either in Bidder's own facilities or through arrangement, with other providers. Services shall be made available immediately for an emergent medical condition including a mental health or substance use condition. In accordance with 42 CFR 438.114(d)(1)(i), the Bidder may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge; and that determination is binding on the Bidder, as specified in 42 CFR 438.114(b) as responsible for coverage and payment. The provision of emergency services must also conform to the Rhode Island Medicaid Managed Care *Emergency Medical Services Policy*.

Bidder must cover and pay for Emergency Services, as defined herein, regardless of whether the provider that furnishes the services has a contract with the Health Plan. In accordance with 42 CFR 438.114 (d)(1)(ii), Bidder may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's PCP or Health Plan of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services. A Member, who has an emergency medical condition, as defined herein, may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The Bidder may not deny payment for treatment obtained when a representative of the entity instructs the enrollee to seek emergency services. The Federal and State requirements governing emergency services will be provided to Members in a clear, accurate and standardized form at the time of enrollment and annually thereafter.

- Days to Appointment for Non-Emergency Services

Bidder shall make services available within twenty-four (24) hours for treatment of an Urgent Medical Condition including a mental health or substance use condition. Bidder agrees to make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Bidder agrees to make services available within five (5) business days for diagnosis or treatment of a non-emergent, non-urgent mental health or substance use condition.

Appointment	***Access Standard***
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within 24 hours

Routine Care Appointment	Within 30 calendar days
New Member Appointment	30 calendar days
Physical Exam	180 calendar days
EPSDT appointment	Within 6 weeks
Non-emergent, non-urgent mental health or substance use condition	Within ten (10) business days for diagnosis or treatment

- Post-Stabilization Care Services

  Members have the right to receive Post-Stabilization Care Services after they have been stabilized following an admission for an emergency medical condition; provided, however, that the provider of Post-Stabilization Care Services must request prior authorization for those services in accordance with the provisions of this Agreement and a Contractor. Contractor must pay for Post-Stabilization Care Services if (1) Contractor pre-approved such services; (2) Contractor authorizes those services in accordance with the provisions of the Health Plan; (3) Contractor did not respond to the request for prior authorization within one hour of the request; (4) Contractor cannot be contacted; or (5) Contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and the Contractor's physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with the care of the patient until a plan physician is reached or one of the criteria of 42 CFR 422.133(c) is met. The requirements of Federal and State law governing Post-Stabilization Care Services will be provided to Members in clear, accurate, and standardized form at the time of enrollment and annually thereafter.

  The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when (1) a Health Plan physician with privileges at the treating hospital assumes responsibility for the Member's care; (2) a Health Plan physician assumes responsibility for the Member's care through transfer; (3) Contractor's representative and the treating physician reach an agreement concerning the Member's care; or (4) the Member is discharged as specified in 42 CFR 438.114 (e).

  The Contractor must limit charges to enrollees for post-stabilization care services to an amount no greater that what the organization would charge the enrollee if he or she had obtained the services through the Health Plan as indicated in 42 CFR 422.113.

- Access for Women

  Bidder will allow women direct access to a women's health care specialist within the Bidder's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified health care professional. Enrollment in Medicaid Managed Care does not restrict the choice of the provider from whom the person may receive family planning services.

3.2.5 Provision of Covered Services/Benefits

The Contractor must be able to provide the comprehensive benefit package to members covered under this LOI. The comprehensive benefit package includes Medically Necessary inpatient and outpatient hospital services, physician services, behavioral health services (a continuum of care including mental health and substance use disorder services), family planning services, prescription drugs, laboratory, radiology and other diagnostic services, and preventive care.

This benefit package includes virtually all Medicaid covered services with very few "carve outs" facilitating Bidder's ability to advance coordinated health services programs responsive to the individual needs and circumstances of capabilities of member. More than the provision of a defined set of specific services set of services EOHHS is seeking a consumer focused, comprehensive, integrated health program clearly directed to achieving the Triple Aim. Achievement of improved individual and population health outcomes should drive Bidder efforts. Alternative Payment Methodologies provide a vehicle for furthering outcome-based delivery of cost effective health services.

Most of the covered services included in this procurement have long been a part of Rhode Island's Medicaid managed care program, including a comprehensive continuum of behavioral services for children and adults. Within the past year and as part of the Re-inventing Medicaid initiative additional important services have identified as covered services or that have moved from Medicaid fee-for-service to the managed care program. These include:

- Home and Community Services for Children under 21 years of age,
- Integrated Health Home (IHH) and Assertive Community Treatment (ACT) services for adults,
- Services provided through Opioid Treatment Program (OTP) Health Homes
- Gender dysphoria services
- Telehealth services
- HIV case management
- Habilitative Services for persons with Intellectual Development Disabilities

Bidders will be required to demonstrate their ability and readiness to provide both the traditional service package and provide specific assurances of their readiness to provide these additional services.

3.2.6 Care Coordination and Care Management

3.2.6.1 Comprehensive Care Coordination and Care Management

The Bidder is required to ensure that it meets the Care Coordination and Care Management requirements highlighted below.

The Bidder coordinates all covered services, which involves the organizing and marshaling of personnel and other resources needed to carry out all medically necessary activities required by members and is often managed by the exchange of information among participants responsible for the different aspects of care. The State considers interactive communications between the primary medical provider and medical specialists to be an important program objective to ensure that members receive the right care in the right setting.

The Bidder must also coordinate care between the primary care provider (PCP) and other service providers as needed. Contractor should leverage existing provider and community based care management

resources in performing care management program requirements to ensure no duplication, and may also delegate care management responsibilities to network providers including but not limited to patient-centered medical home providers, health homes and community health team.

Bidder shall ensure coordination of care of all covered benefits under this Agreement including those provided for children, adolescents and adults for RIte Care, Rhody Health Partners, and the Affordable Care Act Adult Expansion Populations. Coordination of care includes identification and follow-up of high risk Members, ensuring coordination of services and appropriate referral and follow-up. In particular, Bidder shall ensure coordination between medical services and behavioral health services required by the members.

In reference to Community Health Teams, Bidder is required to coordinate, participate, and collaborate in the enhancement and improvement of Community Health Teams. In reference to the Home Stabilization program, the Bidder is required to refer members identified for home stabilization services to the EOHHS designee for this program. The Bidder will be required to coordinate with the out of plan home stabilization services providers as part of the member's plan of care.

Bidder shall have an EOHHS approved Care Management Plan that addresses the preventive and chronic health care needs of its members, inclusive of behavioral health, social services and supports, and other social determinants that may impact members' health outcomes. The Bidder's strategy should address how it will engage in care management activities in collaboration with members who are at high risk of poor health outcomes due to significant health and social needs and how the Bidder will coordinate its activities with those who also intervene with members, including but not limited to PCPs, CMHOs, Health Homes, and Cedar Family Centers. The Bidder's Care Management Plan should include strategies that focus on, but are not limited to, care management or care coordination needs for members such as (1) adults with complex medical and/or behavioral health needs; (2) Children with Special Health Care Needs (CSHCN); (3) adolescents with special health care needs who are transitioning to adulthood; (4) members experiencing significant changes in their health status or resource needs that will affect health outcomes (i.e., social determinants of health); (5) members receiving home and community based services; (6) members affected by HIV or AIDS; (7) members with needs due to substance use; and (8) members who have been recently discharged from correctional facilities.

In reference to HIV case management, for all Medicaid members, HIV positive; HIV negative; HIV medical; and HIV non-medical case management services shall be considered an in-plan benefit. The Bidder shall ensure that it has a robust provider network to meet the needs of the community. The Bidder shall provide reporting on these services to EOHHS, at a frequency determined by EOHHS. The Bidder shall ensure that all of its contracted providers for this service as in compliance with the State's HIV Targeted Care/Case Management (TCM) Provider Manual and accompanying HIV TCM Toolbox. The Bidder shall also be responsible for monitoring and reporting on quality metrics in reference to these programs. The Bidder shall submit evidence of compliance to this requirement.

To oversee and manage the care management programs for the health plan, Bidder will designate a Program Coordinator. The Program Coordinator will be a licensed professional who shall assure that the Health Risk Assessment (HRA) and appropriate care management activities are completed for each member; for performance of this role the Program Coordinator/Care Manager must be currently licensed by the Rhode Island Department of Health as one of the following: licensed independent clinical social worker, bachelor's or master's prepared registered nurse, or psychologist. The responsibilities of the Program Coordinator/Care Manager as outlined shall be inclusive of behavioral health services; the Care Manager shall assure that behavioral health services are provided in compliance with EOHHS Care Management

protocols and in active coordination with other services provided by Bidder. The Program Coordinator/Care Manager shall ensure that the component elements of care management are completed on a timely basis. The Health Risk Assessment must be completed within ninety (90) days of the Member's enrollment with the Bidder. In such event where Bidder is unable to complete the Health Risk Assessment on a timely basis, Bidder must be able to provide documented evidence that is satisfactory to the EOHHS of bona fide efforts to conduct the Initial Adult Health Screen. In the initial start-up period, the Health Plan has one hundred and eighty (180) days to conduct the HRA of members who become eligible at the beginning of the contract.

For those members for whom they are applicable (1) the Level I Needs Review and Short-Term Care Management must be completed within thirty (30) days of completion of the Health Risk Assessment and (2) the Level II Needs Review and development of the Intensive Care Management plan must be completed within thirty (30) days of either the completion of the Health Risk Assessment or completion of the Level I Needs Review. Contractor shall maintain records to identify Short-Term Care Management and Intensive Care Management activities. For all Members receiving Level II Needs Review, records shall include the resulting Intensive Care Management Plan or documentation of why such a plan is not needed.

Care management plans are to be evaluated and updated as needed while active, but no less frequently than every six (6) months.

Care management is to be performed by Health Plan staff, contracted provider entities, or other subcontractors or agents located in the State of Rhode Island and may be augmented by Health Plan expertise located in other areas. The Bidder's Rhode Island staff will be key for their ability to work closely with local resources (e.g. Cedar Family Center). Face-to-face meetings shall be conducted where appropriate; to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs and out-of-plan services. The Bidder's Program Coordinator (and/or Care Manager) and all their needed support staff shall be located in Rhode Island

3.2.7 Member and Provider Services

3.2.7.1 Member Services

As part of the Member Services function, the Bidder has an ongoing program of member education that takes into account the multi-lingual, multi-cultural nature of the population including any members with limited English proficiency (LEP). In addition, the Bidder's Member Services function should address how the Health Plan will meet the needs of any members with low literacy skills or any members who have disabilities, including but not limited to deafness, being hard of hearing (HOH), or visual impairments.

The Bidder staffs a Member Services function that is operated at least during regular business hours (8 AM to 6 PM EST including lunch, Monday through Friday). The Bidder maintains a toll-free Member Services telephone number that is staffed during regular business hours as defined above.

Once a year, the Bidder notifies members in writing of their rights to request and obtain information about their benefits, freedom of choice regarding provider restrictions, EOHHS's and the health plan's grievance and appeals processes, after hour and emergency coverage, requirement for prior authorization of services, referrals for specialty care, and other information as identified herein.

Contractor must ensure that services are provided in a culturally competent manner to all Members. Specifically, Contractor (1) must give the concerns of Members related to their racial and ethnic minority status full attention beginning with the first contact with a Member continuing throughout the care process, and extending to evaluation of care; (2) must make interpreter services available when language barriers exist and are made known to Contractor, including the use of sign interpreters for Members with hearing impairments and the use of Braille for Members with vision impairments; and (3) as appropriate, should adopt cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its Member population; (4) develop policies and procedures for the provision of language assistance services, which includes but is not limited to interpreter and translation services and effective communication assistance in alternative formats.

3.2.7.2 Provider Services

As part of its Provider Services function, the Bidder has an ongoing program of provider education relating to covered benefits, program requirements, and the needs of members.

Contractor will make available a Provider Relations Representative who will provide face-to-face, facility-based or practice-based assistance and training when necessary. The Provider Relations Representative will be based in Rhode Island (preferably) or in New England and must be readily accessible to meet the needs of providers in a timely manner.

The Bidder maintains a toll-free telephone line and staffs a Provider Services function to be operated at least during regular business hours (8 AM to 6 PM EST including lunch, Monday through Friday).

The Bidder requires providers to report any changes in address or telephone number at least thirty (30) calendar days prior to the change occurring.

The Bidder may not prohibit, or otherwise restrict, a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a member.

3.2.8 Medical Management and Quality Assurance

The Rhode Island Department of Health regulates the Utilization Review and quality assurance, or quality management (UR/QA) functions of all licensed Health Plans. The Bidder, therefore, complies with all Department of Health UR/QA standards, in addition to specific standards described in this section.

3.2.8.1 Medical Director

The Bidder designates a Medical Director responsible for the development, implementation, and review of the internal Quality Assurance Program (QAP). The Medical Director has adequate and appropriate experience in successful QA programs and is given sufficient time and support staff to carry out the health plan's QA functions. The Medical Director shall serve full-time and be a salaried employee of the Bidder. It is anticipated that the Bidder may use assistant or associate Medical Directors to help carry out the responsibilities of this office.

The qualifications and responsibilities of the Medical Director include, but need not be limited to, the following:

- Be licensed to practice medicine in the State of Rhode Island and be board-certified, board-eligible, or trained in his or her field of specialty

    - Be responsible for Bidder's UR and QA Committees, direct the development and the implementation of Bidder's internal Quality Assurance Plan, utilization review activities, and monitor the quality of care that members receive
    - Be responsible for the development of medical practice standards and protocols for Bidder
    - Oversee the investigation of all potential quality of care problems, including but not limited to, member specific occurrences of possible Health Care Acquired Conditions and Other Provider-Preventable conditions in accordance with 42 CFR 447.26, 434, 438, and 1902 (a)(4) 1902 (a)(6), and 1903 and possible hospital acquired conditions and recommend development and implementation of corrective action plans.
    - Be responsible for the development of Bidder's medical policies including the implementation and oversight of evidence-based practice guidelines.
    - Be responsible for the Bidder's referral process for specialty and out-of-plan services
    - Be involved in the Bidder's recruiting and credentialing activities
    - Be involved in the Bidder's process for prior authorizing and denying services
    - Be involved in the development and oversight of the Contractor's disease management programs
    - Be involved in the Bidder's process for ensuring the confidentiality of medical records/client information
    - Be involved in the Contractor's process for ensuring the confidentiality of sexually transmitted infection (STI) appointments and mental health and substance use appointments.
    - Serve as liaison between the Bidder and its providers and communicate regularly with the Bidder's providers, addressing areas of clinical relevance including but not limited to:
    - Bidder's utilization management functions
    - Contractor's prescription and over the counter drug formulary for Medicaid enrollees
    - Health promotion and Disease Management programs offered by the Contractor
    - Any prior authorization (PA) requirements
    - Clinical practice guidelines
    - Quality indicators, such as the Bidder's performance on HEDIS® measures

- Serve as the Bidder's representative on the EOHHS Medical Care Advisory Committee.
- Serve as the Bidder's senior clinical officer participating in the health plan's development of Alternative Payment Methodologies (APM), including any total cost of care and related quality metrics.
- Provide clinical executive leadership as Bidder analyzes the outcomes of quality metrics for any Alternative Payment Methodologies, including Accountable Entities.
- Participate in the development of strategies to educate members about health promotion, disease prevention and efficient and effective use of health care benefits.
- Be available to the Bidder's staff on a daily basis for consultation on referrals, denials, complaints and problem

3.2.8.2 Utilization Review

The Bidder has written policies and procedures to monitor utilization of services by its members and to assure the quality and accessibility of care being provided in its' network. The policies and procedures must: (1) conform to 42 CFR 438.240 and 42 CFR 438.242 (2) assure that the UR and QA Committees meet on a regular schedule, and (3) provide for regular UR/QA reporting to the Health Plan(s)' management and provider network, including profiling of provider utilization patterns.

The policies and procedures include protocols for: denial of services, prior approval, hospital discharge planning, physician profiling, and retrospective review of claims. As part of its utilization review function, the Bidder has processes to identify utilization problems and undertake corrective action. The Bidder has a structured process for the approval or denial of covered services. This includes, in the instance of denials, formal written notification to the member and the requesting or treating provider that includes the basis for the denial, and any applicable appeal rights and procedures including EOHHS level appeal within fourteen (14) days of the request for authorization. The Bidder demonstrates to the EOHHS that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically or functionally necessary services to any member. The Bidder may engage in direct discussions and/or patient or patient family interviews, as necessary, in order to consider treatment options or alternatives, and the like for cost-effective, patient-centered medically necessary care.

The Bidder shall provide analytic evidence to the EOHHS that any medical management techniques used by the Health Plan, such as prior-authorization requirements, which are applied to behavioral health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical/surgical benefits. In accordance with the Mental Healthy Parity Act & Addictive Equity Act of 2008 (MHPAEA, PL. 110-343) and Federal Medicaid managed regulations at 42 CFR 438 Subpart F, the criteria used for medical necessity determinations made for behavioral health or substance use disorder benefits must be made available by the Bidder to Members or network providers upon request."

The Bidder must develop written policies and procedures that cover the language and format of any adverse actions. Written notices must be translated for individuals who speak prevalent non-English languages, based on 42 CFR 438.10(c). The Bidder must ensure that it has a strategy to communicate to Members that notice of actions are available in alternative formats and how to access these formats. For potential qualified new entrants, during the readiness review the EOHHS will analyze the Bidder's UR-related policies and procedures, as well as all templates for notice of action.

Bidder must ensure that all utilization reviews to authorize non-hospital based detoxification services are in conformance with EOHHS requirements. The Bidder must offer all levels of residential substance use treatment and to modify the Health Plan's level of care guidelines for residential substance use treatment to accommodate the special needs of Medicaid managed care enrollees recently discharged from a correctional facility.

The Bidder shall provide evidence that it has established a prior authorization process for Adult Day Health services that conform to the minimum review of standards stipulated by EOHHS.

The Bidder shall accept and honor the authorizations that were made prior to the contract commencement date until the authorization period has ended.

3.2.8.3 Quality Assurance

The Bidder has a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of covered services including all subcontractors. At the direction of the EOHHS, the Bidder will complete four (4) Quality Improvement Projects directed at the need of Medicaid enrolled populations, inclusive of special need populations and programs. The QIPS shall be approved by EOHHS, per year. All QIPs are to be documented on the NCQA Quality Improvement Activity (QIA) form. The Bidder reports the status and results of each project to the State, or its designees, in a format to be outlined by the State, at least within 30 days following presentation to Contractor's Quality Improvement Committee or as otherwise requested by the State.

Bidder agrees to cooperate fully with the State or its designees in any efforts to validate performance improvement projects. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

The Bidder supports joint quality improvement projects involving Medicaid-participating Health Plans and EOHHS.

3.2.8.4 Confidentiality

The Bidder has written policies and procedures for maintaining the confidentiality of data, including medical records/client information so as to conform to HIPAA requirements, including those outlined in 45 CFR Part 160 and 164,Subparts A and E (the HIPAA Privacy and Security Rule)

The Bidder agrees to make available to the State and/or its designees on a periodic basis, medical and other records for review of quality of care and access issues.

