Solicitation Information
January 6, 2020

LOI #7599917

TITLE: DENTAL HEALTH PLAN(S) FOR RITE SMILES PROGRAM

Submission Deadline: Monday, February 3, 2020 @ 10:00 AM Eastern Standard Time (EST)

Questions concerning this solicitation must be received by the Division of Purchases at DOA.PurQuestions10@purchasing.ri.gov no later than January 15, 2020 @ 10:00 AM (EST). Questions should be submitted in a *Microsoft Word attachment*. Please reference the LOI #7599917 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.

Dawn Vittorioso, Buyer II

Note to Applicants:

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

THIS PAGE IS NOT A BIDDER CERTIFICATION COVER 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 Dental Plan(s) (DP) services under a managed care capitated contract that will serve the RIte Smiles-eligible population. RIte Smiles beneficiaries are the Rhode Island Medicaid population born on or after May 1, 2000 and who are living in households with income less than 250 percent of the Federal Poverty Level (FPL) until their twenty-first (21st) birthday in accordance with the terms of this Letter of Interest ("LOI") and the State's General Conditions of Purchase, which may be obtained at the Division of Purchases' website at www.ridop.ri.gov.

The initial contract period will begin July 1, 2020 for three (3) years. Contracts may be renewed for up to three (3) additional twelve (12) month periods based on Bidder performance and the availability of funds.

This is a Letter of Interest (LOI), not a Request for Proposal (RFP) or an Invitation to Bid (ITB). Responses will be evaluated on the basis of the relative merits of the technical proposal; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this solicitation, 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 LOI 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 LOI are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this LOI may be rejected as being non-responsive.

(3) All costs associated with developing or submitting a proposal in response to this LOI or for providing oral or written clarification of its content, shall be borne by the vendor. The State assumes no responsibility for these costs even if the LOI is cancelled or continued.

(4) Proposals are considered to be irrevocable for a period of not less than 180 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.

(5) All pricing submitted will be considered to be firm and fixed unless otherwise indicated in the proposal.

(6) It is intended that an award pursuant to this LOI will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all aspects of the work. 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.

(7) The purchase of goods and/or services under an award made pursuant to this LOI will be contingent on the availability of appropriated funds.

(8) Vendors are advised that all materials submitted to the Division of Purchases for consideration in response to this LOI may be considered to be public records as defined in

R. I. Gen. Laws § 38-2-1, *et seq*. and may be released for inspection upon request once an award has been made.

Any information submitted in response to this LOI that a vendor believes are trade secrets or commercial or financial information which is of a privileged or confidential nature should be clearly marked as such. The vendor should provide a brief explanation as to why each portion of information that is marked should be withheld from public disclosure. Vendors are advised that the Division of Purchases may release records marked confidential by a vendor upon a public records request if the State determines the marked information does not fall within the category of trade secrets or commercial or financial information which is of a privileged or confidential nature.

(9) 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 LOI.

(10) By submission of proposals in response to this LOI vendors agree to comply with R. I. General Laws § 28-5.1-10 which mandates that contractors/subcontractors doing business with the State of Rhode Island exercise the same commitment to equal opportunity as prevails under Federal contracts controlled by Federal Executive Orders 11246, 11625 and 11375.

Vendors are required to ensure that they, and any subcontractors awarded a subcontract under this LOI, undertake or continue programs to ensure that minority group members, women, and persons with disabilities are afforded equal employment opportunities without discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability.

Vendors and subcontractors who do more than $10,000 in government business in one year are prohibited from engaging in employment discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability, and are required to submit an "Affirmative Action Policy Statement."

Vendors with 50 or more employees and $50,000 or more in government contracts must prepare a written "Affirmative Action Plan" prior to issuance of a purchase order.

a. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation.

b. Vendors further agree, where applicable, to complete the "Contract Compliance Report" (http://odeo.ri.gov/documents/odeo-eeo-contract-compliance-report.pdf), as well as the "Certificate of Compliance" (http://odeo.ri.gov/documents/odeo-eeo-certificate-of-compliance.pdf), and submit both documents, along with their Affirmative Action Plan or an Affirmative Action Policy Statement, prior to issuance of a purchase order. For public works projects vendors and all subcontractors must submit a "Monthly Utilization Report" (http://odeo.ri.gov/documents/monthly-employment-utilization-report-form.xlsx) to the ODEO/State Equal Opportunity Office, which identifies the workforce actually utilized on the project.

For further information, contact Vilma Peguero at the Rhode Island Equal Employment Opportunity Office, at 222-3090 or via e-mail at ODEO.EOO@doa.ri.gov .

(11) In accordance with R. I. Gen. Laws § 7-1.2-1401 no foreign corporation has the right to transact business in Rhode Island until it has procured a certificate of authority so to do from the Secretary of State. This is a requirement only of the successful vendor(s). For further information, contact the Secretary of State at (401-222-3040).

(12) In accordance with R. I. Gen. Laws §§ 37-14.1-1 and 37-2.2-1 it is the policy of the State to support the fullest possible participation of firms owned and controlled by minorities (MBEs) and women (WBEs) and to support the fullest possible participation of small disadvantaged businesses owned and controlled by persons with disabilities (Disability Business Enterprises a/k/a "DisBE")(collectively, MBEs, WBEs, and DisBEs are referred to herein as ISBEs) in the performance of State procurements and projects. As part of the evaluation process, vendors will be scored and receive points based upon their proposed ISBE utilization rate in accordance with 150-RICR-90-10-1, "Regulations Governing Participation by Small Business Enterprises in State Purchases of Goods and Services and Public Works Projects". As a condition of contract award vendors shall agree to meet or exceed their proposed ISBE utilization rate and that the rate shall apply to the total contract price, inclusive of all modifications and amendments. Vendors shall submit their ISBE participation rate on the enclosed form entitled "MBE, WBE and/or DisBE Plan Form", which shall be submitted in a separate, sealed envelope as part of the proposal. ISBE participation credit will only be granted for ISBEs that are duly certified as MBEs or WBEs by the State of Rhode Island, Department of Administration, Office of Diversity, Equity and Opportunity or firms certified as DisBEs by the Governor's Commission on Disabilities. The current directory of firms certified as MBEs or WBEs may be accessed at http://odeo.ri.gov/offices/mbeco/mbe-wbe.php. Information regarding DisBEs may be accessed at www.gcd.ri.gov.

For further information, visit the Office of Diversity, Equity & Opportunity's website, at http://odeo.ri.gov/ and *see* R.I. Gen. Laws Ch. 37-14.1, R.I. Gen. Laws Ch. 37-2.2, and 150-RICR-90-10-1. The Office of Diversity, Equity & Opportunity may be contacted at, (401) 574-8670 or via email Dorinda.Keene@doa.ri.gov

(13) HIPAA - 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

(14) Eligible Entity - In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSource RI), the contractor 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 contractor 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

The Rhode Island Executive Office of Health and Human Services ("EOHHS") serves as "the principal agency of the executive branch of state government" (R.I. Gen. Laws § 42-7.2-2) responsible for managing the departments of: Rhode Island Department of Health ("DOH"); Rhode Island Department of Human Services ("DHS"); Rhode Island Department of Children, Youth and Families ("DCYF"); and Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals ("BHDDH"). EOHHS is the single state agency ("SSA") for Medicaid in the State.

This procurement is to secure the services of qualified Bidders to serve as the Dental Plan(s) ("DP") for the entire Rhode Island Medicaid RIte Smiles program through a managed care capitated contract. This LOI and any subsequent award(s) are governed by the State's General Conditions of Purchase (available via internet at www.ridop.ri.gov). Currently, the RIte Smiles managed care program is served by one (1) contracted managed care organization. RI EOHHS welcomes qualified Bidders with the capacity and capability to provide high-quality and cost-effective services to Medicaid eligible populations. The State reserves the right to contract with one (1) or more DPs at its discretion.

The below Sections provide potential Bidders with background information about the Rhode Island Medicaid program and the reasons for this procurement.

2.2 Overview of the Rhode Island Medicaid Managed Care Program

The Medical Assistance Program, or Medicaid, is a health care entitlement program for the State's low-income population that is jointly funded by the Federal Government and the State of Rhode Island. Medicaid was established in 1965 as Title XIX of the U.S. Social Security Act. In addition to State oversight, the Centers for Medicare & Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("HHS") monitors the State's Medical Assistance program activities.

Medicaid is a main source of health care coverage and services in Rhode Island, serving approximately one-fourth of the State's population. Medicaid served approximately 316,000 Rhode Islanders in State Fiscal Year (SFY) 2018 at a cost of $2.6 billion dollars which is approximately one-quarter of the State's budget. Between SFY 2015 and 2018, the average total Medicaid medical expenditures based on the date of service has increased annually by 3.3 percent. This overall expenditure increase is associated with a 5.3 percent average annual increase in enrollment during the same time period, combined with a 1.8 percent overall average decrease in per member per month (PMPM) cost. These expenditure trends compare favorably to both national Medicaid expenditures and state commercial PMPM cost trends.

The expenditures for each major population group for SFY 2018 are noted below:

- **Adults with disabilities:** Represents eleven percent (11%) of the Medicaid population (33,177 individuals) and account for the largest share (29%) of Medicaid expenditures ($770 million) at an average PMPM of $1,934. The major source of expenditures for this population is residential and rehabilitation services for persons with intellectual and developmental disabilities and hospital care.

- **Elders:** Represents seven percent (7%) of the Medicaid population (22,235 individuals) and accounts for $609 million or twenty-three percent (23%) of Medicaid expenditures. Compared to all other Medicaid populations, elders have the highest average PMPM cost at $2,284. Nursing facilities account for slightly more than half (53%) of expenditures.
- **Children and Families:** Represents fifty-three percent (53%) of the total Medicaid enrollment (168,489 individuals), including low-income children, parents and pregnant women who meet specific income requirements. This category accounts for twenty-three percent (23%) of the total expenditures ($592 million) and have the lowest PMPM cost of less than $300.
- **Children with Special Health Care Needs (CSHCN):** CSHCN is relatively small population, as it encompasses four percent (4%) of Medicaid recipients and accounts for seven percent (7%) of expenditures ($176 million).
- **Expansion:** Represents twenty-five percent (25%) of the Medicaid population and accounts for eighteen percent (18%) of total expenditures ($473 million). Most of these expenditures are attributed to hospital and professional services.

Hospitals and nursing homes account for 40 percent (40%) of all program expenditures. (Hospitals account for 24 percent (24%) and nursing facilities, including hospice, and nursing facilities account for 16 percent (16%) of expenditures.)

Medicaid expenditures are highly concentrated. The top five percent (5%) of Medicaid users, those with more than $25,000 in annual claims expenditures, account for nearly two thirds (63%) of claims expenditures. High cost users, defined as recipients that incur more than $15,000 annually, account for seventy-one percent (71%) of Medicaid claims expenditures. These users include those residing in institutions or residential facilities, those receiving maternity/delivery services, and others residing in the community, more than half (60%) of which represented by adults with disabilities and the Medicaid Expansion population.

RIte Smiles beneficiaries are the Rhode Island Medicaid population born on or after May 1, 2000, who reside in households with income less than 250 percent of the Federal Poverty Level ("FPL"), until their twenty-first ("21st") birthday. The RIte Smiles program consists mainly of the children and families, CHSCN and Medicaid Expansion major population groups.

