



**State of Rhode Island  
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**Solicitation Information  
June 16, 2014**

**ADDENDUM # 1**

**LOI # 7548793**

**LOI Title: Financial Alignment Demonstration Medicaid Integrated Care Initiative**

**Bid Opening Date & Time: Monday, June 30, 2014 at 10:00 AM (Eastern Time)**

**Notice to Vendors:**

ATTACHED ARE VENDOR QUESTIONS WITH STATE RESPONSES.

NO FURTHER QUESTIONS WILL BE ANSWERED.

**David J. Francis  
Interdepartmental Project Manager**

*Interested parties should monitor this website, on a regular basis, for any additional information that may be posted.*

**Vendor Questions for LOI 7548793 Financial Alignment Demonstration  
Medicaid Integrated Care Initiative**

Question 1: Section 1, Introduction; Section 2.1; Section 2.2.6; other Sections.

This LOI makes several references to the Medicaid-only LTSS product and the RHO contract. Is it EOHHS' intent, when awarding the dual Medicare/Medicaid product to a bidder, to also bind such bidder to enter into a contract for, and offer the product, which was issued with an opening date of March 27, 2013 and entitled LOI-Medicaid Integrated Care Initiative for the Rhody Health Option Program (Phase 1)?

Answer to question 1:

Yes, that is EOHHS' intent. Bidders that respond to this LOI are responding to participate in the Demonstration, and also participate in managed LTSS, either absent the demonstration or in concert with the Demonstration. EOHHS reserves the right to reconsider this requirement after additional review and evaluation of the first phase of the ICI.

Question 2: 1, Introduction; Section 2.1; Section 2.2.6; other Sections.

The LOI makes reference to the winning bidders' signing the RHO contract. Is it EOHHS' expectation that this contract would be signed for administration of the Rhody Health Options product separate and apart from the signing of the 3-way contract with CMS and EOHHS, and are the capitation rates that exist currently under such RHO contract, and that are utilized for the existing RHO MCO vendor (Neighborhood Health Plan), those same capitation rates that would be available for the winning bidders of this present LOI for the RHO portion of the product offerings? Additionally, can EOHHS please articulate what the contractual Order of Precedence will be as it relates to the 3-way contract with CMS and EOHHS, the RHO contract, the MOU, and this LOI?

Answer to question 2:

Yes, it is EOHHS' expectation that a separate contract would be signed between a successful bidder and EOHHS for administration of the existing Rhody Health Options product, for Medicaid-only and MME members. EOHHS reserves the right to reconsider this requirement after additional review and evaluation of the first phase of the ICI. The rates that were released with this LOI are the current rates in effect with the existing Contractor (Neighborhood Health Plan of RI) for the period July 1, 2014 through June 30, 2015. These rates will need to be adjusted for a successful bidder for the period April 1, 2015 through June 30, 2015.

In the case of the stand-alone contract between EOHHS and the Contractor, the contract language prevails over the LOI. Potential vendors can refer to the existing three-way contracts for order of precedence for the demonstration. For example, below is language from the IL contract:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/IllinoisContract.pdf>

## 5.6 Order of Precedence

5.6.2 In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

5.6.2.1 The Contract terms and conditions, including all appendices;

5.6.2.2 Capitated Financial Alignment Application;

5.6.2.3 The Memorandum of Understanding between CMS and Illinois;

5.6.2.4 The Request for Proposal number 2013-24-004 or number 2013-24-004 issued by the Department, including the Department's responses to questions submitted by potential bidders;

The Contractor's proposal in response to the Request for Proposal number 2013-24-004 or number. 2013-24-004; and

5.6.2.5 Any State or Federal Requirements or Instructions released to MMPs. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, and Enrollment Guidance.

