Solicitation Information
March 2, 2021

RFI# 7611871

TITLE: Rhode Island Medicaid Managed Care Program Request for Information

SUBMISSION DEADLINE: March 30, 2021 at 1:00 PM ET

Questions concerning this solicitation must be received by the Division of Purchases at doa.purquestions1@purchasing.ri.gov no later than **March 11, 2021 @ 1:00 PM ET.** Questions should be submitted in a *Microsoft Word attachment.* Please reference the **RFI#** on all correspondence. Questions received, if any, will be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

Nina M. Lennon, Interdepartmental Project Manager

Note to Applicants:

- Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov
- Proposals received without a completed RIVIP Bidder Certification Cover Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION COVER FORM

COVID-19 EMERGENCY PROTOCOL FOR BID OPENINGS

Vendors and the public are advised that due to Covid-19 emergency social distancing requirements bid openings at the Division of Purchases shall be conducted via live streaming on the ZOOM website/application. Vendors and the public shall not be permitted to enter the Division of Purchases to attend bid openings. Vendors and the public who attend bid openings via live streaming shall be required to identify themselves and a record of all such attendees shall be maintained by the Division of Purchases. Vendor bid proposals shall be opened and read aloud at the date and time listed herein. The results of bid solicitations requiring a public copy for public works projects shall be posted on the Division of Purchases website as soon as possible after the bid opening. For RFP solicitations only vendor names shall be read aloud at the opening.

Vendors and the public are further advised that visitor access to the Powers Building at One Capitol Hill, Providence, RI requires pre-screening at the entrance to the building. In accordance with the Governor's Executive Order(s) and Department of Health emergency regulations all visitors to the Powers Building must wear a cloth mask which covers the nose and mouth. Vendors delivering bid proposals to the Division of Purchases should allow sufficient time for the pre-screening process. The Division of Purchases assumes no responsibility for delays caused by the screening process or any other reason. Vendors are solely responsible for on time delivery of bid proposals. The Division of Purchases shall not accept late bids for any reason.

BID OPENING ZOOM INFORMATION

Division of Purchases is inviting you to a scheduled Zoom meeting.

Topic: 7611871

Time: Mar 30, 2021 01:00 PM Eastern Time (US and Canada)

Join Zoom Meeting

https://us02web.zoom.us/j/83526607017?pwd=MkEwVTlFOFlGb3F3VnVLVU5xUjdjdz09

Meeting ID: 835 2660 7017

Passcode: 535105

One tap mobile

+13017158592,,83526607017#,,,,*535105# US (Washington DC)

+13126266799,,83526607017#,,,,*535105# US (Chicago)

Dial by your location

+1 301 715 8592 US (Washington DC)

+1 312 626 6799 US (Chicago)

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+1 253 215 8782 US (Tacoma)

+1 346 248 7799 US (Houston)

+1 669 900 9128 US (San Jose)

888 788 0099 US Toll-free

833 548 0276 US Toll-free

833 548 0282 US Toll-free

877 853 5247 US Toll-free

Meeting ID: 835 2660 7017

Passcode: 535105

Find your local number: https://us02web.zoom.us/u/kurr5QSbG

Table of Contents

SECTION 1. INTRODUCTION

The Rhode Island Department of Administration on behalf of the Executive Office of Health and Human Services, is soliciting informational responses from qualified potential vendors and other interested parties to inform the procurement of its Medicaid Managed Care Program serving the RIte Care, Rhody Health Partners and Adult Expansion populations, in accordance with the terms of this Request for Information ("RFI") and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases' website at www.purchasing.ri.gov.

Instructions and Notifications to Offerors:

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

2. The State invites comments, suggestions and recommendations from potential vendors and other interested parties on any questions or issues raised in this RFI. Other interested parties include but are not limited to Medicaid enrollees, Medicaid member advocacy organizations, community-based organizations, health systems, Medicaid accountable entities, medical and behavioral health providers, associations, and organizations representing providers, and administrative entities. Respondents are not required to answer all questions. If you choose not to respond to a question under one of the RFI categories, please note that you do not intend to submit a response to that question.