2.3 Evolution of Managed Care in Rhode Island

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 progression has been a focus upon improved access and quality, along with cost management. Contracting with managed care organizations ("Health Plans") provides a structure for measuring and enforcing performance standards. Both of Rhode Island's medical Medicaid managed care organizations were rated 4.5 out of 5 by the National Committee for Quality Assurance ("NCQA").[1]

The State's first 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 Health Plans to 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 in managed care for CSHCN became mandatory in 2008.

In 2008, voluntary enrollment in Rhody Health Partners was implemented for persons with disabilities. In the fall of 2009, all Medicaid eligible "aged, blind and disabled" ("ABD") adults without third-party coverage ("TPL") 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 15,000 enrolled in the Rhody Health Partners Program.

This progression of expanded enrollment in managed care is characterized by enrollment of populations with increasingly complex health needs. Over this period, the State has expanded the program requirements and covered benefits contained in the Health Plans contracts, while also increasing the Health Plan performance requirements for managing the health care needs of complex populations. Health Plans were not required, however, to pay for home and community-based services but are required to pay for up to thirty (30) days of nursing home stays.

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. It is estimated that 28,000 Rhode Islanders over age sixty-five (65) and individuals with disabilities/chronic conditions who have Medicaid coverage or Medicare and Medicaid coverage (dual eligibility) are eligible. As of November 1, 2013, almost 4,500 individuals were enrolled in either Rhody Health Options program. The program was sunset in October 2019.

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. The RIte Share Program reduces the amount of State Medicaid funds that would otherwise be necessary to serve these State residents if the RIte Share Program did not exist.

In SFY 2018, ninety-one percent (91%) of the Medicaid population were enrolled in a Health Plan and accounted for seventy-eight percent (78%) of Medicaid expenditures. The Rhode Island Medicaid Managed Care Plan have consistently been ranked among the best in the nation. Please reference the *Rhode Island Annual Medicaid Expenditure Report* for further details regarding Medicaid managed care expenditures.

Currently, there are four (4) health plans participating in the Medicaid managed care program. Three (3) medical Medicaid managed care programs: (1) Neighborhood Health Plan of Rhode Island ("NHPRI"); (2) UnitedHealthcare Community Plan of Rhode Island ("UHCCP-RI"); and, (3) Tufts Health Public Plans, Inc. The total enrollment in all medical health plans was 269,902 as of November 2019: NHPRI has 170,580 members; UHCCP-RI has 89,992 members; and, THP has 9,330 members. The fourth participating health plan and only Medicaid dental managed care provider for the RIte Smiles program, (4) UnitedHealthcare Dental, has 110,389 members as of November 2019.

2.4 Rhode Island Managed Care in 2019

The Rhode Island Medicaid Managed Care Program's mission is to provide for the holistic delivery of Medicaid health benefits to meet individual Rhode Islander's needs and foster improvements in health and well-being, while simultaneously demonstrating improvement across population health outcomes and health care system financial sustainability.

EOHHS envisions a Managed Care Program which rapidly evolves into the next generation of managed care as articulated in the 2015 *Report of the Working Group to Reinvent Medicaid* . EOHHS is focused upon the continued development of a Managed Care Program through payment and delivery system reform that achieves and promotes the following strategic goals:

- **Sustainably achieve better health outcomes and lower costs** for all Rhode Islanders eligible for Medicaid by aligning incentives across delivery system actors to ensure that improved population health and operational efficiency are reflected in all actors' financial interests;
- **Integrate care to support whole-person health by leveraging a strong primary care infrastructure** with an orientation toward prevention and wellness, that is able to respond holistically to a member's medical, behavioral health, socio-economic, or long-term care needs;
- **Foster choice and engagement** among Rhode Islanders eligible for Medicaid, such that members are active participants in the selection of a health plan and providers, as well as the care they receive; and,
- **Build upon the respective strengths of payers and providers** to prioritize high-quality care, minimize unnecessary duplication, and improve efficiency.

This next generation of Managed Care programs will have as their foundation Managed Care Organizations ("MCOs") that will serve as the critical vehicle in the transition to accountable care in Medicaid. MCOs will contract with Accountable Entities ("AEs") to provide person centered health care delivery, increase access and efficiencies. AEs are integrated provider organizations responsible for the total cost of care and quality outcomes of an attributed population. The transition to MCOs contracting with AEs is consistent with initiatives taking hold across the country and represents a strategic movement toward increased integrated care coordination and value-based payment methodologies to support delivery system reform.

2.5 Overview of the RIte Smiles Program

In the fall of 1998, DHS (which was then the Medicaid SSA) established the Medicaid Dental Advisory Committee ("MDAC") with the purpose of developing recommendations for improving access to dental services for individuals covered by Rhode Island Medicaid, including children and families enrolled in RIte Care and uninsured working families. The committee included representatives of the Rhode Island Dental Association, Samuels Dental Center at Rhode Island Hospital, St. Joseph Hospital Dental Program, the Rhode Island Health Center Association, Rhode Island KIDS COUNT, the Rhode Island Foundation, the Rhode Island Dental Hygienist Association, Crossroads RI, the Rhode Island HMO Association, two (2) Rhode Island-based dental benefit managers, private practice dentists, other State agencies and consumer advocacy groups.

In 1999, MDAC recommended that DHS develop purchasing specifications for a Dental Benefit Manager ("DBM"). The DBM program was expected to be implemented as an alternative to the FFS dental system for all Medicaid program enrollees. Later that year, DHS developed a Request

for Proposals ("RFP") soliciting a qualified organization to serve as DBM for Rhode Island Medicaid recipients through a program called RIte Smiles. The State issued a Bid Specification Document to procure the services of a DBM in December 2005.

The RIte Smiles program was implemented in September 1, 2006 as a children's Medicaid managed care dental program. RIte Smiles is designed to improve access and augment outcomes of dental services by increasing the number of dental providers participating in the Medicaid program, promoting preventive and primary dental treatment, and reducing the need for high cost restorative and emergency dental procedures for children.

As of November 30, 2019, there were 110,389 members enrolled in RIte Smiles.

RIte Smiles dental providers practice in three (3) types of dental settings: (1) Federally Qualified Health Centers (FQHCs); (2) Hospital-based clinics; and, (3) Private practice settings.

The RIte Smiles program continues to receive national attention. In FFY 2017, RI had forty-nine percent (49%) utilization among those under twenty-one (21), which ranks twenty-seventh (27^{th}) among the states. EOHHS anticipates to further increase utilization to ensure preventive dental care services for the RIte Smiles population.

The RIte Smiles eligibility groups consist of the following:

- *Uninsured Children and/or Young Adults Born on or After May 1, 2000, until their 21^{st} birthday, under 250 Percent of the Federal Poverty Level ("FPL"):* This aid category consists of children born on or after May 1, 2000 living in families whose income is under 250 percent of the FPL.

- *Children in Substitute Care*: This aid category includes children in foster care born on or after May 1, 2000, who are currently enrolled in RIte Care on a voluntary basis or are in Medicaid fee-for-service ("FFS"). These children receive the same benefits as any other children (e.g., RI-WORKS/TANF). The medical benefit of Children in Substitute care is only administered by NHPRI.
- *Children with Special Health Care Needs*: This group includes children on SSI born on or after May 1, 2000, "Katie Beckett" children born on or after May 1, 2000, and children in adoption subsidy born on or after May 1, 2000, who are enrolled in RIte Care currently on a voluntary basis or are in Medicaid FFS. These children also receive the same benefits as other children.

The following children are excluded from participation in this RIte Smiles program irrespective of the membership in the population groups:

- Children residing in a nursing home or an intermediate care facility for persons with intellectual/developmental disabilities ("ICF-I/DD");
- Children with third-party coverage for dental benefits; and,
- Children residing outside of Rhode Island

These children will continue to access their benefits through the State's Medicaid FFS system.

The State reserves the right to add new eligibility groups to the RIte Smiles program at any time. The State shall have sole authority for determining whether individuals meet any of the eligibility criteria and therefore are eligible to enroll in a RIte Smiles dental plan. There is no eligibility

guarantee period for RIte Smiles eligibility groups. Children and/or young adults will need to be re-certified for Medicaid eligibility as required by State Medical Assistance policy or as individual case circumstances may warrant.

The purpose of this procurement is to seek qualified vendors to serve as a Dental Plan for the RIte Smiles program in Rhode Island as indicated in the following section. The successful Bidder(s) must consider how to most effectively manage the contract, in terms of cost, quality of care and member satisfaction of dental services.

SECTION 3: SCOPE OF WORK AND REQUIREMENTS

General Scope of Work

The goal of the RIte Smiles Program is to improve access to dental care for eligible enrollees, to increase the percentage of young Medicaid members who receive dental services, to increase the use of medically-necessary dental services, to increase use of dental preventive services, and to provide dental services in hospital, community and private practice settings and other innovative settings designed to reach vulnerable populations.

Specific Activities / Tasks

The Executive Office of Health and Human Services, through issuance of this Letter of Intent ("LOI"), invites qualified Bidder(s) to submit proposals to manage the RIte Smiles Medicaid Dental Benefit Program statewide for eligible beneficiaries for a monthly capitation payment made in accordance with the specifications and conditions set forth herein. In response to this LOI, as outlined in Section 4, Technical Response, qualified Bidder(s) must certify that they will meet all elements outlined in this section 3, Scope of Work, which is further outlined in **Appendix B, Model Contract,** referred to as "Model Contract" throughout sections 3 (Scope of Work) 4 (Proposal). Bidders must provide evidence that further validates their capacity to meet all requirements.

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 dental benefits that represent a continuum of dental 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 in-plan dental 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 meet financial standards;
- Maintain a viable information technology capacity and meet Federal and State reporting requirements;
- Attend and/or preside over meetings with stakeholders on a regular basis;

- Maintain a grievance and appeals process that meets Federal and State requirements; and,
- As a core objective, seek to reduce the use of fee-for-service payment as a payment methodology and to replace fee-for-service payment with Alternative Payment Methodologies ("APM") that provide incentives for better quality, outcomes, and more efficient delivery of services.

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.

3.1 Core Requirements

Experience and Understanding

The Bidder must certify it meets and will comply with all requirements outlined in **Article II Section 2.1, General,** of **Appendix B, Model Contract**. The Bidder must provide supporting evidence when applicable and as required for each section.

3.1.1 Dental Plan(s) Licensure and Organizational Requirements

The Bidder must certify that it that it complies with all contractual requirements as described in **Appendix B, Model Contract, Article II, Section 2.2, Licensure/Certification**.

The Contractor certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 27-41, "the HMO Act" or that it will become licensed as a Health Maintenance Organization (HMO) or Health/dental plan (HP) in the State of Rhode Island by the Rhode Island Department of Business Regulation prior to signing an Agreement with EOHHS. If Contractor is not a licensed HMO in Rhode Island, the Contractor 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:

- Meets that requirements under R.I. Gen. Laws section 27-18.9-8: Benefit Determination and Utilization Review Act.
- Is certified as a utilization review entity by a nationally known health utilization management organization.

