**Solicitation Information**
**May 30, 2014**

**LOI# 7548793**

**TITLE: Financial Alignment Demonstration Medicaid Integrated Care Initiative**

**Submission Deadline: Monday, June 30, 2014 at 10:00 AM (Eastern Time)**

**PRE-BID/ PROPOSAL CONFERENCE: NO**
**MANDATORY:**
**If YES, any Vendor who intends to submit a bid proposal in response to this solicitation must have its designated representative attend the mandatory Pre-Bid/ Proposal Conference. The representative must register at the Pre-Bid/ Proposal Conference and disclose the identity of the vendor whom he/she represents. A vendor's failure to attend and register at the mandatory Pre-Bid/ Proposal Conference shall result in disqualification of the vendor's bid proposals as non-responsive to the solicitation.**

**DATE:**
**LOCATION:**

Questions concerning this solicitation must be received by the Division of Purchases at david.francis@purchasing.ri.gov no later than **Monday, June 9, 2014 at 10:00 AM (EST).** Questions should be submitted in a *Microsoft Word attachment.* Please reference the LOI# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

**SURETY REQUIRED: No**

**BOND REQUIRED: No**

**David J. Francis**
**Interdepartmental Project Manager**

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

**Note to Applicants:**

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

**THIS PAGE IS NOT A BIDDER CERTIFICATION FORM**

## Electronic Solicitation Bidding Information

### Downloading and Accessing Electronic Files

Accessing electronic files on the purchasing website will require Adobe viewer. All bids denoted with a "D" in the "Info" column will require WinZip 8.1 software. The WinZip file may contain one or more files. These files may require additional software such as Microsoft Office.

Bids that have a file for download are marked with a "D" in the "Info" field of the bid search results page located on the Purchasing website. The "D" will indicate an active link to the WinZip file until the bid reaches its opening date. Clicking on the active "D" link will allow you to open or save the WinZip file associated with the bid. Opening the WinZip file will offer you the option of saving to your local computer.

Once saved, you can open the WinZip file and view the files. The individual files can be saved to your computer in a location such as "Desktop" or "My Documents".

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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 and Human Services (EOHHS), is soliciting proposals from qualified firms to provide Technical Proposals from qualified Bidders to provide medically or functionally necessary services to eligible Medicaid-only recipients with long-term services and supports, and Medicare-Medicaid Eligible recipients, through a managed care program under a capitation contract, in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at **www.purchasing.ri.gov**.

The initial contract period will begin approximately April 1, 2015 through December 31, 2017.

This is a Letter of Intent, not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, there will be no public opening and reading of responses received by the Division of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

### INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1. Potential vendors are advised to review all sections of this 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 procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this LOI will be rejected as being non-responsive.

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

4. Proposals are considered to be irrevocable for a period of not less than 120 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 herein.

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

7. It is intended that an award pursuant to this 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. Joint venture and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.

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

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

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

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

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

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

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

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

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

## SECTION 2: BACKGROUND

### 2.1 General State Requirements and Instructions

This Letter of Intent (LOI) chapter includes general State requirements and notifications for interested parties to follow in preparing proposal submissions to serve as a Medicare Medicaid Plan (MMP) under the Rhode Island (RI) Integrated Care Initiative (ICI) that the State intends to contract for in collaboration with the Center for Medicare and Medicaid Services (CMS). This initiative represents RI's capitated Financial Alignment Demonstration (FAD), created by CMS to address issues associated with serving dually eligible individuals. This collaborative EOHHS and CMS effort will be known as the ICI Demonstration.

Under the ICI Demonstration, successful Bidders will enroll adults (defined as age 21+) who are Medicaid and Medicare Eligible (MME) and further qualify for full Medicaid benefits which include, but are not limited to, Long Term Services and Supports (LTSS) which consist of institutional or Home and Community-based care (HCBS). The State will require, under this LOI and a subsequent contract with successful Bidders, MMPs to cover adults who are eligible for Medicaid-only as a requirement of participation in the ICI Demonstration.

This is a LOI and not a Request for Proposal or an Invitation to Bid. Responses to this LOI will be evaluated on the basis of the relative merits of the technical proposal and Bidder's acceptance of the terms in this LOI and the Medicaid capitation rates, to be issued by EOHHS. There shall be no public opening and reading of responses received by the State of RI, other than the names of Bidders who have submitted proposals.

The following indicates the conditions associated with the LOI.

**Conflicts Between this LOI, RI MOU or a Three-way Contract**

To the extent that any content in a RI Memorandum of Understanding (MOU) or a three-way contract for the financial alignment model conflicts with the requirements in this LOI, the MOU and/or three-way contract content shall supersede the content of this LOI. MOUs and three-way contracts from other states are available in the procurement library at http://www.eohhs.ri.gov/IntegratedCare.aspx.

**Issuing Agency and Officer**

The State, in consultation with CMS, issued a LOI that included the State requirements to become an MMP under this Demonstration. The State issued the LOI in February 2013 and selected

Health Plans in June 2013. The State's LOI is available at the following website: http://www.eohhs.ri.gov/IntegratedCare/DocumentsandPresentations.aspx.

Any plan selected via the State's 2013 LOI for the Rhody Health Options (RHO) program does not need to reapply via this LOI.

All MMP applicants are also required to meet the Medicare components of the plan selection process, including submission of a successful Medicare Part C and Part D application to CMS. Successful applicants are required to adhere to any annual contract renewal requirements and guidance updates.

The State may limit the number of selected MMPs per service area to a certain number (no less than two, provided there are at least two qualified applicants) from the qualifying applicants.

MMP selections are contingent on the selected entities passing a CMS and State-sponsored readiness review. Upon final selection, the State and CMS will ultimately enter into a Three-way Contract with selected plans.

**Additional Instructions and Requirements to Bidders**

Bidders will be required to provide the full spectrum of Medicaid services to Seniors and Adults with Disabilities who are not eligible for Medicare (Medicaid SPD Program) under a separate contract with EOHHS outside of the ICI Demonstration. The current Rhody Health Options contract can be found in the procurement library at http://www.eohhs.ri.gov/IntegratedCare.aspx. A health plan may not participate as a Medicaid Medicare Plan (MMP) without serving the Medicaid-only population under separate contract based on eligibility or, at the discretion of the individual. In no event shall a Contractor have the ability to provide fully integrated benefits to MMEs and exclude eligible individuals who wish to receive Medicaid-only benefits.

## 2.2 Medicaid Program Overview

EOHHS is the designated single state agency for Medicaid in the State of RI. This LOI chapter provides potential Bidders background information about the RI Medicaid program and the reasons for issuance of this LOI.

### 2.2.1 RI Medicaid Program

The Medicaid Program is a principal source of health care coverage and services in RI. The RI Medical Assistance Program (Medicaid) has expanded over the years beyond the role of being a safety net to becoming a principal source of health care coverage and services for low-income individuals in the State, having served approximately one-third of the RI population within the last five years. It is now an integral part of the State's health care delivery system, having served over 224,000 Rhode Islanders in SFY 2011, at a cost of $1.824 billion dollars. In 2014, Medicaid expenditures will make up approximately 24 percent of the State's budget or $1,855,780,111 out of total appropriations from all funds of $7,702,222,775.

Between SFY 2008 and 2012, total Rhode Island Medicaid medical expenditures based on date of service have increased an average of 1.3 percent per year. This overall expenditure increase is associated with a 2.2 percent average annual increase in enrollment combined with a 0.9 percent overall average decrease in per member per month (PMPM) costs. The increase in enrollment and the decrease in PMPM can be added together to determine average annual expenditure growth. These expenditure trends compare quite favorably to both national Medicaid expenditures and state commercial per member per month cost trends.

The expenditures for each major population group for SFY 2012 are noted below:

- **Adults with disabilities:** account for the largest share of expenditures (37 percent and $662 million) at an average PMPM of $1,808 expended on 16 percent of the Medicaid population. A major source of expenditures for this population is hospital care (25 percent).

- **Elders:** represent nine percent of the Medicaid population and account for 27 percent of Medicaid expenditures ($476 million). Elders have the highest average PMPM cost of $2,230. Nursing facilities account for 65 percent of the expenditures associated with care provided to elders.

- **Children and families:** represent 69 percent of the total enrollment and account for 27 percent of the total expenditures ($474 million). Average PMPM for Children and families is $ 298.

- **Children with special health care needs (CSHCN):** is a relatively small population (six percent of the recipients) and account for 10 percent of the expenditures ($170 million). The average PMPM for this population is $ 1,164.

Thus, elders and adults with disabilities represent 25 percent of the Medicaid recipients and account for 64 percent of the expenditures. Seventy-seven percent of RI's Medicaid population is enrolled in an MCO, which accounts for 49 percent of Medicaid spending. In part this is because the vast majority of managed care enrollees are enrolled in the RIte Care program, which has a lower PMPM cost than the elder or adult disabled populations**.**

Expenditure on community care and long term care accounts for about 41% of total Medicaid expenditure ($724 million) in SFY 2012. Community care programs are intended to allow states to provide home and community based services to at-risk populations as alternatives to more costly nursing home/institutional options.

For the LTC population enrolled in 2013, hospitals and nursing homes accounted for nearly 48 percent of total program expenditures, representing 29 percent and 19 percent of spending respectively. Payments to hospitals increased by an average of 8.2 percent per year between 2007 and 2011. Payment to nursing homes increased by 1.8 percent between 2007 and 2011.

Over the past five years, Medicaid has seen a decline in low cost users and an increase in high cost users of Medicaid services. If this trend continues, it will have a significant impact on future Medicaid expenditures unless appropriate intervention strategies are implemented.

### 2.2.2 Evolution of Managed Care

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 acting as a payer of services to an active purchaser of care. Central to this shift has been a focus on improved access and quality and cost management as a means to meet core program objectives.

The State's initial Medicaid managed care program, RIte Care, began in 1994 and enrolled over 70,000 low income children and families at the outset. A key contractual element was a "mainstreaming" provision, which required that MCOs must ensure that any provider which accepted enrollees from commercial lines of business must also accept RIte Care enrollees without discrimination.

The number of providers participating in RIte Care MCOs networks represented marked expansion over FFS and primary care provider participation more than doubled along with physician visits, which more than doubled by June 1998. In November 1998 RIte Care expanded to families with children under age 18 including parents and relative caretakers with incomes up to 185 percent of FPL; and, in 1999 the program further expanded to children up to age 19 in households with incomes up to 250 percent of the FPL with the passage of federal legislation establishing the State Child Health Insurance Program (SCHIP). Children in Substitute Care Arrangements were voluntarily enrolled in RIte Care in December 2000 and Children with Special Health Care Needs (CSHCN) were voluntarily enrolled in RIte Care in 2003. Enrollment for CSHCN became mandatory in 2009.

The Program for All-inclusive Care for the Elderly (PACE) was implemented in December 2005. On average today, 200 beneficiaries are enrolled in the State's fully integrated PACE program for frail elders who are Medicare and Medicaid Eligible (MME) beneficiaries. To be eligible for PACE, participants must be age 55 or older, meet a nursing facility level of care, and live in the service area where PACE is offered. The PACE program features a comprehensive medical and social service delivery system in an adult day health center that is supplemented by in-home and referral services in accordance with participants' need. By coordinating and delivering a full spectrum of services, PACE helps enrolled beneficiaries remain independent and in their homes for as long as possible. PACE is operated and funded through a three-way agreement between CMS/Medicare, RI Medicaid, and The PACE Organization of RI (PORI).

The Connect Care Choice (CCC) program was implemented in 2007 as the State's Primary Care Case Management model to serve the adult populations with complex medical and behavioral health conditions. The CCC program offers extensive care management services through 17 comprehensive medical home practice sites. In 2013, the State built upon the CCC foundation to create the Connect Care Choice Community Partners *(CCCCP)*, described below under long-term care options for MMEs and Medicaid-only consumers.

In 2008, the state launched a fully capitated managed care organization model for adults with disabilities and chronic illnesses. Rhody Health Partners (RHP) began with voluntary enrollment and in the fall of 2009, all Medicaid eligible "aged blind and disabled" (ABD) adults without third-party coverage who resided in the community were required to either enroll in a MCO

through the RHP program, or in the State's FFS Primary Care Case Management (PCCM) program, CCC.

This progression of members since the program's inception can be characterized by enrollment of populations with increasingly complex health care requirements. Since the program began, contractual program requirements and covered benefits have expanded to meet the needs of these populations, given their greater needs.

Currently, there are two MCOs participating in the RI managed care programs: (1) Neighborhood MCO of RI (Neighborhood Health Plan), and (2) UnitedHealthcare Community Plan of New England (United). As of February 2014, the enrollment in both of these MCOs for the RIte Care and Rhody Health Partners (RHP) program was 143,702. Table 1 below indicates managed care enrollment in RIte Care and RHP for Medicaid recipients by MCO as of February 2014.

| PROGRAM | NHPRI | UNITED | CCCCP | TOTAL |
|---|---|---|---|---|
| **RIte Care*** | 89,412 | 42,348 | - | 131,760 |
| **RHP** | 6,524 | 7,477 | - | 14,001 |
| **Expansion** | 10,945 | 8,904 | - | 19,849 |
| **Rhody Health Options** | 12,801 | - | 3,647 | 16,448 |

Table 1: Managed Care Program Enrollment (as of February 2014)[1]

[1] EOHHS RIte Care/RIte Share Recap as of February 2014

| | | | | |
|---|---|---|---|---|
| **TOTAL:** | 119,682 | 58,729 | 3,647 | 182,058 |

*includes Children with Special Health Care Needs; Excludes Foster Children Enrolled in a Health Plan

The total managed care capitation expenditures for SYF 2011 were $646.9 million. The expenditures for each managed care population group are indicated in Table 2 below.