3. Alternative approaches and/or methodologies to accomplish the desired or intended results of this RFI are solicited.

4. This is a request for information, and as such no award will be made because of this solicitation.

5. All costs associated with attending the pre-solicitation conference and/or developing or submitting responses to this RFI or providing oral or written clarification of the content of a response shall be borne by vendors. The State assumes no responsibility for any costs.

6. Responses misdirected to other locations, or which are otherwise not present in the Division of Purchases at the above stated date/time of opening for any cause will be determined to be late and shall 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 of Purchases.

7. Vendors are advised that all materials submitted to the State for consideration in response to this RFI shall not be considered to be public records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island unless and until there is a contract award through a subsequent, related procurement.

8. Interested parties are instructed to monitor the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released as addenda.

SECTION 2. REQUEST FOR INFORMATION

This RFI outlines the type of information being solicited and response structure requested from potential respondents.

A. Background

Medicaid Managed Care in Rhode Island Today

The Executive Office of Health and Human Services ("EOHHS") administers Rhode Island's $2.6 billion[1] Medicaid program, which provides health care coverage for one third (1/3) of all Rhode Islanders of all ages and from various ethnic and racial backgrounds. As of the end of January, 2021, the program serves 276,179 individuals through the RIte Care (children and families, including children with health special health care needs and in substitute care), Medicaid Expansion (expansion adults nineteen (19) to sixty-four (64) years of age), and Rhody Health Partners (qualified aged, blind, and disabled adults) managed care programs. Managed care expenditures for these populations account for approximately sixty percent (60%) or $1.4 billion of the Medicaid program expenditures. Both RIte Care, Medicaid Expansion and Rhody Health Partners managed care programs cover acute, primary and specialty care, pharmacy, and behavioral health services on a mandatory basis across the state. Currently, EOHHS contracts with three (3) managed care organizations ("MCOs") to provide care for members in these three (3) managed care programs[2]:

1) Neighborhood Health Plan of Rhode Island;
2) Tufts Health Public Plan; and
3) United Health Care Community Plan

The Rhode Island Health System Transformation Project ("HSTP") is a component of the State's 1115 Demonstration Waiver with the Centers for Medicare and Medicaid Services ("CMS"). HSTP aligns with the goals of the Institute for Health Care Improvement's Triple Aim: improve the member experience and quality of care, improve population health, and reduce the total cost of care. HSTP has guided significant investments and has enabled EOHHS to implement and invest in delivery system changes aimed at achieving all three goals. The HSTP provides the financial and structural support for growth and development of Accountable Entities ("AEs"), which partner with MCOs to improve member health while controlling health care costs. AEs are provider organizations who are accountable for quality health care, outcomes, and the total cost of care for enrollees. Current AEs include health centers, hospitals, and primary care providers. All

[1] This $2.6 billion expenditure is inclusive of federal funds, general revenues, and restricted receipts.
[2] Neighborhood Health Plan of Rhode Island is the sole plan currently serving the substitute care population.

members that are attributed to an AE are also enrolled in an MCO. Children, families, and the Medicaid Expansion population account for the largest number of AE enrollees. Since their implementation, the AEs have served 191,345 members, accounting for approximately seventy-one percent (71%) of managed care enrollees.

In partnership with its contracted MCOs, EOHHS' vision is to continue to deliver high quality care to members in an accessible, affordable coordinated, cost-effective manner, improving the population health of Medicaid beneficiaries, while reducing the per capita cost of health care. In the past year, EOHHS has responded to critical developments and disruptions impacting Rhode Island's health care landscape and continues to be faced with ongoing challenges including:

- The continuing effects of the COVID-19 pandemic upon Rhode Islanders, its economy, and its healthcare systems.
- Racial and ethnic disparities and systemic racism within the healthcare delivery system and their effect on overall population health equity.
- The need for improved community engagement and development of health equity zones.
- A lack of behavioral healthcare service continuum, integration, and parity within the current healthcare systems.
- The need for improved children's behavioral health, for our general Medicaid population and for our child welfare population.
- The impacts of Social Determinants of Health ("SDoH") on health status and improvement opportunities.
- The need for alternative and value-based payment ("VBP") models for the investment of the State's Medicaid dollars amidst the rising costs of healthcare, focusing spending on maximizing health and reducing waste.
- The need to collect data and utilize evidence-based practices.