3.2.8.5 Practice Guidelines

The Bidder has or will develop or adopt and disseminate practice guidelines that comply with 42 CFR 438.236 and are based on valid and reliable medical evidence or a consensus of health professionals in the particular field, consider the needs of members, are developed in consultation with contracting providers, that are reviewed and updated periodically as appropriate. The Bidder will disseminate the guidelines to all affected providers and, upon request, to members and potential members. Decisions for utilization management, member education, coverage of services, and other areas to which the practice guidelines apply must be consistent with the practice guidelines.

3.2.8.6 Service Provision

The Bidder provides services in the amount, duration, and scope of service in a manner that is expected to achieve the purpose for which the services were provided. The Bidder may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

3.2.8.7 Provider Credentialing

The Bidder has written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State, or state in which the covered service is furnished, and are qualified to perform their services. The Bidder also has written policies and procedures for monitoring its providers and for disciplining providers who are found to be out of compliance with Bidder's medical management standards.

The Bidder has a uniform credentialing and re-credentialing process and ensures that the process complies consistently with State regulations and current NCQA "Standards and Guidelines for Accreditation of Health Plans". For organizational providers, the Bidder must adopt a uniform credentialing and re-credentialing process and that consistently complies with State regulations.

The Bidder does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Bidder agrees not to employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

The Bidder has written policies and procedures that pertain to disclosures by providers. In accordance with 42 CFR Section 455.104, disclosures must be obtained from any provider or disclosing entity at any of the following times: when submitting a provider application, when executing a provider application, upon request during re-validation or re-credentialing process, within thirty-five (35) day of any change in ownership. For the purposes of this section, a disclosing entity is any entity other than an individual practitioner or group of practitioners as defined by 42 CFR 544.101 that is a participating provider in the Bidder's network

Providers must disclose any individual who has ownership (i.e. five percent or more) or interest in the provider that has been convicted of a criminal offense.

The Bidder may refuse to enter into or renew an agreement with a provider if any person: who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program. The Bidder may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure. The Bidder promptly notifies EOHHS of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Bidder's concern about Medicaid program integrity or quality.

The Bidder also promptly notifies EOHHS of any action that it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called, when this action is based on the Bidder's concern about Medicaid program integrity or quality. This includes, but is not limited to, suspension actions and settlement agreements.

3.2.9 Operational Reporting

The Bidder shall comply with all of the reporting requirements established by EOHHS and detailed in the most recent version of the *Managed Care Reporting Calendar and Templates.* If Bidder delegates any responsibilities to a subcontractor or vendor, the Bidder shall ensure that the subcontractor understands and

complies with the established reporting requirements.

Bidder shall submit all reports to EOHHS and other State agencies and delegates in the require format/template and in the timeframes included in the Managed Care Reporting Calendar and Templates. If EOHHS requests any revisions to the reports already submitted, the bidder shall make the changes and re-submit the reports in a format and timeframe indicated by EOHHS.

Bidder will submit all reports electronically and will ensure that all reports are complete and accurate. Reports contain the required information for all lines of business covered in this contract.

As part of its QM/QI program, the Bidder shall review all reports submitted to EOHHS to identify any instances and/or patterns of non-compliance and implement actions to correct instances of non-compliance and to address patterns of non-compliance and identify and implement quality improvement activities to improve performance.

The health plan's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the health plan's CEO or CFO must certify the data. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of the data and the documents submitted to EOHHS. The Bidder complies with standards and operating rules of the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act Requirements (HIPAA).

The Bidder submits person-level records at intervals specified by the State and in a format determined by the State. The health plan submits aggregate data quarterly and no more than ninety (90) days past the end of the reporting quarter and assists EOHHS in its validation of utilization data by making available medical records and a sample of its claims data.

With respect to 837 encounter data report, the Bidder must ensure that they are in compliance with EOHHS guidance document "*Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance"*. The EOHHS' 837 Companion Guide and related business design documents are included as an Appendix to that document and incorporated therein. The State reserves the right to make changes to the guidance and related business documents at any time. Failure to implement changes timely may result in financial sanctions on the Bidder.

The Bidder must participate in regular meetings with the State relating to the 837 processing and must submit reports to the State on 837 processing, at a frequency defined by the State. The Bidder is responsible for monitoring their 837 submissions and subsequent 277CA reports. The Bidder shall submit encounter data to the State monthly, at a minimum. Encounter data should be submitted in an ongoing fashion but no later than 30 days after a close of a month in which the claim was paid. The Bidder is responsible for ensuring that all of their third party administrators (for example, a behavioral health subcontractor) submit data to them in the timeframes stated above as to meet the States' requirements. Financial sanctions may be imposed on the Bidder for failure to submit encounter data timely. The Bidder is solely responsible for ensuring that its third party administrators above are in compliance with the State's requirements. The Contractor must submit accurate and clean encounter data ninety-nine (99%) of the time. The Contractor is responsible for re-submitting any errored off/rejected claims to the State within thirty (30) days of the receipt of the 277CA reports. The Contractor must notify the State ten (10) business days prior to the due date of submissions if the Contractor anticipates a delay in submission/ processing and request an extension.

The State has sole authority for approving or denying any extension requests.

3.2.10 Grievance and Appeals

The State has established a Grievance and Appeals function through which members can seek redress against Health Plans. This system includes a grievance process, an appeals process, and access to the State's Fair Hearing system.

The Bidder must demonstrate that it will comply with the requirements governing the grievance and appeals process requirements as described herein. Specifically, the Bidder must demonstrate that it adjudicates grievances and appeals in a timely and compliant manner and that it monitors the execution of such functions by any of its subcontractors. The Bidder must also demonstrate its ability to analyze the outcomes of grievances, appeals, and Fair Hearings.

Grievance Processes: A grievance is a formal expression of dissatisfaction about any matter other than an "action" as described below. Members may file a grievance with the Bidder either orally or in writing. The Bidder must address each grievance and provide notice in writing, as expeditiously as the Member's health condition requires, within ninety (90) days from the day the Contractor receives the grievance.

Appeal Processes: The Bidder's policies and procedures for processing grievances must permit a provider, acting on behalf of a Member and with the Member's notification, to file an appeal of an action within thirty (30) days from the date of the Health Plan's Notice of Action. An Action means (1) whether or not a service is a covered Service; (2) the denial or limited authorization of a requested service, including the type or level of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, or (6) the failure to act within the prescribed time frame. The time frames for mailing a Notice of Action must comply with 42 CFR 438.404. The Bidder must also notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

For appeals, the Bidder's process must (a) provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date), unless the Member or the provider requests expedited resolution; (b) provide the Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing; (c) provide the Member and his or her representative opportunity, before and during the appeals process, to examine the case file, including clinical records and other documents and records considered during the appeals process (under certain circumstances certain categories of clinical records and other documents may not be available to the Member based on the type of record including but not limited to mental health records); and (d) include, as parties to the appeal, the Member and his or her representative, or the legal representative of a deceased Member's estate.

The Bidder must provide written notice of the disposition of all administrative appeals within thirty (30) calendar days and fifteen (15) calendar days for clinical appeals from the time the Bidder receives the appeal. For notice of an expedited appeal, the Bidder plan must also make reasonable efforts to provide oral notice. The Bidder must continue to provide services during the appeals process if the Member filed for an appeal within ten (10) days of the Notice of Action.

The Bidder must establish and maintain an expedited review process for appeals, when the Health Pan determines (for a request from a Member) or the provider indicates (in making the request on the Member's

behalf or supporting the Member's request) that taking time for a standard resolution could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function.

If the Health Plan takes an action to deny, limit or delay services a member may request, in addition to an External Review through the Rhode Island Department of Health, a State Fair Hearing after the member has exhausted the Bidder's Appeal Process. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member by the Bidder, or by its subcontractor if appeal adjudication functions are conducted by the subcontractor.

3.2.11 Program Integrity and Compliance

The following requirements are core components of EOHHS Program Integrity efforts, which include: (1) the identification and recovery of third-party liabilities (TPL), (2) a mandatory Corporate Compliance Plan, and (3) the prevention, detection, investigation, and reporting of potential fraud, waste, and abuse.

3.2.11.1 Identification and Recovery of Third-Party Liabilities

To ensure the appropriate use of Federal and State funds, Rhode Island's overarching goal is that Medicaid will be the payer of last resort. The Bidder must demonstrate its effective use of technology, including interfaces between the Health Plan's claims processing and clinical management systems to identify other potential sources of third party liability (TPL). The Bidder should describe or otherwise depict with workflows how it: (1) queries data sources to identify potential sources of TPL at the time when a new Member is enrolled and subsequently afterwards at periodic intervals, (2) identifies other potential TPL when adjudicating members' claims (e.g., auto insurers or liability insurers when a claim is related to an accident), (3) notifies the State's Fiscal Intermediary in a timely manner when a source of TPL is identified, and (4) makes efforts to recover funds related to other TPL coverage.

3.2.11.2 Corporate Compliance Program

The Bidder must demonstrate that in accordance with 42 CFR 438.608, the Health Plan has administrative and management arrangements, including a mandatory written Compliance Plan that is based on the "Seven Pillars" of an effective Compliance program and designed to guard against fraud, waste, and abuse. The Bidder must attest that it has a Corporate Compliance Officer and a functioning Corporate Compliance Committee, which are accountable to the Health Plan's Senior Executive. The Bidder must describe: a) the mechanisms used by the Health Plan in establishing its annual Corporate Compliance Plan; and b) how the Compliance Committee analyzes the outcomes of the Corporate Compliance Plan and the effectiveness of the Corporate Compliance Program on an annual basis. The Bidder should provide a chart of the organization to clearly demonstrate that the Corporate Compliance Officer has unimpeded access to the Health Plan's Chief Executive Officer (or its Rhode Island-based Executive Director). The Bidder must describe or depict processes that are used for its oversight and ongoing monitoring of major subcontractors, including but not limited to the Health Plan's pharmacy benefits manager and its behavioral health subcontractor, and contracted vendors.

The Bidder must demonstrate workflows to ensure that the Health Plan: (1) prohibits affiliations with individuals who are debarred from Federal or State program participation, (2) will disclose its ownership and controlling interest within thirty-five (35) days of contract execution, (3) requires providers to disclose

ownership and controlling interest, (4) requires providers to furnish the Federal and State governments full and complete information related to business transactions, within thirty-five (35) days upon request, (5) requires that providers must disclose any individual who has more than five (5) percent interest in the provider who was convicted of a crime, and (6) Reports to EOHHS within ten (10) days any provider removed from the network for quality or program integrity issues.

3.2.11.3 Fraud, Waste, and Abuse

The following requirements are a core component of EOHHS Program Integrity efforts, which include: (1) the identification and recovery of third-party liabilities, (2) a mandatory compliance plan, and (3) the prevention, detection, investigation, and reporting of potential fraud, waste, and abuse. The first two sets of requirements were discussed in the previous section; the following highlights requirements related to fraud, waste, and abuse.

The Health Plan must demonstrate that it has a strategic and robust approach to the prevention, detection, investigation, reporting of potential Medicaid fraud, waste, and abuse to assure that Medicaid funds are appropriately expended. Specifically, the Health Plan:

- Operates a comprehensive program for providing targeted feedback to providers and vendors whose coding, documentation, or billing, although not fraudulent, appears problematic.
- Develops mechanisms for educating members and network providers about the impacts of Medicaid fraud, waste and abuse on overall program costs and on clinical outcomes for enrollees.
- Integrates approaches to processing and investigating leads about possible fraud, waste and abuse, which may be identified from multiple sources, including the health plan's toll-free fraud, waste, and abuse reporting hotline, as well as any calls or written correspondence directed to the Health Plan's customer service, provider relations, utilization management, medical management, or care management departments.
- Employs analytic systems which make use of algorithms to identify: billing for mutually exclusive codes; deviations from time standards; excessive daily billings; excessive diagnostic procedures; outliers in service utilization; provider peer profiling outliers; potential up-coding; potential unbundling; and any services billed after the date of death of the enrollee or the provider.
- Executes systematic processes for conducting special investigations, provider site inspections, and focused clinical record reviews.
- Engages with the fraud, waste and abuse detection and investigations programs operated by the Bidder's subcontractors.
- Demonstrates interfaces between the Bidder's clinical management, provider credentialing, utilization management, compliance, legal, and special investigations units to analyze patterns of apparent over-utilization on the part of providers, vendors, or members.
- Uses a cohesive approach to synthesizing quantitative and qualitative data to determine whether possible Medicaid fraud, waste and abuse have been discovered.
- Makes good faith referrals to EOHHS in a secure, timely, and thorough manner when the Bidder's initial investigation has concluded that there is a suspicion of fraud and abuse on the part of a provider, vendor, or member.

3.2.11.3.1 Electronic Visit Verification

As part of EOHHS program integrity efforts, EOHHS requires implementation of certain initiatives, one

such initiative is EVV.

EVV is a system established to enhance program efficiencies and quality assurance for various in-home and community-based care services administered by EOHHS and the managed care organizations. EVV is an in-home visit scheduling, tracking and billing system that employs controls within the delivery of home based services to ensure client's quality of care.

3.2.12 Security and Confidentiality Requirements

The Bidder must demonstrate that it has a robust and comprehensive program for ensuring compliance with all Federal and State requirements, including those stipulated by Public Law 104-191 (the Health Insurance Portability and Accountability Act of 1992, also referred to as HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, which pertain to privacy and security safeguards for individually identifiable health information. As a Covered Entity as defined by Section 45 CFR 160.163, the Bidder should:

- Demonstrate that it internally assesses its ongoing performance in meeting the requirements of the HIPAA Privacy and Security Rule, as outlined in 45 CFR Part 160 and Subparts A & C of Part 164.
- Administer a series of procedural, technical, and physical controls to protect against the improper use, access to, or disclosure of confidential information, including individually identifiable health information, also referred to as protected health information (PHI).
- Designate a Privacy & Security Officer (or indicate which senior-level administrator has responsibility for the oversight and management of its privacy and security functions).
- Conduct periodic HIPAA Privacy & Security risk analyses as needed.
- Establish, re-evaluate, and update, as warranted, a Security mitigation plan.
- Conduct mandatory privacy and security training for all employees and develop role-focused specialized training for those employees whose work functions may include the collection, analysis, maintenance, storage, and/or transmission of individually identifiable health information.
- Confirm the presence of current Human Resources policies and procedures, which focus on privacy and security, including but not limited to: a) internal investigation processes in the event of suspected privacy and security violations; b) the communication of disciplinary rules to all employees; and c) fair and equitable enforcement standards.
- Demonstrate how it oversees the compliance of its subcontractors with all Federal and State laws and regulations that pertain to the conduct of Business Associates (BAs).
- Outline its policies and procedures regarding the loss or suspected loss of remote computing or telework devices such as laptop computers, PDAs, BlackBerrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and disks.
- Establish and maintain policies and procedures that would be activated without unreasonable delay in the event of a breach of unsecured protected health information, including any breach that involves five hundred (500) or more individuals.
- Have established mechanisms for the authorization and oversight of telework and associated procedures to ensure that confidentiality is not breached.
- Establish workflows and safeguards for the safe destruction of protected health information, including electronic data such as electronic mail, scanners, fax and photocopy machines.

3.2.13 Financial Standards, Record Retention and Compliance

3.2.13.1 Health Plan Financial Standards

The Rhode Island Department of Business Regulation regulates the financial stability of all licensed health plans in Rhode Island. The Bidder agrees to comply with all Rhode Island Department of Business Regulation standards and all requirements described herein.

3.2.13.2 Record Retention

Bidder shall retain the source records relating to services and expenditures covered under the Contract including reports to the State and source information used in preparation of such reports. These records include but are not limited to financial statements, contracts and subcontracts, records relating to quality of care, medical records, and prescription files. Records must be maintained for a minimum of ten (10) years and must have written policies and procedures for storing this information. The Bidder also preserves and maintains all records for a minimum of ten years from expiration of the contract. If records are related to a case in litigation, then these records are retained during litigation and for a period of seven (7) years after the disposition of litigation.

3.3 Model Contract Terms and Conditions

Attachment 3 of the LOI contains the Model Contract for the forthcoming procurement period. Bidders are urged to read the Model Contract carefully and thoroughly. The Model Contract describes the binding requirements between the State and the Contractor. The successful Bidder(s) will be bound to the requirements and capitation rates contained in Attachment 2, the successful Bidder(s) MUST attest to the acceptance of these requirements and capitation rates. Contractors are expected to have policies, procedures and practices that demonstrate compliance with the requirements contained in this Model Contract.

The Bidder is required to meet the Terms and Conditions described in Article III "Contract Terms and Conditions" of the Model Contract which cover (1) the general provisions of the contract, (2) interpretations and disputes including compliance with Federal and State requirements, (3) contract amendments, (4) payments, (5) guarantees, warranties and certifications including "hold harmless" and insurance requirements as well as requirements related to patents and copy write infringement, non-assignment of the contract, clinical laboratory improvement amendments, (6) personnel and staffing requirements, (7) performance standards and damages including requirements related to fraud and abuse, (8) inspection of the work performed and access to information, (9) confidentiality of information, (10) termination of the contract, and (11) other required terms and conditions.

On May 6, 2016, following an extended period of review and public comment on proposed rules, CMS issued its final rule governing Medicaid managed care programs. (Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability). The final rule, as presented, is intended to modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery system. Given the recent date of the release of the Final Rule, the Model Contract does not incorporate all the changes that may be needed to come into compliance with these requirements. Bidder is advised that final contracts pursuant to this LOI will need to be compliant with the Final Rule. For reference, a copy of the Final Rule and associated public comment is included in the Procurement Library for this LOI.

3.3.1 Exception to the Model Contract

Attachment N of the Model Contract (Special Terms and Conditions) sets forth the Risk Share/Gain Share methodology, including the respective (a) corridors in relation to Baseline and (b) health plan and EOHHS shares of gains or expenses. Bidder may opt to propose alternative corridors and/or shares. Should Bidder opt to propose alternative arrangements that would be done in Section 4.17 of the Technical Proposal.

Section 4: Technical Proposal

Narrative and format: The separate technical proposal should address specifically each of the required elements as set forth in this section. Bidder shall respond in the order presented in this LOI. Attachment 1 of this LOI provides a "Technical Proposal Specifications Summary Checklist". The checklist indicates the key elements of the Bidder's proposal as described in this Section 4, Technical Proposal along with points assigned to each section and a suggested number of pages for the Bidder's response, excluding attachments. The Bidder is to complete the last two columns of the checklist by providing the page number(s) on which the Bidder's response to the requirements can be found. The second column from the right pertains to pages in the proposal. The furthest column on the right pertains to attachments.

The bidder will attach the completed checklist to its proposal.

4.1 Letter of Transmittal

Bidder shall submit a letter of transmittal signed by the owner, officer or authorized agent of the firm or organization, acknowledging and accepting the terms and conditions of this LOI, and tendering an offer to the State. The transmittal letter includes statements regarding the following:

1. A statement that the Bidder has read, understands and accepts the conditions and limitations of this LOI
2. A statement that the Cost Proposal and Technical Proposal are effective for 60 days from the date of submission and agree that their proposal remains in effect for an additional 120 days.
3. Identification of any proposed sub-contractor (excluding direct health service providers) arrangements in the proposal with a value of $2 million dollars or more.
4. Any other information that the Bidder may want to convey to the State

4.2 Assurances/Attestations

1. A statement that the Bidder is a corporation or other legal entity and is properly licensed to perform the duties of this contract in Rhode Island or will become so within thirty (30) days of the submission date for this LOI;
2. A statement that the Bidder is or will become accredited by NCQA in Rhode Island as a Medicaid managed care plan within twelve (12) months
3. A statement that the Bidder has read, understands, and accepts the mandatory requirements, responsibilities, and terms and conditions associated with this procurement.
4. A statement that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidder(s).