Table 2: Managed Care Program Expenditures (SFY 2012)

| PROGRAM | EXPENDITURES |
|---|---|
| **RIte Care** | $447.2 Million |
| **RHP** | $199.7 Million |
| **TOTAL** | $646.9 Million |

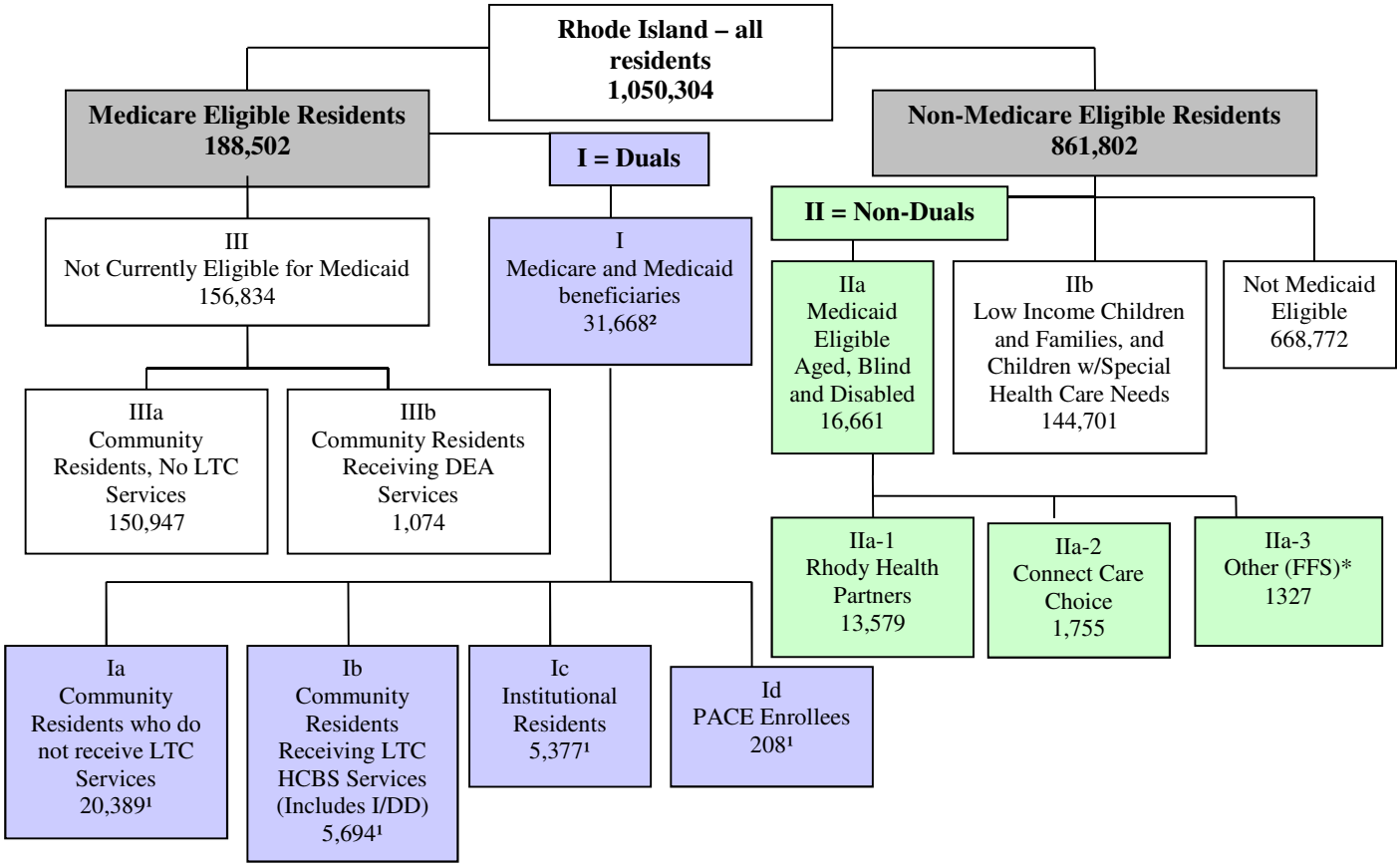
Currently there are seventeen CCC practice sites statewide. In a snapshot taken on February 1, 2014, the CCC and CCCCP programs had approximately 2500 enrollees, of which 1700 were dually eligible for Medicaid and Medicare.

### 2.2.3 MME Population

The MME population presents many challenges. Individuals in this group often have complex co-morbid behavioral and medical conditions (including multiple co-morbid medical diagnoses) as well as functional impairments and social support needs. In general, this population is socially isolated and has less education than individuals who have Medicare-only. As a result, the MME population is more complex and costly to serve than the Medicaid-only population. This sub-population of Medicaid consumers who also have Medicare coverage is commonly referred to as "Dual-Eligibles" or "Medicare and Medicaid Eligibles" (MMEs).

The Table below provides an additional perspective on the Medicare and Medicaid populations in the State as well as the populations receiving long-term services and supports (LTSS).

Figure 1: Medicare and Medicaid Eligible Populations (2012)




* Includes non-dual beneficiaries who are either in institutions or have non-Medicare third party coverage.
Sources: Rhode Island population is from the 2012 US Census. Medicare enrollment comes from the Kaiser State Health Facts, 2012 data. Medicaid data are based on SFY 2012.

The data in Figure 1 describes the overall population in RI and provides some detail on the subset of Rhode Islanders who are eligible for Medicare, eligible for Medicaid, and eligible for both programs. The shaded box Ia illustrates that the majority of dual eligibles in R I reside in the community, and are not yet connected with the long-term care system. Of these roughly 20,389 dual eligible individuals who presently reside in the community without HCBS, Fig 1, Box Ia), approximately 4,000 of them are persons with severe and persistent mental illness (SPMI). Also within this group of community-based dual eligibles, RI estimates that upward of ten percent (10%) are at increased risk for needing HCBS within two years. Effective identification and preventive services could help delay this and other costly acute episodes.

The MME population consists of individuals in the community who are receiving Long Term Care Home and Community-Based services (5,694), community-based residents who do not receive LTC services (20,389), residents who live in an institutional setting (5,377) and PACE enrollees (208). The 21 percent of the Medicaid population that lives in an institutional setting accounts for approximately 74 percent of total Medicaid expenditures for all MMEs. Approximately, 14 percent of the MME population is enrolled in a Medicare Advantage Plan (MAP).

The average number of RI residents who were eligible for both Medicare and Medicaid in 2013 was 32,866, the vast majority of which are eligible for full Medicaid benefits. Total Medicaid expenditures for this population in SFY 2013 was $714 Million. That same population had another $941.4 million in Medicare expenditures.

Residential and long-term care expenditures for institutional and waiver services constitute over 94 percent of the Medicaid costs for MMEs. By contrast, 63 percent of the expenditures for the Medicaid-only Enrollees lie in acute care services. For this group, the costs for hospital services represent 62 percent of the total acute care cost. The hospital setting of care is the most utilized and leading cost of care for the Medicaid-only beneficiaries.

### 2.2.4 The Existing Disconnect Between Medicare and Medicaid

The Medicare and Medicaid programs were created separately in 1964 and 1965 respectively and were not designed to complement one another. The two programs operate independently with different requirements, leading to confusion for consumers and providers. The incongruences between the two programs, including the benefits covered and the way in which services are delivered for MMEs, makes it difficult for MMEs to access benefits in both programs. In particular, the programs do not recognize consumers' person-centered needs and the disconnect between the two programs creates challenges to delivering coordinated care.

Medicare benefits emphasize medically-oriented interventions or acute care needs. For the majority of Medicare beneficiaries, the coverage is adequate. However, as health status deteriorates and becomes more complex, especially when psychosocial issues are involved, Medicare's coverage frequently becomes too limited and insufficient. For individuals who are dually eligible for Medicare and Medicaid, Medicare alone is typically insufficient.

By design, Medicaid funds predominately long-term services and supports, including nursing home care and HCBS for frail individuals. Without supportive HCBS, the consumer is at risk for poor outcomes and the potential to return to a hospital or nursing facility.

For MMEs including elders and other adults with disabilities, many consumers are likely to need Medicaid covered services as a result of an adverse health event. For example, an individual may break a hip and require hospitalization and rehabilitation in a nursing facility, particularly when there is no caregiver at home to support the Enrollee during the recovery period. As a result, that individual may require admission to a long term care facility. The Medicare nursing home benefit is limited to 100 skilled nursing days per year. If an MME needs longer-stay nursing home coverage, they need to apply for LTSS. Many clients also need to 'spend down' their assets to meet the financial eligibility requirements.

The fragmentation between the two programs is most evident at critical transitions from one setting of care to another. For example, when an MME is ready for discharge from an acute care hospital (which is covered by Medicare) home, the hospital-based discharge planning process is typically not well coordinated with long-term care support services providers who generally support the consumer upon discharge home. These providers – and the services they offer – also help the MME remain in the community and avoid nursing home placement. Few incentives,

resources, or mechanisms to coordinate care have been available between the two systems until the Affordable Care Act (ACA).

There are at least three critical issues that must be addressed to improve cost-effectiveness and coordination of care for the MME population which will be addressed under the ICI Demonstration. Specifically, the ICI Demonstration seeks to:

- **Align Financial and Quality Incentives.** A longstanding barrier to care coordination for MMEs is the financial misalignment between the Medicare and Medicaid programs resulting in inefficiencies in the way in which consumers access care, the way in which providers deliver care and the way in which managed care organizations and states coordinate care. The current payment systems for Medicare and Medicaid do not support MME's person-centered needs nor do they provide access to the "right services, at the right time, in the right location" which are cost-effective.

- **Improve Care Coordination.** Without coordination of care across the full continuum (e.g. across hospital, nursing home and home and between physical health care, behavioral health care and social supports) and, without appropriate transition planning for MMEs who must move between one site of care and another (e.g. hospital to nursing home or nursing home back to the community), MMEs are vulnerable to potentially avoidable poor outcomes such as re-admissions to the hospital or to nursing home stays that are either avoidable or longer than necessary. MMEs with multiple co-morbid conditions require coordination of care across the full continuum of Medicaid- and Medicare-covered services, often including social supports. The absence of coordinated care can result in the systems' inability to meet consumer strength-based preferences and needs. At the same time, the system likely promotes unnecessary or inappropriate health care utilization and expenditures.

- **Improve System Navigation.** The Medicare and Medicaid programs not only cover different benefits, but also have different administrative procedures and rules. These differences require MMEs to navigate a bifurcated set of benefits and rules. In addition, there is no single source of information for MMEs and their caregivers to direct questions regarding benefits, provider networks, appeals, information regarding enrollment, or other critical issues. If a provider does not agree with a benefit determination, the MME is often forced to spend an inordinate amount of time determining which program to seek prior approval from in order to deliver services, which program to submit claims to, and which program to appeal to. Among other advantages, a more integrated system would allow Enrollees and providers to have a single source of information on benefits, billing, grievances and appeals, and general information.

These factors have created the impetus for RI to pursue CMS's Financial Alignment Demonstration (FAD) with the goal of improving care integration, access, quality and cost-effectiveness of care relative to the current system.

### 2.2.5 Long-Term Care

In State Fiscal Year (SFY) 2011, Medicaid EOHHS expenditures for long-term services and supports for full-duals were $ 342 million. Institutional care expenditures were $288 million or 84 percent and HCBS were $53 million or 16 percent.

Long-term care services are particularly critical for the frail elderly, as well as adults with disabilities. All too often, these individuals are served in an institutional rather than in a community-based setting.

Access to and the availability of long-term care services and supports is a critical issue in RI as evidenced by RI's long-term commitment to improving the availability of long-term care options. Some of the most salient initiatives to improve long-term care options include the following:

- The Governor's Cabinet on Chronic and Long Term Care. In 2004, the Acting Director of the Center for Gerontology and Health Research at Brown University conducted a special study entitled *A Vision for the Present and Future: Rethinking Chronic and Long Term Care in RI.*

- In 2006, the RI Department of Human Services, pursuant to a joint resolution of the RI General Assembly commissioned the University of Maryland, Baltimore County, conducted a study about existing efforts and recommendations to improve the delivery of community-based LTSS in the State.

- The Long-Term Care Service and Finance Reform Act (Perry/Sullivan) legislation, created in 2006 which included: provisions for nursing home savings reinvested in HCBS, uniform long term care provider cost reports, improved information and referral, streamlined identification and assessments, and increases for specific HCBS providers.

- The Real Choice System Transformation Grant to improve Information and Referral, Long-Term Care Services and Supports, Quality Management, and Finance and Payment reforms, awarded to RI in 2006.

- The Rhode Island Comprehensive Section 1115(a) Demonstration Waiver (1115 Waiver) was approved by CMS in 2009. The overriding purpose of the 1115 Waiver is to provide the State with the flexibility to get the right services, to the right people, at the right time and in the right setting. The 1115 Waiver is built upon three fundamental goals:

    - To rebalance the State's long-term care system,

    - To integrate care management across all Medicaid populations, and

    - To complete the transition from a payer to a purchaser of care.

  RI's 1115 Waiver establishes a new State-Federal compact that provides the State with substantially greater flexibility than was available in previous guidelines. RI uses the additional flexibility to redesign the Medicaid program to provide more cost-effective services and care in the least restrictive and most appropriate setting. Today, the State

operates its entire Medicaid program under the 1115 Waiver. The 1115 Waiver also establishes an aggregate budget ceiling for Federal reimbursement, with the exception of disproportionate share hospital payments, administrative expenses, phased Medicare Part D contributions and payments to local education agencies.

- The Medical Assistance Reform Act passed by the General Assembly in June 2009, provided the Legislative authority to implement the 1115 Waiver, and provided for a cross-section of stakeholders to be convened on a monthly basis to provide input on the implementation of the provisions of the 1115 Waiver changes.

- Affordable Care Act (ACA) of 2010 provides additional opportunities to rebalance the Long-Term Care delivery system in RI and to implement systems that provide for a continuum of coordinated care for individuals with complex medical conditions.

- A Long-Term Care Coordinating Council that meets regularly has the Healthy RI Task Force bring together stakeholders to improve the long- term care delivery system in the State and to identify opportunities created under the ACA, respectively.

Over the past several years, the State has convened on-going workgroups with diligent stakeholders who have worked hard to develop consensus recommendations to reform the Medicaid program in RI, including LTSS.

RI recently made a number of systems reform improvements to rebalance the delivery of long term care services from the institutional setting to a home and community-based setting. RI developed and implemented a standardized long-term care assessment tool and created level of care criteria for long-term care services. In addition, the State implemented a Nursing Home Transition Program to help an individual transition from a nursing facility to the community. A State staffed Assessment Team (composed of a registered nurse and a licensed clinical social worker) in collaboration with all nursing homes statewide created a process to: (1) identify potential Medicaid beneficiaries that may be transitioned to a home or community based setting, (2) conduct an assessment to determine whether the beneficiary is appropriate for a home/community setting, (3) provide information about options so beneficiaries and their families can make an informed decision, (4) ensure that needed supports and services are in place prior to the nursing home discharge, and (5) work with the beneficiaries with medically complex conditions throughout the transition period. During the YTD SFY 2014 the State transitioned 102 individuals back into the community from a nursing home. Table 3 below provides the transition placements by month from July 2013 to February 2014.

Table 3: Transition Placement by Month (July 2013-Feb. 2014)

| Transition Placement by Month of Transition – Data as of 03/13/2014 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Transitioned to:** | July – 13 | Aug – 13 | Sept – 13 | Oct – 13 | Nov – 13 | Dec – 13 | Jan – 14 | Feb – 14 | Total |
| **Home With LTSS** | 11 | 14 | 8 | 13 | 7 | 9 | 4 | 6 | 72 |
| **Self-Directed** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Assisted Living** | 4 | 3 | 7 | 3 | 3 | 5 | 2 | 2 | 29 |
| **Shared Living** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **DD Group Home** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Data Unavailable** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| **YTD** | 15 | 17 | 15 | 16 | 10 | 14 | 7 | 8 | 102 |

In April 2011, RI received a Money Follows the Person (MFP) demonstration grant from CMS to transition eligible RI residents that are in an institutional setting for 90 days or more to "MFP qualified" community-based settings. The MFP program in RI is known as the *Rhode to Home (RTH)* program. The RTH program introduced the use of Transition Coordinators who provide intensive case management services to elders and adults with physical disabilities during the MFP demonstration period. This program is design to address MFP-eligible individual's needs for a comprehensive array of HCBS and supports. In doing so, MFP seeks to ensure, to the greatest extent possible, that these individuals can remain in the community.

RTH also provides Peer Mentoring services which are an important support for people with disabilities. Peer Mentors are individuals with disabilities who are successfully living in the community and are able to help consumers who receive services under MFP to also remain in the community. First and foremost, Peer Mentoring services are provided during the transition period from the nursing home to the community and thereafter, as needed.

In June 2011, legislation was passed to change the payment methodology for Nursing Facilities. The legislation eliminated the cost basis principles of reimbursement and replaced it with a base payment structure that reimbursed Nursing Facilities appropriately based on the needs of the Medicaid beneficiary. Individual-level acuity payment adjustments were implemented in July of 2013.

In 2013 the State issued procurements for two delivery system models to better serve individuals with Medicare and Medicaid as well as Medicaid members who receive LTSS. With these two procurements, the state officially launched the first phase of Integrated Care Initiative (ICI Phase I). In this first phase, the state contracts for both a fully capitated Medicaid health plan (Rhody Health Options), and enhancements to the state's current Primary Care Case Management Program (Connect Care Choice Community Partners).