3.1.2 Dental Plan(s) Administration

The Bidder must agree to maintain sufficient administrative staff and organizational components to comply with all program standards as described in **Appendix B, Model Contract, Article II section 2.3, Dental Plan(s) Administration**. Contractor agrees to staff qualified persons in numbers appropriate to its size of enrollment. Contractor shall be required to have In-State presence to conduct outreach, approved marketing efforts, and attend or preside at meetings with stakeholders at community agencies throughout the State at health fairs and in other health related events. At a minimum, the Bidder must include each of the following functions in accordance with the standards outlined in the section:

A. Executive Management

B. Other Administrative Components

   a. Dental Director's Office

   b. Accounting and Budgeting Function

   c. Member Services Function

   d. Provider Services Function

   e. Dental Management Function, including quality assurance, prior authorization, concurrent medical review/discharge planning, and retrospective dental review

   f. Grievance and Appeals Function

   g. Claims Processing Function

   h. Management Information System

   i. Program Integrity and Compliance

C. RI Works Participants

3.1.3 Eligibility and Program Enrollment

The Bidder(s) must comply with the eligibility and program enrollment requirements outlined and described in **Appendix B, Model Contract, Article II, Section 2.4, Eligibility and Program Enrollment.**

A. **Eligible Population**: RIte Smiles eligible population is defined to consist of information provided in (Sections 2.4.A through and including 2.4.I of **Appendix B, Model Contract**) different eligible groups. Qualification for the program is based on a combination of factors, including family composition, income level, insurance status, and/or pregnancy status. The scope of benefits, program cost sharing options/requirements and enrollment procedures vary by eligibility group aid and are described herein. The following are eligible populations that will be enrolled in the RIte Smiles Program:
   a. Children and/or young adults born on or after May 1, 2000, up until their 21st birthday, under 250 Percent of the FPL;
   b. Children in Substitute Care; and,
   c. Children with Special Health Care Needs.

B. **Excluded Populations**: The following children and/or young adults are excluded from participation in RIte Smiles:
   a. Children and/or young adults residing in a nursing home or an intermediate care facility for the mentally retarded (ICF/MR);
   b. Children and/or young adults with third-party coverage for dental benefits; and,
   c. Children and/or young adults residing outside of Rhode Island.

C. **New Eligibility Groups:** The State reserves the right to add new eligibility groups at any time.

D. **Eligibility Determination**: The State shall have sole authority for determining whether individuals meet the eligibility criteria and therefore are eligible to enroll in a Dental Plan.

E. **Guaranteed Eligibility**: There are no eligibility guarantees for members.

F. **Voluntary Selection of Dental Plan by Members**: At the time of application or at other times determined in its sole discretion by EOHHS, applicants or beneficiaries shall be

offered the opportunity to select a Dental Plan or another program option, if applicable. In accordance with 42 CFR 438.54, beneficiary's enrollment in a Dental Plan is voluntary. If an eligible member does not select a Dental Plan or does not select another program option, he or she shall be automatically assigned to a Dental Plan. This process does not apply to periods designated for open enrollment.

G. **Automatic Assignment to Dental Plans**: EOHHS shall employ a formula, or algorithm deemed by EOHHS to be in the best interests of the members that may include quality metrics, Dental Plan performance of contract requirements, including but not limited to, Dental Plan financial performance, or other considerations such as, Market Share Capacity, to assign any eligible member that does not make a voluntary selection.

H. **Automatic Re-Assignment Following Resumption of Eligibility**: Members who are disenrolled from a Dental Plan, due to loss of eligibility and who regain eligibility within sixty (60) calendar days of disenrollment, may select a Dental Plan of their choice. Members who do not make a Dental Plan selection will be automatically re-enrolled, or assigned, into their previous Dental Plan upon reinstatement of their Medicaid eligibility. If more than sixty (60) calendar days have elapsed and the Medicaid member does not make a Dental Plan selection at the time eligibility was reinstated, the member will be auto-assigned to a Dental Plan based on EOHHS' algorithm.

I. **Lock-in**: Following their initial enrollment into a dental plan, RIte Smiles eligible children and/or young adults will be restricted to that RIte Smiles dental plan after the first ninety (90) days of enrollment until the next open enrollment period, unless disenrolled under one of the conditions described in **Appendix B, Model Contract, Section 2.5.J Member Disenrollment**.

J. **Market Share Capacity Limit**: EOHHS may, at its sole discretion, institute a market share capacity limit if more than one (1) Bidder is awarded a Contract. EOHHS may implement a market share cap using the following method:

- If two (2) Bidders are awarded the Contract, no one (1) Contractor shall be assigned more than sixty percent (60%) of the total market share;
- If three (3) or more Bidders are awarded the Contract, no one (1) Contractor shall be assigned more than fifty percent (50%) of the total market share.

EOHHS retains sole authority to determine the total market share and implementation of a market share cap.

Member choice always prevails and shall not be impacted by market share cap.

3.1.4 Member Enrollment and Disenrollment

The Bidder must comply with the eligibility and program enrollment requirements outlined and described in **Appendix B, Model Contract, Article II, Section 2.5, Member Enrollment and Disenrollment.**

A. **Dental Plan Marketing Requirements:** The successful Bidder(s) is required to submit to EOHHS for review and written approval all materials, in any media, and any other materials associated with marketing for open enrollment periods that will be distributed to members or potential members (referred to as member and marketing materials) before they are distributed. Plan materials developed or distributed by subcontractors or providers also require review and approval before being distributed. The successful Bidder(s) is required to use *RI Managed Medicaid Model Member Handbook*, *RI EOHHS Guidelines*

for Marketing and Member Communications for Medicaid Managed Care Program, *Appeals/Grievances Notification Model Documents*, as outlined further in **Appendix B, Model Contract**.

B. **Dental Plan(s) Enrollment Procedures:** EOHHS will provide successful Bidder(s) with a monthly list of members newly enrolled into the Dental Plan. Bidder(s) agrees to accept enrollment information in the data format submitted by the State. Bidder(s) agrees to have written policies and procedures for enrolling these members effective on the first (1st) day of the following month after receiving notification from the State. Newly enrolled members must be mailed notification of enrollment including effective date and how to access care within ten (10) calendar days after receiving notification from EOHHS of their enrollment.

   Bidder(s) agrees to enroll, in the order in which he or she applies or is assigned, any eligible beneficiary who selects it or is assigned to it, regardless of the beneficiary's race, color, national origin, sex, sexual orientation, gender identity, disability, age, ethnicity, language needs, health status, or need for health services.

   EOHHS will, at times mutually agreed upon by the State and the Bidder(s) (such approval not to be unreasonably withheld), conduct an Open Enrollment process for existing RIte Smiles members. Each member shall be given the choice of the RIte Smiles program participating Dental Plans. Siblings within a family unit shall be required to participate in the same Dental Plan, unless there is a compelling reason not to do so, as determined by the State. Members who are so auto-assigned will be allowed to choose a different Dental Plan within the first ninety (90) days of being assigned to the Dental Plan. Enrollment shall be assigned to the Bidder(s) following the effective date upon reasonable determination of the Contractor's readiness

   Successful Bidder(s) will not use any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

C. **Change in Member Status:** Bidder(s) agrees to report any changes in the status of individual members within five (5) days of their becoming known, including but not limited to changes in address or telephone number, out-of-State residence, deaths, household composition (such as birth of a child or change in legal guardianship of a minor), and sources of third-party liability.

   Successful Bidder(s) shall have a process for performing outreach calls and an approach for determining a member's most recent address and accurate address and telephone number.

   Successful Bidder(s) shall ensure through written agreements and contracts that all subcontractors will report such changes in status to the Contractor.

D. **Enrollment and Disenrollment Updates:** EOHHS shall provide the successful Bidder(s) with a monthly full roster of all members enrolled. EOHHS will send the roster to the Contractor during the second financial cycle of each month. Contractor agrees to have written policies and procedures for receiving these updates and incorporating them into its management information system.

E. **Services for New Members:** Successful Bidder(s) agrees to make available the full scope of dental benefits to which a member is entitled immediately upon new member

enrollment.

F. **New Member Orientation:** Successful Bidder(s) shall have written policies and procedures for orienting new members to their dental benefits, how to utilize services in other circumstances, how to register a complaint or file a grievance. These policies and procedures shall take into account the multi-lingual, multi-cultural nature of the population.

G. **Identification Cards:** Successful Bidder(s) agrees to issue a member identification card to its members to use when obtaining Covered Services. The member identification card may identify the holder a RIte Smiles member and as a member through an alpha or numeric indicator but shall not be overtly different in design from the membership identification card issued to other enrolled groups.

   Successful Bidder(s) must agree to issue all members a permanent membership identification card within ten (10) days after receiving notification from EOHHS of their enrollment. The card must include at least the following information:

   a. Dental Plan name;
   b. Twenty-four (24) hour Dental Plan telephone number for use in urgent or emergent medical situations
   c. Telephone number for Member Services function (if different)

H. **Member Handbook:** Successful Bidder(s) must agree to use the *RI Managed Medicaid Model Member Handbook* developed by EOHHS and make it available to all new and existing members at all times. An electronic copy of the Handbook is to be included on the Bidder(s) member website and available for viewing and downloading. Additionally, members may request an alternate version (paper, audio or specific language) by contacting the successful Bidder(s) member services department.

I. **Transitioning Members between Plans:** The successful Bidder(s) shall have written policies and procedures for transferring relevant patient information in an efficient manner, including medical records and other pertinent materials, when transitioning a member to or from another Dental Plan.

J. **Member Disenrollment:** EOHHS has sole authority for disenrolling members from Dental Plans. A member may request disenrollment without cause during the ninety (90) days following the date of the recipient's initial enrollment with the Dental Plan.

   Bidder(s) cannot refuse to cover services because of moral or religious objections.

   EOHHS reserves the right to disenroll members whom the Bidder(s) is unable to contact within contractual timeframes, members for whom the Bidder(s) cannot produce evidence of services provided within contractual timeframes or fails to meet readiness standards set by EOHHS.

   Bidder(s) is required to provide member information, including requested written documentation, if member requests to be disenrolled from Dental Plan. Bidder is responsible for providing member assistance to submit disenrollment request to EOHHS, including translation services. Disenrollment information and EOHHS *Medicaid Health Plan Change Request Form* must be accessible to member on Bidder(s) website and mailed to member upon disenrollment request.

3.1.5 In-Plan Services/Benefits

Bidder(s) must comply with the outlined and described in **Appendix B, Model Contract, Article II, Section 2.6, In-Plan Services and ATTACHMENT A: SCHEDULE OF IN-PLAN BENEFITS**

A. Description of Comprehensive Benefit Package

1) General

The Bidder(s) is required to meet all requirements stated in **Article II, Section 2.6** of **Appendix B, Model Contract**. Specifically, the Bidder(s) must provide a full range of comprehensive dental services as In-Plan Services. These in-plan services are described in **Attachment A: Schedule of In-Plan Benefits** of **Appendix B, Model Contract**.

The Bidder(s) is also required to coordinate out-of-plan services that are provided to members and paid for on a fee-for-service basis by the State or the member's medical managed care organization In-Plan benefit. These services are described in **Attachment B: Schedule of Out-of-Plan Benefits** the attached **Appendix B, Model Contract**.

Attachment C: Non-Covered Plan Benefits of **Appendix B, Model Contract** identifies the non-covered benefits.

2) Dental Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

The Bidder(s) must provide dental EPSDT services as described in **Appendix B, Model Contract,** and based on the *Dental EPSDT Periodicity Schedule* in accordance with **Attachment D** of **Appendix B, Model Contract**.