4.3 Health Plan's Experience, Understanding, and Readiness to Perform

4.3.1 Description of Bidder Organization

Description of Bidder Organization regarding the type of organization and ownership; historical perspective of organization; special Federal and State designation businesses (e.g. small businesses, minority/women owned business and disability business enterprises); size of company, national recognitions; and other information that the Bidder would deem appropriate.

4.3.2 Description of Bidder's Subcontractors

Description of Bidder's subcontractors and their specific roles in assisting the Bidder to meet the performance contracts of this procurement. Subcontractor description should include review of the subcontractors' organization; special Federal and State designation businesses (e.g. small businesses, minority/women owned business and disability business enterprises); size of company, national recognitions; and other information that the Bidder would deem appropriate. Note that the successful Bidder retains full responsibility for meeting all requirements of this procurement.

4.3.3 Bidder's Ability to Provide Medicaid Services as a Health Plan in Rhode Island

Bidder should provide concise description of its ability to provide Medicaid services as a health plan in Rhode Island under a risk-based contract. This should include a concise description of the Bidder's experience providing Medicaid services as a Medicaid managed care plan, if applicable, in other states under a risk-based contract. This description must include information on the Bidder's approaches to serve diverse populations.

4.3.4 Understanding of the RI Environment and Populations Covered

4.3.4.1 Understanding of the RI Environment

Bidder must demonstrate an understanding of, and familiarity with, the RI environment. A successful Bidder will be actively engaged as a member of this health care community. Bidder should display understanding of the conditions surrounding this procurement and knowledge of and experience with the Medicaid population in Rhode Island. If the Bidder is not currently serving as a Medicaid managed care plan in Rhode Island, then the Bidder should also describe its related experience in other states.

4.3.4.2 Populations Covered

Bidder shall demonstrate understanding of populations covered and their characteristics and needs for services.

4.3.5 Understanding of the Programmatic Goals for this Procurement

Bidder shall provide a concise statement of its understanding of the State's programmatic goals for this procurement and its preparedness to advance these goals. Bidder shall also provide a statement of its ability and commitment to meet and/or exceed existing levels of performance in RI managed care.

Bidder shall provide documentation as to its NCQA Quality Compass for Medicaid rankings over the past five years.

4.3.5.1 Bidder's View of the Role of MCO in Advancing the Programmatic Goals for this Procurement

Bidder is further requested to provide its perspective on the role of the MCO in assisting the State in transforming the system of health care in Rhode Island. Bidder might identify what they think they would need from the State in order to be successful in aiding this transition. Bidder might recommend appropriate metrics to help both measure and incent progress.

4.3.6 Readiness

In this section of the LOI Bidder should provide a high-level summary of its readiness to perform and meet the requirements of the contract. The Bidder must describe its ability to be ready to serve members by the state contract commencement date. All Bidders should provide a clear succinct description of their readiness to perform the requirements of this contract and, as applicable, identify any areas of capability that are still being developed and provide realistic timeframes for completion.

EOHHS recognizes that (a) for a potential new entrant into the Rhode Island Medicaid managed care program there may be some areas for which capability is still being developed and (b) for a current participating MCO there may be defined areas of enhanced capability or improvement. If this is the case, Bidder should provide clear statements of Bidder's self-assessment of readiness and identify critical areas and work plans where additional development work is needed to meet requirements. In this Section Bidder should address this issue at a more summary level, highlighting critical areas.

In the subsequent parts of the Technical Proposal, Bidders are asked to describe their procedures and/or plans for meeting the more specific requirements of this procurement. In those sections, Bidders should clearly differentiate between those pieces that are in place as the Bid submission is developed and those that are planned and/or in development. Clearly, EOHHS is seeking to enter into contracts with MCOs that are prepared to serve the enrolled population beginning on February 1, 2017. At the same time, EOHHS will consider strong proposals with substantial evidence of both current development and concrete plans and capability to fully meet all requirements at or close to the projected start of the contract and include a timeline or project work plan that would guide a new entrant's completion of core activities needed to "go live" no later than two months following this effective date.

Note that for any successful Bidder EOHHS shall conduct readiness reviews both to ensure the accuracy of information contained in the Technical Proposal and to ensure Bidder preparedness to perform the requirements of this engagement. Readiness shall be conducted during the tentative award and contract negotiation phase. EOHHS, with approval from the State Purchasing Agent, reserves the right to defer the contract start date for up to two months beyond February 1, 2017. RI EOHHS or their designee will identify to the Bidder areas where EOHHS does not deem Bidder to be ready and able to meet its obligations under the tentative award. EOHHS will provide reasonable opportunity for the Bidder to correct such areas to remedy all deficiencies prior to the contract effective date.

If, for any reason, the Contractor does not fully satisfy RI EOHHS that it is ready and able to perform its obligations under the tentative award prior to the contract start date and RI EOHHS does not agree to

postpone the contract start date or extend the date for full compliance with the with the tentative award, then RI EOHHS may not award a final contract.

4.3.7 Additional Information from Bidder

The Bidder may provide other information it believes is essential to provide value-based quality services to the Medicaid populations.

4.4 Health Plan Licensure and Organizational Requirements

4.4.1 Licensure and Organizational Requirements

Description of how the Bidder meets the Licensure and Organizational requirements in Section 3.2 (Core Requirements) of this LOI. Bidder submits copies of its State Licenses with their response to this LOI. This shall include the Bidder's description of how it meets Utilization Review Requirements.

4.4.2 Accreditation and Quality Standards

The Bidder shall provide documentation that it is accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid managed care organization in Rhode Island, or, otherwise for a newly entering plan:

- The Bidder must submit a PDF copy of its current NCQA accreditation certificate for a Medicaid managed care organization in another State and;
- Submission shall identify the Bidder's NCQA accreditation level
- The Bidder must provide a specific timeline outlining the Bidder's plan to achieve full accreditation within twelve months of the execution of a contract.

Failure to obtain NCQA accreditation by the date specified will result in the suspension of enrollment.

4.4.3 Staffing Capacity and Presence in Rhode Island

The Bidder is required to have the staffing capacity with the appropriate expertise. The Bidder is required to have a Medical Director that meets the requirements as well as an adequate staffing to complete the administrative procedures, develop an organizational structure, maintain a management information system and perform all the functions required under this contract (e.g. program and service development, member enrollment, member services, claims processing, accounting and finance, quality assurance, medical management and utilization review, provider network development and continuing relations, care management, grievance and appeals systems, corporate compliance, and fraud waste and abuse investigations and reporting, etc.).

The Bidder is required to have an office in the Greater Providence area of Rhode Island. The Bidder may perform some administrative functions out-of-state, with the approval of EOHHS, as long as it does not affect the quality, effectiveness, and efficiency of the services or functions performed by the Bidder in the judgment of EOHHS.

A strong presence in Rhode Island is considered essential to effective performance of the requirements of the Medicaid managed care program. Bidder is expected to have an in-state presence to conduct outreach and approved marketing activities within all communities throughout the State and to maintain active and productive provider and member relations.

The Bidder must include an appended organization table and description of the units responsible for administering the elements of the Medicaid managed care program and identify where the respective staff is located.

4.4.4 Health Plan Financial Viability

Bidder must include a clear statement of its acceptance of the State Capitation Rates to be paid for Medicaid enrollees as set forth in Attachment 2 of the LOI. Such acceptance is to be provided as part of Bidder's submission in response to Section 4.2 of this LOI, "Assurances/Attestations". Section 4.2, item #5 requires: "A statement that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidder(s).

Bidders that accept the capitation rates will meet the Cost Proposal requirements of this LOI. Proposal submissions that fail to include a signed attestation of acceptance of the State's Capitation Rates will be deemed non-responsive and will not be considered.

The Bidder must provide evidence that it is financially solvent, has the capital, and has the financial resources and management capability to operate under this procurement's risk-based contract that reimburses the successful Bidder with capitation rates. Bidder shall satisfactorily demonstrate to EOHHS that it is able to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC).

Bidder shall provide a description of financial solvency as a health plan operating in Rhode Island. Documentation to be provided by Bidder shall include:

- Presentation of the company's financial position for the past two years (2014 and 2015) in relation to plan-specific levels of risk-based capital (RBC) and the company's Authorized Control Level. Bidders that may be newly entering the Rhode Island market should provide comparable documentation to demonstrate financial solvency and compliance with Rhode Island requirements.
- Annual NAIC Financial Statements;
- 3rd Quarter 2015 Quarterly NAIC Financial Statement;
- 2014 and 2015 Annual Audited Financial Statements;
- 2014 and 2015 Annual Report to Owners, Shareholders, Members, and Others;
- Company's General Liability and Directors' and Officer's Insurance Coverages;
- Claims Reinsurance Coverage and attachment points;
- Where applicable, evidence that the parent Company provides 100% of subsidiary's financial backing.

Bidder must describe its financial viability (as well as any adverse factors that may affect the Bidder's financial viability including but not limited to bankruptcy proceedings, major lawsuits, fines, etc.).

The Rhode Island Department of Business Regulation regulates the financial stability of all licensed health plans in Rhode Island. The Bidder agrees to comply with all Rhode Island Department of Business Regulation standards.

4.4.5 References

The Bidder must provide three references where the Bidder provided similar services as requested in this LOI, including the Agency, contact person, e-mail address, mailing address, telephone and fax numbers, and a description of the size and scope of the engagement.

4.5 Plan for Meeting Contract Goals for this Procurement and Special Initiatives Requirements

The Bidder must provide a description of its plans for meeting the Special Initiatives Requirements.

4.5.1 Defined, Integrated Programmatic Focus on Population Health

Population health is typically described as the health outcomes of an identified group of individuals, including the distribution of outcomes of subpopulations within the larger population. Over 80% of Medicaid eligible people are enrolled in the Medicaid managed care program. This is a diverse population including many subpopulations of children and adults, persons with complex medical and behavioral health and social needs. A population health approach seeks to maintain and improve the health status of the entire population while systematically identifying those subpopulations with complex needs and implementing strategies to improve their health status and reduce health inequities among population groups. Throughout this LOI EOHHS has worked to include requirements promotive of a population health approach. This includes the emphasis on transition to value based payment arrangements with Accountable Entities, effective communication, meaningful analytic capacity and metrics, integrations of care across disciplines as appropriate, recognition of and strategies to address social determinants of health, care coordination, care management, and others. The multiple actions and interventions of the successful Bidder will display how these components of their program function within a thoughtful and integrated strategy to impact population health. This will include steps to assess current population health status, define targets and where possible, linking payments to those targets.

Bidder will describe its understanding of population health and how principles of a population health approach inform and guide its managed care program. This should include approaches to such components as:

- Measuring population health status and outcomes, including sub-groups within the population
- Identifying baseline measures and targets for health improvement
- Identifying determinants of health outcomes and the identification of strategies for targeted interventions
- How such strategies integrate required components of this procurement and other Bidder developed initiatives combine to represent a comprehensive approach to population health
- Other considerations Bidder may seek to present.

4.5.2Alternative Payment Methodologies and Accountable Entities

Section 2.4.2 of this LOI and delineates the contract requirements for Alternative Payment Methodologies. Implementation of APMs in accord with the guidance provided in "Rhode Island Executive Office of Health and Human Services, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" (included in the Procurement Library for this LOI found at: http://www.eohhs.ri.gov/ReferenceCenter/ImportantLinks.aspx) is a central element in this procurement.

Bidder's submission should demonstrate an understanding of the APM contract goals and requirements. Additionally, Bidder is asked to identify (a) what it considers to be key strategic considerations in advancing the goals of Re-inventing Medicaid in moving from fee-for-service to a value based accountable system of care and (b) to articulate the MCO's approach to advancing these goals through APMs. This should include description of Bidder's strategies to promote effective MCP-APM partnerships with providers.

4.5.1.1 Contracting Arrangements with EOHHS Certified Accountable Entities

Bidder should identify its current contract status with each of the EOHHS certified Accountable Entities highlighting key elements that it views as important to be able to advance the programmatic goals of this procurement. Bidder should provide a concise description of its current and/or planned contract arrangements (differentiating between the two) with both Type 1 and Type 2 Accountable Entities. For each, Bidder should describe the range of services and attributed populations included. Bidder should describe its use of quality scores and their application to any shared savings pool calculations.

Bidder should provide its written plan for monitoring and oversight of the performance of AE subcontractors. Such oversight shall include ensuring compliance with all requirements pertaining to marketing, member communications, and member choice.

4.5.1.2 Description of Contracting Status for Any Other Alternative Payment Methodologies

Bidder should describe any other contracting arrangements it has in place that incorporate Alternative Payment Methodologies. This can include:

- Specialized population APM contracts
- Contracts with Integrated Health Homes
- Other Specialized Population TCOC contract models
- Episode Based Bundled Payments
- Infrastructure based provider incentive arrangements

For each, Bidder should describe the range of services and attributed populations included. Bidder should describe its use of quality scores and their application to any shared savings pool calculations and/or incentive payments.

Bidder should provide its written plan for monitoring and oversight of subcontractors including its plan for monitoring and oversight of the performance of AE subcontractors. Such oversight shall include ensuring compliance with all requirements pertaining to marketing, member communications, and member choice.

4.5.1.3 Submission of Completed Alternative Payment Methodology Reporting Template

Bidders shall submit a completed "Alternative Payment Methodology Reporting Template. This template enables the Bidder to provide a succinct summary of these relationships. The Template is provided as Attachment D to the "Rhode Island Executive Office of Health and Human Services, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" and is available at: http://www.eohhs.ri.gov/ReferenceCenter/ImportantLinks.aspx

4.5.2 Rhode Island Medicaid Health System Transformation Program

Section 2.4.2 of this LOI describes EOHHS' plan for initiation of the Rhode Island Health System Transformation. As a result of this transformation of the Rhode Island Medicaid program (and in partnership with other efforts such as SIM) RI anticipates that by 2022 readmission rates, preventable hospitalizations and ED visits will be significantly decreased; and the balance of long-term care expenditures will shift from institutional to 80 percent community-based.

A core component of this initiative is development of Accountable Entities into mature, multi-provider organizations, capable of coordinating, communicating, and being accountable for each patient's care without significant infrastructure investment. Medicaid is proposing to award performance-based infrastructure funding over the next five years through Health Plans to Medicaid Certified Accountable Entities. The RI Medicaid Health System Transformation Program will support and incentivize the critical transformation of RI's system of care by awarding performance-based infrastructure funding through MCOs to Medicaid Certified Accountable Entities, using a combination of state funds matched with federal Medicaid funds. The program will be implemented in collaboration with contracted MCOs, building on the current Pay for Performance arrangements to operationalize the program. Payments to AEs will be made via the MCOs

In this Section of its submission, Bidder shall affirm its commitment to positive collaboration in this program.

4.5.3 Primary Care Practice Transformation

Primary care practice transformation through the development of PCMHs is a core element of Rhode Island strategies for system transformation. Section 2.4.3 (Primary Care Practice Transformation) of this LOI provides background on the contract requirements for engaging with PCMHs. Bidder shall delineate the status of contracting arrangements with PCMHs as defined in the referenced OHIC documents for adults as well as for children. Bidder shall identify the portion of their respective PCPs are part of a PCMH. Bidder shall describe its contracting arrangements with PCMHs including any shared savings calculations that are used along with the use of quality scores and their impacts on payments. The "Alternative Payment Methodology Presentation Template for Bid Submission" referenced above includes a tab for reporting on contracting with PCMHs that shall be completed as part of the bid submission.

In its description, Bidder should address:

- Contracting arrangements/status with adult PCMH
- Contracting arrangements /status with PCMH-Kids

4.5.4 Alignment with Rhode Island State Innovation Model (SIM)

Healthy Rhode Island"/SIM is a central element of the State's efforts to achieve measurable improvement in health and productivity of all Rhode Islanders, and to achieve better care while decreasing the overall cost of care. Fundamental is transitioning from a disparate and health care provider and payer-centric environment to an organized delivery and payment system that is outcomes-oriented and person-centric. This work is further closely aligned with the Affordability Standards established by the Rhode Island Office of the Health Insurance Commissioner (OHIC). Success in these efforts requires the active engagement of key participants in the health care system including Medicaid managed care organizations. Bidders shall describe their current involvement with SIM activities and their commitment to participating going forward as engaged and positive participants in this work.

4.5.5 CurrentCare

CurrentCare is a secure electronic network that gives authorized medical professionals access to their enrolled patients' most up-to-date protected health information from multiple sources in one place. Through this program, providers have timely access to critical information at the point in time when it can support high quality, informed, and coordinated care. It is a free service for patients and providers that can help reduce fragmentation duplicate testing while supporting proper follow-up and medication management. The State's goal is to maximize the effectiveness in part by maximizing patient participation of CurrentCare. The broader the population of the participation, the better it works in support of high quality care. Signing up for CurrentCare is voluntary on the part of the patient. Almost 50% of all Rhode Islanders have enrolled to this point; however, enrollment of Medicaid members in CurrentCare lags behind that of the state's Rhode Island's population more generally.

Bidders shall describe the efforts they commit to undertake to promote member awareness of the potential benefits of CurrentCare and how members might take steps to enroll.

4.5.6 Movement of Additional Services into Managed Care Contracts

As noted in Section 3.2.2 above, certain additional services previously provided in fee-for-service Medicaid became covered benefits in managed care contracts during state fiscal year 2016. Bidders are asked to address these services in later sections of their proposals.

4.6 Plan for Meeting Member Enrollment and Dis-enrollment Requirements

The Bidder clearly describes its plan for enrolling the Medicaid populations..

As part of its response, the Bidder identifies and describes its capability and its policies, procedures and practices, including the following:

4.6.1 Procedures for Enrollment and Dis-enrollment

Bidder should provide a description of how it will accept and process the State supplied enrollment files, including Policies and Procedures for enrollment transactions. The policies and procedures should address initial connectivity to the state systems, ability to capture enrollments, timing of accepting the transactions, successful acceptance of the transaction into the Bidder's system (including downstream systems such as care management). Please provide a flow chart and/or detailed diagrams for the pathways described above as well as an organizational chart and description of the enrollment unit.

Bidder should include a description of:

- Procedures for processing and monitoring enrollment/dis-enrollment files to ensure members are enrolled/dis-enrolled within the designated timeframe after receiving notification from the State
- How the Bidder will monitor the enrollment process including processing of enrollment files, timely issuing of ID Cards, mailing initial Member materials and Health Risk Assessments for quality assurance,

4.6.2 Processes for New Member Orientation and Providing Information to Members

Bidder should describe its process for mailing notification of health plan enrollment to members including effective date and how to access care within ten (10) calendar days after receiving notification from the State and how Bidder will orient new members.