In the Rhody Health Options program, EOHHS contracts with Neighborhood Health Plan of Rhode Island to deliver all Medicaid-covered services, including LTSS. In the Connect Care Choice Community Partners (4CP) program, EOHHS contracts with Carelink, a Coordinating

Care Entity (CCE) to provide a Community Health Team (CHT) that coordinates the social supports and services for the Medicaid-only and MME Enrollees.

The RI Medicaid program offers a comprehensive array of community-based and institutional LTSS, listed in Attachment A of the RHO Contract. As of April 1, 2014, the long-term care providers in the State include: 83 nursing homes; approximately 29 home health providers; 53 home care providers; 18 adult day care centers; and, 34 assisted living facilities operating in different locations throughout the State. A list of the State's long-term care providers is contained in Appendix B Provider Listing of this LOI. These initiatives and others will continue to position RI to achieve the goal of rebalancing the LTSS system.

RI licenses Home Nursing Care Providers and Home Care Providers. Home Nursing Care Providers deliver skilled nursing services and can also provide more general home care services i.e. assistance with daily living and care, housekeeping, companion shopping). Home Care Providers do not provide "skilled" services, but deliver assistance with daily living and personal care. Network providers are subject to the rules and regulations of the Department of Health. Home Nursing Care Providers can also be certified to meet Federal Medicare services authorized under the Federal CFR Title 18 regulations and are "certified for Medicare." Businesses that provide homemaker and companion assistance only do not require a license.

### 2.2.6 Integrated Care Initiative (ICI) – Phase 2

This LOI serves to allow Bidders to apply to participate in the ICI Demonstration and, to serve certain eligible Medicaid-only beneficiaries. The ICI Demonstration will require any RHO plan that qualifies to serve as an MMP to provide both Medicare and Medicaid covered services to ICI Demonstration Enrollees and to further provide Medicaid-only benefits to individuals who qualify for such services and do *not* qualify for Medicare benefits.

The ICI Demonstration will seek to: test an innovative payment and service delivery model to meet Enrollees' person-centered health and functional needs; decrease fragmentation and improve coordination and integration of acute, preventive, behavioral, social support and other long-term care services for MMEs; improve transitions among care settings through enhanced care integration; enhance quality of care; reduce costs for both the State and the Federal governments; and, decrease health disparities among ethnic and racial minority populations. CMS and the State expect MMPs and providers to arrange and coordinate care based on philosophies of independent living and recovery, wellness principles, and cultural competence to contribute to achieving these goals.

CMS and the State of RI EOHHS will establish a federal-state partnership to implement the ICI Demonstration to better serve MMEs. The Federal-State partnership will be governed by a Three-way Contract between CMS, the State, and successful Bidders or MMPs. The ICI Demonstration will begin on April 1, 2015 and continue until December 31, 2018, unless terminated pursuant to terms between the State and CMS. Such terms will be documented in a MOU between the State of RI and Providence Plantations and CMS.

The target populations under the ICI Demonstration and this LOI fall into the following categories:

- MMEs living in the community receiving no long-term care services or supports;
- MMEs living in the community receiving long term care services and supports;
- MMEs living in an institutional care setting; and
- Medicaid-only adults who receive LTSS in a nursing home or in the community.

Under the Demonstration EOHHS will carve-out certain services for individuals with Intellectual or Developmental Disabilities (ID/DD) and individuals with Serious and Persistent Mental Illness (SPMI). EOHHS reserves the option to include such services in the Demonstration at a later date. A list of services that are carved out, and provided on a wrap-around basis to individuals with SPMI and I/DD, can be found in section 3.3.5 of this document.

Under this initiative, MMPs will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-covered services, as well as additional items and services, under a capitated financing model. MMPs will be required to coordinate all LTSS and Medicaid Covered Services for individuals who are eligible for Medicaid only. CMS, the State, and the MMPs will ensure that Enrollees have access to an adequate network of medical, behavioral and supportive services.

MMEs will have the ability to choose among multiple enrollment options and can either opt-out of the ICI Demonstration or change MMPs as they desire. MMEs will have choice of:

1) a RHO plan that offers both Medicare and Medicaid benefits on a capitated basis;
2) a different MMP (if available);
3) a RHO plan for Medicaid benefits only, plus FFS Medicare or Medicare Advantage and a PDP;
4) the CCCCP plus FFS Medicare or Medicare Advantage and a PDP;
5) the PACE program; or,
6) FFS Medicaid plus FFS Medicare or Medicare Advantage and a PDP.

EOHHS will provide timely outreach and enrollment notices under the Demonstration. Such notices will, among other information, inform MMEs of all enrollment options. Enrollment counselors will also be available to inform MMEs of their delivery system options.

Except as otherwise specified in this LOI and/or applicable Medicaid Waiver or Section 1115(a) demonstration standards and conditions or State Plan Amendments, MMPs will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as ICI Demonstration-specific and evaluation requirements, as will be further specified in a Three-Way Contract to be executed among the MMPs, the State, and CMS. CMS and the State will implement the ICI Demonstration under Medicare Parts C and D and demonstration authority for

Medicare, and State Plan and RI 1115 Waiver authority for Medicaid, as described in the Memorandum of Understanding between EOHHS and CMS.

Consistent with the goals of the State's 1115 Waiver and the ICI, key goals of the ICI Demonstration are to:

- Enhance person-centered care;
- Improve and maintain Enrollee quality of life and quality of care;
- Develop an integrated system of care and coordination of services;
- Increase the proportion of individuals successfully residing in a community setting;
- Reduce long-term care costs by providing person-centered care in the most appropriate and cost-effective setting;
- Decrease avoidable hospitalizations, emergency room utilization and reduce nursing facility admissions and length of stay; and,
- Evaluate the effect of an integrated care and the payment model on MMEs who receive care and supports in the community and in institutions.

In order to accomplish these objectives, under a three-way contract between successful Bidders or MMPs, EOHHS and CMS will specify access, quality, network, financial solvency, and oversight requirements and standards. Contract management, which will be jointly accomplished by the State and CMS, will focus on performance measurement and continuous quality improvement.

As part of the ICI Demonstration, CMS and the State will implement a new Medicare and Medicaid capitated payment methodology designed to support the stated Demonstration goals and objectives. This approach to payment and financing will seek to align incentives between Medicare and Medicaid and support an integrated, person-centered approach that produces the best possible outcomes for Enrollees. MMPs will be fully accountable for managing capitated payments to best meet the needs of MMEs and Medicaid-only consumers.

Under the new capitated payment system, CMS and the State expect MMPs to achieve savings through better integration and coordination of care. Subject to CMS and State oversight, MMPs will have flexibility to deliver innovative Intensive Case Management (ICM) and Care Coordination services and, to provide a range of community-based services as alternatives to, or means to avoid, high-cost services if appropriate.

The Bidder should demonstrate use of Alternative Payment Methodologies that will advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees. The Bidder must comply with the requirements of M.G.L. Chapter 224, Section 261 of the Acts of the 2012. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w-111, Sec. 1860D-11(i). Alternative Payment Methodologies or methods are defined as, methods of payment that are not

solely based on fee-for-service reimbursements; provided that, "alternative payment methodologies" may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements; provided further, that "alternative payment methodologies" may include fee-for-service payments, which are settled or reconciled with a bundled or global payment.

Pursuant to provisions of the ACA, CMS established the FAD seeking to better align Medicare and Medicaid financing and integrate primary, acute, behavioral health and long term services and supports for MMEs. This LOI is the result of EOHHS's efforts to pursue a three year capitated ICI Demonstration. Any three-way contracts issued pursuant to this LOI will exist to carry out the ICI Demonstration.

As part of the Demonstration, CMS and EOHHS, along with other participating states, want to ensure that every selected MMP is ready to accept enrollments, protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers, and fully meet the diverse needs of the MME population. As such, every selected MMP in RI must pass a comprehensive joint CMS/State readiness review which will include a desk review and potentially, an on-site review by CMS and the State.

To participate in the ICI Demonstration, Bidders must meet all Medicare requirements established by CMS for the Capitated Financial Alignment Demonstration, including but not limited to Medicare Part D requirements and the requirements associated with a readiness review process.

During the Demonstration, individuals with SPMI and with I/DD can enroll in a MMP; however, certain services for these individuals will continue to be funded and managed through the Department of Behavioral Health Developmental Disabilities and Hospitals (BHDDH) as an ICI service carve-out. Section 3.3.5 of this LOI identifies those services that will remain "out-of-plan" during the first year of the Demonstration. EOHHS will collaborate with BHDDH to develop an approach to carve-in these services for individuals with I/DD or SPMI during the second or third year of the Demonstration. EOHHS is committed to reviewing the experiences and best practices of other states in this area in partnership with BHDDH to ensure that the needs of adults with intellectual or developmental disabilities and with SPMI will be well served within the ICI Demonstration.

In the event that EOHHS and BHDDH jointly agree to include these services in the capitation payment, EOHHS and BHDDH will establish program performance requirements and capabilities that will serve as the basis for managing these programs.

EOHHS/CMS reserve the right to include other carved-out benefits in the demonstration in year two or three.

### 2.2.7 Enrollment Volume and Approach

This section highlights the number of individuals who are eligible for the Demonstration as well as enrollment options and processes.

EOHHS conducted enrollment into ICI Phase 1 in several phases over six (6) months. ICI Phase I included MMEs and Medicaid only clients with LTSS. Eligible members, including MMEs, were given the option to opt-out of either RHO or CCCCP. As of April 2014, there are approximately 16,000 members enrolled in RHO and 5,900 members enrolled in CCCCP. An additional 5,700 individuals opted out of Phase 1. The tables below describe the enrollment by category into RHO and CCCP.

| Total RHO Enrollment | Nursing Home > 90 Days | Community with LTSS | People with intellectual and developmental disabilities | People with Severe and Persistent Mental Illness | Community no LTSS | RHO MA Only* |
|---|---|---|---|---|---|---|
| 16,155 | 2,952 | 1,092 | 1,474 | 1,051 | 9,169 | 417 |

| Total CCCCP Enrollment | Nursing Home > 90 Days | People with intellectual and developmental disabilities | People with Severe and Persistent Mental Illness | Community with LTSS | Community no LTSS | MA Only* |
|---|---|---|---|---|---|---|
| 5,285 | 351 | 481 | 739 | 518 | 2,427 | 769 |

| Total ICI Mailing | Nursing Home > 90 Days | Community with LTSS | People with intellectual and developmental disabilities | People with Severe and Persistent Mental Illness | Community no LTSS | RHO MA Only* |
|---|---|---|---|---|---|---|
| 29,755 | 4,897 | 2,823 | 1,479 | 4,063 | 15,896 | 597 |
| Number of Opt Outs | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **5,784** | **1,120** | **1,090** | **282** | **714** | **2,497** | **81** |
| **Opt Out Rate** | | | | | | |
| **19%** | **23%** | **39%** | **19%** | **18%** | **16%** | **14%** |

The State's enrollment strategy will begin with an opt-in only enrollment period for the first three months of the Demonstration, beginning April 1, 2015 and ending June 30, 2015.

Following the opt-in only period, the State will conduct passive/opt-out enrollment, focused on two groups, beginning July 1, 2015. EOHHS reserves the right to auto-assign these members solely to a new successful bidder.

Group 1: Current RHO members enrolled in NHPRI, who are not also Medicare Advantage members. These members will be assigned to NHPRI as their MMP. These members can opt-out or switch to another participating MMP, either during open enrollment, or at any time during the demonstration, on a monthly basis.

Group 2: Clients who opted out of Phase 1, who are not also Medicare Advantage members. These members will be assigned to another participating MMP, subject to readiness.

The passive enrollment of Group 2 will be conducted in three separate waves, subject to MMP readiness, as follows:

- Wave 1: The tentative effective enrollment date for the first wave of passive enrollment is July 1, 2015, or three months after the first opt-in effective enrollment date, and will include individuals who are eligible to receive LTSS benefits in the community.
- Wave 2: The tentative effective enrollment date for the second wave of passive enrollment is August 1, 2015, or at least four months after the first opt-in effective enrollment date, and will include individuals who are using nursing facility-based LTSS.
- Wave 3: The tentative effective enrollment date for the third wave of passive enrollment is September 1, 2015, or at least five months after the first opt-in effective enrollment date, and will include individuals not eligible for LTSS.

EOHHS reserves the right to auto-enroll Medicare Advantage clients into the demonstration, if a successful bidder also operates a Medicare Advantage plan in the demonstration area. EOHHS would auto-assign the MME to the same MMP that they are currently enrolled in for Medicare Advantage, with the understanding that the MME could opt-out or change to another participating MMP.

Two months prior to enrollment effective date, MMEs will be sent a communication via US Mail that informs them of their auto-enrollment into the demonstration. Members will be provided a

deadline to indicate their choice of MMPs or to opt-out, and a phone number to call to exercise their preference. Staffing for this hotline will be from trained customer service professionals who are experienced with non-biased enrollment counseling.

If members do not call with their preference by the deadline indicated in the letter, the member will be auto-assigned to the MMP mentioned in the letter. Members may switch between participating MMPs or opt-out to fee-for-service on a monthly basis.

EOHHS' approach to MMP auto-assignment will emphasize preserving existing provider-patient relationships. The first step in auto-assignment is using the Medicare primary care attribution method, to determine where an MME receives primary care, and match those PCPs to the MMP's network of participating providers. EOHHS will also attempt to employ this methodology with other specialties, including LTSS providers.

After the program start date, to enroll newly eligible members, the State will make a "sweep" of new eligible recipients, monthly. They will be auto-assigned to an MMP based on the criteria cited above and a letter will be sent to them two months prior to their enrollment date. For MMEs whose primary provider is in more than one MMP network, then auto-assignment will be equal and random.

MMEs that opt-out of the demonstration can choose which model they wish to enroll in and will have the ability to select among the following options:

1. a RHO plan for Medicaid benefits only, plus FFS Medicare or Medicare Advantage and a PDP;

2. the CCCCP plus FFS Medicare or Medicare Advantage and a PDP;

3. the PACE program; or,

4. FFS Medicaid plus FFS Medicare or Medicare Advantage and a PDP.

A consolidated Member Services call center team will be created to answer incoming calls and to implement or make changes in the MMP assignments and to provide information about the other delivery system options.

### 4.1 Procurement Library

For more detailed information regarding the RI Medicaid Program, see the following Procurement Library at the following web-site: http://www.ohhs.ri.gov/integratedcare/newsandupdates/.

## SECTION 3: SCOPE OF WORK

For the definitions of terms used throughout this LOI, please reference Appendix E Definitions.

### 3.1 Bidder Requirements

The successful Bidder must demonstrate the capacity to provide high quality services in a cost-effective manner to eligible Medicaid populations which are qualified to participate in the ICI including Medicaid-only consumers and MMEs. The selected Bidder must have the capability to meet a defined set of program and technical standards related to their licensure and accreditation status, and ability to:

- enroll the covered population and provide a comprehensive array of medical, behavioral health, and long-term care services and support that represent a continuum of care;
- maintain a robust multi- disciplinary provider network that meets Federal and State accessibility standards;
- demonstrate capacity to see that effective care management is provided to a diverse population with complex needs;
- coordinate both in-plan and out-of-plan services to meet individual Enrollee needs;
- demonstrate capacity to provide responsive Enrollee and provider services;
- provide effective medical management and meet quality standards;
- demonstrate the financial capacity to operate under a risk bearing contract and to meet fiscal standards;
- maintain a viable Information Technology capacity to serve as a MCO and report information to the State; and,
- maintain a grievance and appeals process to meet Federal and State requirements.

The successful Bidder 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.

The following are the guiding principles and core philosophies that Bidders are expected to embrace when serving RHO MMEs including but not limited to MMEs under this procurement.