With these factors and vision in mind, EOHHS intends to issue a separate Request for Proposals ("RFP") in summer 2021. The RFP will solicit qualified health plans to implement new and enhanced approaches to deliver high-quality, cost-effective managed health care for Rhode Island's Medicaid members consistent with Rhode Island's Medicaid program key principles and goals, statutes, regulations, and the CMS-approved 1115 Demonstration Waiver extension in accordance with EOHHS' duties and authority as contained in Rhode Island General Laws sections 42-7.2-2, 42-7.2-5 and 42-7.2-16.

Stakeholder Information Gathering Process

In November 2020, EOHHS began an extensive stakeholder engagement process to gather feedback on the current Medicaid managed care program and explore opportunities and innovations for improvements to align with EOHHS' current initiatives and member needs. The following fundamental principles and policy goals were recognized in this process:

- Provide a fair and open market competition that will ultimately allow for member choice among high quality MCOs.

- Increase the quality of care and experience for members and improve overall population health by promoting innovative payment policies and reforms that transition away from fee-for-service payments, support AE development, and increase alternative payment models ("APMs") that incentivize improved health outcomes and efficiency for members.

- Control the total cost of care, increase the risk taken on by MCOs and AEs, and increase budget predictability in the Medicaid program while maintaining high levels of quality and access to care for our members.

EOHHS has conducted numerous listening sessions with state staff from EOHHS and other state agencies, MCOs, AEs, advocates, providers, and community organizations and received feedback from Medicaid enrollees. EOHHS intends to continue seeking input from stakeholders, pending the release of the RFP, to identify additional innovations and opportunities for improvement within the current managed care program. Thus far, EOHHS has recognized several key themes in the stakeholder comments provided during these sessions:

- Possible changes to the member/MCO enrollment process.
- Potential inclusion of new populations into managed care.
- Options to improve integration of behavioral health services for all members, with particular focus on services for children.
- Ensuring continuity of care for members in transition, such as those moving between fee-for-service and managed care and those moving from an acute care setting to a community-based setting.
- Improvements to the care management process to ensure adequate and timely interventions, especially for children with special health care needs, including children and families involved with the Department of Children, Youth and Families ("DCYF") or the justice-system.
- Movement from a risk corridor as the primary MCO risk mitigation strategy to more targeted risk mitigation techniques.
- Modifying or clarifying roles and responsibilities between the MCOs and the AEs, including appropriate support for AEs by MCOs.

With this RFI, EOHHS seeks to build on the stakeholder engagement process started in the fall of 2020 by gathering input from MCOs and other interested parties. EOHHS will use the information gathered from the stakeholder process and this RFI to develop a formal RFP. EOHHS intends to issue the RFP in the summer of 2021, selecting up to three (3) vendors for new contracts with an operational start date of July 1, 2022.

RFI Response

Vendors and other interested parties should answer the following questions for their RFI response. The following outline is intended to standardize and structure responses for ease of analysis. Vendors should follow the format below and identify the Section and the question numbers for which they are responding, restating the RFI question above the response. Vendors are not required to answer all Sections or all questions but should adhere to the maximum page limits identified at the beginning of each section. Vendors may submit responses that are less than the maximum page limit for the section but are advised that any responses more than the maximum page limits will not be reviewed.

For example:

> Section I. Care and Service Coordination, question 1 - *How should responsibilities be delineated when members are receiving care administered by MCOs, AEs, and/or other outside programs that result in shared accountability for whole-person care while also improving health outcomes and controlling costs?*
>
> ***Response:*** [Include response]

Do NOT include a cost proposal with the RFI response as cost will not be considered.

RFI Questions:

I. Care and Service Coordination (15 Total Pages)

1. Members with complex medical and social conditions often receive services from multiple programs administered by the MCOs, AEs and other providers. How should responsibilities be delineated when members are receiving care administered by MCOs, AEs, and/or other providers and outside programs to reduce duplication of effort, inefficiency, or incentive misalignment between the various parties to improve shared accountability for whole-person care while also improving health outcomes and controlling costs?

2. What recommended actions or best practices do you recommend EOHHS take to support effective care coordination between MCOs and provider entities that leverages the respective strengths of these organizations, particularly in a context in which MCOs, AEs and other providers are bearing financial risk for a common population of members?