As indicated in the Attachment, dental EPSDT consists of the following components: screening, diagnosis and treatment, tracking, and follow-up and outreach.

3) Interpreter/Translation Services

The Bidder(s) makes available interpreter services as described in **Appendix B, Model Contract,** by telephone or in person, if more than fifty (50) members speak a language other than English as their first language. The Bidder also complies with the requirements of the American Disabilities Act ("ADA").

B. Member/Provider Communication

The Bidder(s) may not prohibit, or otherwise restrict, a dental care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a member as described in **Appendix B, Model Contract**.

C. Second Opinion

A RIte Smiles enrolled member is entitled to a second opinion from a qualified dental provider within the network or, if approved by the RIte Smiles dental plan, to a second opinion by a non-participating provider outside the network, at no cost to the member.

D. New In-Patient Services and In-Plan Service Coverage Arrangements

The State reserves the right to add new in-plan services to RIte Smiles at any time. The State's intent to add any new in-plan service and the terms upon which any new in-plan service would be covered under the Contract will be made according to the notice provisions in **Appendix B, Model Contract**. Contractor shall have forty-five (45) days from the date of receipt of such notice to either accept or reject in writing the addition of the new in-plan service and the terms proposed. Acceptance is formalized through an amendment to the Contract, as indicated in **Appendix B, Model Contract**.

The State further reserves the right to modify coverage arrangements for in-plan services. Any such changes shall be made according to the notice provisions in Section 3.1.I of **Appendix B, Model Contract,** and shall be accompanied by an actuarially-sound adjustment to the capitation rates in **Appendix B, Model Contract, Attachment E**. This shall be formalized through an amendment to this Agreement as provided in Article III of **Appendix B, Model Contract**.

1. Transportation

The State has a centralized nonemergency medical transportation ("NEMT") program. Through NEMT, RIte Smiles members are eligible for transportation services to Medicaid allowable services either through no cost bus pass, car/van or, when medically necessary, chair vans or ambulance. Bidder(s) agrees to coordinate the arrangement of transportation with the transportation broker for its members through this centralized service. This service is offered as transportation of last resort to members who are unable to secure transportation to their dental appointments.

3.1.6 Care Coordination

The Bidder(s) is required to ensure that it meets the Care Coordination requirements in **Article II, Section 2.7** of **Appendix B, Model Contract**.

The Bidder(s) shall coordinate all covered dental services, which involves the organizing and marshaling of personnel and other resources needed to conduct all medically necessary dental 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 dental provider and dental 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 a member's primary care provider ("PCP") and dental services as needed, ensure that members have timely access to prescriptions through coordination with other payers and through provider education. The synergy between the PCP and the dentist is essential to ensure that the medical and dental needs of members are met in a coordinated and integrated fashion.

3.1.7 Provider Networks

The Bidder(s) is required to ensure that network providers meet the Provider Network requirements in **Article II, Section 2.8** of **Appendix B, Model Contract**.

The Bidder(s) shall maintain a robust multi-disciplinary provider network (1) to provide members with the full range of covered dental services; (2) maintain adequate and sufficient providers by

number, mix and geographic area; and (3) make available all services in a timely manner through a network sufficient to serve the diverse population.

The Bidder(s) agrees to establish and maintain a network that is supported by written agreements and can sufficiently demonstrate to EOHHS' satisfaction their ability to provide covered services under this Agreement. Members must have access to services that are at least equal to, or exceed, community norms.

In establishing and maintaining the network, the Bidder(s) considers the following:

- Anticipated RIte Smiles enrollment
- Expected utilization of services taking into consideration the characteristics and health care needs of specific RIte Smiles 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 RIte Smiles patients
- Geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location and facility provides physical access for members with disabilities
- "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 and/or young adults with disabilities.

The provider network consists of a continuum of care required to meet the diverse and often complex needs of RIte Smiles members and shall contain, but shall not be limited to, general dentists and pediatric dentists to meet the service accessibility standards outlined later in this section as well an adequate specialty network that includes the following specialty dentists: pediatric dentists, periodontists, endodontists, prosthodontists, oral surgeons, and orthodontists.

The Bidder must include in its network, at a minimum, the following provider types and corresponding minimum requirements as outlined in **Article II, Section 2.8 of Appendix B, Model Contract,** to meet the diverse needs of the RIte Smiles population:

- FQHCs/RHCs with Dental Clinics;
- Hospital-Based Dental Clinics;
- School-Based Clinics;
- Mobile Dental Providers;
- Indian Health Care Provider (IHCP);
- Networks Related to Indians;
- Telehealth/Teledental.

In addition, the Bidder(s) is required to provide policies and procedures which describe the organization, policies and procedures surrounding a Telehealth program. A Telehealth program shall include but is not be limited to the following covered services: patient education; medication management; equipment management; review of patient trends and/or other changes in patient condition necessitating professional intervention; and other activities deemed necessary and appropriate according to a member's plan of care.

Every quarter the Bidder(s) shall provide the State with a list of all its participating dental providers, including those whose practices are open to additional RIte Smiles members. The Bidder(s) shall notify the State on a monthly basis of any changes in its network's composition and shall have procedures in place to address changes in its network that may negatively affect the ability of members to access services.

A. Provider Credentialing

The Bidder(s) 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 such services. The Bidder(s) 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)' dental management standards.

The Bidder(s) shall have a uniform credentialing and re-credentialing process and shall ensure that the process complies consistently with State regulations. For organizational providers, the Bidder(s) must adopt a uniform credentialing and re-credentialing process and that consistently complies with State regulations.

The Bidder(s) does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Bidder(s) shall not 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. Bidder(s) must submit the List of Excluded Individuals and Entities (LEIE), as outlined in **Appendix B, Model Contract, Section 3.7, Performance Standards and Damages**.

The Bidder(s) shall have written policies and procedures pertaining 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) days of any change in ownership.

Providers must disclose to the Bidder(s) the identity of any individual who has more than a five percent (5%) ownership interest in the provider or the identity of an individual who has been convicted of a criminal offense.

The Bidder(s) shall 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(s) 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 as required in this section and in **Appendix B, Model Contract**. The Bidder(s) must promptly notify 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(s) must promptly notify 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.

3.5.2 Telehealth/Teledental

The Bidder(s) is required to identify policies and procedures which describe the organization, policies and procedures surrounding a Telehealth program. A Telehealth program should include but is not limited to the following covered services: monitoring of patient vital signs; patient education; medication management; equipment management; review of patient trends and/or other changes in patient condition necessitating professional intervention; and other activities deemed necessary and appropriate according to a member's plan of care.

3.1.8 Service Accessibility Standard

The Bidder(s) is expected to meet the standards as described in **Article II, Section 2.9** of **Appendix B, Model Contract**.

The Bidder(s) shall have written policies and procedures describing how members and providers can contact the Bidder to receive instructions for treatment of an Urgent dental problem. The Bidder(s) shall make available dental services within forty-eight (48) hours for urgent dental conditions.

The Bidder(s) is not responsible for emergency medical or dental conditions as outlined in **Attachment B: Out of Plan Benefits**.

The Bidder(s) shall make available to every member a dental provider, whose office is located within twenty (20) minutes or less driving distance from the member's home. Members may, at their discretion, select a dental provider located farther from their homes.

The Bidder(s) shall make services available within sixty (60) days for treatment of a non-emergent, non-urgent dental problem, including preventive dental care. Contractor agrees to make dental services available to new members within sixty (60) days of enrollment.

The Bidder(s) shall offer members a choice of dental providers accepting new patients.

3.1.9 Member Services

The Bidder(s) shall meet the requirements in **Article II, Section 2.10** of **Appendix B, Model Contract**. As part of the Member Services function, the Bidder(s) has an ongoing program of member education that considers the multi-lingual, multi-cultural nature of the population and recognizes that some members have disabilities.

The Bidder(s) shall staff a Member Services function that is operated at least during regular business hours (8 AM to 6 PM including lunch, Monday through Friday), except State observed holidays, and the Bidder's staff shall conduct the functions identified in **Appendix B, Model Contract**. The Bidder(s) maintains a toll-free Member Services telephone number that is staffed during regular business hours as defined above.

Once a year, the Bidder(s) shall notify members in writing of their rights to request and obtain information about their benefits, freedom of choice regarding provider restrictions, State's and Dental 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 in **Article II, Section 2.10** of **Appendix B, Model Contract.**

3.1.10 Provider Services

The Bidder(s) shall meet the requirement described in **Article II, Section 2.11** of **Appendix B, Model Contract**. As part of its Provider Services function, the Bidder(s) shall have an ongoing program of provider education relating to RIte Smiles benefits, program requirements, and the needs of RIte Smile members.

Bidder(s) shall 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 the RIte Smiles providers in a timely manner.

The Bidder(s) shall maintain 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 including lunch, Monday through Friday), excluding State observed holidays.

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

3.1.11 Dental 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 and Dental Plans. The Bidder(s), therefore, shall comply with all Department of Health UR/QA standards, in addition to specific standards described in this section.

The requirements for clinical management and quality assurance are described in **Article II, Section 2.12** of **Appendix B, Model Contract,** and are highlighted below.

A. Dental Director

The successful Bidder(s) shall employ and designate a full-time Dental Director responsible for the development, implementation, and review of the internal quality assurance program ("QAP"). The Dental Director will have adequate and appropriate experience in successful QA programs and be given sufficient time and support staff to carry out the Dental Plan's QA functions. The successful Bidder(s) may use assistant or associate Dental Director to help carry out the responsibilities of this office.

Bidder(s) shall assure that the Dental Director meets all qualifications and responsibilities as outlined in **Appendix B, Model Contract**.

B. Utilization Review and Quality Assurance (UR/QA)

The Bidder(s) shall have 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 438.350, (2) assure that the UR and QA Committees meet on a regular schedule, and (3) provide for regular UR/QA reporting to the Dental Plan(s)' management and providers, including profiling of provider utilization patterns.

The policies and procedures include protocols for: denial of services, prior approval, provider profiling, and retrospective review of claims. As part of its utilization review function, the

Bidder(s) shall have processes to identify utilization problems and undertake corrective action. The Bidder(s) have a structured process for the approval or denial of covered services. This shall include, 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(s) shall demonstrate to the EOHHS that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically or functionally necessary services to any member. The Bidder(s) may engage in direct discussions and/or patient or patient family interviews, as necessary, to consider treatment options or alternatives, and the like for cost-effective, patient-centered medically necessary dental care.

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

1) Quality Assurance

The Bidder(s) shall have 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. The Bidder(s) shall complete two (2) Quality Improvement Projects, approved by EOHHS, per year. The Bidder(s) must report the status and results of each project to the State, or its designees, in a format to be outlined by the State.

Bidder(s) shall 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(s) shall support joint quality improvement projects involving RIte Smiles dental plan(s) and EOHHS.

Please reference **Appendix B, Model Contract, Section 2.12.C, Utilization Review and Quality Assurance (UR/QA)**.

2) Confidentiality

The Bidder(s) shall have written policies and procedures for maintaining the confidentiality of data, including dental records/client information so as to conform to HIPAA requirements.

The Bidder(s) shall 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) State and Federal Reviews

Bidder(s) shall make available to the State and/or its designees on an as needed basis, medical and other records for review of quality of care and access issues.