Bidder should describe:

- How it will determine the most recent and accurate telephone numbers and mailing addresses of its members to maximize its success in contacting and outreaching to members.
- Its success rates in reaching new members for orientation, conducting the HRA.
- Its process and success rates for mailing initial Member materials (or Member Handbook) to members within ten (10) calendar days after receiving notification from the State to engage/educate new members about their about their benefits, how to utilize services in other circumstances, how to register a complaint or file a grievance and advance directives in accordance with Federal and State legal requirements. Bidder should submit a copy of their proposed Member Handbook.
- How it will identify the diverse population characteristics of its members and design member information in a way that is culturally and disability competent appropriate.
- How it will address requests to dis-enroll/change Health Plans.

4.6.3 Assignment of PCP

Bidder should identify its description of process and/or algorithm to be used by the Bidder to identify/assign Primary Care Provider (PCP) to those members who do not select a PCP at time of enrollment. Bidder should address how its assignment algorithm addresses the following requirements including:

- Language needs
- Travel time and distance
- Monitoring to ensure that providers have not exceeded their panel size
- Auto-assignment first to providers in a PCMH practice affiliated with an EOHHS certified Accountable Entity and second to a PCMH not affiliated with an Accountable Entity before auto assigning to non-PCMH providers.
- Provider's ability to comply with the State's specified access standards
- Provider's ability to accommodate persons with disabilities or other special health
- How the assignment logic is structured, in the event of a full panel or access issue, so that the algorithm for auto assignment allows a provider to be skipped until the situation is resolved

Bidder may provide reports on recent PCP auto assignments demonstrating how requirements are applied. Bidder should include a description of how members may change their PCP.

4.6.4 Marketing

Bidder should provide a description of, and the policy and procedure detailing its approach for ensuring its compliance with EOHHS marketing requirements as detailed in "Guidelines for Marketing and Member Communication Materials for Rhode Island's Medicaid Managed Care Programs

4.7 Plan for Meeting Provider Network Requirements and Assuring that Service Accessibility Requirements Are Met

4.7.1 Plan for Meeting Provider Network Requirements

Member access to a robust comprehensive provider network is fundamental to the Medicaid managed care program. The Bidder describes its current provider network and/or plans for network development so as to demonstrate how it addresses the elements described in Section 3.2.4.1 (Provider Network) of this LOI. Specifically, the Bidder will include content in its response to the LOI, which addresses the EOHHS' requirements that have been summarized in Section 4.7.1.1 (Description of the Bidder's Provider Network) through Section 4.7.6 (Plan for Meeting Requirements for Access for Women):

4.7.1.1 Description of the Bidder's Provider Network

This section should include Bidder's description of its contracted provider network. This should be presented in the context of how the Bidder evaluates and monitors its strengths and weaknesses in assessing in determining whether its network is sufficient to provide its members with the full range of covered services for the anticipated members in the service area. This should include consideration of:

- The full continuum of health services for members, including primary, preventive, and tertiary care; family planning and women's health; behavioral health services, including substance use treatment, and services for members with serious and persistent mental illness; specialty and sub-specialty medical and behavioral health care; services for children and adolescents with special health care needs**; imaging and laboratory services; pharmacy and durable medical equipment; vision care; home health care; inpatient hospitals; skilled nursing facilities; rehabilitation facilities; respite services; and ancillary services, including but not limited to physical therapy, speech therapy, and occupational therapy.
- Geographic accessibility
- Cultural diversity and mobility needs of its members
- Essential community providers, including but not limited to a description of the network contracted to provide comprehensive services for members with HIV/AIDS
- As appropriate, Bidder shall identify areas of potential weakness and describe its plans for continuous recruitment and retention of new providers to support ongoing network development and plans to create goal targets for specific numbers of providers in networks.
    - Note that Section 4.8.5 (Behavioral and Substance Use Services) of this LOI is specifically focused on behavioral health services, including Section 4.8.5.1(Mental Health, Substance Use, and Developmental Disability Services for Children) on services for children and Section 4.8.5.2 (Behavioral Health and Substance Use Services for Adults) on services for adults. The Bidder's primary description of behavioral health related services and its

** Note: Detailed review of the continuum of behavioral health and substance use services is to be addressed in Section 4.8.5.

behavioral health provider network should be contained in those sections; however, given the importance of physical health and behavioral health integration, Bidder may opt to highlight related aspects of its plan in this Section 4.7.1.1.

As part of its analysis of its provider network the Bidder shall provide a detailed GeoAccess analysis, including maps and/or charts as appropriate, of its capacity to serve all categories of members. This analysis should address the standards for access to care used by the Bidder to determine network sufficiency. This should include primary care providers, primary care sites, FQHCs, hospitals, maternity care physicians, community mental health centers, other significant traditional providers, others specialty providers, and ancillary services (e.g. PT, OT, speech).

Bidder should provide its HEDIS© 2015 for Medicaid final audited result for the Board Certification (BCR) measure and the corresponding Quality Compass for Medicaid percentages for the following provider specialties:

- Family Medicine
- Internal Medicine
- Pediatricians
- OB/GYN
- Geriatricians
- Other physician specialties.

If the Bidder is not currently participating in Rhode Island's Medicaid managed care program, provide this information for another relevant/regional New England Medicaid market and identify that location.

The Bidder should also include as an attachment to its proposal an electronic file with a complete listing of its comprehensive provider network including names, addresses, town or city, telephone numbers, provider specialties and foreign language(s) spoken (if any), whether the practice is accepting new patients, and accessibility for individuals with mobility disabilities.

4.7.2 Plan for Selective Contracting, as applicable

Bidder should identify any selective contracting approaches it may employ in network development and management in primary care, specialty and/or other services.

4.7.3 Network Management and Relations

Bidder should include:

- Description of how the Bidder maintains accurate and current provider network demographics, frequency of maintenance, and quality of information
- Effective description of how the Bidder will design and implement specific measures to improve provider capability to improve the cost-effectiveness of care,
- Description of how Bidder ensures that its provider network is able to meet the multi-lingual, multi-cultural, and disability needs of its members

- Description of how Bidder monitors compliance with the requirement that no more than fifteen hundred (1,500) Members are assigned to any single PCP in its network. Bidder should identify any circumstances where assignment is approaching that threshold (e.g. 1,200 or more members).
- Policies and procedures for providing necessary services out of network when services are not available in network.
- Policies and procedures regarding transition of care between network and non-network providers (all covered services including medical and behavioral health)
- Bidder should provide a sample Provider Participation Agreement with all applicable attachments; provisions regarding "mainstreaming" provisions shall be included and a copy of Provider Administrative Manual.
- Any policies and procedures regarding any service or billing limitations for certain providers such as Advanced Practice Registered Nurses, Physician's Assistants, Behavioral health providers.
- Description of comprehensive services for members with HIV/AIDS
- Other topics deemed appropriate by the Bidder.

4.7.4 Plan for Meeting Service Accessibility Requirements

Timely access to covered services is a core requirement for this program. The Bidder shall clearly describe how it establishes and implements mechanisms to ensure that network providers comply with access and timely appointment availability requirements. Bidder should identify processes and procedures to monitor access and availability standards of the network to determine compliance and take corrective action if there is a failure to comply. Bidder should identify how it determines that service access is assured for persons with special needs including for example, appropriate equipment for exams for persons in wheelchairs.

Bidder should describe its plan for ensuring that the required service accessibility standards are met. Bidder shall provide evidence:

- That it has established access and benchmarks for all participating providers and for each service accessibility standard;
- That it monitors providers regularly to determine compliance and take corrective action;
- That Policies and Procedures are in place for specific actions taken to determine compliance; this shall include approaches to assuring access for persons with special health needs;
- Processes associated with on-going monitoring and analysis of the accessibility, availability, and adequacy of its provider network, and its plan for submitting all associated reporting to the EOHHS.
- Sample reports of service accessibility monitoring activity, what concerns, if any, about access have been identified and corrective actions that have been taken.

Bidder should, in turn, address:

4.7.4.1 Plan for Meeting Travel Time Requirements

Bidder shall describe how it assures timely access to the population to be served including a PCP, whose office is located within twenty (20) minutes or less travel distance from the member's home. Bidder should identify how travel time is an element in the algorithm for assigning members to a PCP if they have not otherwise made a PCP selection. Note that members may, at their discretion, select PCPs located farther from their homes.

4.7.4.2 Plan for Meeting Service Accessibility Standards for Appointments

The table below sets forth required service accessibility standards as summarized in the table below.

Appointment	***Access Standard***
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
New Member Appointment	30 calendar days
Physical Exam	180 calendar days
EPSDT appointment	Within 6 weeks
Non-emergent, non-urgent mental health or substance use condition	Within ten (10) business days for diagnosis or treatment

Bidder should provide recent reports where it has assessed whether these service accessibility standards are being met and should, in turn, describe its plan to address requirements for:

- Twenty-Four Hour Coverage

Bidder shall describe how it assures access to medical and behavioral health services, either directly or through its PCPs, to Members on a twenty-four (24) hours per day, seven (7) days per week basis. If PCPs are to provide such coverage, Bidder must have a back-up plan for instances where the PCP is not available. Bidder must also have written policies and procedures describing how Members and providers can contact the Bidder to receive instructions for treatment of an emergent or urgent medical problem.

- Emergency Medical Services

Bidder shall describe it plan for complying with requirements for emergency medical services as set forth below.

Pursuant to 42 CFR 438.114, Bidder shall provide or ensure access to Emergency Services which are available twenty-four (24) hours a day and seven (7) days a week, either in Bidder's own facilities or through arrangement with other providers. Services shall be made available immediately for an emergent medical condition including a mental health or substance use condition. In accordance with 42 CFR 438.114(d)(1)(i), the Bidder may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge; and that determination is binding on the Bidder, as specified in 42 CFR 438.114(b) as responsible for coverage and payment.

Bidder must cover and pay for Emergency Services, as defined herein, regardless of whether the provider that furnishes the services has a contract with the Health Plan. In accordance with 42 CFR 438.114 (d)(1)(ii), Bidder may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's PCP or Health Plan of the Member's screening and

treatment within ten (10) calendar days of presentation for emergency services. A Member who has an emergency medical condition, as defined herein, may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The Bidder may not deny payment for treatment obtained when a representative of the entity instructs the enrollee to seek emergency services. The Federal and State requirements governing emergency services will be provided to Members in a clear, accurate and standardized form at the time of enrollment and annually thereafter.

- Days to Appointment for Non-Emergency Services

Bidder shall make services available within twenty-four (24) hours for treatment of an Urgent Medical Condition including a mental health or substance use condition. Bidder agrees to make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days.

- Bidder agrees to make services available within five (5) business days for diagnosis or treatment of a non-emergent, non-urgent mental health or substance use condition.

4.7.5 Plan for Ensuring Access to Post-Stabilization Care Services

Bidder should describe its plan to meet the requirements with regard to Post-Stabilization Care Services. Members have the right to receive Post-Stabilization Care Services after they have been stabilized following an admission for an emergency medical condition; provided, however, that the provider of Post-Stabilization Care Services must request prior authorization for those services. Bidder must pay for Post-Stabilization Care Services if (1) Bidder pre-approved such services; (2) Bidder authorizes those services in accordance with the provisions of the Health Plan; (3) Bidder did not respond to the request for prior authorization within one (1) hour of the request; (4) Bidder cannot be contacted; or (5) Bidder's representative and the treating physician cannot reach an agreement concerning the enrollee's care and the Bidder's physician is not available for consultation. In this situation, the Bidder must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with the care of the patient until a Health Plan physician is reached or one of the criteria of 42 CFR 422.133(c) is met. The requirements of Federal and State law governing Post-Stabilization Care Services will be provided to Members in clear, accurate, and standardized form at the time of enrollment and annually thereafter.

The Bidder's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when (1) a Health Plan physician with privileges at the treating hospital assumes responsibility for the Member's care; (2) a Health Plan physician assumes responsibility for the Member's care through transfer; (3) Bidder's representative and the treating physician reach an agreement concerning the Member's care; or (4) the Member is discharged as specified in 42 CFR 438.114 (e).

4.7.6 Plan for Meeting Requirements for Access for Women

Bidder shall describe how it assures that women have direct access to a women's health care specialist within the Bidder's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified

health care professional. Note that enrollment in Medicaid Managed Care does not restrict the choice of the provider from whom the person may receive family planning services.

4.8 Description of the Plan for Providing Covered Services

4.8.1 Description of Bidder's Overall Plan

The Contractor must be able to provide the comprehensive benefit package to members covered under this Agreement. The comprehensive benefit package includes Medically Necessary inpatient and outpatient hospital services, physician services, behavioral health services (a continuum of care including mental health and substance use services to individuals with SPMI and cognitive limitations), family planning services, prescription drugs, laboratory, radiology and other diagnostic services, and preventive care.

This benefit package includes virtually all Medicaid covered services with very few "carve outs" thereby facilitating the Bidder's ability to advance coordinated health services programs responsive to the individual needs and circumstances. More than the provision of a defined set of specific services set of services EOHHS is seeking a consumer focused, comprehensive, integrated health program clearly directed to achieving the Triple Aim. Achievement of improved individual and population health outcomes should drive Bidder efforts. Alternative Payment Methodologies provide a vehicle for furthering outcome-based delivery of cost effective health services.

This agreement sets forth defining core values for service delivery and identifies covered services. Most of the covered services included in this procurement have long been a part of Rhode Island's Medicaid managed care program. Within the past year and as part of the Re-inventing Medicaid initiative additional important services have been moved from Medicaid fee-for-service to the managed care program. The Bidder will be required to demonstrate their ability and readiness to provide Rhode Island's traditional managed care service package and give specific assurances of their readiness to provide these additional services.

In this section Bidder should provide a clear description of how it will ensure the full range of In-Plan covered services to all of its members, including those with special needs. Bidder description should include (a) its approach to ensuring integration of physical and behavioral health services and (b) how its approach advances the core values for service delivery.

4.8.2 Description of Approach to Certain Services

Bidder's response shall include description of its approach to coverage for:

- Gender Dysphoria
- HIV Case Management

Submission shall include Bidder's internal Policies and Procedures for each of these services.

4.8.3 Translation and Interpreter Services

If Contractor has more than fifty (50) Members who speak a single language other than English as a primary language, Contractor describes how it will make available general written materials, such as its Member

Handbook, in that language. Bidder shall identify the languages for which it has made such arrangements and provide copies of sample materials. If the Bidder is not currently participating in Rhode Island's Medicaid managed care program, then it should provide the templates that it would use to monitor: a) the utilization of translation and interpreter services; and b) the count and distribution (by language spoken) of its non-English speaking members

Bidder is required to make available interpreter services by telephone or in person to ensure that Members are able to communicate with Contractor and its providers and to receive all covered benefits in a timely manner. Members shall have the option of in-person interpreter services, if planned sufficiently in advance according to Contractor policies and procedures.

Bidder shall describe its procedures for provision of these services and provide recent sample reports of the frequency with which such services have been requested and provided.

In addition, Contractor shall describe how it conforms with standards outlined in the Americans with Disabilities Act (ADA) for purposes of communicating with, including about out-of-plan services, and providing accessible services to its visually and hearing impaired, and physically disabled Members, including special equipment (e.g. for exams, weighing of persons in wheel chairs).

4.8.4 Implementation of Requirements for EPSDT

EPSDT provisions are a core requirement for the provision of services to children. The Bidder must provide EPSDT services. EPSDT consists of the following components:

- Screening,
- Diagnosis and treatment
- Tracking, and follow-up
- Outreach.

Bidder shall describe how it will meet and measure performance on each of the requirements. Bidder shall provide sample recent reports on performance in these areas. If the Bidder is not currently participating in Rhode Island's Medicaid managed care program, then it should provide a sample EPSDT performance report from another State in which the Bidder participates in Medicaid managed care.

4.8.5 Behavioral Health and Substance Use Services

High performing comprehensive behavioral health services are critical to an effective delivery system for Medicaid managed care members. Children and adults with co-occurring physical and behavioral health needs are frequently among the highest need, highest cost users. Thirty-day hospital re-admission rates for those admitted with behavioral health as a primary diagnosis are notably high.

EOHHS seeks demonstration that Bidders are able to provide a strong behavioral health service program including strong BH partners, a demonstrated robust continuum of care for children and for adults, effective means of identifying and engaging persons in need of services, clear communication strategies to strengthen integration and promote health and wellness, and the capacity to provide specialized services to children and adults.

The Bidder must be able to provide the comprehensive behavioral health benefit package to members covered under this Agreement:

- Overall description of Bidder's approach to meeting the behavioral health needs of members, including substance use.
- Description of the BH organizational structure and description of Bidder's behavioral partners or subcontractors, including subcontractor arrangements and responsibilities, and the location of those subcontractors.
- Evidence that the Bidder's Behavioral Health Care Subcontractors are appropriately licensed and accredited by the National Committee for Quality Assurance (NCQA), satisfactorily meeting NCQA standards for Accreditation of Managed Behavioral Healthcare Organizations.
- Policies and methodologies designed to improve the use of BH, SUD and DD diversionary services by promoting continuity of care after discharge from ED and Inpatient settings in order to deter further use of such restrictive and costly services.
- Approaches to maximizing physical health and behavioral health integration including substance use and including processes to work with PCPs, Cedar Family Centers, Community Health Teams (CHTs) and other care coordination entities collaboratively to help manage BH, SUD and DD and medical needs across the continuum;
- Identification of Bidder screening and predictive measurement tools/methods used to determine members who are at risk in order to ensure effective diversion and transition between Levels of Care while ensuring timely access to Acute and Intermediate levels of Care.
- Communications with providers
- Policies and Procedures outlining Bidder's approach to:
    - Provide BH, SUD and DD service providers with access to Health Plan Care Managers to facilitate the coordination of medical and behavioral health care;
    - Utilization of screening and data (e.g. inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive modeling to identify members with new health risks and identify for Care Plan Management and to refer for BH, SUD and DD services.
    - Provision of data to BH, SUD and DD providers to support their care management efforts;
    - Oversight of BH, SUD and DD providers to ensure contract terms are being met regarding timely access to behavioral health services and compliance with State regulations/standards;

4.8.5.1 Mental Health, Substance Use and Developmental Disabilities Services for Children

Bidder shall clearly describe its capability to provide mental health, substance use, and disabilities services for children.

4.8.5.1.1 <u>Services for Children</u>: Continuum of Mental Health and Substance Use Services and Developmental Disabilities Services

Bidder describes how it will ensure that it provides all enrolled children a full continuum of mental health and substance use services to address all levels of need. Bidder shall demonstrate that it has a robust network of providers that meet the needs of the members including a mix of CMHCs and community based providers.

4.8.5.1.1.1 Provider Network

Bidder should describe its contracted provider network and how it is sufficient to provide its members with the full range of BH, SUD and DD services for the anticipated members in the service area.

A description of population metrics and other methods the Bidder uses to evaluate the strengths and weaknesses of its provider network to assure it has an adequate number of participating providers in all behavioral health specialties, including substance use, that are geographically accessible, physically accessible, and meet the diverse cultural needs of its members. Bidder should identify pertinent target populations, hours of service (day and/or evening), services that are home or center based, and catchment areas, if applicable.

Metrics should include specific means employed to ensure that service accessibility standards are being met, including results from a recent analysis of service accessibility.