3. EOHHS may consider an MCO contract requirement for care management and coordination functions to be delegated to AEs or primary care providers. What requirements would EOHHS need to have in place to ensure successful delegation of care management and care coordination to the AE and provider level, that preserves NCQA accreditation and ensures that resources are appropriately allocated to successfully take on additional functions, including financial risk? Are there other functions that EOHHS should consider requiring MCOs to delegate to AEs or other providers?

4. Describe best practices for the exchange of care management information and data between EOHHS, MCOs, AEs, and contracted and non-contracted care management entities and providers.

5. Are there policies or strategies EOHHS should adopt to improve the continuity, and coordination, of care for members who transition between coverage tiers, care settings, and/or the Medicaid managed care and fee-for-service delivery systems (e.g., LTSS, Medicaid & Medicaid Plan, Dual Special Needs Plans)?

6. Currently, individuals up to age 26 who are enrolled in the managed care delivery system receive dental services covered by one MCO. They may receive their other medical and behavioral health services from the same or a different MCO. What policies or strategies should EOHHS consider improving the coordination and continuity of care for these individuals?

7. Currently, individuals enrolled in an MCO who become eligible for LTSS are disenrolled from managed care. Should EOHHS consider maintaining these members in their MCO for acute and behavioral health care services? If EOHHS were to implement this approach, what should a MCO's strategy be for coordinating

care between the physician and hospital (on the managed care side) and the HCBS service provider (delivering services on a fee-for-service basis)?

II. Behavioral Health (15 Total Pages)

1. What best practices (including evidence-based practices) should EOHHS adopt in the MCO contract to integrate high-quality behavioral health, substance use disorder treatment services, and physical health across the care continuum for adults and children while maintaining member choice/person-centered care? What behavioral health performance measures should be included and how should EOHHS ensure consistent monitoring and evaluation of these measures?

2. What do you see as the roles of MCOs, AEs, and primary care providers in person-centered/person-directed behavioral health, substance use disorder treatment, and primary care integration? What are the barriers that will need to be prioritized to improve client centered care and how should they be addressed?

3. What strategies or policies should EOHHS and its constituent agencies, such as the Department of Behavioral Health, Developmental Disabilities and Hospitals ("BHDDH"), and DCYF consider adopting to support and improve the integration of behavioral health at the provider level? What if any, current state policies, operations, payment models or practices restrict this integration that should be considered for changes?

4. EOHHS seeks to prevent situations in which members, including both children and adults, are "stuck" in acute behavioral health settings due to a lack of access to the full behavioral health continuum of care. What should EOHHS consider when setting requirements for MCOs to develop a child and adult behavioral health care continuum that serves members in the least restrictive, lowest cost, medically necessary environment? What suggestions can you offer to build and expand network and provider capacity to deliver the full continuum of behavioral health services (including treatment and recovery), in both the child and adult behavioral health service delivery system? What suggestions can you offer for adults and children with co-occurring disabilities (e.g., intellectual and developmental disabilities, autism, deaf and hard of hearing)?

5. Stakeholders sometimes comment that members receiving behavioral health services do not receive timely outpatient follow up and coordination when discharged from an acute care setting, leading to relapse or crisis that requires hospitalization or in some cases overdose death. What do you see as the role of MCOs, AEs, and primary care providers in proactively following up in these situations in order to effectively act as a stable touch point for these members?

6. How can MCOs incentivize behavioral health providers to improve medication management for individuals with a behavioral health disorder, especially with individuals who are often difficult to engage such as individuals with a substance use disorder or a serious mental illness?

7. How can EOHHS ensure MCOs provide statewide uniformity in providing access to the public mental health system, so that members and families aren't responded to in significantly different ways simply because of where they happen to live?

8. How can EOHHS better align MCO program requirements with other programs offered by the Rhode Island's BHDDH, DCYF, and Department of Health ("RIDOH")?

III. SDoH/ Population Health/ Health Equity (10 Total Pages)

1. Describe how MCOs and providers can support efforts to reduce the impact of structural racism on members, including, but not limited to social, economic, or geographic/ environmental disadvantages.

2. How can MCOs identify and prioritize issues that disproportionately affect Rhode Island's Black, Indigenous, and People of Color ("BIPOC")?

3. How can MCOs progressively work to identify their members' social needs and implement innovative strategies to address SDoH, including food insecurity, lack of housing, and interpersonal violence in the context of the members race, ethnicity and culture?