CMS and/or the State may designate an outside review agency to conduct an evaluation of the Rhode Island Medical Assistance dental program and its progress toward achieving program goals. Bidder(s) agree to make available to CMS' and/or the State's outside review agency medical and other records for review as requested.

Bidder(s) shall undergo annual, external, independent reviews of the quality, timeliness, and access to the services covered under each contract, in accordance with 42 CFR 438.350.

4) Practice Guidelines

The Bidder(s) shall have developed and/or adopted and disseminated 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(s) shall 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.

When developing practice guidelines, the Bidder(s) follows the principles and the guidelines promulgated by the American Academy of Pediatric Dentistry (AAPD).

5) Service Provision

The Bidder(s) shall provide 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(s) shall 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.

Contractor shall provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR 440.230 and for members under the age of twenty-one (21), as set forth in 42 CFR 441 Subpart B.

3.1.12 Operational Data Reporting

A. General

The Bidder(s) must comply with all EOHHS-established reporting requirements, as outlined in **Appendix B, Model Contract, Article II, Section 2.13**. EOHHS shall provide the Contactor with the appropriate reporting formats, instructions, submission timetables and technical assistance, as required. EOHHS may at its discretion, change the content, format or frequency of reports. If the Contractor delegates responsibility to a subcontractor, the Contractor shall ensure the subcontracting relationship and subcontracting documentation comply with EOHHS reporting requirements. EOHHS will develop and maintain a *Managed Care Reporting Calendar and Templates for Dental Plans* to document reporting requirements for each of the following elements of the contract:

- Encounter Data Reporting
- Grievance and Appeals Data
- Quality Assurance Data
- Member and Provider Satisfaction Report
- Fraud and Abuse
- Presentation of Findings
- HIPAA
- Certification of Data

- Patient Protection and Affordable Care Act
- MLR Reporting
- All required financial reports

Reporting templates shall be provided to successful Bidder(s) during readiness implementation timeframe.

B. Encounter Data Submission

Pursuant to 42 CFR 438.242(c), the Bidder(s) must submit to EOHHS complete, accurate, and timely encounter data for all services for which the Bidder(s) has incurred any financial liability, whether directly or through subcontracts or other arrangement. The Bidder(s) will submit encounter data monthly and in compliance with the EOHHS guidance document *Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance*. EOHHS reserves the right to make changes to the guidance document at any time. The Bidder(s) shall implement all changes within ninety (90) calendar days of notification. The Bidder(s) is solely responsible for submitting all subcontractor encounter data in compliance with EOHHS' encounter data requirements.

Bidder(s) is responsible for collecting, monitoring, submitting and ensuring the accuracy of all 837 submissions and subsequent 277CA reports. The Bidder(s) shall submit complete, accurate, and timely encounter data for all services that it, or its subcontractors, have incurred a financial liability within thirty (30) business days of the end of the month in which the liability was incurred. The Bidder(s) shall ensure that ninety-eight percent (98%) of submitted encounters are accepted and do not reject, upon initial submission. Bidder(s) may be subject to a monthly liquidated damage for failing to comply with timely and accurate encounter data.

Submitted encounters and encounter records must pass all the EOHHS designated Medicaid Management Information System ("MMIS") edits. Submitted encounters or encounter records must not be duplicates of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.

The Bidder(s) is responsible for re-submitting any errored off/rejected claims to the State within thirty (30) business days of the receipt of the rejection and/or applicable rejection report, such as 277CA reports. The Bidder(s) is subject to corrective action and/or financial sanctions for non-submitted, late, or persistently rejected/incorrect data submissions.

3.1.13 Grievance and Appeals

The Bidder(s) shall meet the requirements governing the grievance and appeals process as described in **Article II, Section 2.14** of **Appendix B, Model Contract**.

The State has established a Grievance and Appeals function through which members can seek redress against Dental Plans. The appeal/grievance system includes a grievance process, an appeals process, and access to the State's Fair Hearing system. EOHHS requires that the Dental Plan resolve member and provider complaints through internal mechanisms whenever possible. In accordance with CMS Medicaid and CHIP Managed Care Final Rule, the Bidder(s) is required, per CMS Medicaid and CHIP Managed Care Final Rule, to utilize EOHHS model member notices to notify members of denied authorizations or services, appeal and grievance results and appeal and grievance rights.

The Bidder(s) is required to have written policies and procedures conforming to Federal and State requirements for resolving member complaints and for processing grievances and appeals when requested by the member or when the time allotted for complaint resolution expires. Such procedures will not be applicable to any disputes that may arise between the Bidder(s) and provider regarding the terms, conditions, termination or any other matter arising under a participation agreement or regarding any payment or other issues relating to providers. The Bidder(s) shall provide to all providers and subcontractors at the time they enter into a contract, information specified in § 438.10(g)(2)(xi)(C) about the grievance and appeal system, including the availability of assistance to enrollees with filing grievances and appeals.

The Bidder(s) shall maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

The Bidder(s')'s policies and procedures for processing grievances permit a provider, acting on behalf of a member and with the member's written consent, to file an appeal of an action within thirty (30) days from the date of the Dental 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 of the Dental Plan to act within prescribed time frame as indicated in **Appendix B, Model Contract**. The information that is required to be in a Notice of Action is also included in **Appendix B, Model Contract**. The time frames for mailing a Notice of Action must comply with 42 CFR 438.404. The Dental Plan also notifies 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.

Bidder may be subject to a liquidated damage for failing to comply with grievance and appeals performance standards.

3.1.14 Payments to and from Plans

The Bidder(s) shall accept the capitation rates as contained in **Appendix B, Model Contract**. The State makes capitation payments to the Dental Plan monthly via electronic funds transfer as described in **Article II, Section 2.15** of **Appendix B, Model Contract**.

Bidder(s) shall consider entering into creative or performance-based payment arrangements intended to foster and reward effective utilization management and quality of care. The Bidder(s) shall conduct procurement practices and to establish provider reimbursement systems that enhance the access, quality and cost-effectiveness of care.

Bidder(s) shall meet the requirement of **Appendix B, Model Contract,** related to (1) special reimbursement provisions for FQHCs and RHCs, (2) paying providers within thirty (30) days of receipt of a "clean claim", (3) payment of hospital-based dental clinics, (4) applying Federal and State limitations on provider incentive plans, (5) Third Party Liability ("TPL"), (6) reinsurance, (7) maintaining reserves and accounting for incurred but not reported ("IBNR") claims, (8) payment adjustments with respect to non-payment of provider preventable conditions, and (9) the State conducting audits of the Dental Plan.

TPL is one of three (3) components of EOHHS Program Integrity efforts (compliance and fraud/abuse are the other (two) subsequently discussed herein). The Bidder(s) shall make every

effort to identify and pursue TPL to the fullest extent possible to assure that other funds are used before Medicaid funds are expended, including but not limited to: (1) identifying potential other TPL when a member initially is enrolled with a Dental Plan and periodically thereafter, (2) identifying other potential TPL when adjudicating member claims (e.g. auto insurers or liability insurers when acclaim is related to an accident), (3) notifying the State Fiscal Intermediary when TPL is identified, and (4) making efforts to recover funds related to other TPL coverage

3.1.15 Financial Standards

A. Dental Plan(s) Financial Standards

The Rhode Island Department of Business Regulation regulates the financial stability of all licensed Dental Plans in Rhode Island. The Bidder(s) agrees to comply with all Rhode Island Department of Business Regulation standards in addition to specific requirements described in **Article II, Section 2.16** of **Appendix B, Model Contract**.

The success of the Rhode Island RIte Smiles program is contingent on the financial stability of participating Dental Plans. As part of its oversight activities, the State has established financial viability criteria, or benchmarks, used in measuring and tracking the fiscal status of the Dental Plans. The areas in which financial benchmarks are established include the following:

- Current ratio
- Plan equity per enrollee
- Administrative expenses as a percent of capitation
- Net medical costs as a percent of capitation
- IBNR and RBUC levels, including days claims outstanding

Bidder(s) must follow required financial data reporting as specified in the *EOHHS Medicaid RIte Smiles Requirements for Reporting and Non-Compliance*.

3.1.16 Record Retention

As required by **Article II, Section 2.17** of **Appendix B, Model Contract**, Bidder(s) must retain the source records for its operational data reports and financial records for a minimum of ten (10) years and must have written policies and procedures for storing this information. The Bidder(s) also preserves and maintains all dental records for a minimum of ten (10) 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 years after the disposition of litigation.

3.1.17 Compliance

The compliance requirements are discussed in **Section 2.18** of **Appendix B, Model Contract.** In accordance with 42 CFR 438.608, the Bidder(s) has administrative and management arrangements, including a mandatory written Compliance Plan, which is designed to guard against fraud and abuse. An electronic copy of the Compliance Plan including all relevant operating policies, procedures, workflows, and relevant chart of organization, and the information noted in **Appendix B, Model Contract,** are submitted to EOHHS for review and approval within ninety (90) days of the execution of the contract and then on an annual basis thereafter. Compliance is one of three (3) component of the State's Program Integrity efforts (identification and recovery of TPL and detection and control of fraud and abuse are the other two (2) components). Specific requirements related to efforts to identify and recover TPL and to control fraud and abuse are discussed in

Section 3.07.03 of **Appendix B, Model Contract**.

The Bidder(s):

(1) is prohibited to have affiliations with individuals debarred by Federal agencies,

(2) must disclose ownership and controlling interest within 35 days of contract execution,

(3) must require providers to disclose ownership and controlling interest,

(4) must require each to furnish the Federal and State governments full and complete information related to business transactions, within 35 days upon request,

(5) must require that providers must disclose any individual who has more than five percent interest in the provider who was convicted of a crime, and

(6) must disclose to the State any individual who has more than five percent ownership who has been convicted of a crime. These requirements are more fully discussed in **Appendix B, Model Contract**.

The Bidder(s) shall provide a policy and procedure to ensure compliance with H.R. 6 The SUPPORT Act Title 1; Section 1004, which mandates the following:

- Contractor must have automated drug utilization review safety edits for opioid refills;
- Automated claims review process to identify refills in excess of State limits;
- Monitor concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics);
- Maximum daily morphine equivalent (MME) safety edits; and
- Concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

3.2 Model Contract Terms and Conditions

The attached **Appendix B** contains the **Model Contract** for the forthcoming procurement period. The Bidder(s) 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) shall be bound to the requirements and capitation rates contained in this **Model Contract**. Contractors are expected to have policies, procedures and practices that demonstrate compliance with the requirements contained in this **Model Contract**.

The Bidder(s) shall meet the Terms and Conditions described in Article III "Contract Terms and Conditions" of **Appendix B, Model Contract,** that covers: (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. Bidder(s) are urged to review the specific requirements related to the terms and conditions in **Appendix B, Model Contract**.

The fraud and abuse requirements merit additional discussion because they are the other component of EOHHS Program Integrity efforts which include: (1) the identification and recovery of third-party liabilities, (2) compliance plan, and (3) fraud and abuse. The first two points were discussed in the previous section; the following highlights requirements related to fraud and abuse.