5.6.3 In the event of any conflict between this Contract and the MOU, the three-way Contract shall prevail.

### Question 3: Section 3.2

This Section states, "[t]he three-way contract will set forth the terms of agreement with CMS and with EOHHS for an award pursuant to this LOI. In the absence of a complete model three-way contract, on a preliminary basis, the RHO Contract (in combination with all Medicare requirements described in this LOI) offer guidelines to respond to this LOI and, to establish a significant portion of Medicaid-related requirements under the ICI Demonstration. Bidders are urged to read the RHO Contract carefully and thoroughly. Contractors are expected to have policies, procedures and practices that demonstrate compliance with the requirements contained in this RHO Contract and to address all Medicare requirements described in this LOI. The RHO contract is available in the procurement library found at <http://www.eohhs.ri.gov/IntegratedCare.aspx>."

Is it EOHHS' intent to utilize the RHO contract as binding terms for the Medicare/Medicaid enrollee product, notwithstanding the Rhody Health

Options product? Would the use of the RHO contract be in the event that the three-way contract is not signed at the time of implementation, or also subsequent to the signing of the three-way contract? Is it the expectation of EOHHS that it will be looking to combine all terms from the RHO contract into the three-way contract, and if such terms do not get integrated, is it EOHHS' expectation that the RHO contract will supersede and/or supplement all Medicaid terms in the three-way contract between the MCO (MMP), EOHHS and CMS?

Answer to question 3:

Please see response to questions #1 and #2. It is EOHHS' intent to enter into a separate contract between a successful bidder and EOHHS for the existing Rhody Health Options program for managed LTSS. This contract would be in addition to the three-way contract for the Demonstration. EOHHS reserves the right to reconsider this requirement after additional review and evaluation of the first phase of the ICI. The order of precedence is addressed in question #2, but in areas of dispute, the contract will prevail. The three-way contract would prevail for members enrolled in the demonstration, and the state contract would prevail for members enrolled with the plan, but not in the demonstration.

Question 4: Section 1 states, "Subcontracts are permitted, provided their use is clearly indicated in the vendor's proposal. And the subcontractor(s) to be used is identified in the proposal." Subcontractors may not all be identified at the time of proposal response. Is it EOHHS' intent that bidders may provide notification to EOHHS of additional subcontractors as such are identified?

Answer to question 4:

Yes, bidders should provide information on all known subcontractors at the time their proposal is submitted. As additional subcontractors are identified post-submission, bidders should notify EOHHS. EOHHS retains the right to review language in subcontractor arrangements.

Question 5: Section 1 states, "Vendors are advised that all materials submitted to the State for consideration in response to this LOI 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." Section 38-2-2 (4)(B) provides that trade secrets and commercial or financial information that is privileged and confidential are exceptions to Public Records. Can EOHHS advise whether redacting is permitted for a specific copy marked "Public" or is it appropriate for bidders to mark such

trade secrets or commercial/financial privileged information with the legend that such pages are excepted from Public Records?"

Answer to question 5:

Public copies are not required. Any confidential material should be marked as "confidential"; the state will ultimately determine what is deemed confidential.

Question 6: Section 1 states, "In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSourceRI), 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."

Can EOHHS elaborate on what responsibilities the winning bidder would have with services related to the Rhode Island Health Benefits Exchange (HealthSource RI)?

Answer to question 6:

The language is general language that does not pertain to this offering.

Question 7: Section 2.2.6 states that the term of the contract will begin on April 1, 2015 and continue until December 31, 2018. Section 1 references a term date through December 31, 2017. Can EOHHS please advise which is the correct expiration date?

Answer to question 7:

The three-way contract term will begin April 1, 2015 and end on December 31, 2017. In the case of the stand-alone contract between EOHHS and the Contractor, the contract start date will align with the demonstration start date, but subsequent contract years will align with the state fiscal year, which is July 1 through June 30.

Question 8: Sections 2.2.6 ; 3.2.15 reference MGL Section 224, which is a Massachusetts law. Can EOHHS please advise whether this is intentional, and whether the LOI and subsequent contracts bind bidders to abide by Massachusetts law?

Answer to question 8:

This reference was included in errors. Bidders are not expected to comply with Massachusetts General Law.

Question 9: Section 3.2.1 states that bidders must "support CurrentCare." Can EOHHS articulate what such support entails? It is the understanding of the bidder that this means only education provided to its membership and that there is no financial impact to bidder? Can EOHHS confirm?