4. What MCO contract requirements or policies should EOHHS consider ensuring MCOs are fully engaging with their members and putting the member at the center of their care? What requirements or policies should EOHHS consider building trust between members and the healthcare system?

5. What MCO contract requirements or policies should EOHHS consider supporting providers in implementing care delivery strategies that are culturally relevant and foster respect, trust, and empathy?

6. A population-based approach to healthcare goes beyond the traditional biomedical model and addresses the importance of cross-sectoral collaboration in promoting the health of communities. What are best practices that EOHHS should implement to ensure MCOs identify and meet the unmet medical and behavioral healthcare needs in communities of color?

7. What suggestions can you offer for MCOs to play a greater role in creating housing opportunities for people who live with serious medical and behavioral health illness, and whose illness may require changing levels of intensity or support and care across their lifespan?

8. How can MCOs strengthen the RI health care system to ensure it provides a comprehensive range of evidence-based practices and supports at the local community level? What evidence-based practices and services do you feel are important to add to the benefit plan to address the needs of adults and children in their natural environment?

IV. Value-Based Payments and Alternative Payment Models (16 Total Pages)

1. EOHHS is interested in increasing the amount of financial risk that MCOs, Accountable Entities (AEs) and other providers take while jointly managing cost and quality of care for members. What strategies or policies should EOHHS consider increasing financial risk and accountability for cost and quality of care for members?

2. What infrastructure, tools, and resources should MCOs provide to encourage and support primary care providers, AEs, integrated health delivery systems and other providers to take on greater accountability for improved members' health outcomes and total cost of care?

3. In addition to the AE program, what other value-based payment methodologies should MCOs be required or strongly encouraged to adopt?

4. EOHHS is considering a delivery system that would enable AEs to contract with a single MCO to enable sufficient volume for risk-based contracting, as well as to support AE and MCO partnership that is customizable to the unique strengths and capacities of the AE and MCO. What are the benefits and challenges of an AE landscape that enables exclusivity? What impacts would such a change have on member access, quality, and financial viability of MCOs, AEs, and other providers?

5. EOHHS intends to align quality and population health goals among MCOs, AEs, and other providers. What clinical quality measures should be prioritized in both the managed care contract and value-based payment arrangements to improve overall population health in RI communities, including communities of color and cultural and ethnic diversity?

6. What level of flexibility should EOHHS give to MCOs to design their own VBP arrangements, as opposed to requiring specific methods across all MCOs and providers? Should MCOs be able to develop the structure, payment methods, and quality measures for AEs? Are there ways to provide MCOs flexibility while minimizing provider abrasion and administrative challenges? Are there specific components that you would suggest not be within the MCOs' discretion?

7. For any value-based payment arrangements adopted by MCOs (whether per an EOHHS requirement or not), should EOHHS or the MCOs be responsible for developing:

a. The method for determining payment to providers (e.g., primary care capitation rates);
b. The risk adjustment methodology (as needed for the methodology in question);
c. Any quality or non-financial measures;
d. The data and reports necessary to support accountability for improved members' health outcomes and total cost of care.

8. What value-based payment methodologies or other strategies should EOHHS consider improving the quality and coordination of care delivery for members requiring:
    a. Behavioral Health services
    b. Long-Term Services and Supports
    c. Pediatric care and other child and family services
    d. SDoH

V. Member Enrollment (5 Total Pages)

1. In order to provide enrollees with an opportunity to make an informed choice amongst all contracted MCOs, EOHHS is considering an open enrollment process. The open enrollment would require **all** members to actively select an MCO following the procurement, with impartial member choice counseling available. What factors should EOHHS consider in designing and implementing a member education and outreach process to facilitate and encourage members to make an informed and active MCO selection, thereby reducing MCO auto-assignment? Should AE and primary care provider education and selection be considered as part of the MCO enrollment process at initial or open MCO enrollment?

2. For members who do not make an active MCO selection during initial and open enrollment periods, EOHHS applies an auto-assignment algorithm to assign members to an MCO. EOHHS currently uses a weighted algorithm that assigns members to among contracted plans. EOHHS may consider changes to the auto-assignment process to assign members to higher performing MCOs (e.g., MCOs with higher quality and member satisfaction ratings, expanded access to care, high financial performance, and AE affiliations). What factors or metrics should EOHHS consider when auto-assigning members to an MCO?