The Bidder(s) must adopt a strategic and robust approach to the prevention, detection, investigation and reporting of potential Medicaid fraud, waste and abuse to assure that Medicaid funds are appropriately expended. Specifically, the Dental Plan(s) shall:

- Operate a comprehensive program for providing targeted feedback to providers and vendors whose coding, documentation, or billing, although not fraudulent, appears problematic.
- Develop 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.
- Integrate approaches to processing and investigating leads about possible fraud, waste and abuse which may be identified from multiple sources, including the Dental Plan(s)'s toll-free fraud, waste, and abuse reporting hotline, as well as calls or written correspondence directed to the Dental Plan(s)'s customer service, provider relations, utilization management, medical management, and care management departments.
- Employ 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; services billed after the date of death of the enrollee or the provider.
- Execute systematic processes for conducting special investigations, provider site inspections, and focused clinical record reviews.
- Engage with the fraud, waste and abuse detection and investigations programs operated by the Bidder's subcontractors.
- Demonstrate 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.
- Use a cohesive approach to synthesizing quantitative and qualitative data to determine whether possible Medicaid fraud, waste and abuse have been discovered.
- Make referrals to EOHHS in a secure, timely, and thorough manner when the Bidder's initial investigation concludes that a case has reached the level of a suspected case of fraud and abuse on the part of a provider, vendor, or enrollee.

3.3 Model Contract Addendums

Appendix B, Model Contract, contains addendums and critical requirements that the Bidder(s) shall meet. These requirements are related to: (1) fiscal assurance, (2) notice to EOHHS providers of their responsibilities under Title VI of the Civil Rights Act of 1964, (3) notice to EOHHS providers of their responsibilities under Section 504 of the Rehabilitation Act of 1973, (4) drug free work place policy, (5) drug free work place provider certificate of compliance, (6) subcontractor compliance, (7) certification regarding environmental tobacco smoke, (8) instructions for certification regarding the debarment , suspension and other responsibility matters primary covered transactions, (9) certification regarding lobbying, (10) supplemental terms and conditions for contracts funded whole or in part by the American Recovery and Reinvestment Act of 2009, and (11) business associate agreement.

The Addendums are signed prior to the commencement date of the contract.

3.4 Model Contract Attachments

Appendix B, Model Contract, contains the following Attachments which are key requisites to achieving the desired procurement results. The Bidder(s) are urged to read **Appendix B, Model Contract,** and are required to meet the requirements contained in these Attachments.

These Attachments contain:

(1) Schedule of In-Plan Benefits;
(2) Schedule of Out-of-Plan Benefits;
(3) Schedule of Non-Covered Services;
(4) Dental EPSDT Periodicity Schedule;
(5) Monthly Capitation Rates;
(6) Actuarial Basis for Capitation Rates;
(7) Special Terms and Conditions;
(8) Contractor's Insurance Certification; and
(9) Contractor's Locations.

SECTION 4: PROPOSAL

Bidder must adhere to 50-page limit; any additional pages after 50 pages will not be considered. Attachments and supporting documentation are not included in page limit of Technical Proposal.

A. Technical Proposal

Narrative and format: The proposal should address specifically each of the following elements:

1. **Letter of Transmittal *(Recommended pages: 1)***

Bidder(s) 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 shall include statements regarding the following:

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

2. **Assurances/Attestations *(Recommended pages: 1)***

The Bidder(s) at minimum shall include the following statements and assurances in their proposals.

A. **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 and will become accredited in Rhode Island as a Dental Plan within twelve (12) months after the State has notified the Contractor of an appropriate accreditation body.

B. **A statement** that the Bidder agrees to support joint quality improvement projects involving Dental Plans and EOHHS, and that the Bidder agrees to use the Quality Improvement Activity Form for reporting all quality improvement activities to the State.

C. **A statement** that the Bidder has read and accepts the mandatory requirements, responsibilities, and terms and conditions associated with this procurement.

D. **A statement** of whether the Bidder or any of the Bidder's employees, agents, independent contractors or subcontractors have been convicted of, pled guilty to or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have been debarred or suspended by any Federal or State governmental body, and if so, an explanation providing relevant details. Bidder shall include the Bidder's parent organization, affiliates and subsidiaries.

E. **A statement** that the Bidder has read, understands, and accepts the mandatory requirements, responsibilities, and terms and conditions associated with this procurement, as reflected in **Appendix B, Model Contract**.

F. **A statement** that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidder(s).

G. **A statement** of Affirmative Action that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, sexual orientation, political affiliation, national origin, or handicap and complies with the Americans with Disabilities Act.

3. Bidder's Experience, Understanding, and Readiness to Perform *(Recommended pages: 5)*

The Bidder(s) shall provide a high-level summary of readiness to perform and meet the requirements outlined in **Section 3, Scope of Work**, and **Appendix B, Model Contract**. The summary must include, at a minimum, the following:

A) **A description** of how the Bidder meets the Licensure and Organizational requirement in Section 3 of this LOI and **Sections 2.1, 2.2 and 2.3** of **Appendix B, Model Contract**. Bidder submits copies of its State Licenses with their response to this LOI.

B) **A description** of the Bidder, and its subcontractors, 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.

C) **A substantial description** of the Bidder's ability to provide Medicaid services as a Dental Plan in Rhode Island or, if applicable, in other states, under a risk-based contract. The Bidder must submit an organizational chart and corresponding staffing model specific to the RIte Smiles program. Both must include dedicated or full-time equivalent ("FTE") staff for each administrative function, as well as an identification of which staff shall be located in Rhode Island. Please indicate which percentage of dedicated staff will be staffed locally and which will be located elsewhere.

   a. This description must include information on the Bidder's approaches to serve

diverse populations.

D) **A concise description** of the Bidder's experience serving as a commercial Dental Plan in Rhode Island under a risk-based contract and the population served. This description must include information on the Bidder's approaches to serve diverse populations.

E) **A demonstration** of an understanding of the Rhode Island environment; the conditions surrounding this procurement and knowledge of and experience with the Medicaid population in other states. The Bidder must describe potential promising approaches to providing Medicaid services in a way that meets the unique needs of the enrolled local population. 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.

F) **A description** of its capability and capacity to provide the Medicaid services to the eligible populations under a risk sharing arrangement including an appended organization table and description of the units responsible to administering the elements of the RIte Smiles Program.

G) **A description** of 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.).

H) **A description** of its relationship and linkages with existing Rhode Island Health Plans.

I) **Three (3) References from parties familiar with the** Bidder providing similar services as requested in this LOI, including the Agency, contact person, e-mail address, address, telephone and fax numbers, and a description of the size and scope of the previous engagement.

J) **Information** the Bidder believes is essential to provide value-based quality services to the Medicaid populations. The Bidder must describe its perspective on the Dental Plan's role in assisting the State with transforming Rhode Island's healthcare system. The Bidder should identify what would be needed from the State to be successful in aiding this transformation. Bidder might recommend appropriate metrics to help both measure and incent progress. The Bidder is encouraged to recommend appropriate metrics to both incent and measure progress toward the State's healthcare system transformation.

K) **A description** of the Bidder's ability to be ready to serve members by July 1, 2020;

L) **A clear, succinct description** of the Bidder's readiness to perform the requirements of this contract;

M) **A description** of areas of capability still under development, as applicable, accompanied by realistic timeframes for completion.

N) **A description** of how the Bidder meets the Dental Plan(s) Licensure and Organizational Requirements described in the Scope of Work and discussed further in **Appendix B, Model Contract, Section 2.2, Licensure/Certification**.

O) **Documentation** that Bidder's organization has the staffing capacity with the appropriate expertise for the Scope of Work described in Section 3 of this LOI. The Bidder must have a Dental Director that meets the requirements and adequate staffing to complete the administrative procedures, develop an organizational structure, maintain a management information system and perform all the functions required in **Appendix B, Model Contract**.

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.

P) **A clear statement** of the Bidder's acceptance of the State Capitation Rates to be paid for Medicaid enrollees. 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 #6 requires: "A statement that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidder(s). Proposal submissions that fail to include a signed attestation of acceptance of the State's Capitation Rates shall be deemed non-responsive and will not be considered.

Q) **The Bidder shall 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. The Bidder(s) 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).

R) **The Bidder(s) shall provide a description and/or provide evidence** of financial solvency as a Dental Plan operating in Rhode Island or outside of Rhode Island. Documentation to be provided by the Bidder(s) shall include:

- Presentation of the company's financial position for the past two (2) years (2018 and 2019) in relation to plan-specific levels of risk-based capital (RBC) and the company's Authorized Control Level. Bidder(s) newly entering the Rhode Island market should provide comparable documentation to demonstrate financial solvency and compliance with Rhode Island requirements.
- Annual NAIC Financial Statements;
- Most recent Quarterly NAIC Financial Statement;
- 2017 and 2018 Annual Audited Financial Statements;
- 2017 and 2018 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; and,
- Where applicable, evidence that the parent Company provides 100% of subsidiary's financial backing

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 Dental Plan there may be defined areas of enhanced capability or improvement. If this is the case, Bidder(s) should provide clear statements of Bidder(s')'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(s) should address this issue at a more summary level, highlighting critical areas.

Note that for any successful Bidder(s) EOHHS shall conduct readiness reviews both to ensure the accuracy of information contained in the Technical Proposal and to ensure Bidder(s)

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 (2) months beyond July 1, 2020. RI EOHHS or their designee will identify to the Bidder(s) areas where EOHHS does not deem Bidder(s) to be ready and able to meet its obligations under the tentative award. EOHHS shall provide reasonable opportunity for the Bidder(s) to correct such areas to remedy all deficiencies prior to the contract effective date.

If, for any reason, the Bidder(s) 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.

EOHHS is seeking to enter into contracts with Dental Plans that are prepared to serve the enrolled population beginning on July 1, 2020. 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 (2) months following this effective date.

4. Technical Response

The following describes the Technical Responses required from the Bidder(s). EOHHS is interested in practical cost-effective interventions based on the Bidder(s')'s knowledge and experience, when responding to the Plans identified in the following subsections (A-M).

The separate technical proposal should address specifically each of the required elements as set forth in this section. Bidder(s) shall respond in the order presented in this LOI. Evaluation criteria and corresponding point values for each section of the Bidder(s')'s response to this LOI is outlined in **Section 5, Evaluation and Selection**. As part of the Technical Response, further described in subsection **M**, **Plan for Enhanced Care Coordination and Member Satisfaction**, the Bidder(s) must choose whether to elect to propose a value-added benefit(s), to be offered as covered benefits to its enrollees.

The checklist indicates the key elements of the Bidder(s')'s proposal as described in this **Section 4, Proposal**, along with points assigned to each section and a suggested number of pages for the Bidder(s')'s response, excluding attachments.

The Bidder(s) shall attach the completed checklist to their proposal.

A) Plan for Best Practices *(Recommended pages: 5)*

The Bidder(s) shall provide a proposed plan(s) for designing and implementing "best practices" under the terms of **Appendix B, Model Contract**. The Bidder(s) shall submit a clear and tangible proposed design plan and an implementation plan.