Answer to question 9:

Bidders should include language in all provider contracts to require provider enrollment in CurrentCare, including direct messaging and hospital alerts. Bidders should also include language that requires providers to encourage and assist their high utilizing patients to enroll in CurrentCare. High utilizers are defined by the bidder.

Question 10: In section 4.2.3 of the LOI the state requests the bidder to attest to its ability to provide services under a risk sharing arrangement. There is no risk sharing arrangement cited in the ICI LOI.

If there will be a risk sharing arrangement, is EOHHS agreeable to discuss the provisions with awardees to ensure the program has enough flexibility to allow for successful implementation of Alternative Payment Programs requested by EOHHS?

Answer to question 10:

This risk sharing arrangement is described in the existing Rhody Health Options contract, which is available in the procurement library. These risk share corridors would apply to the Contract between the successful bidder and EOHHS. However, EOHHS is still negotiating what the risk arrangement and corridors would be in the three-way contract with CMS. Final arrangements are not available at this time.

Question 11: In Section 2.2.7 of the LOI, EOHHS provides information on the current opt out membership that comprise the potential enrollees for the MMP FAD. Can the State please provide more data on this subset of members? Specifically enrollment by PCP (actual volume by Primary Care site including all PCMH and CSI sites), zip codes of members, nursing home sites (volume by NH), Assisted Living enrollment by site, Shared Living enrollment by provider, Rite to Home enrollment, average total cost of care, utilization and cost by inpatient, outpatient, physician, home care, home health, adult day, Behavioral Health and pharmacy categories.

Answer to question 11:

Fulfillment of this request will take analytic resources that are not available in the time frame which these responses are needed. EOHHS will however begin to process this request, and will work with a successful bidder to answer these questions. EOHHS will only be able to provide data on the cost of Medicaid covered services – EOHHS does not have access to Medicare cost data at this time. Medicare is the primary coverage and would cover outpatient, physician, and most pharmacy expenses.

**Question 12:** Section 3.2.5-For consistency, we assume the state will follow the CMS approach of reporting access in miles and not minutes. Will the state please confirm that this is the only requirement for access reporting.

**Answer to question 12:**

The access standards in the three-way contract will be in miles, not minutes. CMS has approved this access standard in the draft Memorandum of Understanding. Additional access requirements are outlined in detail in LOI Section 3.2.5. Selected bidders will be expected to report on compliance with all the access standards outlined in this section.

**Question 13:** Section 3.2.6 of the LOI states awardees must reimburse as EOHHS reimburses. When will EOHHS share the current Medicaid and Medicare rates and codes used for Essential Community Providers?

Essential community providers are listed in Appendix C, and include DEA Case Management Agencies, RItE @Home agencies, and also agencies that provide self-directed services.

DEA Case Management Services bill with **T1016** \$15 per 15 minute unit; \$60 for one hour (4 units)

**RItE @ Home Rate Structure**  
**Rates Effective 10/1/12**

<b>Code</b>	<b>Description</b>	<b>High LOC</b>	<b>Highest LOC</b>
T2025	Case Management Admin. Per Diem High LOC	\$26.03	
T2025 L1	Case Management/Admin Per Diem, Highest LOC		26.99
T1028	Development of Safety Plan	\$300.00	\$300.00
T1005	Respite, Per 15 minute units	Pay as billed – up to 3,000 maximum per recipient per year	
S5136 U1	Stipend, per diem, high LOC, no adult day	\$38.00	
S5136	Stipend, per diem, high LOC, client attended adult day	\$32.30	
S5136 TGU1	Stipend, per diem, highest LOC, attended adult day		\$48.11

S5136 TG	Stipend, per diem, highest LOC, attended adult day		\$40.89
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Personal Choice (Self-Directed)

Fiscal Intermediaries are paid \$100.00 per person per month for services completed in accordance with policy guidelines.

Service Advisement Agencies are paid \$125.00 per person per month for services completed in accordance with policy guidelines.

PCA wages can vary from the current minimum wage up to a maximum of \$15.00 per hour. A PCA cannot work over 40 hours per week.