- Establish and maintain a person-centered system of care;
- Facilitate access to coordinated, timely, appropriate, accessible and quality primary care, acute care, specialty care, behavioral health care, long-term services and supports;

- Include in the network Patient-Centered Medical Homes (PCMHs) as designated by NCQA. All NCQA recognized practices should be included in the MMP network;

- Provide Enrollees with the full continuum of Demonstration covered services through a multi-disciplinary network of providers;

- Promote an integrated and coordinated system of care that meets Enrollee needs;

- Ensure that the primary care settings serve as an effective medical home;

- Conduct a comprehensive needs assessment or coordinate with community providers, to assess the Enrollee's medical status, functional status, behavioral health, risk factors and social service needs;

- Develop or coordinate with community providers to develop an integrated ICP tailored to Enrollee's medical, behavioral health, LTSS, social services, and special needs;

- Implement payment, measurement and incentive strategies that ensure that services are delivered in the most appropriate care setting for each Enrollee based on their medical, functional, behavioral health, and social service needs;

- Increase the proportion of individuals successfully residing in a community setting;

- Implement payment, measurement and incentive strategies that decrease avoidable hospitalizations, emergency room utilization and reduce nursing home admissions and lengths of stay;

- Build on and link with existing community resources to meet Enrollee needs;

- Tailor "successful evidenced-based practices" from other environments to meet the needs of Rhode Islanders;

- Maximize the use of technology that improves access and the provision of care while reducing costs and integrating or coordinating with the state;

- Empower Enrollees to self-direct their care, when appropriate;

- Build on existing Medicaid long-term care rebalancing initiatives including the Money Follows the Person/Rhode to Home grant to leverage existing resources and to improve quality and health care outcomes in community based settings.

The following highlights the key programmatic and technical requirements that successful Bidders are expected to meet for this procurement.

## 3.2 ICI Demonstration Requirements

The three-way contract will set forth the terms of agreement with CMS and with EOHHS for an award pursuant to this LOI. In the absence of a complete model three-way contract, on a preliminary basis, the RHO Contract (in combination with all Medicare requirements described in this LOI) offer guidelines to respond to this LOI and, to establish a significant portion of Medicaid-related requirements under the ICI Demonstration.

Bidders are urged to read the RHO Contract carefully and thoroughly. Contractors are expected to have policies, procedures and practices that demonstrate compliance with the requirements contained in this RHO Contract and to address all Medicare requirements described in this LOI. The RHO contract is available in the procurement library found at http://www.eohhs.ri.gov/IntegratedCare.aspx.

The following sections highlight the major elements and key requisites for being a successful Bidder and a compliant Contractor. Medicare guidance which states the conditions under which MMPs will provide services to MMEs are available in the procurement library, found at http://www.eohhs.ri.gov/IntegratedCare.aspx.

### 3.2.1 MMP Organization

**State Requirements**

The Bidder must meet all State requirements as described in Chapter One of this LOI. The bidder must agree to accept all Medicaid products.

To serve as an MMP, the Bidder must be licensed as a Health Maintenance Organization (HMO) or as a MCO (HP) in the State of RI by the RI Department of Health and the RI Department of Business Regulation prior to signing an Agreement with the State.

The Bidder must also be accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid managed care organization or otherwise for a newly entering plan. In the latter case, the Contractor must submit:

1) a PDF copy of its current NCQA accreditation certificate for a Medicaid managed care organization in another State,

2) a specific time line outlining the Contractor's plan to achieve full accreditation within twelve months of the execution of the contract.

Failure to obtain accreditation by the date specified will result in the suspension of enrollment into the MMP. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) days of receipt of the Final Report from the NCQA and may result in termination of the State's Agreement with the Contractor. In the event that NCQA denies accreditation to the Contractor, the State shall consider this to be cause for termination of the Agreement.

The Bidder agrees to forward to EOHHS any complaints received from the RI Department of Business Regulation, the RI DOH, or NCQA concerning its licensure, certification, and/or accreditation within thirty (30) days of Contractor's receipt of a complaint.

The Bidder must be in good standing with the Medicare and Medicaid programs and NCQA. The licensure, accreditation and certification requirements are more fully discussed in the RHO Contract in Section 2.02.

The Bidder must demonstrate compliance with the EOHHS Affordability Standards. The Affordability Standards aim to improve the affordability of health care in the State by requiring companies issuing health insurance to:

(1) expand and improve primary care infrastructure

(2) adopt patient centered medical homes,

(3) support CurrentCare, the State's information exchange, and

(4) work toward comprehensive payment reform across the delivery system.

Details regarding the affordability standards can be found in the Procurement Library at http://www.eohhs.ri.gov/IntegratedCare.aspx.

The success of the RI Medicaid managed care program is contingent on the financial stability of participating MMPs. The Bidder must be financially solvent, have the capital, and have the financial resources and management capability to operate under this procurement's risk-based contract that reimburses the MMP with capitation payments.

The Bidder is required to have the staffing capacity with the appropriate expertise and administrative procedures, organizational structure and management information system to perform all the functions required under the three-way contract (e.g. program and service development, enrollment, Enrollee services, claims processing, accounting and finance, quality assurance, medical management, and utilization review, provider network development and continuing relations, care management etc.).

The Bidder is required to have an office in or near Providence, RI. The Bidder may perform some administrative functions out-of-state, with the approval of EOHHS, as long as it does not affect the quality, effectiveness, and efficiency of the services or functions performed by the Bidder in the judgment of EOHHS. Care management staff should be locally based in Rhode Island.

**Federal Requirements**

As noted, the Bidder will not be able to participate as an MMP unless it has met all Medicare requirements established by CMS for the capitated financial alignment model, including all Medicare Part D requirements. For additional information, see the Procurement Library.

### 3.2.2 Implementation Schedule and Contract Period

The three-way contract between a successful Bidder, CMS and EOHHS will become effective on April 1, 2015.

### 3.2.3 Member Enrollment and Disenrollment

The bidder must have policies and procedures to enroll and disenroll MMEs from the demonstration MMP. Successful bidders must demonstrate the ability to accept enrollment transactions from CMS' and the state's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, posted at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-CoordinationOffice/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Successful bidders will begin to accept opt-in enrollments from the population eligible for the ICI Demonstration no sooner than January 1, 2015 for coverage starting no sooner than April 1, 2015. Enrollment requests received through the 19th day of the month will take effect on the first day of the following month. Enrollment requests received on the 20th day of the month or later will take effect on the first day of the second month after the request was submitted.

When no active choice has been made, enrollment for eligible beneficiaries (as described above in Section 2.2.7) may be conducted using a seamless passive enrollment process that provides the opportunity for Enrollees to make a voluntary choice to enroll or disenroll from the MMP on a monthly basis. Individuals who are eligible for the Demonstration and who are enrolled in an RHO plan for Medicaid benefits may be passively enrolled into that same plan under the ICI Demonstration, with the opportunity to opt-out. Passive enrollments will commence no sooner than three months after the Demonstration begins.

Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted MMPs (if available) no fewer than sixty (60) calendar days prior to the effective date of enrollment and will further have the opportunity to opt out prior to effective enrollment. MMP enrollments, including changing enrollment from one MMP to a different MMP, and opt outs, shall become effective on the same day for both Medicare and Medicaid.

Disenrollment from MMPs and transfers between MMPs shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. All disenrollments will be effective the first day of the month after the choice is made. A disenrollment request is any action that terminates the Enrollee's enrollment in the ICI Demonstration, and includes, for example, the right to choose a Medicare Advantage Plan, to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan (PDP), and to receive Medicaid services in accordance with the State's approved State Plan, Section 1115(a) demonstration, and any approved waiver programs.

CMS and the State will utilize an independent third party entity (Enrollment Counselor) to facilitate all enrollments into the MMPs and to provide unbiased enrollment counseling. This will

be discussed in more detail in the three-way contract. For those who lose Medicaid eligibility during the month, coverage and enrollment in the MMP will continue through the end of that month.

CMS and the State will monitor enrollments and disenrollment for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations, and CMS policies, for the purpose of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and the State will monitor any unusual shifts in enrollment by individuals identified for passive enrollment into a particular MMP to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and the State may discontinue further passive enrollment into an MMP. Any illegal marketing practices will be referred to appropriate agencies for investigation.

CMS and the State will also monitor any enrollments or disenrollment based on beneficiary health needs. Any MMPs under the same parent company as any Medicaid managed care plan for which the State has terminated or suspended enrollment and marketing activities related to the Medicaid managed care plan are not permitted to conduct enrollment or marketing activities related to the MMP until the Medicaid managed care plan deficiencies are resolved or may be disqualified from the Demonstration. Per January 13, 2014 guidance from CMS, any MMP under Medicare enrollment and/or marketing sanction will be ineligible to participate if it is under sanction as described in 42 CFR Part 422.750 and 42 CFR Part 423.750 at the time CMS and the State seek to execute the Three-way Contract. Also as articulated in the January 13, 2014 guidance from CMS, any MMP that is an outlier in the CMS past performance analysis for Contract Year (CY) 2014 and/or has a Consistently Low Performing Icon on the Medicare Plan Finder will be ineligible to receive passive enrollment until it is no longer considered by CMS to be a past performance outlier and/or no longer has a Consistently Low Performing Icon on Medicare Plan Finder.

The Bidder is required to enroll an Enrollee no more than seven (7) days after receiving notification from the State. MMEs are mailed notification of MMP enrollment including effective date and how to access care within ten (10) days after receiving notification from the State of their enrollment. The Bidder agrees to report any changes in the status of individual Enrollees 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 (e.g. birth of a child or change in legal guardianship of a minor) and sources of third-party liability.

Bidders must demonstrate a mechanism for receiving timely information about all disenrollments from the Contractor's plan, including the effective date of disenrollment, from CMS and EOHHS systems.

CMS and the State shall develop uniform enrollment and disenrollment forms and other documents.

The Bidder is required to provide orientation to new Enrollees about their benefits, the role of the PCP, what to do in an emergency or urgent medical situation, how to utilize services in other circumstances, how to register a complaint or file a grievance and how to implement advance directives in accordance with Federal and State legal requirements. Instructional materials relating to Enrollees are written at no higher than a sixth-grade level, presented in a manner and

format that may be easily understood. All written materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All Enrollees are informed that information is available in alternative formats and how to access those formats.

The Bidder is required to make at least four attempted welcome calls, on different days, to all new community-based Enrollees within thirty (30) days of enrollment effective date to provide the same information as in the paragraph above. Welcome call scripts also solicit whether Enrollees have new or existing health care needs, including pregnancy or any chronic disease, such as asthma, diabetes, or a behavioral health need. In the event that a welcome call identifies any new Enrollees who have existing health care needs immediate steps will be taken (e.g. referral to an appropriate provider, or to Care Management) to ensure the Enrollee's needs are met. Any scripts developed or used by the Bidder are subject to review by EOHHS and CMS. The Bidder is required to make at least four attempts, not counting two on the same day**,** to contact the Enrollee within ten (10) days of notification of enrollment to provide information on options for selecting a PCP.

The Bidder offers freedom of choice within the PCP network of participating providers to MMEs in making a PCP selection. If an Enrollee does not select a PCP during the enrollment process, the Bidder will make an automatic assignment, taking into consideration such factors as current provider relationships, language needs (to the extent they are known), the MMEs place of residence and the relative proximity of the PCP to the MMEs residence. Whenever feasible, auto-assignment of a PCP will be to an NCQA-recognized PCMH. The Bidder notifies the MME in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired.

### 3.2.4 Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

Successful bidders are subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 C.F.R. §§ 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260, 438.104(a) et. seq.; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual). Bidders may not display or distribute marketing materials, nor solicit Enrollees in any other manner, within fifty feet of Medicaid eligibility and enrollment offices, unless it has received permission to do so from the State.

MMP outreach and marketing materials will be subject to a single set of marketing rules defined by CMS and the State, and further detailed in the three-way contract.

CMS and the State shall work with MMPs to develop a single identification card that can be used to access all care needs**.** The Bidder issues this identification card within ten (10) days after receiving notification from the State/CMS of an MME's enrollment. The card includes at least the following information: (1) MMP name, (2) twenty-four hour MMP telephone number for use in urgent or emergent medical situations, (3) telephone number for Enrollee Services function (if different), and (4) PCP, or PCP practice, name and office telephone number (can be affixed by sticker to card).

The Bidder is required to publish a member handbook prior to any enrollment into the ICI Demonstration. The Bidder mails this Handbook to all Enrollees within ten (10) days of being notified of their enrollment. The Bidder publishes a revised and updated Enrollee Handbook annually , or when there are material changes needed as determined by EOHHS/CMS. The Bidder includes all required information in the Enrollee Handbook based on specifications issued by the State.

### 3.2.5 Services and Accessibility Standards

The Bidder will provide the full range of primary care, acute care, specialty care, behavioral health care and long-term services and supports (institutional care and HCBS and supports) as described below, and will further meet the service accessibility standards as specified by the State.

The following table contains the demonstration services the MMPs must provide. Specific service definitions will be included in the three-way contract.

| | |
|---|---|
| Abdominal Aortic Aneurism Screening | Adult Day Health Care |
| AIDS Adult Day Health Care | Alcohol Screening and Counseling |
| Ambulance | Ambulatory Surgical Centers |
| Assisted Living Program | Assistive Technology (State Plan and Supplemental to State Plan) |
| Bone Mass Measurement | Cardiac Rehabilitation Services |
| Cardiovascular disease Screening | Cervical and Vaginal Cancer Screening |
| Chemotherapy | Chiropractic |
| Clinical Research Studies | Colorectal Screening |
| Community Integration Counseling | Community Transitional Services |
| Comprehensive Medical Case Management | Consumer Directed Personal Assistance Services |
| Continuing Day Treatment | Cost-Effective Alternative Services |
| Day Treatment | Defibrillator (implantable automatic) |
| Depression Screening | Diabetes Monitoring (Self-Management Training) |
| Diabetes Screening | Diabetes Supplies |
| Diagnostic Testing | Durable Medical Equipment (DME) |
| Emergency Care | Environmental Modifications |

| | |
|---|---|
| Family Planning | Family-Based Treatment |
| Health/Wellness Education | Hearing Services |
| HIV Screening | Home and Community Support Services |
| Home Delivered and Congregate Meals | Home Health |
| Home Maintenance Services | Home Visits by Medical Personnel |
| Hospice | Immunizations |
| Independent Living Skills and Training | Inpatient Hospital Care (Including Substance Abuse and Rehabilitation Services) |
| Inpatient Mental Healthcare | Inpatient Services during a Non-Covered Inpatient Stay |
| Interpreter Services | Kidney Disease Services |
| Laboratory Services | Long Term Care/Rehab |
| Mammograms | Medicaid Pharmacy Benefits as Allowed by State Law (Prescription and Non-Prescription) |
| Medical Nutrition Therapy | Medical Social Services |
| Medicare Part D Prescription Drug benefit as Approved by CMS | Medication Therapy Management |
| Non-Emergency Medical Transportation | Nursing Facility (Medicaid) |
| Nutrition (Including Nutritional Counseling and Educational Services) | Obesity Screening and Counseling |
| Oral Surgery | Outpatient Drugs |
| Outpatient Hospital Services | Outpatient Mental Health |
| Outpatient Rehabilitation (OT, PT, Speech) | Outpatient Substance Abuse |
| Outpatient Surgery | Palliative Care |
| Pap Smear and Pelvic Exams | Partial Hospitalization (Medicaid) |
| Partial Hospitalization (Medicare) | Peer Mentoring |
| Peer-Delivered Services | PCP Office Visits |
| Personal Care Services | Personal Emergency Response Services (PERS) |
| Personalized Recovery Oriented Services (PROS) Podiatry | Positive Behavioral Interventions and Support |
| Prostate Cancer Screening | Private Duty Nursing |
| Pulmonary Rehabilitation Services | Prosthetics and Orthotics |

| | |
|---|---|
| Respite | Routine Physical Exam 1/Year |
| Second Opinions | Service Coordination |
| Skilled Nursing Facility | Smoking and Tobacco Cessation |
| Specialist Office Visits | Social and Environmental Supports |
| STI Screening | Substance Abuse Services |
| Telehealth | Transplants |
| Urgent Care Vision Care Services | Vision Care Services |
| Wellness Counseling | |

Supplemental Benefits – The State and CMS may consider adding certain supplemental benefits to the required ICI Demonstration benefit package in Demonstration years 2 and 3. These services may include but are not limited to the following:

- Integrated Pain management program;
- Screening, Brief Intervention and Referral to Treatment (SBIRT); and
- Non-medical transportation.