The Bidder(s) shall submit a design and implementation plan for "best practices" for the enrolled population. These plans include references to the following:

(1) **A description** of how the Bidder will identify specific "best practices" from other jurisdictions that may benefit Rhode Island (e.g., use of caries risk assessment tools and

how implementation of those tools leads to better outcomes and reduced expenses);

(2) **A description** of a draft outreach protocol directed at parents, schools, physicians, and other community agencies to increase program enrollment;

(3) **A description** of how the Bidder will identify and implement caries risk assessment techniques/measures/tools for RIte-Smiles-enrolled children and/or young adults, including those with special needs;

(4) **A description** of a draft protocol to educate parents around the benefits of good oral health and to engage parents in intervention activities that may lower a child's risk for more extensive and costly care;

(5) **A draft** protocol for ensuring continuity of care between the primary health care physician and the dentist or dental practice;

(6) **A description** of how the Bidder will identify and implement specific clinical practices, guidelines and protocols that improve the outcome of care;

(7) **A description** of how the Bidder will use technology to improve the outreach efforts, the delivery of care and the administration of the program; and

(8) **A description** of protocols that address other areas that may improve the RIte Smiles program, including methods that may be used to monitor and control the increase in orthodontic expenditures. The Bidder must clearly describe plans for containing these rising costs.

B) **Plan for Enrollment** ***(Recommended pages: 4)***

The Bidder(s) shall clearly describe a plan for enrolling the RIte Smiles populations and meeting the requirements of **Sections 3.1.3 and 3.1.4** of the LOI and **Section 2.5** of **Appendix B, Model Contract**.

As part of its response, the Bidder(s) shall identify and describes its capability and its policies, procedures and practices, including the following:

(1) **A description** of how the Bidder will accept the State supplied monthly list of Dental Plan enrollees, including a flow chart and/or detailed diagram(s) that illustrate the pathways described above, as well as an organizational chart and description of the enrollment unit;

(2) **A description** of how the Bidder will enroll members on the first day of the following month after receiving notification from the State;

(3) **A description** of how the Bidder will mail notification of Dental Plan enrollment to members including effective date and how to access care within ten (10) calendar days after receiving notification from the State;

(4) **A draft orientation** protocol and procedure that will be used to engage new members 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;

(5) **A description** of how the Bidder will make at least three (3) attempts, on different days and on different times, to make a welcome call to all new members within thirty (30) days of enrollment;

(6) **A description** of how the Bidder will provide members with a permanent identification

card within ten days after receiving notification from the State;

(7) **A description** of how the Bidder will mail a Member Handbook, or, if preferred by the member, make handbook available on the website, to all members within ten (10) days of being notified of their enrollment;

(8) **An update** to the Member Handbook when material changes are needed as determined by EOHHS;

(9) **Marketing materials** developed with EOHHS approval;

(10) **A description** of how the Bidder will identify the diverse population of its members and design member information in a way that is culturally and disability competent appropriate;

(11) **A description** of how the Bidder will determine the most recent and accurate telephone numbers and mailing address of its members;

(12) **A description** of how the Bidder will identify and implement other member outreach protocols on an as-needed basis.

C) **Plan for Providing Covered Services and Meeting Accessibility Standards**
(Recommended pages: 5)

The Bidder clearly describes its plan for providing the covered services and meeting accessibility standards contained in S**ection 3, Scope of Work,** and **Sections 2.6 and 2.9 of Appendix B, Model Contract**. This section includes

(1) **A description** of how the Bidder will provide the full range of in-plan dental services to all of its members, including its members with special needs,

(2) **A description** of how the Bidder will integrate dental EPSDT, interpreter/translation services, coordination of care, member/provider communications, and second opinions within its continuum of services,

(3) **A description** of how the Bidder will ensure that it is meeting and exceeding the service accessibility standards that governs the provision of services,

(4) **A description** of how the Bidder will ensure that it is meeting and exceeding additional standards that the Bidder employs above **Appendix B, Model Contract,** requirements,

(5) **A draft design protocol** of how the Bidder will engage and serve RIte Smiles members with special health care needs,

(6) **A description** of how the Bidder will ensure members have access to the appropriate limited English proficiency (LEP) interpreter services, including the Bidder's plans to contract with an interpreter and/or provide access to bi-lingual staff, as well as how the Bidder will identify LEP members and their families and provide comprehensive program and benefits documentation;

(7) **A description** of how the Bidder will ensure the member cohort has access to age-appropriate services and an adequate provider network, including an example of the member and provider strategy and collaboration in support of EPSDT;

(8) **A description** of how the Bidder will monitor EPSDT and identify children and/or young adults who have not specifically received the appropriate services, as well as how this learned information will engage non-compliant members and provide sufficient access to care;

(9) **A description** of how the Bidder will design and implement a plan for honoring all existing service authorizations for the designated transition period,

(10) **A description** of the Bidder's approach to evidence-based third molar (wisdom tooth) management.

(11) **Ideas** for active, regular involvement in the Rhode Island oral health community's activities and initiatives (e.g. the RI Oral Health Commission), and

(12) **Other topics** deemed appropriate by the Bidder.

D) Plan for Care Coordination *(Recommended pages: 3)*

(1) **A description** of its plan for coordinating benefits that meet the requirements of **Section 3** of this LOI and **Section 2.7** of **Appendix B, Model Contract**.
(2) **A description** of its plan for coordinating in-plan and out-of-plan dental benefits and coordinating care with member's PCP or other providers, when necessary.

E) Plan for Maintaining a Robust Provider Network *(Recommended pages: 5)*

The Bidder(s) shall describe its plans to develop and maintain a robust and comprehensive network of providers to meet the diverse and complex needs of RIte Smiles members as described in **Section 3** of this LOI and in **Section 2.8** of **Appendix B, Model Contract**. Specifically, the Bidder(s) shall include:

(1) **A description** of how the Bidder will provide its members with the full range of covered dental services for the anticipated members in the service area;

(2) **A description** of how the Bidder will increase the number of providers in sufficient number, mix and geographic area to meet the needs of its members. 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;

(3) **A description** of how the Bidder will ensure that all services are available to members in a timely manner;

(4) **A description** of how the Bidder will monitor and increase the specific provider network including a geographic access analysis of the network to determine accessibility of services that meet the needs of all members;

(5) **A description** of how the Bidder will effectively design and implement specific measures to improve provider capability to improve the cost-effectiveness of care;

(6) **A description** of specific plans for meeting the multi-lingual and multi-cultural needs of RIte Smiles members;

(7) **A description** of how the Bidder will communicate with providers about best practices, provider concerns, and suggested programmatic improvements (e.g., through establishing an advisory group);

(8) **A description**, as appropriate, of areas of potential weakness and the plan for continuous recruitment and retention of new providers to support ongoing network development and plans to create goal targets for specific numbers of in-network providers; and

(9) **Other topics** deemed appropriate by the Bidder.

The Bidder(s) must include as an attachment to the proposal a complete listing of its provider

network, including but not limited to provider names, addresses, town or city, telephone numbers, provider specialties, and foreign language(s) spoken (if any). The Bidder(s')'s GeoAccess analysis demonstrates that the network is sufficiently robust and assures timely access to services for RIte Smiles members based on providers who are currently accepting new members. This analysis must address the standards for access to care the Bidder will used to determine network sufficiency, and at a minimum must include a list of the provider specialties.

F) Plan for Providing Member and Provider Services *(Recommended pages: 5)*

(1) **A clear description** of its plan for providing member and provider services as described in **Section 3** of this LOI and **Sections 2.10 and 2.11** of **Appendix B, Model Contract**, respectively.

(2) **A clear description** of its efforts to provide multi-lingual, culturally competent and disability-centric member services and to enhance provider services that promote the integration and coordination of care, and other topics deemed appropriate by the Bidder.

G) Plan for Conducting Dental Management and Quality Assurance Efforts *(Recommended pages: 5)*

The Bidder(s) shall describe and discuss its plan for conducting dental management and quality assurance activities as described in **Section 3** of this LOI and **Section 2.12** of **Appendix B, Model Contract**.

The Bidder(s) shall include the following:

(1) **A description** of the Dental Director's background and experience as well as his/her role and responsibilities, including supporting proposal attachments that include but are not limited to the Dental Director's resume and his/her job description;

(2) **A description** of how the Bidder will implement utilization review protocols and criteria that affect the provision, the approval, or the denial of care,

(3) **A description** of 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 for children and/or young adults with special needs to both primary and specialty dental care,

(4) **A description** of how the Bidder will implement practice guidelines,

(5) **A description** of how the Bidder will monitor provider credentialing activities including a reasonable timeline to complete the process;

(6) **Other topics** deemed appropriate by the Bidder; and

(7) **An outline and description** of three (3) or more performance-based and/or value-based quality measures intended to enhance the quality of services provided to the RIte Smiles population. The description must include, at a minimum: (1) the Bidder's approach to delivering the measures; (2) how quality will be monitored through a Quality Improvement Program imposed on providers; (3) actions the Bidder will take if quality issues are identified; (4) and the types of reporting to be delivered.

An example of the type of measure the State would encourage Bidders establish includes:

Caries Risk Assessment: Require that caries risk assessment be administered as part of every routine, preventive dental office visit, including input of the appropriate risk-based dental code to enable providers to focus on intervention for members with the high and moderate caries risk codes (e.g., D0602 and D0603) for value-based reimbursement.

H) Plan for Meeting the Operational Data Reporting Requirements *(Recommended pages: 2)*

The Bidder(s) description of its plan for meeting the operational data reporting requirements described in **Section 3** of the LOI and in **Section 2.13** of **Appendix B, Model Contract**.

Specifically, the Bidder(s) shall provide the following:

(1) **A description** of how the Bidder will provide EOHHS with uniform utilization, quality assurance, and member satisfaction/complaint data on a regular basis;

(2) **A description** of how the Bidder will provide, in a time-frame determined by the State, a person-level record of all services provided;

(3) **A description** of how the Bidder will provide aggregate utilization data for all members at such intervals as required by EOHHS;

(4) **A description** of how the Bidder will provide quarterly grievance and appeals report due no later than 30 days after the end of the reporting quarter;

(5) **A description** of how the Bidder will submit internal quality assurance reports periodically;

(6) **A description** of how the Bidder collects member satisfaction data through an annual survey of its members;

(7) **A description** of how the Bidder will submit a quarterly fraud and abuse report due no later than thirty days after the end of the reporting period;

(8) **A description** of how the Bidder will submit a compliance dashboard report due no later than 30 days after the end of the reporting quarter;

(9) **A description** of how the Bidder will submit an informal-complaints report due no later than 30 days after the end of the reporting quarter; and

(10) **Other topics** deemed appropriate by the Bidder.

These reports shall be prepared in conformance with reporting templates established by the State during the readiness period.

I) Plan for Meeting Grievance and Appeals Requirements *(Recommended pages: 2)*

The Bidder(s) shall clearly describe its plan for meeting the grievance and appeals process requirements described in **Section 3** of the LOI and in **Section 2.14** of **Appendix B, Model Contract**.

Specifically, the Bidder(s) shall provide the following:

(1) **A description** of the Bidder's policies for processing grievances permits a provider, acting on behalf of a member and with the member's written consent, to file an appeal of an action within thirty (30) days;

(2) **A description** of the Bidder's detailed procedures and processes to meet Federal and State requirements;

(3) **A description** of how the Bidder will interface with the State Appeals process; and

(4) **Other topics** deemed appropriate by the Bidder.

J) Plan for Payments to and from the Dental Plan(s) ***(Recommended pages: 2)***

The Bidder(s) shall clearly describe its plans for meeting the requirement for payments to and from the Dental Plan(s) as described in Section 3 of the LOI and in Section 2.15 of **Appendix B, Model Contract**.