The Bidder will also describe its plans for a continuous recruitment and retention of new providers, plans for ongoing network development, and plans to create goal targets for specific numbers of providers in networks.

Description of any selective contracting approaches Bidder employs in network development and management,

Description of how Bidder ensures that its provider network is able to meet the multi-lingual, multi-cultural, and disability needs of its members

Policies and procedures for providing necessary services out of network when services are not available in network.

The Bidder should include as an attachment to its proposal an electronic file with a complete listing of its comprehensive provider network including names, addresses, town or city, telephone numbers, provider specialties and foreign language(s) spoken (if any), accepting new patients and any other limitations, handicap accessibility. The Bidder shall provide a detailed GeoAccess analysis that demonstrates that the network is sufficiently robust and assures timely access to all covered services for all members based on providers who are currently accepting new patients. The analysis shall identify the standards for access to care used by the Bidder to determine network sufficiency.

Bidder should address:

Acute Services

- Evidence of the availability of the following mental health services for children:
  - Emergency/Crisis Intervention
  - Observation/Crisis Stabilization/Holding Bed
  - Inpatient Acute
  - Residential Treatment

Substance use Services

- Evidence of the availability of the following substance use services for children:

- Residential Treatment
- Outpatient/ Intermediate Services

Outpatient Mental Health Services

- Evidence of the availability of the following outpatient mental health services for children:
  - Traditional Outpatient Services
    - Diagnostic evaluation
    - Developmental evaluations
    - Psychological testing
    - Individual therapy
    - Family therapy
    - Group therapy
    - Specialty Group therapy (Special populations)
    - Medication management

Intermediate Mental Health Services

- Evidence of the availability of the following intermediate mental health services for children:
  - Partial Hospitalization
  - Day/Evening treatment
  - Intensive Outpatient treatment (IOP)
  - Enhanced Outpatient Service

4.8.5.1.1.2 Utilization Management and Level of Care Determination

The Bidder should provide a description of utilization management for BH, SUD and DD services, including:

- Admission criteria
- Continuing stay criteria
- Discharge criteria
- Procedures for assessment and utilization of level of care tools
- Procedures for ensuring appropriate transition between service levels of care including but not limited to: Inpatient to Outpatient; Out of Network to In Network (vice versa); more intensive to less intensive services.

4.8.5.1.1.3 Plan for Early Identification and Ensuring Timely Access, Availability, Referral And Triage.

The Bidder should describe its policy and methodology for:

- Promoting access to care and early identification of BH, SUD and DD services
- Identifying members and developing discharge plans for those members who may be in an inpatient setting and who will require outpatient services facilitating and following discharge.
- Identifying members at risk of an inpatient setting.
- Permitting members to self-refer for in-network BH, SUD and DD services

- Ensuring performance criteria for timely access, availability, referral and triage that meet and/or-exceed NCQA standards.

4.8.5.1.1.4 Communication Plan

Bidder shall describe its communication plan, including timeline and materials, for conducting outreach and education to promote effective awareness, utilization and timely accessing of behavioral health services to the following:

- Advocates
- Members (particularly BH specific members and CSHCN)
- Behavioral Health Providers
- Adult & Children Health Homes
- Primary Care Physicians
- Specialty Providers

4.8.5.1.2 Home and Community Based Services for Individuals under Age 21 Years of Age

Effective January 1, 2016 EOHHS moved into managed care certain services for children with complex health needs that had previously been provided through the fee-for-service system. This action is intended to integrate all home and community based services for children and adolescents in an effort to meet Rhode Island's goals of the Triple Aim and to provide continuity and appropriate service delivery to children and their families. It is intended that the Bidder will further expand the service array available for children enrolled in the Bidder's Health Plan and fully manage the health care of the whole child within the context of their families. The Bidder will provide these services to any Medicaid member under age 21, per Federal EPSDT regulation. Services are not specific to any particular product line or population but are intended to meet the needs of children with serious or chronic health needs to attain their fullest potential and to remain as independent as possible within their communities.

Bidder shall describe its plan for meeting the requirements of Home and Community Based Services for Individuals under Age 21 Years of Age for the provision of:

- Home Based Therapeutic Services
- Evidence Based Practices
- Adolescent Residential Substance Use Treatment
- Personal Assistance Services and Supports (PASS)
- Respite

4.8.5.2 Services for Adults: Behavioral Health and Substance Use Services for Adults

Contractor commits to providing all Medicaid managed care adults a full continuum of mental health and substance use services. Contractor's services will address all levels of need. Contractor shall have a robust network of providers that meet the needs of the community. Providers should be a mix of CMHCs and community based providers. All services should be provided to any adult member, as needed.

4.8.5.2.1 Continuum of Behavioral Health and Substance Use Services for Adults

Bidder describes how it will ensure that it provides all enrolled adults a full continuum of mental health and substance use services to address all levels of need. Bidder shall demonstrate that it has a robust network of providers that meet the needs of the members including a mix of CMHCs and community based providers.

4.8.5.2.1.1 Provider Network

The Bidder should provide a description of its contracted provider network and how it is sufficient to provide its members with the full range of BH, SUD and DD services for the anticipated members in the service area. This should include:

- A description of population metrics and other methods the Bidder uses to evaluate the strengths and weaknesses of its provider network to assure it has an adequate number of participating providers in all behavioral health specialties that are geographically accessible, physically accessible, and meet the diverse cultural needs of its members. Bidder should identify pertinent target populations, hours of service (day and/or evening), services that are home or center based, and catchment areas, if applicable.
- Metrics should include specific means employed to ensure that service accessibility standards are being met, including results from a recent analysis of service accessibility.
- The Bidder will also describe its plans for a continuous recruitment and retention of new providers, plans for ongoing network development, and plans to create goal targets for specific numbers of providers in networks.
- Description of any selective contracting approaches Bidder employs in network development and management,
- Description of how Bidder ensures that its provider network is able to meet the multi-lingual, multi-cultural, and disability needs of its members
- Policies and procedures for providing necessary services out of network when services are not available in network.

The Bidder should include as an attachment to its proposal an electronic file with a complete listing of its comprehensive provider network including names, addresses, town or city, telephone numbers, provider specialties and foreign language(s) spoken (if any), whether the provider or practice is accepting new patients, and accessibility for individuals with mobility disabilities. The Bidder's shall provide a detailed Geo Access analysis that demonstrates that the network is sufficiently robust and assures timely access to all covered services for all members based on providers who are currently accepting new patients. The analysis shall identify the standards for access to care used by the Bidder to determine network sufficiency.

Bidder should address:

Acute Services

- Evidence of the availability of the following mental health services for adults:
  - Emergency /Crisis Intervention
  - Observation/Crisis Stabilization/Holding Bed
  - Inpatient Acute
  - Inpatient Detoxification (ASAM Level 4.0)
  - Acute Crisis Stabilization Unit
  - Inpatient (non-hospital) detoxification (ASAM Level 3.7)

- Substance Use Services Evidence of the availability of the following substance use services for adults:
  - ASAM Level 3.5 Clinically Managed High - Intensity Residential
  - ASAM Level 3.3 Short- Term Clinically Managed - Medium Intensity Residential
  - ASAM Level 3.1 Clinically Managed Low - Intensity Residential Services

- Evidence of the availability of the following intermediate/outpatient substance use disorder services for adults:
  - Partial Hospitalization
  - Day/Evening
  - Intensive Outpatient treatment (IOP)
  - Enhanced Outpatient Services
  - General outpatient
  - Medication Assisted Treatment including Methadone Maintenance and Suboxone treatment.

- Evidence of the availability of the following intermediate/outpatient mental health services for adults:
  - Partial hospitalization
  - Day/evening
  - Intensive Outpatient treatment (IOP)
  - Enhance Outpatient Services
    - Assertive Community Treatment (ACT)
    - Integrated Health Home (IHH)
  - Clubhouse
  - Integrated Dual Diagnosis Treatment for substance use disorders
  - General Outpatient
  - Mental Health Psychiatric Rehabilitative Residence (MHPRR)
  - Supervised apartments

4.8.5.2.1.2 Utilization Management and Level of Care Determination

The Bidder should provide a description of utilization management san of appeals process for BH and SUD services. Use of ASAM is expected as an element of utilization management. Description should include:

- Admission criteria
- Continuing stay criteria
- Discharge criteria
- Procedures for assessment and utilization of level of care tools
- Procedures for ensuring appropriate transition between service levels of care including but not limited to: Inpatient to Outpatient; Out of Network to In Network (vice versa); more intensive to less intensive services.

4.8.5.2.1.3 Plan for Early Identification and Ensuring Timely Access, Availability, Referral And Triage.

Bidder will describe its policy and methodology for:

- Promoting access to care and early identification of BH and SUD and services
- Identifying members and developing discharge plans for those members who may be in an inpatient setting and who will require outpatient services facilitating and following discharge
- Identifying members at risk of an inpatient setting.
- Permitting members to self-refer for in-network BH and SUD services
- Ensuring performance criteria for timely access, availability, referral and triage that meet and/or exceed NCQA standards.

4.8.5.2.1.4 Communication Plan

Bidder shall describe its communication plan, including timeline and materials, for conducting outreach and education to promote effective awareness, utilization and timely accessing of behavioral health services to the following:

- Advocates
- Members (particularly BH specific members)
- Behavioral Health Providers
- Adult Health Homes
- Primary Care Physicians
- Specialty Providers

4.8.5.2.2 Integrated Health Home (IHH) and the Assertive Community Treatment Programs (ACT)

Effective January 1, 2016 EOHHS moved into managed care certain services for adults with serious mental illness that had previously been provided through the fee-for-service system. Specifically, this refers to the Integrated Health Home Program (IHH) and the Assertive Community Treatment Programs (ACT). These services are specific to members with serious mental illness. Adults with serious mental illness require specialized programs that deliver recovery-oriented care, addressing all clinical needs both behavioral and medical. These specialized programs are responsible for ensuring integration of care that includes coordinating the recipient's comprehensive health care needs including physical health, mental health, substance use and social supports. The performance of these programs will be measured and the goal is improved access to high quality community based services and decreased costs.

Bidder shall describe its plan for meeting the requirements for the provision of Assertive Community Treatment (ACT) services and Integrated Health Home (IHH) Services.

Bidder should describe:

- The status of its contracting arrangements with each of the IHH and ACT providers, including description of reimbursement arrangements
- Its plan for communication with CMHOs to facilitate the coordination of medical and behavioral health care

- Its plan for using utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with CMHOs.
- Its plan for adhering to the withhold payout requirements based on a reporting calendar

4.8.5.2.3 Opioid Treatment Program Health Home Program

The Opioid Treatment Program (OTP) Health Home (HH) initiative is a state-wide collaborative model designed to decrease stigma and discrimination, monitor chronic conditions, enhance coordination of physical care and treatment for opioid dependence, and promote wellness, self-care, and recovery through preventive and educational services. It is the fixed point of responsibility in the provision of person centered care; providing timely post-discharge follow-up, and improving consumer health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers. The Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) licenses Opiate Treatment Programs and OTP Health Homes.

The services of Opioid Health Homes are included as "in-plan" services. Bidder should affirm participation of certified providers in its provider network and describe referral and treatment arrangements for members as part of its continuum of care.

Bidder should briefly describe its (1) understanding of the OTP HH program and (2) its current contracting arrangements including a status report of contracts with licensed OTP health homes.

4.8.5.2.4 Habilitative Services for persons with Intellectual and Developmental Disabilities

Habilitative services for persons with Intellectual and Developmental Disabilities are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs. Habilitation services also include personal care, physical, occupational, or speech therapy and focus on enabling the member to attain or maintain his or her maximum potential.

The Bidder will describe their understanding of the purpose and intended outcome of Habilitative services. The Bidder will describe its plan for how they will how they will approach authorization for these services.

4.9 Plan for Care Coordination and Care Management

4.9.1 Overall Plan for Care Coordination and Care Management

In this Section the Bidder will describe its plan for care coordination, care management, Coordination with Out-of-Plan Services and Other Health/Social Services available to members, Care Management Protocols for all members and Communities of Care.

High performing care coordination and care management are fundamental to the added value the EOHHS seeks through its contracting arrangements with Medicaid managed care organizations. Bidder will identify its approach to implementation of effective care coordination and care management for its members to optimize individual and population health status and outcomes. It is essential that members know and understand their covered benefits and how to access them. Care coordination will assist in navigating a complex system of multiple service providers. Effective health assessments and risk profiling will aid in organizing and directing efforts according to need and opportunity. For the "community well" the focus would be on promoting an ongoing program of preventive care and being sensitive to any changes that may call for an increase in care. For those with emerging needs, key is an early identification of rising need to maximize the opportunity for timey interventions. For the highest need populations with complex and unique health and social needs in particular, care management programs can be critical to preventing avoidable hospitalizations, emergency department visits, promoting safe transitions, coordinating multiple courses of treatment, facilitating effective self/home care, etc. The care coordination and care management requirements emphasize various elements of care management programs including designated program staff, the conduct of Health Risk Assessments, development of person centered and strength based care plans, assurance of member involvement, clear attention to social determinants of health and management of health conditions, outreach to members, client engagement strategies, process flows, and IT tools being used to ensure effective management, monitoring and tracking of care coordination and care management programs.

The contractual requirements for strong care coordination and care management programs are not the same as saying that the MCO must be the performing party for all of the involved tasks. There is widespread agreement that the most effective care management programs, particularly for those at greatest risk, are high touch, culturally sensitive, well organized, attentive and responsive to real time events, and occurring closest to a point of regular contact and care with the member. As the prime contractor for its membership, the MCO has overall responsibility for meeting the needs of members. At the same time, many members may be directly engaged with providers in an Accountable Entity, a patient centered medical home (PCMH), Community Health Teams, additional contractors or community agencies, and/or providers that have an active and coordinated engagement with members. The Bidders care coordination and care management program must ensure that all the requirements herein are met for all members; it is not necessary that they be met in the identical manner.

In the subsections below Bidder is asked to address several elements of its plan for care coordination and care management.

In the subsections Bidder should, in turn, describe how these special provisions for children with special health care needs and for adults in Rhody Health Partners are linked with or coordinated with care coordination and care management activities for the membership as a whole. In Subsection 4.9.1.8 the Bidder is asked to provide a specific description of its Communities of Care program. If the Bidder is not currently participating in Rhode Island's Medicaid managed care program, then it should describe its proposed project management plan, including timeline, for the implementation of Communities of Care. In its program descriptions Bidder should clearly identify the respective roles and responsibilities that are performed directly and those performed by providers or other parties and, if provided externally, how Bidder tracks care management performance and compliance with contract requirements.

The Care Coordination and Care Management Plan shall describe the program including but not limited to the policies, procedures, practices and criteria for conducting Health Risk Assessments, providing care management and care coordination services.

4.9.1.1 Bidder's Description of the Structure of its Overall Program

Bidder provides an overview description of its structure and plan for care coordination and care management inclusive of key components of each program, type of service provided, roles and responsibility of staff involved in the provision of each services and how members will be identified for care coordination versus care management. To facilitate review and understanding of the Bidder's program, Bidder may provide representative reports used for activities described in the sections below.

Bidder's description should include:

- Bidder's plan for care coordination
    - Description of care coordination function
    - Key activities and performance expectations
- Bidder's plan for care management
    - Descriptions should address staffing models and staff loading. As appropriate, this should address specific care coordination or care management programs utilized for physical health, behavioral health, and any specialized programs Bidder may have.
    - Contractual relationships, if any, that support the contractor's ability to coordinate care, including information sharing and care planning, for a member among multiple providers. Description of contractor(s) and role.
    - The projected number of members that would be engaged in active care management based on the Bidder's current experience in Rhode Island or in another state's Medicaid managed care program. The Bidder description should include identification of the percent and/or number of members engaged in active care management, either (a) by direct MCO staff or contracted agencies or (b) in known/identified relationships with community providers.

4.9.1.2 Care Plan Development

Bidder should describe its approach to care plan development. Bidder should:

- Describe care plan development including delineation of the main components of the care plan and the process for developing the care plan.
- Identify how shared decision is incorporated into care plan development and how principles of person –centered and strength-based planning help to guide this process.
- Describe the process by which a Member (or the Member's parent or guardian) can request to inspect or have changes made to a plan of care.
- For adolescent-aged members with special health care needs, describe how guidance will be offered to these individuals prior to their transition to programs for adults.
- Bidder should describe who leads the development and implementation of the member's care plan and the role of the member's provider, how a member would alter or make modifications to their plan.
- For persons returning to a community setting the Bidder shall provide shall have policies and procedures that address transitions of care and discharge planning activities, ensuring all members

have the appropriate medical, social and behavioral health needs met when they are back in the community.

4.9.1.3 Risk Stratification Tools and Workflows for the Identification of Members with High Needs

- The Bidder is expected to implement an HRA that determines the specific needs for access to services and/or continuity of care that would address whether the member's need is at the care coordination level and/or if other risk factors are present that would indicate the need for care management. Bidder should describe how it currently uses a HRA. Bidder should address such issues as: Is the HRA used to identify at risk and/or high risk members? Is the HRA based on validated evidence based tools? What domains are included? How is the HRA to be used to help assess health, behavioral health and social needs of member? Is the HRA methodology one that has been developed by the Bidder or is it one that has been developed by an external source? If the latter, please provide the name of that organization.
- In addition to the HRA, Bidder should describe any other tools or methods such as predictive modeling, provider communications, or other means used to identify at risk, emerging risk, and high-risk children and adults.
- When at risk or high risk children or adults are identified, Bidder should describe how that is data used to inform care and the delivery of services, how that data is put into action.
    - This should include specific actions for children or adults at risk of admission or re-admission to the hospital and/or other institutional settings
    - Bidder should identify any methods specifically in place for children and adults with co-occurring medical and behavioral health needs

4.9.1.4 Coordination with Provider and Community Based Care Management Resources

Bidder should describe the following:

- Its methodology for identifying members in need of care management/care coordination who are already connected with an outside care management resource (such as Accountable Entities, CHT, PCMH or CMHO).
- How its care management system employs and/or collaborates with community and provider based care coordinators and care managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a member. This should address coordination processes with:
    - Accountable Entities
    - Patient Centered Medical Homes, including PCMH-Kids
    - Cedar Family Centers
    - Community Health Teams
    - Integrated Health Homes/Community Mental Health Centers
    - OTP Health Homes
    - Other

- Its procedures for communication with providers to provide timely and actionable data reporting including data system capabilities of information that can be shared and corresponding time frames. Also, include how information will be sent to providers (e.g. pushed data through secure email or uploaded to portal for provider download).

4.9.1.5 Physical Health-Behavioral Health Integration

Bidder should describe how the Bidder will support and facilitate the integration and coordination of services between behavioral and medical services, including coordination and collaboration with Cedar Family Centers, CMHOs, and agencies such as DCYF and BHDDH.

4.9.1.6 Coordination with Out-of-Plan Health/Social Services, Social Determinants of Health and Housing Stabilization

EOHHS supports various special service programs targeted to persons who may be covered by RIte Care or Rhody Health Partners. The Bidder is not obligated to provide or pay for any non-plan, non-capitated services. However, these services can be essential to overall health and well-being and to assuring optimum outcome of clinical services. Bidder should help to ensure Member awareness of these services and, as appropriate develop policies and procedures to guide coordination of its in-plan and other service delivery with services delivered outside of the Health Plan. EOHHS expects that Bidder Care Plans and Care Management will promote and coordinate such services to promote best outcomes.