Answer to question 13:

Question 14: We understand that certain services for the demonstration will be carved out from the demonstration for individuals with ID/DD and SPMI at the start of the contract per page 20 of the LOI. Please confirm that the draft premium and data provided in the data book excludes the experience for these covered services as well

Answer to question 14:

Yes, the carved-out services were not considered in the data that was used to set the capitation rates.

Question 15: In Appendix A, there are a number of examples including transition targets for member movements. What are the final transition targets the State has negotiated with CMS? Are these annual or monthly transition targets?

Answer to question 15:

EOHHS is not negotiating transition targets with CMS as part of the Medicaid rate development process. Alternatively, CMS reviews EOHHS' methodology and approves the methodology overall. The transition targets that are identified in Appendix A are annualized. Transition assumptions are built into the rate and displayed in Table 6. They are as follows:

Enrolled Group	Current	Target
Community to Waiver	3.77%	2.5%
Community to LTC	3.59%	3.0%
Waiver to LTC	10.05%	5.0%

LTC to Waiver	1.52%	3.0%
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**Question 16:** Appendix A -What are the assumed savings percentages by Demonstration Year?

Answer to question 16:

CMS will determine the assumed savings percentages – these have not been determined yet. EOHHS is using other states’ negotiated MOUs as a basis for understanding what the estimated saving percentages may be, and will attempt to negotiate similar savings targets, with the goal being smaller savings in the first year, and incremental increases in savings in year 2 and 3 of the demonstration.

**Question 17:** Section 3.2.9. states that “strong consideration should be given to the use of the State’s Health Information Exchange, Currentcare, to support information exchanges, particularly around care transitions.” We would encourage the state to work with bidders to make this information accessible from the HIE to deliver the best care to individuals and align with the goals laid out in the State’s SIM proposal.

Answer to question 17:

EOHHS appreciates this statement and will continue to work with Current Care to provide access for health plans.

**Question 18: Medicare-Medicaid Plan (MMP) Definition**

Will all MMPs be required to offer a Medicaid only plan?

Answer to question 18:

Yes, this procurement is for the demonstration, as well as for a stand-alone managed LTSS contract with EOHHS. The current managed LTSS contract does enroll Medicaid-only clients.

**Question 19: Medicare-Medicaid Plan (MMP) Definition**

Is an RHO plan synonymous with an MMP plan?

Answer to question 19:

For purposes of this LOI, the MMP references health plans in the demonstration, and the RHO plan references the stand-alone Managed LTSS program.

**Question 20: Medicare-Medicaid Plan (MMP) Definition**

Page 20 - What is the definition of “a different MMP”, (if available).

Answer to question 20:

This section speaks to the various delivery system options available to eligible members. A different MMP references the successful bidder to this procurement, if there is indeed a successful bidder that the state and CMS enter into a contract with.

Question 21: **Pharmacy**

Is the UR process (PA review, denials, appeals etc.) associated with the ADD drugs (drugs not commonly covered by Medicare Part D) governed by the Part D regulations or the requirements set forth for “non-Part D” services under the LOI?

Answer to question 21:

They would be governed by the non-Part D requirements.

Question 22: **Pharmacy**

Will the plans be required to honor pharmacy authorizations for 60days?

Answer to question 22:

Yes, the plans will be required to honor pharmacy authorizations for 60 days in both the demonstration and the stand-alone Medicaid contract.

Question 23: **Cross-Over Claims**

Is the bidder expected to process cross-over claims for all members in all categories?

Answer to question 23:

Yes, the bidder is expected to process cross over claims for all MMEs.

Question 24: **Benefits**

Is non-emergency medical transportation and in plan or out of plan benefit?

Answer to question 24:

Non-emergency medical transportation is an out-of-plan benefit. It is the expectation that the MMP would coordinate with the state’s transportation broker for members who need to access transportation.

**Question 25: Benefits**

For benefits in the LOI not defined for the bidder prior to the submission of the PBP, will health plan have an opportunity to modify the PBP?

**Answer to question 25:**

Yes, prospective MMPs will have an opportunity to modify their PBP and ADD. Tentative dates for revisions are late June/early July.

**Question 26: Benefits**

When does the state depend on defining the benefits in 3.2.5?