Flexible Benefits – MMPs will have discretion to use the capitated payment to offer flexible benefits, as specified in the Enrollee's ICP, as appropriate to address the Enrollee's needs. The MMPs will have the flexibility to cover items or services that are not traditionally included as Medicare or Medicaid covered services, but that are necessary and appropriate for the Enrollee and are covered as cost-effective alternative services.

Out-of-plan Benefits – The following benefits will be available to Enrollees through the fee-for-service delivery system and not through the MMP benefit package. These services are currently out-of-plan benefits in RHO. MMPs will be required to refer to and coordinate these services as appropriate. CMS and EOHHS may seek to include these services in the ICI Demonstration at a later point in time.

- Clinician's services delivered at a Community Mental Health Organization (CMHO) for individuals with SPMI enrolled in the Community Support Program (CSP)
- CMHO Health Home
- Community-based detoxification
- Community-based narcotic treatment
- Community Psychiatric Supportive Treatment (CPST)

- Consumer Oriented System of Care (CSOC)
- Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP)
- Court-ordered mental health and substance abuse services
- Dental services
- Mental Health Psychiatric Rehabilitation Residence (MHPRR)
- Non-emergency transportation services (non-emergency transportation is coordinated by the contracted MMPs);
- Opioid Treatment Provider Health Home
- Psychiatric Rehabilitation Day Programs
- Residential services for Enrollees with intellectual and developmental disabilities
- Residential treatment.

Election of Medicare Hospice Benefit – As in Medicare Advantage, if, after enrollment, an Enrollee elects to receive the Medicare hospice benefit, the Enrollee will remain in the MMP, but will obtain the hospice service through the Medicare FFS benefit and the MMP would no longer receive Medicare Part C payment for that Enrollee. Medicare hospice services and all other Original Medicare services would be paid for under Medicare fee-for-service. MMPs and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care, including with Medicaid and Part D benefits, and any additional benefits offered under the MMPs. MMPs would continue to receive Medicare Part D payment, for which no changes would occur. Medicaid services and payments for hospice Enrollees must comply with the ICI Demonstration 1115(a) demonstration requirements.

The Bidder provides 365 days of nursing home care as medically and/or functionally necessary for MMEs inclusive of skilled care, custodial care or any other level of nursing home care including but not limited to emergency placement, hospice and respite care.

The bidder will make available to every Enrollee a PCP whose office is located within the maximum timeframes outlined in the Medicare Advantage standards, currently: in Providence County, ten (10) minutes or less driving time from the Enrollee's home; and in all other counties, fifteen (15) minutes or less. Enrollees may, at their discretion, select PCPs located farther from their homes.

The Bidder provides coverage, either directly or through its PCPs, to Enrollees on a twenty-four (24) hours per day, seven (7) days per week basis. If PCPs are to provide such coverage, Bidders must ensure that there is a back-up plan for instances where the PCP is not available. Pursuant to 42 CFR 438.114, the Bidder will ensure access to Emergency Services which are available twenty-four (24) hours a day and seven (7) days a week, through arrangement with other providers.

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

The Bidder allows women direct access to a women's health care specialist within the Bidder's network or outside the network for women's routine and preventive services. The Bidder must meet the Access Standards described in Section 3.3.6 of this LOI.

The Bidder demonstrates that sufficient capacity exists to provide timely access to quality institutional care and HCBS and supports. The Bidder is required to provide coverage, either directly or through contracted home care agencies, to Enrollees with LTSS needs twenty four (24) hours per day, seven (7) days per week. The coverage must include the necessary LTSS for Enrollees residing in the community who have an immediate need for a service that was scheduled and did not occur. These immediate needs include, but are not limited to: failure of a personal care attendant (PCA) to arrive at the scheduled time; failure of home delivered meals to arrive at scheduled times; or, failure of an assistive device to be delivered at a scheduled time.

The Bidder provides a consultation/assessment for LTSS within fifteen (15) days of a Enrollee's or caregiver's request. Other specific assessment standards are described in Section 3.3.9 Care Management of this LOI. The required LTSS for Enrollees must be in place within five (5) days of an Enrollee's determined need.

The Bidder contracts with a nursing home network that is located within ten (10) miles of the Enrollee's address of record, unless a nursing home is selected by the MME that is more than ten (10) miles. Assisted Living residences, Adult Day Service Centers and other community-based LTSS agencies must be located within twenty (20) minutes driving time of the Enrollee's address of record, unless an Enrollee selects a provider that is more than twenty (20) minutes driving time of an Enrollee's address of record.

The Bidder provides all necessary HCBS, as defined above. In addition, the Bidder will honor all existing CMS and EOHHS approved service authorizations for the period of time authorized by CMS or EOHHS, and with the provider that received the authorization. CMS or EOHHS will provide all necessary information to the Bidder to comply with this requirement. The Bidder will allow the use of cost effective alternative services, whether listed as a covered or non-covered service or omitted from this LOI. This may include, for example, use of nursing facilities as a

step down alternative to acute care hospitalization or hotel accommodations for persons on outpatient radiation therapy to avoid the rigors of daily transportation.

The Bidder assures that Enrollees receive an in-person visit to their residence within twenty-four (24) hours of being discharged from a hospital or nursing facility.

The Bidder must coordinate with providers for the provision of all out-of-plan services. The Bidder is expected to coordinate behavioral health services with providers who are funded by BHDDH for Enrollees with SPMI and Enrollees with developmental disabilities. The three-way contract will describe the Bidder's coordination responsibilities.

### 3.2.6 Provider Network

The Bidder ensures that network providers meet the Provider Network requirements below and in the three-way contract.

The Bidder maintains a robust multi-disciplinary provider network: (1) to provide Enrollees with the full range of covered services inclusive of primary care, acute care, specialty care, behavioral health care and LTSS for the anticipated Enrollees in the service area, (2) that maintains providers in sufficient number, mix and geographic area, and (3) makes available all services in a timely manner.

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

- Anticipated MME and RHO enrollment
- Expected utilization of services, taking into consideration the characteristics and health care needs of specific RHO populations for which Contractor is, or 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 RHO patients
- Geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities
- "Disability Competency" of providers and the physical accessibility of their offices; "Disability Competency" is defined as the capacity of health professionals and health educators to support the health and wellness of people with disabilities through their disability knowledge and expertise

The Bidder's provider network consists of a continuum of care required to meet the diverse and often complex needs of MMEs and will contain, but not be limited to, the following:

- Primary Care Providers including Federally Qualified Health Centers, NCQA-recognized medical homes, and home-based primary care providers
- Specialty Providers
- Behavioral Health Providers
- Hospitals
- Therapy Providers (Physical, Occupational, Speech)
- Durable Medical Equipment Providers
- Labs and Radiology
- Institutional Long-Term Care Providers (Licensed nursing homes, nursing facilities and assisted living residences)
- HCBS Providers (home care agencies, home health agencies, adult day care health centers, RIte @ Home providers, care management providers, fiscal agents for self-directed care, etc.).

Network home care providers who are not Medicare-certified, must be overseen by a Medicare certified home care provider.

At the time an MME transitions into managed care, the Bidder maintains the Enrollee's current network of providers, including but not limited to, nursing home providers, assisted living providers, and home care providers for a period of six (6) months after the MME's start date. MMEs who reside in a nursing facility at the time of enrollment who do not intend to return to the community may remain in that nursing home or assisted living facility, regardless of whether that nursing home or assisted living facility is in the Bidder's network.

The Bidder honors the service authorizations and providers used by Enrollees (including staying in the nursing home they reside in) enrolled in the MMP during the start-up period for the duration of the current service authorization. New Enrollees who are enrolled in the MMP after the initial start-up date will be required to use the Bidder's provider network.

The Bidder develops and maintains its network to maximize the availability of primary and specialty care access, to reduce utilization of emergency services, preventable hospital admission/re-admissions, and the use of avoidable costly medical procedures. The Bidder includes in its network certain current FFS providers as "essential community providers", unless the Bidder demonstrates a valid reason for not including them. These "essential community providers" are listed in Appendix C Essential Community Providers. The Bidder maintains the EOHHS contract terms with these "essential community providers", at EOHHS reimbursement rates, for a period of one (1) year. The Bidder notifies the State monthly of any changes in its network's composition.

The Bidder agrees to include the following mid-level practitioners in the network: Certified Nurse Practitioners, and/or Physician Assistants. The State recognizes the ability of mid- level practitioners to provide primary care to MMEs.

EOHHS considers mainstreaming of Enrollees into the broader health delivery system to be an important program objective. The Bidder establishes and maintains policies and procedures and contractually obligates all of its network providers accept Enrollees for treatment. The Bidder agrees to have policies and procedures in place such that any provider in its network who refuses to accept an MME for treatment cannot accept non-MMEs for treatment and remain in the network.

The Bidder maintains written agreements with providers in their network that incorporate the requirements stated in this LOI. The Bidder will comply with the requirements specified in 42 C.F.R. 438.214 which includes the selection and retention of providers, credentialing and re-credentialing requirements and non-discrimination. The Bidder maintains written protocols approved by EOHHS in the following areas:

- Credentialing, re-credentialing, certification and performance appraisal processes that all providers maintain knowledge, ability, and expertise in the service or specialty in which they practice.

- Nationally recognized practice guidelines and protocols that foster the quality of care and improve clinical outcomes (in accordance with 42 C.F.R. 438.236).

- Training and continuing education programs to ensure providers are knowledgeable about their specialty or subspecialty areas.

- Provider profiling to assess a provider's performance regarding the under/over utilization of services, clinical performance, interdisciplinary team participation, Enrollee access to care, Enrollee satisfaction, and other critical areas.

- A corrective action plan for a provider whose performance is unacceptable.

- Adequate reimbursement to maintain an adequate network that is based on value-based provider procurement contracting and performance-based reimbursement.

These elements are key requisites for an effective quality assurance program and are also discussed in Section 3.3.12 of this LOI.

The Bidder's network of providers adheres to the following guiding principles of this Contract regarding the provision of care:

- Services are to be provided in accordance with State and Federal laws, regulations and requirements.

- Services are to be provided that promote the tenets of a person-centered care system.

- Services are provided promptly and are accessible in terms of the location and hours of operation as well as open access scheduling.

- Strong specialty care capabilities exist to address issues of cognitive impairment, frailty, disability, co-morbidity, late-stage life management issues and other special medical needs such as dementia.

- Policies and procedures that empower Enrollees, family and caregivers with enhanced self-management abilities.

- Services and care delivery focus on the prevention of illness and disabilities as well as the treatment of disease.

- Services are tailored to meet specific Enrollee needs and provided in a coordinated and integrated manner through a multi-disciplinary team approach.

- Policies and procedures exist to ensure that the rights and responsibilities of Enrollees are respected.

- Intervention strategies are implemented to identify and rectify unnecessary use of the emergency room, preventable hospital admission or avoidable institutionalizations.

- Innovative evidenced-based best practices are implemented to enhance the quality and cost-effectiveness of care (including the use of technology to support service delivery such as: the use of electronic medical records, e-mailing, and employing mobile medical technology).

- Alternative services are utilized to the minimize the reliance on limited medical resources to meet Enrollees' social service and support needs (such as the use of paramedical staff, medical concierge services, Transition Coordinator, Peer Navigators and a Enrollee informal support system) shall be implemented.

The Bidder maintains policies and procedures approved by EOHHS to: (1) monitor providers to assure that they meet Federal, State and contract requirements, (2) evaluate the quality of care delivered by providers (3) provide and arrange for medically and functionally necessary covered services, and (4) monitor the adequacy, accessibility and availability of its provider network to meet the needs of its Enrollees, including the provision of care to Enrollees with special needs and with limited proficiencies in English.

### 3.2.7 Person-Centered System of Care

The Bidder employs a person-centered system of care that governs the care provided to MMEs. The focus of a person-centered system of care is on the individual, their strengths, and their network of family and community supports in developing a flexible and cost effective plan to allow the individual maximum choice and control over the supports they need to live in the community. Person-centered care takes into account the holistic needs of the individual MME

including, but not limited to, race, ethnicity and culture and the impact of the Enrollee's beliefs on their health care delivery.

A person-centered system of care respects and responds to an individual's needs, goals, and values. Within a person-centered system of care, individuals and providers work in full partnership to guarantee that each person's values, experiences, and knowledge drive the creation of an individual plan of care as well as the delivery of services. A person-centered system of care is built on the principle that Enrollees' have rights and responsibilities, know their circumstances and needs first-hand, and should be invested in the care they receive. Person-centered care establishes a foundation for independence, self-reliance, self-management, and successful intervention outcomes.

For Enrollees requiring LTSS, the Care Manager's role in the person-centered process is to enable and assist LTSS Enrollees to identify and access covered services and available LTSS providers. The Enrollee's personally defined outcomes, preferred methods for achieving them; training supports, therapies, treatments, and other services needed to achieve those outcomes become part of a written person-centered services and support plan. The person-centered ICP also supports individuals' ability to self-direct services.

A person-centered system of care takes into consideration the Enrollee's strength-based needs and preferences as a primary factor in integrating, coordinating and facilitating care delivery. Interventions are crafted based on the unique set of strengths, resources, and motivations that each Enrollee brings while recognizing and addressing needs, deficits and supports. The Enrollee, and/or his/her designee, is meaningfully involved in all phases of the care management process including completing the Comprehensive Functional Needs Assessment, development of an integrated ICP, delivery of care and support services, and in evaluating the effectiveness and impact of care including the need for continued care or supports. In a person-centered system of care, the Enrollee has the primary decision-making role in identifying his or her needs, preferences and strengths, as well as a shared decision making role in determining the services and supports that are most effective and helpful to them. A person-centered system requires the leveraging of existing community resources to support Enrollee needs and the involvement of the Enrollee's informal support system. Person-centered systems often require agreements with community organizations to provide peer navigators/mentors to address the non-medical needs of Enrollees. Most importantly, person-centered systems require direct "High-Touch," face-to-face contact throughout the care management process as discussed in Section 3.3.9 of this LOI between Lead Care Managers and the Enrollee. The Bidder must ensure that these values and requisites prevail in the program for MMEs. The person-centered system of care facilitates a partnership among the Enrollee, his/her designee, providers, and treatment team coordinators.

The following are illustrative key requisites of a person-centered system of care that Bidders must demonstrate and adhere to:

- MMEs participate in developing choices with respect to their services and supports, and must hold decision-making authority over which of the available services and supports to employ and which of the available providers to work with. Enrollees must not face any penalty or reduction in benefits for exercising freedom of choice.

- MMEs have control over who is included in the development of an ICP and the care planning process.

- MMEs have choices about the extent of involvement of their PCP(s) in their Interdisciplinary Care Team and appeal processes (ranging from no involvement to acting on an individual's behalf for all care decisions).