- Multiple services are available through programs sponsored by BHDDH, DCYF, DOH, DHS, Special Education, and others. Bidder should describe its plan for ensuring successful referrals and collaboration of out-of-plan services and other locally based social services that help people address the social determinants of poor health (e.g. a need for stable access to food, treatment for chemical dependency).
- Bidder should describe its plan to identify the manner that social determinants inform its care management strategy and how care plans incorporate strategies to mitigate the impact of social determinants of health. This should include, for example, issues related to housing stabilization and services for adults returning to the community upon release from the Department of Corrections.
- EOHHS supports a housing stabilization program that provides sheltering to those for whom homelessness is unavoidable, and rapidly re-houses the homeless in stable, permanent housing. The Bidder shall describe its policies and procedures for identifying and connecting at-risk members with physical health, behavioral health, and other social support needs to the housing stabilization program. As appropriate, the Bidder should also describe its plan for ensuring coordination between its efforts and those of its subcontractors (including but not limited to Accountable Entities (AEs), Cedar Family Centers, Integrated Health Homes (IHHs), Community Mental Health Centers (CMHCs), Patient Centered Medical Homes (PCMHs), and the health plan's behavioral health subcontractor.

4.9.1.7 Outreach and Engagement

Key to improving health outcome and reducing costs is the ability to successfully reach and connect with those members who could benefit from services but who are difficult to reach. Additionally, recognizing and seeking to mitigate the impacts of social determinants of health can be critical to managing chronic health conditions, improving outcomes, and reducing costs.

- Bidder should describe its outreach strategies to maximize its ability to connect with hard-to-reach members, people who have missed key preventive screenings or post-discharge appointments, and persons recently released from corrections.
- Describe how the Bidder will ensure the linguistic and cultural needs of a member are met from a HRA and care management perspective and how language and culture shape Bidder's member engagement strategy. Bidder should identify metrics used and its level of success with engagement strategies and/or use of social media.

4.9.1.8 Process Flows and Data Systems

To provide a systematic view of its care management processes Bidder should provide:

- Description/diagram of the process flows depicting Bidder's care management systems.
- Describe data systems and IT tools that are used to support care coordination, care management, and care transition work.
- Identify key metrics used by Bidder to monitor and track performance, including a sample of a recent representative report.

4.9.1.9 Description of the Communities of Care Program

Bidder should describe its plan for meeting the Communities of Care requirements. These include:

- Identification for Enrollment in Communities of Care
- Health Service Utilization Profile
- Assignment to Pharmacy Home Program (i.e. "Lock-In") when warranted
- Care Management and/or Peer Navigator Components
    - Outreach and Engagement
    - Coordination with Bidder's Care management program
    - Coordination with care manager at physician/clinical care site
    - Coordination with Peer Navigator
    - Individualized Care Plan
- Integrated Pain Management Program for Communities of Care Members
    - Identification, stratification, outreach and assessment
    - Holistic nurse services and Care Plan Development
    - Coverage of Complementary Alternative Medicine /services

4.10 Plan for Providing Member and Provider Services

The Bidder clearly describes its plan for providing member and provider services.

4.10.1 Member Services

The Bidder will describe how it meets the requirements to provide multi-lingual, culturally competent and disability-centric member services:

- Staffs a Member Services function that is operated at least during regular business hours (8 AM to 6 PM EST including lunch, Monday through Friday)
- Maintain a toll-free Member Services telephone number that is staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and on weekends.
- Ensure TYY/TDD services and foreign language interpretation are available when needed by a Member who calls the Member Services telephone number.
- Notify members in writing at least once annually of their rights to request and obtain information about their benefits, freedom of choice regarding provider restrictions, State's and the health plan's grievance and appeals processes, after hour and emergency coverage, requirement for prior authorization of services, referrals for specialty car.
- Bidder should provide evidence (e.g., staff training and monitoring, policies and procedures, and any other processes) of active efforts to promote cultural competence to ensure that services are provided in a culturally competent manner to all Members including (1) giving the concerns of Members related to their racial and ethnic minority status full attention beginning with the first contact with a Member, continuing throughout the care process, and extending to evaluation of care; (2) making interpreter services available when language barriers exist and are made known to Contractor, including the use of sign interpreters for Members with hearing impairments and the use of Braille for Members with vision impairments; and (3) as appropriate, adopting cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its Member population. Bidder should provide evidence (e.g. staff training and monitoring, Policies and Procedures, other) of active efforts to promote cultural competence.

4.10.2 Provider Services

The Bidder will describe how it meets requirements to have an ongoing program of provider education concerning the Medicaid Managed Care benefits and the needs of the Member population covered under managed care program. The provider education program shall include a quarterly provider newsletter and shall submit a proposed template for its Provider Manual.

Bidders shall describe its approach to making available a Provider Relations Representative who will provide face-to-face, facility-based or practice-based assistance and training when necessary who is readily accessible to meet the needs of providers in a timely manner. Bidder shall identify if Provider Relations representative are located in Rhode Island. Bidder shall demonstrate that it maintains a toll-free telephone line and staffs a Provider Services function operated at least during regular business hours (8 AM to 6 PM EST including lunch, Monday through Friday).

4.11 Plan for Conducting Medical Management and Quality Assurance Efforts

The Bidder should clearly describe its plan for meeting medical management and quality assurance requirements as described in Section 3.2.8 (Medical Management and Quality Assurance) of this LOI. Specifically, the Bidder should provide a description, workflow, or depiction for each of the following:

4.11.1 Office of the Medical Director

The bidder should describe the following:

- The structure and functions of the Office of the Medical Director and address the ways the Office supports the functions.
- The background and experience of the Medical Director and any Assistant or Associate Medical Directors as well as their role and responsibilities. The Bidder should attach the Medical Director's resume and his/her job description to its proposal as an attachment.
- The role played by the Office of the Medical Director in the health plan's development of Alternative Payment Methodologies (APM), including any total cost of care and related quality metrics.
- The structure and staffing of its Quality Management department inclusive of the quality management plan and monitoring protocols to assure quality of care and access to services across all delivery areas, including subcontractors

4.11.2 Utilization Review

The bidder should describe the following:

- Its Utilization Review procedures identifying how they comply with 42 CFR 438.350, describe the activities and meeting schedule of the UR and QA Committees, and identify the way that regular UR/QA reporting is provided to health plan's management and providers. Policies and Procedures should be included.
- Its processes review related to medical, behavioral, and pharmacy services including communications to members and treating providers.
- For a recent representative period, the Bidder should provide sample reports, which are used to monitor the volume and type of utilization reviews and the turn-around times for response and resolution.

4.11.3 Quality Assurance and Quality Improvement

The bidder should describe the following:

- Demonstrate that it has a written and active quality assurance program that monitors, assures, and improves the quality of care delivered over a wide range of services.
- Include a description of the specific strategies, programs and practices to assure quality of care, including a plan for developing and implementing measurement tools to measure access to care, average wait times for appointments, and access to primary and specialty care for children with special needs (CSHCNs), individuals who are newly released from correctional institutions, and adults with serious and persistent mental illness.
- Describe how the Bidder utilizes claims data, HEDIS®/CAHPS outcomes and various data analytic tools to monitor utilization and outcomes of care and how the Bidder utilizes data to inform the identification and implementation of evidenced based strategies and interventions. Demonstrate the use of quality improvement tools to evaluate the effectiveness of interventions and programs
    - Bidder should provide reports of performance levels on key quality metrics it uses
- Demonstrate the use of quality improvement tools to evaluate the effectiveness of interventions and programs.
- Provide sample workflows associated with the development of the Health Plan's Quality

Improvement Plan for its Medicaid membership, its analysis of the outcomes of the preceding year's Quality Improvement Plan, and submission of both documents to the EOHHS

- Describe or map its processes for conducting Quality Improvement Projects (QIPs), analyzing findings, developing interventions for performance improvement (if needed), and submitting the QIPs in the format required by the EOHHS
- Provide reports from Quality Assurance/Quality Improvement projects conducted within the most recent year.

4.11.4 Confidentiality

The Bidder should:

Describe or map the administrative, technical and physical controls, and security safeguards that are in place to protect against the improper use, loss, access to, or disclosure of confidential information and protected health information.

- Provide an attestation that the Bidder has a designated Privacy & Security Officer (or state which senior-level administrator has responsibility for privacy and security functions).
- Provide the date of its most recent HIPAA Privacy risk analysis.
- Provide the date of its most recent HIPAA Security risk analysis.
- Provide a description of its current Security mitigation plan.
- Outline how frequently it conducts privacy and security training for all employees and how it provides specialized education for those individuals whose role involves working more closely with PHI and/or those individuals who maintain PHI on portable devices, for example, outreach workers or nurse case managers who visits members in the community.
- Confirm the presence of current Human Resources policies and procedures, which focus on privacy and security, including but not limited to: a) internal investigation processes in the event of suspected privacy and security violations; b) the communication of disciplinary rules to all employees; and c) fair and equitable enforcement standards.
- Demonstrate how it oversees the compliance of its subcontractors with Federal and State laws and regulations that pertain to the conduct of Business Associates (BAs).
- Outline its policies and procedures regarding the loss or suspected loss of remote computing or telework devices such as laptop computers, PDAs, BlackBerrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and disks.
- Describe the Breach Notification process that would be activated without unreasonable delay in the event of a breach of unsecured protected health information, including notices to the RI EOHHS, the US DHHS Office of Civil Rights, and impacted individuals.
- Explain its mechanisms for the authorization and oversight of telework and how it ensures confidentiality is maintained off site.
- Describe or depict the safeguards that are in place for the safe destruction of protected health information, including electronic data such as electronic mail, scanners, fax and photocopy machines.

4.11.5 Practice Guidelines

The Bidder should:

- Demonstrates its approach to developing, adopting, and disseminating practice guidelines that comply with 42 CFR 438.236.
- Describe how it promotes the development and implementation of evidence-based practices.

4.11.6 Provider Credentialing

The Bidder should:

- Describe its credentialing and re-credentialing processes, policies and procedures. Bidder's description shall identify how its approach is compliant with State and Federal regulations.
- Identify how it monitors provider-credentialing activities to determine its own compliance with timeliness and completeness. A recent report should be included as an attachment.
- If the bidder does not currently participate in the Rhode Island Medicaid managed care program, then a sample report or template used for another State Medicaid program should be provided.

4.12 Plan for Meeting the Operational Data System and Reporting Requirements

The Bidder will clearly articulate its functional capabilities and business plan for meeting the operational data reporting requirements as established by the EOHHS. The Bidder must demonstrate its:

4.12.1 Overall Plan for Review and Submission of Mandatory Operational and Financial Reports

The Bidder should address its approach to each of the following:

- Operating, analytic, and financial management systems utilized for meeting the operational reporting requirements, including timeliness of reporting, for the Medicaid managed care lines of business. Refer to the Managed Care Reporting Calendar and Templates included in the Procurement Library.
- Quality control processes for the internal review of all mandatory operational reports, to ensure their accuracy and completeness prior to timely submission according to EOHHS timeframes
- Processes for the review and analysis of all mandatory reports, to identify any emerging trends or patterns of noncompliance with EOHHS performance requirements and implement interventions for remediation and performance improvement
- Methods for oversight to ensure subcontractors' performance in fulfilling EOHHS reporting requirements
- Maintaining a detailed plan for complying with all of the financial reporting requirements established by the EOHHS

4.12.2 Plan for Encounter Data Reporting

4.12.2.1 Processes for Encounter Data Submission

The Bidder should address its approach to each of the following:

- Workflows and policies and procedures for meeting the requirements associated with data capture and quality controls for the production and submission of encounter data
- How it will ensure that all of its subcontractors (for example, a behavioral health subcontractor) submit data to them in the timeframes stipulated.

4.12.2.2 Processes for Ensuring Timeliness and Accuracy of Data Submittal and Correction of Rejected Claims

The Bidder should:

- Describe and present its workflows outlining the processes for transmitting accurate and clean encounter data in a fully HIPAA-compliant manner as well as workflows for monitoring any problems with its 837 submissions.
- Describe and present its workflows for identifying any encounter data that has not been successfully accepted within the MMIS and re-submitting any errored off/rejected claims to the State within thirty (30) days of the receipt of the 277CA reports.

4.12.2.3 Processes for Data Validation

The Bidder should describe its process to submit monthly reports that summarize file submission status by vendor, line of business and fiscal year, including:

- Encounter Claims Incurred (total volume and dollars)
- Encounter Claims Submitted (total volume and dollars)
- Encounter Claims Accepted (total volume and dollars)
- Number of claims and dollar value by error type (total volume and dollars)
- Documentation and explanation with these reports of variances of greater than 1% between and among the total value for categories 1-3 above for data outside of timely submission or correction timeframes described herein.

4.12.3 Processes for HEDIS® and CAHPS® Measurement and Reporting

The Bidder's proposal should address its approach to each of the following:

- Workflows associated with the annual HEDIS® measurement cycle, culminating with reporting to the NCQA and the submission of final, audited HEDIS® results to the EOHHS
- Workflows associated with the annual conduct of CAHPS® for Medicaid surveys: a) for Adults in Medicaid; and b) Children in Medicaid, with Item Set for Children with Chronic Conditions and the submission of the CAHPS® survey reports to the EOHHS

4.12.4 Reporting Attestation

- The Bidder should provide Affirmation that it will fully comply with the attestation requirements for the certification of data and reports submitted to the EOHHS

4.13 Plan for Meeting Grievance and Appeals Requirements

The Bidder should clearly describe its plan for meeting Federal and State grievance and appeals process requirements. The description should provide a workflow or depiction for each of the following:

4.13.1 Plan for Meeting Federal and State Requirements

Bidder should identify operating policies and procedures that comport with 42 CFR 438 Subpart F and RI DOH R23-17.12-1-UR, which focus on grievances, appeals, and Medicaid Fair Hearings. Description should include how members with low literacy skills, hearing impairments, or limited English proficiency (LEP) will be accommodated by the Bidder when such members seek to file an appeal or a grievance. Bidder should provide a sample Notice of Action appeal template.

4.13.2 Plan for Grievance and Appeals Functions

Bidder should describe the operating system that will be used to support grievance and appeal adjudication functions, such as assigning a date-stamp and unique tracking number to each incoming grievance and appeal to ensure that mandatory timeframes are not exceeded.

Bidder description should include:

- Internal processes for the periodic analysis, by the Bidder's Medical Director, Director of Quality, and Quality Improvement Committee, of the outcomes of grievances, appeals, and Fair Hearings by Medicaid managed care enrollment line of business and type of service.
- Any quantitative or qualitative systems that are used to trend the outcomes data identified in the preceding item, so that emerging or ongoing issues that warrant remediation can be addressed by performance improvement projects.
- Operating system functionality that will permit grievance and appeal data to be disaggregated by Accountable Entity subcontractor.
- Operational processes to ensure that the Bidder submits all mandatory grievance and appeal reports, using the State's stipulated formats, within the timelines established by the State.
- Processes for the Bidder's ongoing oversight, monitoring, and analysis of outcomes of the appeal adjudication processes that are conducted by any subcontractors, including but not limited to the Bidder's behavioral health subcontractor and its pharmacy benefits manager.
- A brief description of the operating system that will be used to stamp a unique tracking number to each incoming grievance and appeal to ensure that mandatory timeframes are not exceeded.

4.14 Plan for Meeting Program Integrity and Compliance Requirements

The Bidder will clearly describe its comprehensive plan for meeting the State's requirements related to the three components of Program Integrity and Compliance identified in Section 3.2.11 of this LOI.

4.14.1 Third Party Liability

For Third Party Liability the Bidder should clearly demonstrate:

- Its effective use of technology, including interfaces between the Health Plan's claims processing and clinical management systems to identify other potential sources of third party liability (TPL).
- Workflows depicting how the Health Plan queries data sources to identify potential sources of TPL when new members are enrolled and the periodicity of subsequent TPL queries.

4.14.2 Plan for Corporate Compliance

For its Corporate Compliance Plan the Bidder should clearly demonstrate:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
- An attestation that it has a Corporate Compliance Officer and a functioning Corporate Compliance Committee, which are accountable to the Health Plan's Senior Executive.
- A chart of organization that depicts that the Corporate Compliance Officer has unimpeded access to the Health Plan's Chief Executive Officer (or its Rhode Island-based Executive Director).
- That it has an annual written Compliance Plan that is based on the "Seven Pillars" of an effective Corporate Compliance Program and a functioning Compliance Committee that is accountable to the Health Plan's Senior Executive.
- Effective training and education for the Compliance Officer and the organization's employees
- The processes by which the Compliance Committee analyzes the outcomes of the Corporate Compliance Plan and the effectiveness of the Corporate Compliance Program on an annual basis.
- Process for identifying and reporting prohibited affiliations with individuals debarred from Federal or State program participation.
- Process for identification and disclosure of the Bidder's ownership and control interest.
- Process for identifying and reporting disclosures about persons convicted of crimes.
- Evidence of oversight and ongoing monitoring of major subcontractors and contracted vendors.

4.14.3 Plan for Fraud, Waste and Abuse Prevention, Detection, Investigation, and Reporting

For Fraud, Waste, and Abuse the Bidder will clearly describe its comprehensive plan for meeting the State's requirements related to establishing and maintaining internal controls designed to prevent, detect, investigate, and report suspected Medicaid fraud, waste, and abuse that may be committed by providers, subcontractors, employees, or other contracted third parties. The Bidder will also describe how it will address allegations of fraud, waste, or abuse by Health Plan members and how this information will be reported to the State in a timely manner.

4.14.3.1 Overall Plan for Fraud, Waste, and Abuse

Specifically, the Bidder should demonstrate its:

- Overall plan of organization in the area of fraud, waste and abuse

- Allocation of programmatic resources dedicated to fraud prevention, detection, investigation, and reporting, including a chart of organization and count of FTEs assigned to such functions as related to RI's Medicaid managed care program
- Mechanisms for the development of annual audit plan for the detection and investigation of suspected Medicaid fraud, waste, and abuse, which includes an analysis of outcomes (e.g., special investigations launched, dollar recoveries, corrective action plans initiated and completed, and number of good faith reports to the EOHHS and Office of Program Integrity) from the preceding year's audit plan
- Use of outlier algorithms for peer profiling and interface with the Health Plan's Medical Director for further analysis when practice and claiming outliers are identified
- Utilization of claims editing software, preferably real time
- Annual plan for Employee education about false claims recovery

4.14.3.2 Plan Elements Focused on Members and Providers

The Bidder should demonstrate its:

- Tools and techniques for Member and Provider education about Medicaid fraud, waste, and abuse
- Evidence of recipient verification procedures, including the use of Explanation of Member Benefits (EOMBs)
- Provision for prompt response to detected offenses and for development of corrective action initiatives.
- Methods for the development of corrective action plans (CAPs), including timeframes for outreach, education and reassessment, for Providers whose claims have billing issues
- Processes for the regular review of relevant Federal databases, including the List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM), and other States' Provider Exclusion Lists for excluded providers and vendors
- Provision and publicity of the Health Plan's toll-free telephone number for reporting suspected cases of Medicaid fraud, waste, and abuse

4.14.3.3 Plan for Reporting and Collaboration with External Agencies

The Bidder should demonstrate its:

- Escalation processes for reporting good faith suspected cases of fraud, waste, and abuse to the State's Office of Program Integrity
- Processes for identifying and reporting suspected cases of Medicaid fraud, waste, and abuse by providers and members to the EOHHS, including but not limited to the submission of the MCO Program Integrity Quarterly Report and Member Fraud/Out of State Report.
- Compliance with provider credentialing functions in conformance with standards established by the National Committee for Quality Assurance (NCQA)

4.14.3.4 Electronic Visit Verification (EVV)

As part of EOHHS program integrity efforts, EOHHS requires implementation of certain initiatives, one such initiative is EVV.