**Answer to question 26:**

EOHHS is unclear how to respond to this question. Definitions of covered benefits are available in the RHO contract, which is located in the procurement library. Other documents in the procurement library also offer additional detail on covered benefits.

**Question 27: Benefits**

Will the MOU or contract define the benefits as Medicare covered versus Medicaid covered?

**Answer to question 27:**

The three way contracts will not differentiate between the Medicare and Medicaid covered services, but do provide guidance for benefits that overlap. The contract will specify that the plan must cover all Medicare part A, B and D benefits, and all services that are standard to Medicaid and any pharmacy products not covered by part D, but covered by Medicaid.

**Question 28: Benefits**

The following services are listed in Phase I - 8/7/13 contract but are not identified in the Phase II – LOI 5/30/14. Will these services remain out-of-plan for Phase II? Out of Plan in Phase I 8/7//13 included: Aids Non-Medical Case Management and RI Assertive Community Treatment I and II

**Answer to question 28:**

Both AIDS non-medical case management and RI Assertive Community Treatment are out-of-plan benefits.

**Question 29: Benefits**

The following Phase I – LTSS services from 8/7/13 contract are not listed in section 3/2/5 of the LOI. Can the Plan assume these will remain LTSS services and covered in-plan or will these services change in definition/service? Phase I –LTSS services from 8/7/13 contract include: Homemaker, Residential Supports, Day Supports, Supported Employment, RIt@ Home, Senior Companion, Financial Management Services, Physical Therapy Evaluation Services.

**Answer to question 29:**

The Long-term services and supports listed in this question will be in-plan benefits for the demonstration. All in-plan benefits are described in detail in Attachment A of the Rhody Health Options contract, located in the document library.

**Question 30: GAU**

How many levels of internal appeals does the enrollee have? Currently, we have 2 levels of internal appeals before an IRE or Fair Hearing can be requested?

**Answer to question 30:**

Enrollees will be entitled to two levels of health plan administrative appeals. This appeal step must be exhausted prior to requesting a fair hearing or the IRE.

**Question 31: Medical Management**

Page 62 - The requirement “ICM and Care Coordination services and support during transitions must be available twenty four hours a day, seven days a week (24/7). Is this a standard for the entire population or just MFP?

**Answer to question 31:**

This requirement would apply to anyone who is transitioning among the settings that were described in that section:

- Hospital to nursing home
- Hospital to home/community
- Nursing home to hospital
- Nursing home to community
- Community to nursing home
- Community to hospital

**Question 32: Medical Management**

Page 34 – Home visits by medical personnel. Will the state allow home visits to be conducted by various disciplines; nurses, social workers, care coordinators, community health workers and peer navigators?

Answer to question 32:

Yes, MMPs will be permitted to customize the home visit to best meet the member's needs.

**Question 33: Medical Management**

Page 38 – The bidder provides an in-person visit to their residence within twenty-four (24) hours of being discharged from a hospital or nursing facility. Will the state reconsider this time frame given the complexity of people coming out of the hospital?

Answer to question 33:

EOHHS understands that the complex needs of MMEs will require a post-hospital discharge visit, and this visit is critical to ensure a safe transition and prevent readmissions. Therefore EOHHS is not reconsidering this requirement. MMPs can meet this requirement however with their own staff, through a contracted network home health agency or by coordinating with one of the many safe transitions initiatives operating in the state.

**Question 34: Quality**

Will the health plan be assigned QIPs for MMP from the State or CMS?

Answer to question 34:

EOHHS will most likely assign QIPs to the MMPs, and also permit MMPs to propose their own QIPs.

**Question 35: Quality**

Page 23-24 – In the table on these pages the sum of RHO enrollment, CCCC enrollment, and those opting out does not equal the number given for Total ICI Mailing. Is there another group and is it eligible for RHO?

Answer to question 35:

The difference in the numbers is 2,531. This data reflects a mailing that occurred in April, but enrollment was not effective for members who received that mailing until June 1. That is why the mailing number is higher than the enrollment number.