- MMEs have the right to choose to designate someone (e.g. a family member, friend or care giver) to serve as their representative for a range of purposes or time periods if they wish to do so. If a representative is needed at a point in time when an individual is too impaired to make a choice, the representative should be someone who has a history of close involvement with the MME.

- MMEs and designated family and/or caregivers are a part of the Interdisciplinary Care Team at the election of the MME.

- ICT meetings are held at a time and place that is convenient and accessible to the Enrollee.

- MMPs provide information that allows an Enrollee to understand and make informed decisions about service options including providing information about *Olmstead*[4] rights to all individuals who use LTSS. MMPs must also provide information about advance directives.

- Mechanisms are in place to minimize conflict of interests in the facilitation and development of the ICP.

In RI, the self-directed program is called Personal Choice. The goal of the Personal Choice program is to provide a home and community-based personal care program where individuals who are eligible for LTSS have the opportunity to exercise choice and control (i.e., hire, fire, supervise, manage) individuals who provide their personal care, and to exercise choice and control over a specified amount of funds in a participant-directed budget. Participants choose a service advisement agency and a fiscal agent to assist in making informed decisions that are consistent with their needs and that reflect their individual circumstances. Additional information regarding the Personal Choice program is available in the Procurement Library at http://www.eohhs.ri.gov/IntegratedCare.aspx.

The Bidder is required to implement a self-directed model for Enrollees. The Bidder works with EOHHS in adopting self-directed programs and in identifying the appropriate population groups and Enrollees to participate in a self-directed program.

Person-centered systems of care emphasize self-direction, which is a service model that empowers public program participants and their families by expanding their degree of choice and control over the LTSS they need to remain in the community. Many Enrollees participating in a self-directed program share authority with or delegate authority to family members or others including a representative that enables adults with cognitive impairments to participate in self-directed programs.

Self-direction represents a major paradigm shift in the delivery of publicly funded HCBS. In the traditional service delivery model, decision making and managerial authority is vested in professionals who may be either state employees/contractors or service providers. Self-direction transfers much (though not all) of this authority to participants and their families (when chosen or required to represent them).

Self-direction has two basic features, each with a number of variations. The more limited form of self-direction—which CMS refers to as employer authority—enables individuals to hire, dismiss, and supervise individual workers (e.g. PCAs and homemakers). The comprehensive model—which CMS refers to as budget authority—provides participants with a flexible budget to purchase a range of goods and services to meet their needs. RI utilizes both of these models.

The core feature of self-direction is the choice and control that participants have in regard to the paid personnel who provide personal care assistance services. This is because almost all participants receiving HCBS receive personal care assistance services and, for many, this is either the only or the primary service they use.

In administering a self-directed model, the Bidder is required to continue to contract with the state's current subcontractors, PARI, Tri-Town, and Options for the first twelve (12) months of program operations to support self-directed Enrollees. These sub-contractors conduct on-line assessments, background checks on care givers as well as serve as a fiscal intermediaries and advisors to Enrollees. The Bidder will oversee and approve Plans of Care and personal budgets. The Bidder will indicate in the Interdisciplinary Care Plan (ICP) how they perform these functions. After the first 12 month period, the Bidder is required to subcontract with organizations to perform fiscal intermediary responsibilities for Enrollees who receive self-directed supports and services. The Bidder has the option to enable the fiscal intermediary sub-contractor to perform ICM and Care Coordination functions and to conduct re-assessments.

[4] The Supreme Court decision in Olmstead v. L.C. is a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. More information is available at http://www.ada.gov/olmstead/index.htm.

A website known as Rewarding Work (www.rewardingwork.org ) provides an online registry of personal care assistants/individual support providers to people with disabilities and/or their families. RI is one of several States that has an agreement with Rewarding Work Resources, a 501 (c) (3) nonprofit corporation, to provide access to the Registry for Medicaid recipients enrolled in self-directed care programs. RI Medicaid recipients who are enrolled in the following programs receive free access to the worker registry on Rewarding Work:

- Personal Assistance Services and Supports (PASS)
- Respite for Children Program
- Personal Choice Program

MMPs have access to the Registry as well in order to assist participants in locating and hiring support staff. RI has participated in Rewarding Work since 2007 and there are currently 750 Medicaid recipients and/or their families who have members subsidized by this agreement and they have access to a pool of approximately 2800 workers from which to choose.

The Bidder will maintain policies and procedures to ensure that a person-centered system is maintained that will also be part of the Bidder's Care Management Program description.

### 3.2.8 Risk Profiling

The Bidder proactively identifies Enrollees who require care management – either Intensive Care Management (ICM) or Care Coordination for moderate and low-risk members. These terms are more thoroughly defined in the next section. Bidders must also establish priorities and determine Enrollee risk levels and ICM and Care Coordination needs including duration, intensity and the composition of Care Management services.

Based on experience in other programs, the MME population will consist of individuals with varying medical, behavioral health and LTSS needs, including individuals in different care settings and, in different life stages. Consequently, Enrollees will require different levels and types of ICM services and Care Coordination. Conceptually, there may be Enrollees with Low-Moderate-, and High-risk levels depending on the complexity of their medical, behavioral and social support needs including the availability of informal supports.

To meet the varied needs of Enrollees, the Bidder maintains proactive policies, procedures, practices and systems that identify MMEs who are at high-risk of poor health outcomes and excessive or inappropriate costs associated with the delivery of health care services. The Bidder identifies Enrollees who may need and benefit from, ICM and Care Coordination services. Bidders establish priorities regarding who receives ICM services well as the duration, intensity and scope of ICM services that MMEs at high-risk, regardless of eligibility for LTSS services, receive.

The State shall require MMPs to utilize predictive modeling software to stratify Enrollees for whom claims history exists into low-, moderate-, and high-risk categories. At a minimum, MMPs will utilize predictive modeling software that uses claims data and evidence-based

algorithms to categorize Enrollees. Such software will further identify Enrollees at risk for poor health outcomes who may benefit from Care Management services. With regard to predictive modeling data, MMPs will be required to:

- Use predictive modeling data, to identify Enrollees' changing needs on an ongoing basis, where claims history is available. MMPs must stratify Enrollees' needs based on acuity as well as risk for hospitalization or nursing facility placement.

- Include a thorough analysis of claims data, encounter data, and/or data from other systems over a one-year period in predictive modeling activities, where a full year of claims data exists for an Enrollee. Where one year of data does not exist, the MMP will determine whether and how to conduct predictive modeling activities.

- At least monthly, conduct a data "sweep" and subsequent analysis of claims data for new and existing Enrollees to identify Enrollees at risk of poor health outcomes who may benefit from Care Management services.

- Review predictive modeling data and any other available information for each Enrollee not eligible for LTSS to determine if an in-person CFNA is needed and in what timeframe, as described in Section 3.3.9.

- Generate individualized risk scores for Enrollees for whom sufficient claim history is available to establish the level and type of action or ICM or Care Coordination service that is required.

In addition to predictive modeling activities, MMPs will be required to analyze Enrollee risk and potential needs based upon all available information, including IHS and CFNA results, encounter data, hospital discharge summaries, provider referrals and referrals of all types (including Enrollee self-referral), data collected through utilization management processes, and Enrollee and caregiver input. MMPs will be required to:

i. Utilize all available data, including information gathered via the full range of applicable assessment activities, to identify and plan for each Enrollee's person-centered needs and to inform development of an appropriate ICP, where applicable.

ii. Review referrals and any other available information for each Enrollee not eligible for LTSS to determine if an in-person CFNA is needed and in what timeframe, as described in Section 3.3.9

This is referred to as a "no-wrong door" approach, where Enrollees may be identified as being at high-risk for poor health outcomes at any point of contact with the MMP, the provider network or community-based organizations. As part of this "no wrong door" approach, Bidders will employ a Predictive Modeling capability to identify Enrollees with immediate needs and will further identify those who are at high risk who may benefit from ICM services.

The ability to intervene at any given point of time is most critical to the next treatment phase or to the outcomes of intervention on Enrollees. MME's needs change throughout the care delivery process; thus, their need for care management services also changes. The Bidder must have an integrated system that tracks an Enrollee's condition and documents events (e.g. emergency room encounters, hospital admissions, nursing home admissions) that suggest an Enrollee requires ICM or Care Coordination. The Bidder's system must provide the Lead Care Managers and Care Coordinators with timely vital information so that the appropriate interventions (e.g. Care Coordination, ICM services or modifications to existing services and supports, and/or ICP changes) may be provided to improve a Enrollee's health status and to avoid unnecessary use of limited resources.

### 3.2.9 Care Management

MMPs offer Care Management services to all Enrollees as needed to support health and wellness, ensure effective linkages and coordination between the PCP and other providers and services, and to coordinate the full range of medical and behavioral health services, preventive services, medications, LTSS, social supports, and enhanced benefits as needed, both within and outside the MMP. Care Management services include both Intensive Care Management (ICM) for Enrollees with LTSS needs and other high-risk Enrollees who may benefit from such services, and Care Coordination services for individuals with more limited needs. All Care Management services will be delivered to Enrollees according to their strength-based needs and preferences. Enrollees will be encouraged to participate in decision making with respect to their care.

Bidders must demonstrate effective systems, policies, procedures and practices are in place to identify Enrollees in need of ICM services, including an early warning system and procedures that foster proactive identification of high-risk Enrollees and to further identify Enrollees' emerging needs. A determination of which Enrollees are at high-risk will be made by the MMP as a result of either its predictive modeling results or an individualized Comprehensive Functional Needs Assessment, as described below. Enrollees who are determined to be at high-risk and eligible for ICM may include, but not be limited to, individuals with complex medical conditions that may lead to: the need for high-cost services; deterioration in health status; or, institutionalization.

The objectives of the ICI Demonstration Care Management are as follows:

- Ensure delivery of integrated care based on an Interdisciplinary Care Plan (ICP)
- Offer person-centered, strength-based care that empowers Enrollees to participate in the care delivery process
- Increase the proportion of individuals successfully residing in a community setting
- Ensure that needed services identified through the assessment processes are obtained and that any existing gaps or barriers to necessary services are eliminated with a focus in transitions in care and the integration of physical and behavioral health

- Facilitate access to timely, appropriate, accessible and quality primary, acute, behavioral health, long-term care and community support services

- Assist Enrollees in achieving an optimal level of wellness and function by facilitating timely and appropriate health care service delivery and Enrollee self-advocacy and self-management

- Evaluate and continuously improve the quality and effectiveness of the Care Management program

- Tailor successful evidenced-based practices to meet the needs of Enrollees

- Maximize the use of technology to improve access to care and provision of care while reducing cost

Among other things, the ICI care management model will seek to:

- Achieve cost-effectiveness while improving or maintaining the level of quality

- Maintain Enrollees in the least intensive setting possible with a focus on community-based resources

- Decrease avoidable hospitalizations, emergency room utilization and reduce nursing home admissions and lengths of stay

Clinical care management is most effectively delivered when the care manager is integrated in to the clinical delivery team, and is a trusted partner of both the enrollee and his/her providers. Therefore, the bidder is required to articulate what strategies will be used to ensure that care management is functionally integrated in to the process of clinical care and social supports. Given its lack of effectiveness, telephonic care management is discouraged and should only be offered as a back up to the primary strategy of integrated, on-site and in-person care management for the populations listed below. The bidder should articulate how they will build on and improve the care management capacity of Rhode Island's robust medical home infrastructure as part of this initiative.

*Care Coordination for Low- and Moderate-risk Enrollees*

Upon initial enrollment, Enrollees who reside in the community and are not eligible for LTSS, and have not otherwise been determined to be high risk, will receive a telephonic Initial Health Screen (IHS) which will risk stratify them into either a low-, moderate-, or high-risk category. Those who stratify as high-risk will then receive an in-person Comprehensive Functional Needs Assessment (CFNA), either from MMP staff or a member of the clinical care team. Care management for individuals at low and moderate risk will include, but is not limited to:

1. Routine support from Enrollee Services within the MMP. The Enrollee can contact Enrollee Services as needed to obtain telephonic support.

Enrollee Services will facilitate additional services, as required by the Enrollee;

2. Peer Navigator services, to the extent that MMP care management staff determines such supports to be necessary and beneficial. Low-risk Enrollees will be eligible to receive Peer Navigator services as periodic support to identify and follow-through on referrals and community-based services as needed

3. Targeted support from MMP care management or enrollee services staff, to be designated by the MMP at the time the Enrollee is identified as being in need of support

4. A CFNA, in the event that the Enrollee experiences a change in health status or social supports, as described in this section. The provision of a CFNA may be triggered by: predictive modeling data; a self- or other referral regarding the Enrollee's needs; or contact with MMP staff that indicates the potential for increased risk such that the Enrollee may qualify for ICM services.

5. Home safety checks as needed by an Initial Health Screen or CFNA

6. In-home services on an as-needed basis.

*Integrated Care Management Services for Individuals with LTSS and Individuals Who are Not Eligible for LTSS and are at High-risk*

Intensive Care Management will be available to Enrollees eligible for LTSS, or who are determined to be high-risk via the CFNA or other sources. ICM will include a set of high-touch, person-centered care management activities requiring direct interaction with the Enrollee and ICT; data collection, analysis, interpretation, and communication of data to the ICT; and monitoring and quality assurance of ICM activities. Specific ICM services will include, but are not limited to:

1. Care management and coordination from a Lead Care Manager (LCM) with physical and/or behavioral health expertise, as described below.

2. Creation of an Interdisciplinary Care Plan (ICP), as described in this section. The ICP will be shared with the ICT, including the Enrollee, a caregiver if desired by the Enrollee, the PCP, and any other relevant providers as determined by the PCP or the Enrollee

3. A range of HCBS as needed, including but not limited to Peer Navigator services, to the extent that MMP care management staff determines such supports to be necessary and beneficial

4. Home safety checks as determined by a CFNA

*Requirements for Assessment*

The assessment process consists of two main components: Initial Health Screens for Enrollees who are not eligible for LTSS, and comprehensive functional needs assessments for Enrollees who are eligible for LTSS or who are otherwise determined to be high-risk (as described in this section). Both types of assessment are informed by and result in risk profiling (see Section 3.3.8).

Initial Health Screen

Bidders will develop an IHS, which EOHHS will review and approve. During the first six months of the ICI Demonstration, MMPs will be required to administer a telephonic IHS within 180 days of effective enrollment to all Enrollees who are not eligible for LTSS. After the first six months of the Demonstration, MMPs must administer the IHS within forty-five (45) days of effective enrollment for non-LTSS Enrollees. The MMP will re-administer the IHS for an Enrollee based on the Enrollee's condition or needs, including as indicated by predictive modeling or provider- or self-referral. If the Enrollee or caregiver requests an IHS, it must be completed within fifteen (15) days of the request.

At a minimum, the IHS shall include:

- Complete demographic information including, but not limited to household information including mailing address, and phone number; the Enrollee's preferred language; age/date of birth; and living arrangement (lives alone, lives with family, etc.) and current residence status (community or facility-based);
- Emergency room utilization in the last six months
- History of hospitalizations in the last year
- Presence of co-morbid chronic conditions
- Availability of an informal caregiver
- Prior nursing facility admissions
- Ability to perform activities of daily living (ADLs)
- Perceived risks (e.g. of falls)
- Self-reported health status
- Strength-based needs and preferences

The MMP will stratify each Enrollee who receives the IHS as being low-, moderate- or high-risk. The State will identify minimum required determinants of high-risk status that may include, but are not limited to, three or more emergency department visits in the prior six month period, a hospital re-admission within 60 days prior to enrollment, loss of an informal caregiver in the prior six month period, potential loss of housing, and indication of an unstable chronic disease process in the six months prior to the IHS.