3. Currently, upon determination of Medicaid eligibility, individuals select (or are auto assigned to) an MCO. MCOs attribute their members to an AE based on primary care provider selection or provider utilization data. If EOHHS considers changing the process to require members to select (or be auto-assigned to) an AE upon determination of Medicaid eligibility and then make an MCO selection based on AEs who are contracted with the MCO, what are the benefits of this alternative approach? What are challenges to this alternative and how could EOHHS mitigate

these challenges? Are there other approaches that EOHHS should consider encouraging members to choose their own AE?

4. Some states implement enrollment caps including minimum and maximum sizes for each MCO. Should EOHHS implement similar rules around membership size that would potentially restrict the total number of Medicaid enrollees anyone (1) MCO can have? What factors should EOHHS consider when determining the total number of enrollees each contracted MCO should have?

5. What steps should EOHHS take to manage care transitions between the fee-for-service (FFS) delivery system and managed care to ensure continuity of care for individuals who choose or are assigned to a new MCO due to EOHHS' redistribution of the membership?

6. There are several Medicaid eligibilities groups who do not receive services through the managed care delivery system, e.g. non-duals with long-term service and support needs, Medicare-Medicaid individuals (dual-eligibles). Should EOHHS consider including any of these additional eligibility groups in managed care? If so, please describe which eligibility groups should be considered for inclusion and the timeframe for transitioning these groups to managed care.

VI. COVID-19 Impacts/Telehealth/Data (5 Total Pages)

1. What programmatic flexibilities adopted during the COVID-19 pandemic should be continued beyond the public health emergency?

2. What have you learned through responding to the public health emergency that we should incorporate into an MCO contract? What opportunities do you see for continuing positive trends (for example in emergency department utilization)?

3. How can EOHHS and MCOs better support providers in preparing for future public health emergencies?

4. Describe the strategies an MCO might employ to help EOHHS address the negative budgetary impacts of the economic downturn while maintaining a person-centered, value-based delivery model.

5. How can EOHHS encourage all stakeholders (e.g., MCOs, providers, members, caregivers, advocates) to better utilize telehealth and other technologies for assessments and delivery of services? How can these new technologies and delivery

mechanisms be used to provide the most appropriate care for people in the most appropriate setting?

6. How can EOHHS ensure MCOs are using and sharing complete, accurate, and actionable data with contracted medical providers and AEs to enhance care quality and delivery?

7. How can data sharing between MCOs, AEs, and EOHHS be enhanced or modified to improve the cost and quality outcomes in the AE program?

8. What policy levers should EOHHS consider as part of the MCO procurement to advance Rhode Island's Health IT Roadmap?

VII. MCO Financing and Comprehensive Risk (7 Total pages)

1. EOHHS is interested in ensuring that program administration funding is used in the most efficient manner. Please provide suggestions and information related to approaches for EOHHS to consider assisting with managing administrative spending amounts while encouraging innovative investment in the Rhode Island Medicaid managed care program.

2. EOHHS is interested in increasing the amount of financial risk that MCOs should take in our contract structure, for example by reducing or eliminating the risk- and gain-share corridors that exist in the current contract. What strategies can EOHHS consider facilitating a successful transfer of financial risk from EOHHS to the MCOs? What strategic or operational approaches could MCOs adopt to succeed without a risk corridor while not sacrificing quality of care for members?

3. EOHHS recognizes the importance of MCOs maintaining sufficient Risk Based Capital ("RBC") levels. Please provide information related to how MCOs or EOHHS can balance safeguards for MCO solvency and allowing for cost effective financing of the program.

4. It is common for MCOs to purchase reinsurance coverage to reduce risk associated with low frequency, high-cost events. Please provide input related to the potential for additional MCO contracting requirements related to specific level(s) and/or type(s) of reinsurance coverage.

5. Pharmacy pricing, contracting, and transparency have become a topic of discussion for Medicaid programs across the country. Please provide suggestions for EOHHS's consideration related to policy changes that could assist with controlling

pharmacy costs while increasing quality, accountability, and transparency of the pharmacy benefit in the Rhode Island Medicaid managed care program.