**Question 36: Quality**

Page 24 – What are the plans for enrollment of those in “Group 2”? If only one participating health plan, will those members be assigned to the existing plan

**Answer to question 36:**

If there is only one health plan participating in the demonstration, the clients referenced in Group 2 will be offered enrollment but will not be auto-assigned.

**Question 37: Quality**

Page 28 – What NCQA accreditation will the MOU pursue, Medicare or Medicaid?

**Answer to question 37:**

The requirement to be NCQA accredited is a state requirement. Therefore, an MMP should have Medicaid accreditation.

**Question 38: Quality**

Page 41 – Person-centered care is described as meeting the needs based on the Enrollee’s race, ethnicity, and culture. How will this information be shared with the MMP?

**Answer to question 38:**

MMPs will be expected to solicit this information during the member welcome call and initial health risk assessment. This is not required information during the application process, and therefore that information is not available for all Medicaid beneficiaries. When known, race will be transmitted to the MMP on the monthly enrollment file.

**Question 39: Quality**

Page 70 – What is the designated role of the QIO? Will Rhode Island’s QIO have a role in the ICI?

**Answer to question 39:**

Rhode Island has a designated External Quality Review Organization – IPRO. On an annual basis, the state will solicit information from the MMP to provide to the EQRO. The EQRO will then produce a report annually and provide recommendations to the state and the MMPs. These recommendations often include suggested QIPs and other efforts for

improvement. The successful bidder will be asked to cooperate with the RI QIO on programs relevant to their covered members.

**Question 40: Quality**

Appendix D does not include many of the measures listed in Attachment J (Performance Goals) and Attachment N (Quality and Operations Reporting Requirements) of the current RHO contract for Phase 1. Will all measures reportable under Phase 1 continue to be reportable under Phase 2? Also, does the list in Appendix D replace or add to the list of measures appearing under “Phase 2: Provisional Performance Indicators” in Attachment N?

**Answer to question 40:**

The lists of measures in Appendix D of the LOI are the measures that will be collected for the demonstration. The measures listed in Attachment N and J will be in place for the stand-alone contract between the bidder and EOHHS. Also for the demonstration, there will be a set of quality withhold measures. CMS determines most of the quality withhold measures, and there are also 2-3 state specified measures.

**Question 41:** I just wanted to gain a better understanding if it is still possible to bid since previously I was informed that only plans that had submitted a Notice of Intent to Apply in November in HPMS were eligible.

**Answer to question 41:**

A pre-requisite for bidding on this LOI was to submit a Notice of Intent to Apply (NOIA) through the Health Plan Management System (HPMS) by the deadline of November 2013. If a plan did not submit a NOIA by that deadline, they are not eligible to bid on this procurement.

**Question 42:** Page 24 – Discusses the Passive enrollment for two groups following the period of voluntary enrollment. Group 2 is for those who opted out of Phase I and are not in an MA plan. It states they will be enrolled in another participating MMP subject to readiness. What happens to this group if there is not another MMP?

**Answer to question 42:**

If there is only one health plan participating in the demonstration, the clients referenced in Group 2 will be offered enrollment but will not be auto-assigned.

**Question 43:** Page 25 notes that members will receive a letter with a deadline to indicate their choice of MMP. If they do not respond, they will be auto-assigned. How much time will the MME have to respond to the letter?

Answer to question 43:

MMEs will be given approximately sixty (60) days to respond to the initial letter. Another letter will be mailed thirty (30) days prior to auto-enrollment.

Question 44: Page 59 states that customer service representatives must make certain information available on request to enrollees. The 1<sup>st</sup> bullet reads: “The identity, locations, qualifications, and availability of providers”. Would qualifications include language spoken by provider as this is quite helpful to know for those with limited English skills.

Answer to question 44:

Yes, MMPs should be able to provide the language spoken of providers in their network.

Question 45: Page 77 “Appeals resolution time frames” – item 2 is confusing. Some verbiage is repeated in last sentence and it is not clear what the difference is between the two levels of appeal. Could you please clarify.

Answer to question 45:

There are two levels of health plan internal appeals – level 1 and level 2. They both have the same timeframes for response. A member or provider can request a level 2 appeal if the level 1 appeal decision was not found in their favor.