Specifically, the Bidder(s) shall clearly provide the following:

(1) **A description** of its capability to accept the capitation payments from the State,

(2) **A description** for a plan for the reimbursement of providers,

(3) **A description** of how the Bidder will identify and implement creative or performance-based reimbursement arrangements intended to foster and reward effective utilization management and quality assurance,

(4) **An assurance** that the Bidder has reinsurance and adequate reserves,

(5) **A description** of how the Bidder will implement TPL policies and procedures as well as anticipated results or savings that will be produced as a result of TPL efforts, and

(6) **Other topics** deemed appropriate by the Bidder.

K) Plan for Meeting Financial Standards, Record Retention and Compliance Requirements ***(Recommended pages: 2)***

(1) **A clear description** of its plans for meeting the requirement that the Bidder continue to monitor and maintain its financial viability, record retention and compliance requirements as described in Section 3 of the LOI and in Sections 2.16, 2.17 and 2.18 of **Appendix B, Model Contract**.

(2) **A clear description** that specifies: (a) how it will meet the financial standard requirements; (b) how it will meet the record retention requirements; and (c) how it will meet the compliance requirements.

L) Plan for Meeting Contract Terms and Conditions ***(Recommended pages: 1)***

The Bidder(s) shall clearly describe its plan for meeting the requirement for payments to and from the Dental Plan(s) as described in **Section 3.2** of the LOI and in Article III of **Appendix B, Model Contract**.

Specifically, the Bidder(s) shall provide the following:

(1) **A description** of how the Bidder will ensure compliance with the general terms and conditions of the Contract;

(2) **A description** of how the Bidder will address the fraud and abuse requirements;

(3) **A description** of how the Bidder will ensure confidentiality of information;

(4) **An assurance** of the Bidder's ability to handle risk-sharing contract provisions; and

(5) **Other topics** deemed appropriate by the Bidder.

M) Plan for Enhanced Care Coordination and Member Satisfaction *(Recommended pages: 2)*

As permitted under 42 CFR §438.3(e), managed care organizations may voluntarily agree to provide services that are in addition to covered services under the State plan. The cost of these services is not included in the capitation rates; however, the State encourages Bidder(s) to identify expanded services, known as 'value-added benefits,' to promote increased oral health outcomes to RIte Smiles members. Bidder cost-savings, increased member satisfaction and enhanced care coordination can be attributed to the addition of value-added benefits.

If the Bidder(s) elect to propose a value-added benefit(s), for each value-added benefit, the Bidder must provide, at a minimum:

(1) **A description** of the scope of the benefit, including procedure code(s) and modifier(s), if applicable;

(2) **An explanation** of how the Bidder will provide oversight of the value-added benefit(s);

(3) **An outline** of the per member per month (PMPM) actuarial value of benefit(s) based on current RIte Smiles member enrollment of 110,389 members, accompanied by a statement from the preparing/consulting actuary that is a member of the American Academy of Actuaries, certifying the accuracy of the information.

(4) **A statement** of commitment to provide the proposed value-added benefits for the entire twenty-four (24) month term of the initial contract and for any extensions, if applicable, at no additional cost.

The following are non-exhaustive examples of the types of value-added benefits the State welcomes to enhance the services and quality of care provided to the RIte Smiles member population:

- A strategic plan to encourage value-based care in which the Dental Plan would provide an incentive for oral health providers to enhance access to care using pay-for-performance measures.
- A strategic plan for early orthodontic intervention that includes coverage of procedures that would reduce the long-term, future cost of orthodontic treatment. For example, the Dental Plan could provide palatal expanders, maxillary expanders, and/or other functional appliances that would mitigate the need for more costly, future orthodontic treatment.
- Alternative pain management techniques, such as non-opioid approach(es) to post-operative pain management. For example, rather than providers prescribing traditional pain medication, the Dental Plan could provide for a long-acting local anesthetic/analgesic following a surgical procedure that would remain effective following surgery.
- Strategies and/or provision of services that support the following enhancements:
    - Improve medical-dental integration, especially concerning member data.
    - Re-evaluate the HLD Scoring Index for efficacy and equity.
    - Tuition reimbursement, discounted licensure and training for provider recruitment.

- Utilize technology for more targeted member education, marketing, and outreach.
- Implement member risk level-based dental provider incentives.
- Adopt innovative strategies to address sub-populations with special needs.

SECTION 5: EVALUATION AND SELECTION

To be considered for award(s), all Bidders must first attest to the capitated rates outlined in Model Contract Attachments E (Monthly Capitation Rates) and F (Actuarial Basis for Capitation Rates). Should a Bidder fail to attest to the acceptance of the capitated rates, that Bidder's technical proposal shall not be evaluated for Technical Evaluation Committee (TEC).

The State intends to provide multiple or singular award(s) based on TEC evaluation. It is intended that awards pursuant to this LOI will be made to qualified Dental Plan(s) whose technical proposals meet all criteria described in this LOI.

Each Bidder will submit one (1) bid proposal addressing each component of the Scope of Work, as outlined in Section 3 and further detailed in **Appendix B, Model Contract**. As detailed in Section 4, Technical Proposals will include details about the Bidder's ability to perform duties and obligations in Model Contract.

Technical Proposal Scoring

Technical Proposals accompanied by attestation of capitation rate will be reviewed by a TEC comprised of EOHHS staff. Proposals shall be scored on a **100-point scale.** Each criterion detailed in Section 4 of this LOI shall be weighted as described in the following table.

Criteria	Possible Points
1) Letter of Transmittal	Pass/Fail
2) Assurances/Attestations	Pass/Fail
3) Bidder's Experience, Understanding, and Readiness to Perform	10 points
4) Technical Response	**90 points**
A) Plan for Best Practices	10 points
B) Plan for Enrollment	8 points
C) Plan for Providing Covered Services and Meeting Accessibility Standards	10 points
D) Plan for Care Coordination	6 points
E) Plan for Maintaining a Robust Provider Network	10 points
F) Plan for Providing Member and Provider Services	10 points
G) Plan for Conducting Dental Management and Quality Assurance Efforts	11 points
H) Plan for Meeting the Operational Data Reporting Requirements	5 points
I) Plan for Meeting Grievance and Appeals Requirements	4 points
J) Plan for Payments to and From the Dental Plan(s)	4 points
K) Plan for Meeting Financial Standards, Record Retention and Compliance Requirements	4 points
L) Plan for Meeting Contract Terms and Conditions	3 points
M) Plan for Enhanced Care Coordination and Member Satisfaction	5 points
Total	**100 Points**

To be considered passing, technical proposals must receive a minimum score of 85 points. Any technical proposal scoring less than 85 points will not be considered for an award.

Bidder(s) may be required to submit additional written information or be asked to make an oral presentation before the technical evaluation committee ("TEC") to clarify statements made in the proposal.

SECTION 6: QUESTIONS

Questions concerning this solicitation must be e-mailed to the Division of Purchases at DOA.PurQuestions10@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 LOI #7599917 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 7: PROPOSAL CONTENTS

RESPONSE CONTENTS
Proposals shall include the following:

1. One 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 Technical proposal.*
2. One completed and signed Rhode Island W-9 (included in the original copy only) downloaded from the Division of Purchases website at /documents/Forms/Misc Forms/13_RI Version of IRS W-9 Form.docx. *Do not include any copies in the Technical proposal.*
3. Technical Proposal - Describing the qualifications and background of the Bidder and all requirements in Section 4 of this LOI, including any required attachments or documentation of expertise, Bidder must provide responses in a Technical Proposal. The technical proposal is limited to fifty (50) pages. This technical response page limit excludes any attachments, requested documentation, appendices, resumes of key staff that will provide services covered by this request. Any technical responses containing more than 50 pages will not be considered by TEC.

    a. One (1) Electronic copy on a CD-R, marked "Technical Proposal - Original".
    b. One (1) printed paper copy, marked "Technical Proposal -Original" and signed.
    c. Eight (8) printed paper copies

4. Formatting of proposal response contents should consist of the following:

    - Formatting of CD-Rs – Separate CD-Rs are required for the technical proposal. All CD-Rs submitted must be labeled with:

        - Vendor's name
        - LOI #7599917
        - LOI Title - DENTAL HEALTH PLAN(S) FOR RITE SMILES PROGRAM
        - Proposal type (e.g., technical proposal or cost proposal)
        - If file sizes require more than one 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 for a technical proposal 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 proposal. All files should 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 any other electronic media shall not be accepted. Please note that CD-Rs submitted, shall not be returned.

- Formatting of written documents and printed copies:
  - For clarity, the technical proposal 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.
  - All pages on the technical proposal 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 Bidder(s) name should appear on every page, including attachments. Each attachment should be referenced appropriately within the proposal section and the attachment title should reference the proposal section it is applicable to unlabeled attachments related to the technical proposal shall not be considered by the TEC.
  - Printed copies are to be only bound with removable binder clips.

SECTION 8: PROPOSAL SUBMISSION

Interested vendors must submit proposals to provide the goods and/or services covered by this LOI 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.

Proposals should be mailed or hand-delivered in a sealed envelope marked LOI #7599917to:

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 shall not be accepted. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time shall be determined to be late and shall not be accepted. Proposals faxed, or emailed, to the Division of Purchases shall not be accepted. The official time clock is in the reception area of the Division of Purchases.

SECTION 9: CONCLUDING STATEMENTS

Notwithstanding the above, the Division of Purchases reserves the right to award to accept or reject any or all proposals, and to award in the State's 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.

If a Vendor is selected for an award, no work is to commence until a purchase order is issued by the Division of Purchases.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded for this LOI. The State's General Conditions of Purchases can be found at the following URL: https://rules.sos.ri.gov/regulations/part/220-30-00-13

For more detailed information regarding the Rhode Island Medicaid Program and supplemental documentation for this RIte Smiles procurement, please visit *RIte Smiles Reference Materials Website:*

1. Rhode Island Annual Medicaid Expenditure Report
2. RI Managed Medicaid Model Member Handbook
3. RI EOHHS Guidelines for Marketing and Member Communications for Medicaid Managed Care Program
4. Appeals/Grievances Notification Model Documents
5. Medicaid Health Plan Change Request Form
6. Managed Care Reporting Calendar and Templates for Dental Plans
7. Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds, and Penalties for Non-Compliance
8. EOHHS 837 Companion Guide (1 of 2)
9. EOHHS 837 Companion Guide (2 of 2)
10. Dental EPSDT Periodicity Schedule
11. Medicaid Managed Care Program: Medical Loss Ratio Calculation
12. EOHHS RIte Smiles Contract Requirements for Reporting and Intermediate Sanctions
13. Minimum Fraud and Abuse Prevention, Detection and Reporting Requirements for Members
14. Dental Services Provider Manual
15. Access to Dental Care 2019 RIKC
16. Dental Safety Net 2017
17. BRFSS 2016
18. Oral Health Head Start Report 2017
19. Oral Health of RI Children 2015
20. WIC Survey 2016, RI Dental Association Journal
21. Oral and Behavioral Health Teens 2018
22. Dentist Census 2018
23. Case Study: Driving Improved Teen Dental Utilization through Quality Improvement Strategies in Rhode Island
24. Innovative State Practices for Improving the Provision of Medicaid Dental Services
25. Centers for Medicare & Medicaid Services Waiver List
26. Rhode Island Medicaid Covered Dental Benefits for Children Under Age 21

27. Medicaid Health Plan Change Request Form