The MMP will incorporate the results of the IHS into the Enrollee's ICP as applicable, and will distribute the revised ICP to appropriate ICT members including, but not limited to, Enrollees and their caregivers.

Comprehensive Functional Needs Assessment (CFNA)

For Enrollees eligible for LTSS, and Enrollees not eligible for LTSS but determined to be at high risk based on the IHS, the MMP will perform a CFNA within the timeframes described in this section. MMPs shall develop and submit to EOHHS a CFNA tool and scoring methodology to identify high-risk Enrollees who require ICM services subject to EOHHS review and approval.

MMPs shall complete a CFNA for the following Enrollees, within the following timeframes:

- ✓ Non-LTSS High-risk: Enrollees living in the community who are not eligible for LTSS and who are determined by the MMP based on the IHS or via predictive modeling activities to be high-risk Enrollees, and were not enrolled in a RHO plan prior to the Demonstration will receive an in-person CFNA in their homes (with Enrollee consent). During the first six months of the ICI Demonstration, the CFNA must be completed no later than forty-five (45) days of IHS completion. After the first six months of the Demonstration, the CFNA must be completed no later than fifteen (15) days of IHS completion. Reassessments will be conducted by phone or in-person at least annually or sooner if required based on the Enrollee's condition or needs or the circumstances described in this section. Following a hospitalization, reassessments will be conducted within five (5) days of discharge.

- ✓ Community LTSS: Enrollees who are eligible for LTSS and who reside in the community will receive an in-person CFNA in their homes (with Enrollee consent). During the first six months of the Demonstration, for Enrollees eligible for community-based LTSS who were not enrolled in an RHO plan immediately prior to the Demonstration, the CFNA will be completed no later than one hundred-eighty (180) days of the effective enrollment date. After the first six months of the Demonstration, the CFNA must be completed no later than fifteen (15) days of the effective enrollment date. Reassessments will be conducted by phone or in-person at least every ninety (90) days or sooner if required based on the Enrollee's condition or needs or the circumstances described in this section. Following a hospitalization, MMPs must ensure the availability of transitional care management by the primary treating provider. Monthly telephone contact is required for Enrollees receiving care management services. Quarterly home visits are required with one (1) home visit annually is be unannounced. Home visits for RIte @ Home Enrollees are conducted monthly.

- ✓ Facility-based LTSS: Enrollees who receive LTSS in nursing facilities will be analyzed for their opportunity for nursing home discharge. Bidders will use all available data, including the required quarterly MDS assessment, as well as direct referrals to determine whether there is an opportunity for a nursing home resident to be discharged to a community setting. During the first six months of the Demonstration, for Enrollees receiving facility-based LTSS and who were not enrolled in an RHO plan immediately prior to the Demonstration, the Discharge Opportunity Assessment will be completed no later than one hundred-eighty (180) days of the effective enrollment date. After the first six months of the Demonstration, the Discharge Opportunity Assessment must be completed no later than thirty (30) days of the effective enrollment date. Reassessments will be conducted by phone or in-person at least every one hundred-eighty (180) days or sooner if required based on the Enrollee's condition or needs or the circumstances described in this section. Following a hospitalization, MMPs must ensure the availability of transitional care management by the primary treating provider.

- ✓ Previous RHO: For Enrollees eligible for LTSS who were enrolled in an RHO plan immediately prior to the Demonstration, the previous assessment conducted by the RHO plan will be shared with the ICT within thirty days of ICI Demonstration enrollment. If the RHO assessment was completed within the 180 days prior to MMP enrollment, the Enrollee will be reassessed according to the applicable timeframe for that Enrollee, using the RHO assessment date as the starting point.

For all Enrollees, the MMP will further be required to conduct an in-person re-assessment within fifteen (15) days of identifying a significant change in the Enrollee's condition or needs or the circumstances described in this section. This requirement can performed by MMP staff or by members of the clinical care team. Bidders should development alternative payment approaches for providers that support this work.

At a minimum, a CFNA must include, but not be limited to, an assessment of:

- Enrollee strength-based preferences for care delivery, housing, caregiver involvement and other key factors as they relate to care

- Self-reported health status

- Utilization history for emergency room services, inpatient services, LTSS and nursing facility services within the last 18 months

- Medical and behavioral health history including all chronic conditions and history of exacerbations within the prior 12 months

- Medications and medication management needs

- Mental health screening including, but not limited to, cognitive functioning
- Alcohol, tobacco and other drug use
- Ability to perform Activities of Daily Living (ADLs)
- Fall risks, home safety evaluation, home modifications needed
- Advance directives
- Cultural and linguistic preferences
- Evaluation of visual and hearing needs, (preferences and limitations)
- Caregiver resources and involvement
- Informal and community support systems
- Nutritional status and availability of appropriate food based on the Enrollee's medical needs and preferences
- Housing, social service, legal needs
- Potential to avoid institutional care (e.g. housing status, availability of an informal caregiver)
- Interest in vocational rehabilitation, employment, or volunteer work
- Barriers to meeting goals or complying with the ICP

The CFNA, including reassessments, will be administered by a licensed clinician. Bidders will ensure this assessment is performed, and is encouraged to develop payment strategies that support the development of this capacity in the provider community.

Comprehensive Re-assessment

MMPs will be required to perform comprehensive re-assessments on an ongoing basis for Enrollees eligible for LTSS and high-risk non-LTSS Enrollees using the timelines listed this section. The comprehensive re-assessment will have the same content as the initial CFNA and must be fully updated at the time of re-assessment. Bidders will ensure this assessment is performed, and is encouraged to develop payment strategies that support the development of this capacity in the provider community.

Changes in the Enrollee's condition or needs that may warrant a comprehensive re-assessment include, but may not be limited to: hospitalization; significant changes in medication; change in, or loss of, a caregiver; medical, psychosocial or behavioral health crisis; excessive emergency department utilization; other major changes in the Enrollee's psychosocial, medical, behavioral condition; or major changes in caregivers or housing.

MMPs will incorporate the results of the comprehensive re-assessment into the Enrollee's ICP, and will distribute the revised ICP to appropriate ICT members including, but not limited to, Enrollees and their caregivers.

*Requirements for Lead Care Managers (LCMs)*

The MMP will assign an LCM to each Enrollee who is eligible for LTSS or who is determined to be at high risk for poor health outcomes and/or high costs associated with health care delivery. Such Enrollees will be eligible to receive Intensive Care Management (ICM) services. The LCM can be an MMP staff member, or can be a member of the clinical care team. Bidders should develop payment approaches that develop this capacity in the provider community.

The lead Care Manager is responsible for executing the linkages and monitoring the provision of needed services identified in the ICP. This includes making referrals, coordinating care, promoting communication, ensuring continuity of care, and conducting follow-up. Implementation of the Enrollee's ICP will enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn, and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her ICP.

The MMP will maintain policies and procedures for assigning Lead Care Managers and Care Coordinators in a manner that ensures that Enrollees are served by the staff best qualified to meet their needs. In the event that Enrollees wish to select different Lead Care Managers or Care Coordinators, the MMP shall help them do so. The MMP is expected to leverage existing care management supports that may already be in place. These supports may include a nurse care manager in a primary care practice where the Enrollee receives primary care.

For Enrollees with a primarily medical condition(s), a qualified individual with physical health expertise shall be designated as the LCM. For individuals with a primary mental illness or substance use disorder, a qualified individual with behavioral health expertise shall be designated as the LCM. When necessary, the MMP will make physical health Care Management resources available to the primary behavioral health LCMs, and vice versa, to meet the comprehensive needs of Enrollees. The MMP shall establish the role and responsibilities of each type of LCM.

The LCM will:

- Conduct the CFNA (to the extent that the MMP has sufficient information to assign an LCM with appropriate expertise to an Enrollee prior to full CFNA results) and fully incorporate such results into the Enrollee's ICP. If the MMP does not have sufficient information to assign an LCM to an Enrollee prior to the CFNA, a qualified LCM will perform the CFNA and another LCM with expertise more relevant to the Enrollee's needs may be assigned after the CFNA is completed

- Discuss the Enrollee's desired treatment results and outcomes

- Oversee creation of the ICT with appropriate participants
- Convene a telephonic or in-person meeting of the ICT, if appropriate and necessary, to discuss Enrollee needs and preference
- Hold in-person or telephonic ICT meeting(s) on an as needed basis, including any time an Enrollee experiences a significant change in condition (e.g. hospitalization or loss of caregiver) and qualifies for IC
- Use all relevant information from the CFNA, Enrollee and family input, and other data to create a comprehensive, multidisciplinary ICP
- Develop and implement the ICP in collaboration with the ICT
- Share the ICP with the Enrollee, the Enrollee's family and/or caregiver (with Enrollee consent), and appropriate members of the ICT
- Coordinate service delivery among all providers associated with the Enrollee's care, including but not limited to providers of medical, LTSS, and behavioral health services
- Follow up with providers to obtain necessary test and treatment results, or other information about the Enrollee's health status
- Provide or link Enrollees to self-management and disease management education, with a focus on self-care
- Review the ICP periodically, assessing progress toward achieving Enrollee-centered goals and outcomes, and making appropriate revisions in collaboration with the Enrollee and the Enrollee's providers as the Enrollee's condition and needs change
- Provide information and engage in discussion with Enrollees to help inform decisions about use of medical resources, including the emergency room
- Make referrals for services and assist providers in obtaining the necessary authorization to provide services, including access to alternative therapies

All Lead Care Managers will receive training on interdisciplinary care coordination and key Lead Care Manager responsibilities. Minimum qualifications and experience required for Lead Care Managers, including those with behavioral health expertise, will be included in the Three-way Contract.

*Requirements for Care Coordinators and Care Management Staff for Low- and Moderate-risk Non-LTSS Enrollees*

The MMP will make Care Coordinators and/or Care Management staff available to Enrollees who are not eligible for LTSS and are not otherwise designated as being high-risk. As necessary and appropriate based on the Enrollee's needs, Care Coordinators and/or other Care Management staff will:

- Ensure the IHS is conducted and that data from the IHS is utilized to develop an ICP if needed
- Share the ICP, if needed, with the Enrollee, the Enrollee's family and/or caregiver (with Enrollee consent), and appropriate members of the ICT
- Be available to educate Enrollees on prevention, wellness, and self-care as needed and desired by the Enrollees
- Facilitate referrals to appropriate services, as needed

In addition, as necessary and appropriate based on the Enrollee's needs, Care Coordinators and/or other Care Management staff will:

- Coordinate service delivery among providers associated with the Enrollee's care, including but not limited to providers of medical, LTSS, and behavioral health services as needed
- Provide or link Enrollees to self-management and disease management education, with a focus on self-care as needed
- Make referrals for services and assist providers in obtaining the necessary authorization to provide services, including access to alternative therapies as necessary and appropriate
- Provide Member Services support to link Enrollees who do not receive LTSS to necessary Care Management resources within the MMP
- Address changes in condition and arrange for a CFNA based on the terms in this section, when needed as a result of a change in the Enrollee's condition, and refer Enrollees for ICM services when appropriate
- Arrange home safety checks for the Enrollee, when indicated by the IHS; and
- Provide other support as appropriate

Minimum qualifications and experience required for Care Coordinators or other Care Management staff will be included in the Three-way Contract.

*Requirements for the Interdisciplinary Care Team*

The MMP shall assemble an ICT for each Enrollee based on the Enrollee's person-centered needs. The MMP will utilize the ICT to:

- Serve as a communication hub to coordinate services across the full continuum of care, including but not limited to primary, specialty, behavioral health, LTSS, and other services

- Support transitions from hospital or nursing facility to community, under the direction of the LCM, as applicable

- Collaborate across all physical, behavioral, and social support disciplines with attention to coordinated provision of Enrollee education and self-management support; behavior change techniques and motivational interviewing practices when delivering services to Enrollees; medication management; coordination of community-based services and supports; referrals, as desired by the Enrollee and as appropriate, to end-of-life services and supports; and changes in the Enrollee's condition when additional multidisciplinary planning is necessary and potentially beneficial.

The requirements for the ICT are below.

For Enrollees eligible for LTSS or determined to be high-risk, the Lead Care Manager (LCM) shall oversee development of the ICT. For Enrollees eligible for LTSS or determined to be high-risk, the LCM shall oversee development of the ICT. The ICT shall include the Enrollee, the LCM, and the PCP. Additional individuals, including not limited to the following, may be included as appropriate and applicable:

- Family members and/or caregivers

- PCP

- Behavioral health specialist

- Peer Navigator

- Pharmacist

- Physical, occupational and/or speech therapists

- LTSS providers

- Other key medical specialists or human service provider

For Enrollees not eligible for LTSS and not otherwise determined to be high-risk, the ICT shall include individuals based on the Enrollee's needs and preferences, and as applicable, including but not limited to:

- The Enrollee

- Family members and/or caregivers
- PCP
- Behavioral health specialist if appropriate

*Requirements for the Interdisciplinary Care Plan (ICP)*

The MMP will develop an appropriate ICP for each Enrollee eligible for LTSS or determined to be at high risk (including Enrollees newly determined to be at high risk). The ICP must be developed within five (5) calendar days of completion of the CFNA, or sooner, based on Enrollee needs. The ICP must be modified, if necessary, within five (5) days after a hospitalization. The MMP will comprehensively document within the ICP the needs and interventions identified by the ICT and CFNA, including medical, behavioral health, LTSS, and other critical needs (e.g. legal or housing), and including both services covered by the MMP (i.e. included in the capitated rate) and out-of-plan services.

At minimum, the ICP will include but not be limited to Short- and long-term goals and expected outcomes and measures including timelines for achievement of goals, including reference to any goals, outcomes, and measures listed in other clinical care plans the Enrollee may have outside of the MMP. The ICP will identify barriers to ICM service delivery and strategies to address such barriers as well as measures taken to reduce risks without restricting the Enrollee's autonomy to undertake risks to achieve goals.

The ICP will contain detail on the medical, behavioral, and psychosocial support needs and ICM interventions, including but not limited to:

- Integrated interventions that incorporate medical, behavioral health, LTSS, social service, and community living support needs
- Plans for known or anticipated care transitions
- Disease management/chronic condition management including, but not limited to, self-management and education
- Prevention and wellness goals and strategies
- Home safety needs, issues, and intervention
- Availability of informal support systems, including factors that put the Enrollee's informal supports at risk
- Specific person(s) and/or any provider agency responsible for delivering LTSS, including back-up plans to the extent possible

- Self-directed services and supports
- Advanced care planning
- Other needed interventions (e.g. housing, legal, recreational)
- Signatures (or other indications of consent, where applicable) of all people with responsibility for ICP implementation, including the Enrollee and the Enrollee's designee, if applicable and with the Enrollee's consent, and a timeline for Enrollee and/or LCM ICP review signifying ICP acceptance and an intention to follow the ICP
- Emergency after-hours backup plan that ensures that support is available, if needed, from a contracted agency in person 24 hours per day, seven days per week. The Back-Up Plan identifies key people or agencies that the Enrollee should contact when there is a disruption in the on-going support that is provided to them so that they remain safe and able to function in the community. The Care Manager may utilize the individual's informal or formal supports to comprise initial emergency back-up procedures for the individual. Additionally, the Bidder must assist in obtaining emergency services and supports, in-person when necessary, in urgent cases where the disruption in the on-going support that is provided to the individual has placed him or her at risk. Such emergency situations include but are not limited to: significant change in Enrollee condition, unexpected caregiver absence, fire, or flood.

Care plans are most useful when they are a living document that is well known to the team providing care to the enrollee. The bidder should demonstrate what tools and techniques they will use, such as shared medical records, secure messaging, health information exchange, or other techniques to ensure that the care plan becomes a useful and up-to-date tool in the management of the member's care. Care plans that reside within the MMP and are not familiar to or integrated in to routine care are unlikely to be adhered to. The bidder may choose to incentivize providers to provide the comprehensive functional needs assessment and the care plans in order to maximize the integration of these tools in to the care delivery team.