Question 46: Page 80 contains language dealing with selective competitive procurement system. The budget bill passed by the House Finance Committee on June 5<sup>th</sup> contains Article 18. At the end of the Article there is language dealing with the dual demonstration that refers to any willing provider. Would the language in Article 18 prohibit selective competitive procurement.

Answer to question 46:

EOHHS is still in the process of analyzing the impacts of Article 18 on the Demonstration. EOHHS believes this language was referring to provider networks, and would not therefore limit the state’s ability to competitively procure for the demonstration.

Question 47: Why isn't review of dental needs included as part of comprehensive health assessment? Dental health is a vital part of overall health and while these services are not required to be provided by the MMP, the MMP is required to coordinate provision of these services.

Answer to question 47:

While not called out in the document, dental needs can certainly be part of the comprehensive health assessment. EOHHS would encourage this to be included.

**Question 48:**

What is the process the MMP should follow when it is determined that the member does not have the cognitive capacity to participate in developing the ICP and there is no family member or other appropriate individual to participate in this process.

**Answer to question 48:**

EOHHS is currently consulting with the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) to determine whom the appropriate caregiver would be in the situation described in this section. MMPs would work with anyone who is a legal guardian, has health care power of attorney, or is a designated health care proxy.

**Question 49:** The LOI describes requirements for individuals who are "not eligible for LTSS and are at high risk" . What are examples of these individuals - why wouldn't all "high risk" individuals be eligible for LTSS?

**Answer to question 49:**

The application and eligibility requirements for LTSS are much different than for Medicaid in general. People applying for long-term care have to have both a level of care/clinical determination that is similar to an "institutional level", in addition to meeting all the financial application requirements. Not all Medicaid clients will meet these eligibility standards. However, these MMEs are still both low-income and also disabled, putting them at high-risk for chronic conditions, co-occurring behavioral health conditions, and social stressors like homelessness.

**Question 50:** Is there a role for consumers organizations and other stakeholders in developing the training for Lead Care Managers?

**Answer to question 50:**

Yes, MMPs are encouraged to work with consumer organizations and other stakeholders to develop training for their care management staff.

**Question 51:** How many of the projected Phase II beneficiaries are already enrolled in Medicare Advantage plans?

**Answer to question 51:**

As of 5/28/14, there are 2329 ICI members also enrolled in a Medicare Advantage Plan. There are 1061 MME with Medicare Advantage Plan in FFS. Out of the 2329 ICI members enrolled in Medicare Advantage, 290 are in CCCCPC, and 2039 in RHO.

**Question 52:** Given that the pool of beneficiaries available for enrollment in Phase II is mostly composed of previously assigned members who have already opted out of the program and are therefore unlikely to participate, can EOHHS provide an estimate of the actual, sustained number of additional enrollees in Phase II?

Answer to question 52:

EOHHS cannot provide an estimate of sustained enrollees for Phase 2. EOHHS has provided estimates of the number of available beneficiaries, eligible to enroll in the demonstration. The Demonstration is not mandatory, and members will be able to opt-out at any time. Members can also opt-in at any time.

**Question 53:** In view of the: (i) limitations and composition of the prospective Phase II beneficiary pool and (ii) provider concerns and challenges encountered during Phase I of the program, does EOHHS anticipate being able to implement Phase II if only the current Phase I MCO deems it feasible to participate?

Answer to question 53:

Yes, CMS has indicated to EOHHS that we can move forward with the demonstration, even if only one plan participates.

**Question 54:** While the Medicaid rates are set forth in the Rhody Health Options Data Book, on what date will the Medicare rates for Phase II be released?

Answer to question 54:

The projected date that CMS will issue the RI-specific Medicare rates for the demonstration is summer of 2014. CY2015 Medicare FFS standardized FFS county rates and MA benchmarks released in April 2014.

**Question 55:** Will there be any pre-bid opportunity to conference with EOHHS?

Answer to question 55: No.

**Question 56:** On what date will responses to these bidder questions be available?

Answer to question 56:

Please continue to monitor the website for State responses.