EVV is a system established to enhance program efficiencies and quality assurance for various in-home and community-based care services administered by EOHHS and the managed care organizations. EVV is an in-home visit scheduling, tracking and billing system that employs controls within the delivery of home based services to ensure client's quality of care.

The Bidder should provide a description of any current agreement that it has with a vendor that provides electronic visit verification (EVV) for in-home services.

4.15 Security and Confidentiality Requirements

As a Covered Entity as defined by Section 45 CFR 160.163, the Bidder should describe its comprehensive program for ensuring ongoing compliance with all Federal and State requirements, including the HIPAA Privacy and Security Rule (45 CFR Part 160 and Subparts A & E of Part 164), to protect the privacy and security of individually identifiable health information, also referred to as protected health information (PHI). The Bidder should also articulate how it oversees the HIPAA privacy and security functions of its Business Associates.

The Bidder should:

- Describe or map the administrative, technical and physical controls, and security safeguards that are in place to protect against the improper use, loss, access to, or disclosure of confidential information and protected health information.
- Provide an attestation that the Bidder has a designated Privacy & Security Officer (or state which senior-level administrator has responsibility for privacy and security functions).
- Provide the date of its most recent HIPAA Privacy risk analysis.
- Provide the date of its most recent HIPAA Security risk analysis.
- Provide a description of its current Security mitigation plan.
- Outline how frequently it conducts privacy and security training for all employees and how it provides specialized education for those individuals whose role involves working more closely with PHI and/or those individuals who maintain PHI on portable devices, for example, outreach workers or nurse case managers who visits members in the community.
- Confirm the presence of current Human Resources policies and procedures, which focus on privacy and security, including but not limited to: a) internal investigation processes in the event of suspected privacy and security violations; b) the communication of disciplinary rules to all employees; and c) fair and equitable enforcement standards.
- Demonstrate how it oversees the compliance of its subcontractors with Federal and State laws and regulations that pertain to the conduct of Business Associates (BAs).
- Outline its policies and procedures regarding the loss or suspected loss of remote computing or telework devices such as laptop computers, PDAs, BlackBerrys or other Smartphones, USB drives, thumb drives, flash drives, CDs, and disks.
- Describe the Breach Notification process that would be activated without unreasonable delay in the event of a breach of unsecured protected health information, including notices to the RI EOHHS, the US DHHS Office of Civil Rights, and impacted individuals.
- Explain its mechanisms for the authorization and oversight of telework and how it ensures confidentiality is maintained off site.
- Describe or depict the safeguards that are in place for the safe destruction of protected health information, including electronic data such as electronic mail, scanners, fax and photocopy

machines.

4.16 Plan for Serving Children in Substitute Care Arrangements

All Bidders should submit a specific proposal to enroll children who are in Substitute Care as Section 4.16 of their proposal.

The Substitute Care proposal shall include:

4.16.1 Statement of Understanding

Children in substitute care arrangements clearly represent a unique population with a complex set of social and health care needs. These often include a broad range of high-end behavioral health and mental health needs experienced in the context of circumstances that have led to state protective custody. Historically, this population has experienced difficulties in the provision of behavioral health and mental health services and their coordination with other critical supports. An effective program of care for this population must be able to provide timely access to needed health services combined with close collaboration with DCYF and other providers of out-of-plan but essential services.

In addressing the elements in Section 4.16 Bidder should provide a clear statement of understanding of the uniqueness of this sub-population the strengths of its proposal to provide for the needs of this population but should also include a frank assessment of the challenges faced

This includes any shortcomings in existing systems of care along with the specific capabilities that a MCO should have to be able to effectively serve this group. This may include for example, the presence of waiting lists impacting service accessibility and proposed plans to increase service capacity where waiting lists may be a problem.

For Section 4.16.1, Bidder should provide a clear statement of understanding of the uniqueness of this sub-population, challenges faced, and the specific capabilities a MCO should have to be able to effectively serve this group.

4.16.2 Plan for Enrollment and Orientation

Bidder should describe its policies and procedures for:

- Plan enrollment and orientation procedures

4.16.3 Provider Network and Service Accessibility

Bidder's response should include a description of:

- Its understanding of the distinct behavioral health/mental health needs of children in DCYF care and how that guides the development of a culturally sensitive and multi-lingual network of providers that are able to serve this population
- Bidder should describe how its contracted provider network for behavioral health and mental health services will be able to provide a continuum of care with the provision of high end intensive

services required by children in substitute care arrangements, including providers able who are in the network that provide identified evidence based services.

- Note Bidder should also identify (a) where behavioral health services may be lacking or difficult to access and describe plans to address any deficiencies and (b) any concerns Bidder may have regarding the ability of existing providers to perform effectively (may include, for instance, the track records of providers in delivering such services.)
- Bidder should provide specific information on the availability of child psychiatrists to DCYC children and youth and how it will ensure access to these services for its members
- Bidder should provide a description of population metrics and other methods it uses to evaluate the strengths and weaknesses of its provider network for services to this population, including specific means employed to ensure that service accessibility standards are being met.
- Description of challenges related to capacity within the provider delivery system, any related concerns pertaining to waiting lists, and plans to address related concerns.

4.16.4 Plan for Early Identification and Access to Care

Bidder should describe how it will collaborate with DCYF and Family Care Community Partnerships (FCCP) for Early Identification of members in need of services

4.16.5 Coordination with DCYF and Other Out-of-Plan Services and Supports

Bidder should describe its plan for:

- Coordination with the DCYF Permanency Unit (including the Central Referral Unit CRU) and with FCCP
- How it will support transitions for youth aging out of substitute care and entering the adult BH/MH service system
- Identification of electronic communication tools/methods with DCYF and providers
- How it will subcontract to provide psychotropic medication consultation to DCYF
- How it will interface with DCYF about children in hospitals
- How it will interface with DCYF counselors on a regular (approx. every two weeks) to review the status of each child

4.16.6 Plan for Monitoring and Evaluation

Bidder is encouraged to identify metrics that align with those tracked and/or reported by the Department of Children, Youth, and Families (http://www.dcyf.ri.gov/data_evaluation.php), the Rhode Island State Innovation Model (SIM) plan, the RI Children's Cabinet strategic plan, the CMS Annual Report on the Quality of Care for Children in Medicaid and CHIP, and other recognized state and Federal sources. These include:

- Number of children and adolescents who are placed in residential treatment settings, and their length of stay in such settings
- Proportion of children and adolescents on 2 or more psychotropic medications
- Rate of Mental Health and Substance Use (including Tobacco) screenings of children and

adolescents per the EPSDT Periodicity schedule, and proportion of child/adolescents with alcohol and other drug dependence who successfully complete treatment.

- Proportion of children and adolescents who received Initial Health Screen Completed within 45 Days, and an annual preventive dental service and an annual well child visit
- Rate of unnecessary visits to the ER for children and adolescents Mental Health and Substance Use disorders

Bidder should identify the critical metrics it will use to monitor access and quality of services to this population, including a list of priority outcomes as to how it would evaluate its success in serving this population.

4.17 Exception to the Model Contract

Pursuant to Section 3.3.1 of this LOI, Bidder may opt to propose an alternative to the Risk Share/Gain Share methodology set forth in Attachment N of the Model Contract (Special Terms and Conditions). If Bidder is opting to propose alternative corridors and/or shares in this methodology, this is the appropriate section of the Technical Proposal to do so. Note that as shown in the Technical Proposal Specifications Summary Checklist no points are awarded in the Technical Proposal scoring for an alternative proposal.

Section 5: Cost Proposal

The Cost Proposal for this LOI sets forth the required financial terms for qualification as a Medicaid managed care plan pursuant to this procurement. Bidder must include a clear statement of its acceptance of the State Capitation Rates to be paid for Medicaid enrollees as set forth in Attachment 2 of the LOI. Such acceptance is to be provided as part of Bidder's submission in response to Section 4.2 of this LOI, "Assurances/Attestations". Section 4.2, item #5 requires: "A statement that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidder(s).

Bidders that accept the capitation rates will meet the Cost Proposal requirements of this LOI. Proposal submissions that fail to include a signed attestation of acceptance of the State's Capitation Rates will be deemed non-responsive and will not be considered.

Ongoing payments to a successful contractor will be based on the monthly capitation payments made through the States MMIS system.

Section 6: Evaluation and Selection

6.1 Evaluation Committee

The State shall establish a Technical Review Committee comprised of staff from State agencies to review Health Plan Bids. Only State personnel will serve as voting members of the Committee. However, the state may designate other individuals to serve as staff and/or advisors to the Committee and to provide assistance in its activities per the approval of the State Purchasing Agent.

6.2 Evaluation Process

The State shall conduct a comprehensive and impartial evaluation of all bids. The Technical Proposals will be evaluated for completeness and quality against a set of criteria based on the bid submission requirements. Except for the areas that will be scored pass/fail, a scoring instrument using a rating system of 1 – 10 points will be used to evaluate the Bidder's responses to the specific elements in the Technical Proposal. The maximum amount of points that can be scored for the Technical Proposal is 110 points. **To qualify a Bidder must score a minimum of 70% of all points or 77 points out of a maximum of 110 points on its Technical Proposal.**

Criteria	Possible Points
Letter of Transmittal	Pass/Fail
Assurances/Attestations	Pass/Fail
Health Plan Financial Viability	Pass/Fail
Health Plan Experience, Understanding and Readiness to Perform	5 Points
Health Plan Licensure and Organizational	5 Points
Plan for Meeting Contract Goals and Special Initiatives	20 Points
Plan for Meeting Member Enrollment and Disenrollment	4 Points
Plan for Meeting Provider Network and Service Accessibility	12 Points
Description of the Plan for Providing Covered Services	12 Points
Plan for Care Coordination and Care Management	10 Points
Plan for Providing Member and Provider Services	4 Points
Plan for Conducting Medical Management and Quality Assurance Efforts	5 Points
Plan for Meeting the Operational Data System and Reporting	5 Points
Plan for Meeting Grievance and Appeals	5 Points

Plan for Meeting Program Integrity and Compliance	8 Points
Security and Confidentiality	5 Points
Plan for Serving Children in Substitute Care Arrangements	10 Points
Total Possible Technical Points	**110 Points**

6.3 Contract Award and Special Conditions

The Technical Review Committee shall present its recommendations to the Department of Administration, Office of Purchasing, who shall make the final selection for this procurement.

The state reserves the right to disqualify or not consider any proposal that is determined not to achieve the State goals or be in the best interest of the State. Proposals found to be technically substantively non-responsive will be rejected and not further considered.

The State reserves the right to send clarifying questions and to receive clarifying responses from parties submitting proposals, request interview and presentations, request additional financial information, contact references, and/or use other appropriate means to evaluate a proposal and the submitting party's qualifications per the approval of the State Purchasing Agent..

The State also reserves the right to specify special conditions for individual bidders as part of making awards. The award will not be considered official until the bidder complies with these terms and conditions in full. Special terms and conditions may be a part of a provisional award made to any Bidder.

6.4 Readiness Review

Note that for any successful Bidder EOHHS shall conduct readiness reviews to ensure Bidder is prepared to perform the requirements of this agreement. RI EOHHS or their designee will identify to the Bidder areas where EOHHS does not deem Bidder to be ready and able to meet its obligations under the tentative award. EOHHS will provide reasonable opportunity for the Bidder to correct such areas to remedy all deficiencies prior to the contract effective start date.

If, for any reason, the Contractor does not fully satisfy RI EOHHS that it is ready and able to perform its obligations under the tentative award prior to the contract start date, and RI EOHHS does not agree to postpone the contract start date, or extend the date for full compliance with the applicable tentative award requirement, then RI EOHHS may not enter into a contract.

Section 7: Proposal Submission

Questions concerning this solicitation may be e-mailed to the Division of Purchases at david.francis@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. Please reference **LOI # 7550787 Medicaid Managed Care Services** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to

download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

Offerors are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties will be permitted**. Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

Responses (an original plus eight (8) copies) and one electronic copy should be mailed or hand-delivered in a sealed envelope marked "**LOI# 7550787 Medicaid Managed Care Services**" to:

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed, or emailed, to the Division of Purchases will not be considered. The official time clock is in the reception area of the Division of Purchases.

RESPONSE CONTENTS

Responses shall include the following:

1. One completed and signed three-page R.I.V.I.P generated bidder certification cover sheet (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.
2. One completed and signed W-9 (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.
3. **A separate Technical Proposal** following the guidelines set forth in Section 4 of this LOI. The Technical Proposal shall include a completed Technical Proposal Specifications Summary Checklist.
4. **A separate, signed Cost Proposal** complying with the requirements set forth in Section 5 of this LOI.
5. In addition to the multiple hard copies of proposals required, Respondents are requested to provide their proposal in **electronic format** (**CD-ROM, disc, or flash drive**). Microsoft Word / Excel OR PDF format is preferable. Only 1 electronic copy is requested and it should be placed in the proposal marked "original".

CONCLUDING STATEMENTS

Notwithstanding the above, the State reserves the right not to award this contract or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the LOI. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL: https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf

For more detailed information regarding the Rhode Island Medicaid Program and Medicaid managed care, please see the documents in the Procurement Library at the following URL: http://www.eohhs.ri.gov/ReferenceCenter/ImportantLinks.aspx. Documents included in Procurement Library minimally include those listed below:

ATTACHMENT 1

PROPOSAL SPECIFICATIONS SUMMARY CHECKLIST

Attachment 1

Proposal Specifications Summary Checklist

SECTION 4: TECHNICAL PROPOSAL	Maximum Points	Percent of Section Points Per Each Sub-Section	Suggested Number of Pages	Proposal Page Number (Completed by Bidder)	Referral to a Specific Attachment Location (Completed by Bidder)
4.1 Letter of Transmittal	**pass/fail**		**n.a.**		
4.2 Assurances/Attestations	**pass/ fail**		**n.a.**		
4.3 Health Plan's Experience, Understanding, and Readiness to Perform	**5**		**20**		
4.3.1 Description of Bidder Organization		**10%**			
4.3.2 Description of Bidder's Subcontractors		**10%**			
4.3.3 Bidder's Ability to Provide Medicaid Services as a Health Plan in Rhode Island		**5%**			
4.3.4 Understanding of the RI Environment and Populations Covered		**10%**			
4.3.4.1 Understanding of the RI Environment					
4.3.4.2 Populations Covered					
4.3.5 Understanding of the Programmatic Goals for this Procurement		**15%**			
4.3.5.1 Bidder's View of the Role of MCO in Advancing the Programmatic					
NCQA Quality Compass Ratings		**25%**			
4.3.6 Readiness		**20%**			
4.3.7 Additional Information from Bidder		**5%**			
		100%			
4.4. Health Plan Licensure and Organizational Requirements	5		10		
4.4.1 Licensure and Organizational Requirements	**pass/fail**				
4.4.2 Accreditation and Quality Standards		**25%**			
4.4.3 Staffing Capacity and Presence in Rhode Island		**25%**			
4.4.4 Health Plan Financial Viability		**50%**			
4.4.5 References	**pass/fail**				

SECTION 4: TECHNICAL PROPOSAL	Maximum Points	Percent of Section Points Per Each Sub-Section	Suggested Number of Pages	Proposal Page Number (Completed by Bidder)	Referral to a Specific Attachment Location (Completed by Bidder)
4.5.1 Defined, Integrated Focus on Population Health		15%			
4.5.2 Alternative Payment Methodologies and Accountable Entities		10%			
4.5.2.1 Contracting Arrangements with EOHHS Certified Accountable Entities		25%			
4.5.2.2 Description of Contracting Status for Any Other Alternative Payment Methodologies		10%			
4.5.2.3 Submission of Completed Alternative Payment Methodology Template		10%			
4.5.3 Rhode Island Medicaid Health System Transformation Program		5%			
4.5.4 Primary Care Practice Transformation		15%			
4.5.5 Alignment with Rhode Island State Innovation Model (SIM)		5%			
4.5.6 Current Care		5%			
4.5.7 Movement of Additional Services into Managed Care Contracts					
		100%			
4.6 Plan for Meeting Member Enrollment and Disenrollment Requirements	4		10		
4.6.1 Processes for Enrollment and Disenrollment,		25%			
4.6.2 Processes for New Member Orientation and Providing Information to Members		25%			
4.6.3 Assignment of PCP		25%			
4.6.4 Marketing		25%			
		100%			
4.7. Plan for Meeting Provider Network Requirements and Assuring that Service Accessibility Requirements are Met	12		25		
4.7.1 Plan for Meeting Provider Network Requirements		35%			
4.7.1.1 Description of the Bidder's Provider Network					
4.7.2 Plan for Selective Contracting, as applicable		5%			
4.7.3 Network Management and Relations		10%			
4.7.4 Plan for Meeting Service Accessibility Requirements		30%			
4.7.4.1 Plan for Meeting Travel Time Requirements					
4.7.4.2 Plan for Meeting Service Accessibility Standards for Appointments					

SECTION 4: TECHNICAL PROPOSAL	Maximum Points	Percent of Section Points Per Each Sub-Section	Suggested Number of Pages	Proposal Page Number (Completed by Bidder)	Referral to a Specific Attachment Location (Completed by Bidder)
4.7.5 Plan for Ensuring Access to Post-Stabilization Care Services		10%			
4.7.6 Plan for Meeting Requirements for Access for Women		10%			
		100%			
4.8 Description of the Plan for Providing Covered Services	12		50		
4.8.1 Description of Bidder's Overall Plan		5%			
4.8.2 Description of Approach to Certain Services		5%			
4.8.3 Translation and Interpreter Services		5%			
4.8.4 Implementation of Requirements for EPSDT		10%			
4.8.5 Behavioral Health and Substance Use Services		5%			
4.8.5.1 Mental Health, Substance Use and Developmental Disabilities Services for Children					
4.8.5.1.1 Services for Children: Continuum of Mental Health and Substance Use Services and Developmental Disabilities Services					
4.8.5.1.1.1 Provider Network		10%			
4.8.5.1.1.2 Utilization Management and Level of Care Determination		5%			
4.8.5.1.1.3 Plan for Early Identification and Access to Care Accessibility, Availability, Referral And Triage.		5%			
4.8.5.1.1.4 Communication Plan		2.5%			
4.8.5.1.2 Home and Community Based Services for Individuals under Age 21 Years of Age		8%			
4.8.5.2 Services for Adults: Behavioral Health and Substance Use					
4.8.5.2.1 Services for Adults: Continuum of Behavioral Health and Substance Use Services for Adults		10%			
4.8.5.2.1.1 Provider Network					
4.8.5.2.1.2 Utilization Management and Level of Care Determination		5%			
4.8.5.2.1.3 Plan for Early Identification and Ensuring Timely Access, Availability, Referral And Triage.		5%			
4.8.5.2.1.4 Communication Plan		3%			
4.8.5.2.2 Integrated Health Home (IHH) and the Assertive Community Treatment Programs (ACT)		8%			
4.8.3.2.3 Opioid Health Home Services		5%			
4.8.5.2.4 Habilitative Services		4%			
		100%			
SECTION 4: TECHNICAL PROPOSAL	Maximum Points	Percent of Section Points Per	Suggested Number of Pages	Proposal Page Number	Referral to a Specific Attachment