6. EOHHS recognizes that MCOs may utilize sub contractual relationships for meeting the requirements of the Rhode Island managed care program. In addition, EOHHS recognizes that some of these subcontracted entities may be related entities (owned by the same parent company as the MCO). Please provide information related to approaches EOHHS could consider that would increase the transparency and accountability of these relationships.

VIII. Other (2 Total Pages)

1. EOHHS is considering rebranding of the managed care program serving the current RIte Care (children and families, including children with health special health care needs and in substitute care), Rhody Health Partners (qualified aged, blind, and disabled adults), and Medicaid Expansion (adults nineteen (19) to sixty-four (64) years of age) Populations. Do you have recommendations on the brand name EOHHS could consider for this program?

2. Is there any other feedback that you would like to provide on the current or future program that we should consider?

SECTION 3. QUESTIONS

Questions concerning this solicitation must be e-mailed to the Division of Purchases at doa.purquestions1@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. No other contact with State parties is permitted. Please reference **RFI# 7611871** on all correspondence. Questions should be submitted in writing in a Microsoft Word attachment in a narrative format with no tables. Answers to questions received, if any, shall be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to monitor the Division of Purchases website for any procurement related postings such as addenda. If technical assistance is required, call the Help Desk at (401) 574-8100.

SECTION 4. RESPONSE CONTENTS

A. Responses shall include the following:

1. One (1) completed and signed RIVIP Bidder Certification Cover Form (included in the original copy only) downloaded from the Division of Purchases website at www.ridop.ri.gov. *Do not include any copies in the response.*

2. Response - describing the requirements and concept for this potential project, and all information described earlier in this solicitation. The response is limited to 75 pages.

    a. One (1) Electronic copy on a CD-R, marked "Response – Original."
    b. One (1) printed paper copy, marked "Response -Original" and signed.
    c. Seven (7) printed paper copies

B. Formatting of proposal response contents shall be as follows:

1. Formatting of CD-Rs – All CD-Rs submitted must be labeled with:

    a. Vendor's name

    b. RFI #

    c. RFI Title

    d. If file sizes require more than one (1) CD-R, multiple CD-Rs are acceptable. Each CD-R must include the above labeling and additional labeling of how many CD-Rs should be accounted for (e.g., 3 CD-Rs are submitted and each CD-R should have additional label of '1 of 3' on first CD-R, '2 of 3' on second CD-R, '3 of 3' on third CD-R).

Vendors are responsible for testing their CD-Rs before submission as the Division of Purchase's inability to open or read a CD-R may be grounds for rejection of a Vendor's submission. All files must be readable and readily accessible on the CD-Rs submitted with no instructions to download files from any external resource(s). If a file is partial, corrupt, or unreadable, the Division of Purchases may consider it "non-responsive." USB drives or other forms of electronic media shall not be accepted. Please note that CD-Rs shall not be returned.

2. Formatting of written documents and printed copies:

    a. For clarity, the response shall be typed. These documents shall be single-spaced with 1" margins on white 8.5"x 11" paper using a font of 12-point Calibri or 12-point Times New Roman and may be printed on both sides with page numbers identified and stapled.

    b. All pages on the response are to be sequentially numbered in the footer, starting with number 1 on the first page of the narrative (this does not include the cover page or table of contents) through to the end, including all forms and attachments. The Vendor's name should appear on every page, including attachments. Each attachment should be referenced appropriately within the response section and the attachment title should reference the response section it is applicable to.

    c. Printed copies are to be only bound with staples or removable binder clips.

SECTION 5. RESPONSE SUBMISSION

Interested vendors must submit responses to provide information covered by this RFI 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, shall not be accepted.

Responses should be mailed or hand-delivered in a sealed envelope marked "**RFI# 7611871"** to:

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

SECTION 6. DISCLAIMER

This Request for Information is solely for information and planning purposes and does not constitute a request for proposal or an invitation to bid. All information received in response to the RFI and marked as "Proprietary" shall be deemed to be confidential but may still be subject to disclosure pursuant to the Rhode Island "Access to Public Records Act, R. I. Gen. Laws § 38-2-1, *et seq.*.. EOHHS intends to publicly post a synopsis summarizing the responses received regarding this proposal without identifying individual respondents. Responses to the RFI will not be returned.