		Each Sub-Section		(Completed by Bidder)	Location (Completed by Bidder)
4.9 Plan for Care Coordination and Care Management	**10**		**25**		
4.9.1 Overall Plan for Care Coordination and Care Management					
4.9.1.1 Bidder's Description of the Structure of its Overall Program		**10%**			
4.9.1.2 Care Plan Development.		**10%**			
4.9.1.3 Risk Stratification Tools and Workflows for the Identification of Members with High Needs		**15%**			
4.9.1.4 Coordination with provider and community based care management resources		**10%**			
4.9.1.5 Physical Health-Behavioral Health Integration		**10%**			
4.9.1.6 Coordination with Out-of-Plan Health/Social Services, Social Determinants of Health, and Housing Stabilization		**10%**			
4.9.1.7 Outreach and Engagement		**10%**			
4.9.1.8 Process Flows and Data Systems		**10%**			
4.9.1.9 Description of the Communities of Care Program		**15%**			
		100%			
4.10 Plan for Providing Member and Provider Services	**4**		**10**		
4.10.1 Member Services		**67%**			
4.10.2 Provider Services		**33%**			
		100%			
4.11 Plan for Conducting Medical Management and Quality Assurance Efforts	**5**		**10**		
4.11.1 Office of the Medical Director		**20%**			
4.11.2 Utilization Review		**20%**			
4.11.3 Quality Assurance and Quality Improvement		**20%**			
4.11.4 Confidentiality		**12.5%**			
4.11.5 Practice Guidelines		**15%**			
4.11.6 Provider Credentialing		**12.5%**			
		100%			
4.12 Plan for Meeting the Operational Data System and Reporting Requirements	**5**		**15**		
4.12.1 Overall Plan for Review and Submission of Mandatory Operational and Financial Reports		**20%**			
4.12.2 Plan for Encounter Data Reporting		**55%**			
4.12.2.1 Processes for Encounter Data Submission					
4.12.2.2 Processes for Ensuring Timeliness and Accuracy of Data Submittal and Correction of Rejected Claims					
4.12.2.3 Processes for Data Validation					
4.12.3 Processes for HEDIS® and CAHPS® Measurement and Reporting		**20%**			

4.12.4 Reporting Attestation		**5%**			
		100%			
4.13 Plan for Meeting Grievance and Appeals Requirements	**5**		**10**		
4.13.1 Plan for Meeting Federal and State requirements		**50%**			
4.13.2 Plan for Grievance and Appeals Functions		**50%**			
		100%			
4.14 Plan for Meeting Program Integrity and Compliance Requirements	**8**		**10**		
4.14.1 Third Party Liability		**15%**			
4.14.2 Plan for Corporate Compliance		**25%**			
4.14.3 Plan for Fraud, Waste and Abuse Prevention, Detection, Investigation, and Reporting		**25%**			
4.14.3.1 Overall Plan for Fraud, Waste, and Abuse					
4.4.13.2 Plan Elements Focused on Members and Providers		**15%**			
4.14.3.3 Plan for Reporting and Collaboration with External Agencies		**15%**			
4.14.3.4 Electronic Visit Verification (EVV)		**5%**			
		100%			
4.15 Security and Confidentiality Requirements	**5**	**100%**	**10**		
TOTAL Not including Substitute Care	**100**		**230**		
4.16 Plan for Serving Children in Substitute Care Arrangements	**10**		**15**		
4.16.1 Statement of understanding sub-population, challenges faced, capabilities that a MCO should have to be able to effectively serve this group.		**20%**			
4.16.2 Plan for enrollment and orientation		**5%**			
4.16.3 Provider Network and Service Accessibility		**25%**			
4.16.4 Plan for Early Identification and Access to care - collaborate w/ DCYF, FCCPS		**15%**			
4.16.5 Coordination with DCYF and Other Out-of-Plan Services and Supports		**20%**			
4.16.6 Plan for Monitoring and Evaluation		**15%**			
		100%			
SECTION 4: TECHNICAL PROPOSAL	**Maximum Points**	**Percent of Section Points Per Each Sub-Section**	**Suggested Number of Pages**	**Proposal Page Number (Completed by Bidder)**	**Referral to a Specific Attachment Location (Completed by Bidder)**

Proposal for alternative to the risk/gain sharing provisions of Attachment N of the Model Contract	**0**		**1**		
Total Including Substitute Care	**110**		**246**		

ATTACHMENT 2

CAPITATION RATES

RIte Care
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rate	Admin. Component of Capitation Rate	Risk Margin	Assessments	Non-Profit Plans		For-Profit Plans		
					2% State Premium Tax: Non-Profit Plan	Proposed Capitation Rate	2% State Premium Tax: For-Profit Plan	Est. ACA Issuer Fee: For-Profit Plan	Proposed Capitation Rate
Male or female less than one year of age	$408.65	$39.51	$6.82		$9.29	$464.27	$9.58	$14.37	$478.93
Male or female ages one-five years of age	$128.70	$12.72	$2.15		$2.93	$146.50	$3.03	$4.53	$151.13
Male or female ages six-fourteen years of age	$128.21	$12.34	$2.14		$2.91	$145.60	$3.00	$4.51	$150.20
Males ages 15 – 44 years of age	$178.23	$18.68	$3.00	$1.18	$4.10	$205.19	$4.23	$6.35	$211.67
Females ages 15 – 44 years of age	$268.57	$25.58	$4.48	$1.40	$6.12	$306.15	$6.32	$9.47	$315.82
Male or female 45 years of age or older	$373.32	$37.88	$6.26	$1.66	$8.55	$427.67	$8.82	$13.24	$441.18
Extended Family Planning	$8.84	$0.86	$0.15		$0.20	$10.05	$0.21	$0.31	$10.37
SOBRA	$9,711.00	$949.00	$162.00		$221.00	$11,043.00	$228.00	$342.00	$11,392.00

Risk Margin set at 1.5% of premiums before taxes Assessments include adult immunizations
State Premium Tax is set at 2% of premiums
ACA Issuer Fee is applicable to for-profit plans only

RIte Care
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rate	Admin. Component of Capitation Rate	Risk Margin	Assessments	Non-Profit Plans		For-Profit Plans		
					2% State Premium Tax: Non-Profit Plan	Proposed Capitation Rate	2% State Premium Tax: For-Profit Plan	Est. ACA Issuer Fee: For-Profit Plan	Proposed Capitation Rate
Male or female less than one year of age	$412.15	$39.95	$6.88		$9.37	$468.35	$9.67	$14.49	$483.14
Male or female ages one-five years of age	$129.77	$12.86	$2.17		$2.96	$147.76	$3.05	$4.57	$152.42
Male or female ages six-fourteen years of age	$129.30	$12.48	$2.16		$2.94	$146.88	$3.03	$4.55	$151.52
Males ages 15 – 44 years of age	$179.79	$18.88	$3.03	$1.18	$4.14	$207.02	$4.27	$6.41	$213.56
Females ages 15 – 44 years of age	$270.92	$25.87	$4.52	$1.40	$6.18	$308.89	$6.37	$9.56	$318.64
Male or female 45 years of age or older	$376.56	$38.30	$6.32	$1.66	$8.63	$431.47	$8.90	$13.35	$445.09
Extended Family Planning	$8.89	$0.87	$0.15		$0.20	$10.11	$0.21	$0.31	$10.43
SOBRA	$9,854.00	$965.00	$165.00		$224.00	$11,208.00	$231.00	$347.00	$11,562.00

Risk Margin set at 1.5% of premiums before taxes Assessments include adult immunizations
State Premium Tax is set at 2% of premiums
ACA Issuer Fee is applicable to for-profit plans only

CSHCN and Substitute Care
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rate	Admin. Component of Capitation Rate	Risk Margin	Assessments	Non-Profit Plans		For-Profit Plans		
					2% State Premium Tax: Non-Profit Plan	Proposed Capitation Rate	2% State Premium Tax: For-Profit Plan	Est. ACA Issuer Fee: For-Profit Plan	Proposed Capitation Rate
Adoption Subsidy eligible children	$471.73	$48.78	$7.93	$0.06	$10.79	$539.29	$11.13	$16.69	$556.32
Katie Beckett eligible children	$2,293.02	$232.48	$38.46		$52.33	$2,616.29	$53.98	$80.97	$2,698.91
SSI eligible children, ages < 1 though 14	$1,031.76	$107.59	$17.35		$23.61	$1,180.31	$24.35	$36.53	$1,217.58
SSI eligible children, ages 15 through 20	$906.88	$91.17	$15.20	$0.56	$20.69	$1,034.50	$21.34	$32.02	$1,067.17
Substitute Care	$637.53	$85.38	$11.01	$0.22	$14.98	$749.12	$15.46	$23.18	$772.78

Risk Margin set at 1.5% of premiums before taxes Assessments include adult immunizations
State Premium Tax is set at 2% of premiums
ACA Issuer Fee is applicable to for-profit plans only

CSHCN and Substitute Care
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rate	Admin. Component of Capitation Rate	Risk Margin	Assessments	Non-Profit Plans		For-Profit Plans		
					2% State Premium Tax: Non-Profit Plan	Proposed Capitation Rate	2% State Premium Tax: For-Profit Plan	Est. ACA Issuer Fee: For-Profit Plan	Proposed Capitation Rate
Adoption Subsidy eligible children	$489.56	$49.72	$8.21	$0.06	$11.17	$558.72	$11.53	$17.29	$576.37
Katie Beckett eligible children	$2,375.38	$236.99	$39.78		$54.13	$2,706.28	$55.84	$83.75	$2,791.74
SSI eligible children, ages < 1 though 14	$1,068.91	$109.67	$17.95		$24.42	$1,220.95	$25.19	$37.79	$1,259.51
SSI eligible children, ages 15 through 20	$939.48	$92.94	$15.72	$0.56	$21.40	$1,070.10	$22.07	$33.12	$1,103.89
Substitute Care	$659.75	$86.30	$11.36	$0.22	$15.46	$773.09	$15.95	$23.93	$797.51

Risk Margin set at 1.5% of premiums before taxes Assessments include adult immunizations
State Premium Tax is set at 2% of premiums
ACA Issuer Fee is applicable to for-profit plans only

Rhody Health Partners
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rate	Admin. Component of Capitation Rate	Risk Margin	Assessments	Non-Profit Plans		For-Profit Plans		
					2% State Premium Tax: Non-Profit Plan	Proposed Capitation Rate	2% State Premium Tax: For-Profit Plan	Est. ACA Issuer Fee: For-Profit Plan	Proposed Capitation Rate
Adults with Severe and Persistent Mental Illness	$2,036.41	$181.22	$33.77	$1.66	$45.98	$2,299.04	$47.43	$71.15	$2,371.64
Adults on the Mental Retardation/Developmental Disabilities Waiver	$983.78	$77.96	$16.17	$1.66	$22.03	$1,101.60	$22.73	$34.09	$1,136.39
Other Disabled Age 21 - 44	$804.88	$70.32	$13.33	$1.66	$18.17	$908.36	$18.74	$28.11	$937.04
Other Disabled Age 45 and above	$1,151.80	$101.99	$19.09	$1.66	$26.01	$1,300.55	$26.83	$40.25	$1,341.62

Risk Margin set at 1.5% of premiums before taxes Assessments include adult immunizations
State Premium Tax is set at 2% of premiums
ACA Issuer Fee is applicable to for-profit plans only

Rhody Health Partners
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rate	Admin. Component of Capitation Rate	Risk Margin	Assessments	Non-Profit Plans		For-Profit Plans		
					2% State Premium Tax: Non-Profit Plan	Proposed Capitation Rate	2% State Premium Tax: For-Profit Plan	Est. ACA Issuer Fee: For-Profit Plan	Proposed Capitation Rate
Adults with Severe and Persistent Mental Illness	$2,074.91	$183.14	$34.39	$1.66	$46.82	$2,340.92	$48.29	$72.45	$2,414.84
Adults on the Mental Retardation/Developmental Disabilities Waiver	$1,007.65	$78.79	$16.54	$1.66	$22.54	$1,127.18	$23.26	$34.88	$1,162.78
Other Disabled Age 21 - 44	$820.66	$71.06	$13.58	$1.66	$18.51	$925.47	$19.09	$28.64	$954.69
Other Disabled Age 45 and above	$1,175.07	$103.07	$19.46	$1.66	$26.52	$1,325.78	$27.35	$41.03	$1,367.64

Risk Margin set at 1.5% of premiums before taxes Assessments include adult immunizations
State Premium Tax is set at 2% of premiums
ACA Issuer Fee is applicable to for-profit plans only

Medicaid Expansion
Proposed Capitation Rates
Rate Period 2/1/2017 - 6/30/2017
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rate	Admin. Component and Risk Margin	Assessments	Non-Profit Plans		For-Profit Plans		
				2% State Premium Tax: Non-Profit Plan	Proposed Capitation Rate	2% State Premium Tax: For-Profit Plan	Est. ACA Issuer Fee: For-Profit Plan	Proposed Capitation Rate
Females age 19-24	$294.75	$31.52	$1.13	$6.69	$334.09	$6.90	$10.34	$344.64
Female age 25-29	$384.26	$41.09	$1.47	$8.72	$435.54	$8.99	$13.48	$449.29
Female age 30-39	$464.35	$49.66	$1.78	$10.52	$526.31	$10.86	$16.28	$542.93
Female age 40-49	$556.08	$59.47	$2.13	$12.61	$630.29	$13.01	$19.50	$650.19
Female age 50-64	$588.98	$62.99	$2.26	$13.35	$667.58	$13.77	$20.66	$688.66
Male age 19-24	$219.62	$23.49	$0.84	$4.98	$248.93	$5.14	$7.70	$256.79
Male age 25-29	$263.13	$28.14	$1.01	$5.97	$298.25	$6.15	$9.23	$307.66
Male age 30-39	$346.53	$37.06	$1.33	$7.85	$392.77	$8.10	$12.15	$405.17
Male age 40-49	$484.64	$51.83	$1.86	$10.98	$549.31	$11.33	$17.00	$566.66
Male age 50-64	$631.03	$67.48	$2.42	$14.31	$715.24	$14.77	$22.13	$737.83
SOBRA	$9,711.00	$1,111.00		$221.00	$11,043.00	$228.00	$342.00	$11,392.00

Risk Margin set at 1.5% of premiums before taxes Assessments include adult immunizations
State Premium Tax is set at 2% of premiums
ACA Issuer Fee is applicable to for-profit plans only

Medicaid Expansion
Proposed Capitation Rates
Rate Period 7/1/2017 - 6/30/2018
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rate	Admin. Component and Risk Margin	Assessments	Non-Profit Plans		For-Profit Plans		
				2% State Premium Tax: Non-Profit Plan	Proposed Capitation Rate	2% State Premium Tax: For-Profit Plan	Est. ACA Issuer Fee: For-Profit Plan	Proposed Capitation Rate
Females age 19-24	$301.78	$31.92	$1.13	$6.84	$341.67	$7.05	$10.58	$352.46
Female age 25-29	$393.42	$41.62	$1.47	$8.91	$445.42	$9.19	$13.79	$459.49
Female age 30-39	$475.42	$50.29	$1.78	$10.76	$538.25	$11.11	$16.66	$555.26
Female age 40-49	$569.34	$60.23	$2.13	$12.89	$644.59	$13.30	$19.95	$664.95
Female age 50-64	$603.03	$63.79	$2.26	$13.65	$682.73	$14.09	$21.13	$704.30
Male age 19-24	$224.86	$23.79	$0.84	$5.09	$254.58	$5.25	$7.88	$262.62
Male age 25-29	$269.41	$28.50	$1.01	$6.09	$305.01	$6.29	$9.44	$314.65
Male age 30-39	$354.79	$37.53	$1.33	$8.04	$401.69	$8.29	$12.43	$414.37
Male age 40-49	$496.20	$52.49	$1.86	$11.23	$561.78	$11.59	$17.39	$579.53
Male age 50-64	$646.08	$68.34	$2.42	$14.63	$731.47	$15.10	$22.64	$754.58
SOBRA	$9,854.00	$1,130.00		$224.00	$11,208.00	$231.00	$347.00	$11,562.00

Risk Margin set at 1.5% of premiums before taxes Assessments include adult immunizations
State Premium Tax is set at 2% of premiums
ACA Issuer Fee is applicable to for-profit plans only

ATTACHMENT 3

RATE SETTING PROCESS (DATA BOOKS)

ATTACHMENT 4

MODEL CONTRACT
Attached Electronically

ATTACHMENT 5

PROCURMENT LIBRARY LISTING

Medicaid Managed Care 2016 Procurement Library Listing

1. Rhode Island Healthcare Transformation Program Power Point
2. Grievance and Appeals Process for Medicaid Managed Care
3. Summary and Analysis of High Utilizers
4. Analysis of High Utilizers Fact Pack
5. Rules and Regs for the Utilization Review of Health Care Services
6. Medicaid Managed Care Health Plan Financial Reporting Program
7. Provisions for Stop Loss Claiming for Pharmacy Expenditure in Treatment of Enrollees with Hepatitis C
8. RI Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance
9. 837 Encounter Companion Guide Version 2.4
10. NCPDP Encounter Companion Guide Version 2.1
11. 834 Encounter Data Companion Guide Version 2.1
12. Standard Companion Guide
13. 277CA Companion Guide Version 1.3
14. Medicaid Managed Care Enrollment, Cost, Utilization and Provider Expense
15. Medicaid Managed Care Enrollment, Cost, Utilization and Provider Expense XLS
16. Medicaid Managed Care Providers
17. RI 1115 Waiver Standard Terms and Conditions
18. Medicaid Managed Care Final Rule
19. EOHHS Guidelines for Marketing and Member Communications Materials for RI Medicaid Managed Care Program
20. Managed Care Reporting Calendar and Template
21. RI Medicaid Annual Expenditure Report
22. RI EOHHS Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Organizations
23. RI EOHHS Alternative Payment Methodology Reporting Template for Medicaid Managed Care Organizations
24. Provisions for Separate Risk/Gain Share for Enrollees in an Integrated Health Home (IHH)

ATTACHMENT 6: Attestation Form for Acceptance of State Capitation Payments

On this date, _____ (Name of Bidder), attest that_____ (Name of Bidder) accepts in whole the State Capitation Rates outlined in this LOI #_____.

_____ (Name of Bidder) acknowledges that submissions that fail to include a signed attestation of acceptance of the State's Capitation Rates outlined in LOI# _____ will be deemed non-responsive and will not be considered.

_____

Print Name

_____ _____

Signature & Title Date