The MMP will distribute copies of the original ICP and ICP updates to the Enrollee, the Enrollee's family or caregiver, and providers, as appropriate and with Enrollee consent. For Enrollees who were in a Rhody Health Options plan immediately prior to the Demonstration and who enroll in an MMP not operated by the individual's previous Rhody Health Options plan, the MMP must obtain the current ICP from the previous Rhody Health Options plan. The MMP will develop the ICP with an emphasis on leveraging existing caregivers and services and avoiding duplication with existing resources, including but not limited to sources of Care Management outside of the MMP.

The MMP must write the ICP in a culturally and linguistically appropriate manner that enhances the Enrollee's health literacy while considering the Enrollee's overall capacity to

learn and be self-directed. Goals must be documented in the first person. The MMP will also ensure that the ICP considers processes and strategies for resolving conflict or disagreement within the ICM and care coordination processes. The MMP must maintain clear conflict of interest guidelines for all ICM participants, as well as a method for the Enrollee to request ICP revision. Enrollees must be informed, by the MMP, regarding their rights and the ICP process to appeal the denial, termination, or reduction of a service.

*Requirements for Peer Navigators*

Some Enrollees may require Peer Navigator assistance in accessing support services or coordinating non-medical care, or benefit from a "peer mentoring" relationship. Peer Navigator responsibilities to support such needs include assisting Enrollees in making appointments, transportation, follow-up, and services. The responsibilities of these Peer Navigators (with oversight by the LCM, as applicable) may include:

- Participating in Peer Navigator training administered by the MMP
- Assisting with making appointments for health care services
- Canceling scheduled appointments if necessary
- Assisting with transportation needs
- Following up with Enrollees and providers to assure that appointments are kept
- Rescheduling missed appointments
- Linking Enrollees to alternatives to facility-based medical care, including the emergency room, when appropriate and desired by the Enrollee
- Assisting Enrollees to access both formal and informal community-based support services such as child care, housing, employment, and social services
- Assisting Enrollees to deal with non-medical emergencies and crises
- Assisting Enrollees in meeting ICP goals, objectives, and activities
- Providing emotional support to Enrollees, when needed
- Serving as a role model in guiding the Enrollee to practice responsible health behavior
- Serving as a role model in guiding the Enrollee to practice responsible health behavior

Bidders will be required to subcontract with a community-based organization to provide peer navigator services that meet EOHHS specified performance requirements and meet the performance standards in the Model Contact.

*Requirements for Additional Data Analysis*

In addition to predictive modeling activities, MMPs will be required to analyze Enrollee risk and potential needs based upon all available information, including IHS and CFNA results, encounter data, hospital discharge summaries, provider referrals and referrals of all types (including Enrollee self-referral), data collected through utilization management processes, and Enrollee and caregiver input. Bidders will be required to utilize all available data, including information gathered via the full range of applicable assessment activities, to identify and plan for each Enrollee's person-centered needs and to inform development of an appropriate ICP. Bidders will also review referrals and any other available information for each Enrollee not eligible for LTSS to determine if an in-person CFNA is needed and in what timeframe, as described in Section 3.3.8.

The Bidder uses existing data and analytic capacities to: identify the changing needs and risks of Enrollees; stratify Enrollees' needs according to acuity and risk for hospitalization or nursing home placement; communicate with Care Management Teams regarding high risk Enrollees; and ensure that Enrollees receive appropriate, timely and comprehensive Care Management services. An essential component is the ability to modify Enrollees' ICP to ensure the appropriateness of service delivery. The Bidders must apply systems, science, and information to identify Enrollees with potential ICM needs and assist Enrollees in accessing ICM services with the goal of improving and maintaining quality of life.

In order to optimally manage their population of members, providers will need access to robust data on their quality and cost performance, and the utilization patterns of their members. It is the MMP's responsibility to develop a system of monitoring and feedback that provides contracted providers with the information they need to optimally manage this population. As part of the Alternative Payment Arrangements referred to in Section 3.3.15, the MMP is responsible for developing a system of claims analysis and feedback that allows providers to understand their performance on the relevant quality indicators, total cost of care, and performance in relationship to other providers in the network

The Bidder is responsible for monitoring and ensuring the quality and effectiveness of Care Management activities in multiple ways, including contractual arrangements with PCPs, community health and social service resources or other entities providing ICM services. The effectiveness of the ICM process is measured by the review and analysis of patient outcomes. Bidders are expected to develop processes to collect and submit population based measures to the State quarterly for review. State approved measures must be used to monitor success.

*Requirements for Management of Care Transitions*

Success of the demonstration depends on the ability of the Bidder to manage the transition of Enrollees when they move across care settings, such as:

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

Models for care transitions exist throughout the nation (e.g. The Coleman Care Transitions Intervention program is based on the work of Eric Coleman, MD, from the University of Colorado). The Bidder must adopt or modify existing approaches to care transitions or develop their own to ensure effective transitions and the continuity of care when Enrollees move between care settings and levels of care. A key in care transitions is to have effective strategies that prevent Enrollees from moving to a higher level of care, when it is avoidable.

To successfully transition an Enrollee across settings, ICM and Care Coordination services and support during transitions must be available twenty four hours a day, seven days a week (24/7). This includes transitional ICM services that provide onsite visits with the LCM upon discharge from hospitals, nursing homes, or other institutional settings. LCMs and Care Coordinators will assist with the development of discharge plans. Transitional Care Management reflects RI's best practices in hospital transitions of care, by requiring the Bidder to incorporate experiences, lesson learned and best practices from *RTH* and the Nursing Home Transition Program.

The Bidder must have policies, procedures and practices for transitioning Enrollees between levels of care and care settings that are approved by EOHHS.

*Requirements for Analysis of ICM and Care Coordination Effectiveness, Appropriateness and Patient Outcomes*

The Bidder is responsible for monitoring and ensuring the quality and effectiveness of ICM and Care Coordination services in multiple ways, including through contractual arrangements with PCPs, community health workers or other entities providing integrated Care Management and Care Coordination services. EOHHS will develop expectations for Care Management activities. Each Enrollee with LTSS or, at high-risk of poor health outcomes and excess costs associated with inappropriate care delivery must have a ICP that addresses his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. Enrollees who

are not eligible for LTSS and are not at-risk of poor health outcomes will have access to Care Coordination services.

The effectiveness of the ICM and Care Coordination processes is measured by the review and analysis of patient outcomes. The Bidder develops processes to collect and submit population based measures to EOHHS quarterly for review on Medicaid only and MME Enrollees. EOHHS approved measures are used to monitor success.

The Bidder has effective systems, policies, procedures and practices that govern the Care Management process. The Bidders are expected to have integrated electronic information systems that maximizes interoperability in order to provide Care Managers with access to all essential data related to the Enrollee (including but not limited to: Enrollee's clinical history, diagnosis, sentinel events, urgent/ongoing care need). Other data sources (pharmacy, utilization) and data mining tools (predictive modeling, risk scores) may be used to: (1) place a Enrollee into his/her appropriate Care Management model (for that particular date in time); (2) implement his/her ICP; (3) monitor ICP for effectiveness and appropriateness; and (4) modify the ICP to accurately reflect any change in the Enrollee's circumstances. Strong consideration should be given to the use of the State's Health Information Exchange, **Current*care***, to support information exchanges, particularly around care transitions.

### 3.2.10 Nursing Home Transition MMEs, including Nursing Home Transition Program Participants, and Rhode to Home Participants

The Bidder establishes policies, procedures and practices for Medicaid recipients who are participating in the *Rhode to Home* demonstration program, and the nursing home transition program Enrollees. The Procurement Library contains the CMS approved *Rhode to Home* (MFP) Operational Protocol that the Bidder must comply with. The following describes the process flow currently used in the Nursing Home Transition Program and *Rhode to Home* demonstration grant for individuals transitioning from nursing homes to community-based residences.

*Nursing Home Transition Program- An Enrollee must meet initial enrollment eligibility criteria:*

- *Is residing in a Nursing Home for non-skilled or convalescent acre or*
- *Admission was for skilled care and is still receiving skilled care **and** has submitted a Long Term Care Nursing Home Medicaid application; and*
- *Enrollee must agree to receive HCBS services while residing in the community*

*Rhode to Home Eligibility*

Eligibility for the *Rhode to Home* (*RTH*) demonstration is regulated by Federal requirements. The Bidder must follow EOHHS's policies and procedures related to the *RTH* eligibility process. To identify potential *RTH* participants prior to transition, the Bidder must confirm the following criteria have been met. An Enrollee must meet initial enrollment eligibility criteria:

- Reside in a nursing home for at least 90 consecutive days (the days may not include those days that were for the sole intent and purpose of receiving short term rehabilitation, reimbursed by Medicare).

- Be Medicaid eligible (at least one day prior to discharge); and, (2) obtain an informed consent to participate in the RTH demonstration which is signed by the Enrollee or their legal guardian (if applicable).

The specific criteria to determine an Enrollee's eligibility to participate in the MFP demonstration grant include:

- The Enrollee must move to a RTH qualified residence that meets the requirements established by CMS. Qualified residences include: (1) an individual's home, or apartment like setting that includes areas for sleeping, bathing, living and eating, (2) the home or apartment must be owned or leased by the individual or their caregiver or family Enrollee; and (3) the home may be a group home where no more than four individuals reside.

- Additional qualifying criteria must also apply such as: (1) the individual must have the right to choose their service provider; and (2) unless otherwise assessed and identified as a need within the individual's ICP, the residence must offer unrestricted access to the areas within the residence; cannot require notification of absences; and cannot reserve the right to assign apartments or change apartment assignments.

- EOHHS establishes all required documentation for participation in the RTH Demonstration. The Bidder forwards all required documentation to the EOHHS at periodic intervals established by the EOHHS. Intervals established by the EOHHS may include, but are not limited to: pre-transition (length of stay in the nursing home, Medicaid eligibility status, and signed consent); immediately after transition (residence documentation); and ongoing care coordination (includes but is not limited to: progress and ongoing review, critical incidents, 24/7 back-up plan and all additional documentation and required reporting as established by the State).

*Referrals from Minimum Data Set 3.0 Section Q (MDS Section Q)*

EOHHS receives referrals from the nursing home regarding those individuals who indicated through the MDS Section Q that they are interested in learning more about LTSS that may be available in a community based residence or would like to transition to a community based residence. EOHHS will report to the bidder all MDS Section Q or Nursing Home Transition referrals received in a manner mutually agreed upon by EOHHS and the Bidder.

*LTSS Options Counseling*

The Bidder coordinates with the State's Aging and Disability Resource Center (ADRC) to ensure that LTC Options Counseling is provided to Enrollees who were referred through the MDS

Section Q process as well as other independent referrals received for individuals living in institutions and community based residences. LTC Options Counseling is provided in a manner that: (1) is consistent with the practice established by and provided by State representatives.

*Nursing Home Referrals*

The Bidder proactively reviews data to identify those individuals that have resided in nursing homes or other specified institutions that are likely candidates to transition to a community based residence and could potentially receive community-based care. The Bidder conducts a screen of potential candidates who desire to transition to a community-based residence and may be eligible to receive HCBS.

- For Enrollees that have resided in a Nursing Home for 90 days or longer, the Bidder assesses the individual every 6 months for possible transition. The Bidder must provide documentation to the state, if the individual, individual's guardian or responsible party determine that ongoing assessments are not appropriate.

- A Plan is developed to provide LTC Options Counseling and information for potential transition to a community-based residence.

- The Bidder provides documentation and reports, in the manner established by the state, on all Enrollees assessed, the potential ability to transition, barriers to potential transition, and any additional criteria established by the State.

- Other information is reviewed such as, but not limited to: the patient's length of stay in the facility, assessed needs, the individual's eligibility status for Medicaid, the individual's preferred or potential home and community-based residence including any applicable rental leases as well as other screening criteria established by EOHHS.

This information is submitted to EOHHS.

*Affordable Housing*

The Bidder must develop policies and procedures to identify affordable housing options for Enrollees that are interested in transitioning from nursing homes (and other institutions as specified by the State). The Bidder supports Enrollees to identify:

- Affordable apartment units listed within Public Housing Authorities

- Tenant-based rental assistance and voucher programs

- Opportunities for Enrollees to reside in a home or apartment with a caregiver or family Enrollee

- Supportive housing models including but not limited to: Assisted Living Residences with affordable units including those that participate in the State's Assisted Living

Waiver program, subsidized housing options with personal care assistance and behavioral health supports

- Other affordable housing options including but not limited to low income housing tax credit programs

The Bidder must hire a Housing Coordinator to assist Enrollees who are interested transitioning from a nursing home to a community-based residence. The Housing Coordinator will utilize resources of affordable housing options available to individuals across the State. Resources should include web-based housing search tools such as HomeLocatorRI.net, Rite Resources, SocialServe.com, and written materials for the individual to use in choosing a housing model. The Housing Coordinator discusses with Enrollees varying housing alternatives and assists the Enrollee to choose a suitable residence that is safe and meets their needs. The Housing Coordinator works with the Transition Coordinator in assessing the suitability of housing options.

The Housing Coordinators must have knowledge and experience in working with housing entities and advocating for individuals' rights in landlord-tenant general contracting practices. General knowledge and experience includes: expertise in fair housing regulations, tenant-landlord rights and reasonable accommodation requests. Additionally, Housing Coordinators are familiar with community-based LTSS that can be provided in the varying housing models to help support individuals residing in the community.

*Transitioning Process to a Community-Based Residence*

The Bidder designates a lead staff person to serve as a Transition Coordinator. The Transition Coordinator responsibilities are to ensure the following process occurs.

- **Conduct a Comprehensive Clinical Assessment** that includes but is not limited to: a clinical assessment conducted by a registered nurse, a social services assessment containing a psychosocial evaluation, and a risk assessment.

- **Develop a Person-Centered ICP with the enrollee** to address all of the individual's LTSS needs that will be provided once they transition to a community-based residence. The person centered ICP includes but is not limited to the individuals goals and recommendations, services and care to be provided, clinical and non-clinical supports and services, a risk mitigation plan, and a 24/7 emergency back-up plan.

- **Transition Coordination and Care Management** is provided based on the specifications outlined below, for at least 365 days after the date of transition. Care Management is provided in a manner that meets the individual's varying medical and non-medical needs. Care Management includes non-traditional or specialized care management when needed by the Enrollee. The Bidder's care management policies, procedures and practices are approved by EOHHS. The Bidder is required to have

systems in place to track and document the provision of services and care management provided to Enrollees throughout the transition process.

The Bidder is required to conduct face-to-face visits based upon the following minimum criteria (or more frequently based upon individual's need): (1) conduct a face-to-face visit in the individual's home on the date of discharge from the nursing home, (2) weekly visits and/or phone contact in the community beginning the first month of transition with a minimum of two face-to-face visits, (3) monthly visits and/or phone contact during month two through twelve after the individual transitions to a community based residence. The frequency of face-to-face visits or phone contact occurs with Enrollees based on their individual needs.

The Transition Coordination and Care Management period begins once the Enrollee transitions to a community-based residence and continues for 365 days while the Enrollee lives in the residence. An Enrollee's transition period may extend beyond 365 consecutive days if the individual experiences an interruption in their community support services due to hospitalization, readmission to the Nursing Home, or other extenuating circumstances.

The care management process also includes, but is not limited to, ensuring that a Enrollee's specialized service needs (e.g. physical disabilities, intellectual and/or developmental disabilities, veterans with disabilities, elders with dementia, mental health and substance abuse illnesses, chronic homeless, caregiver support) are met so that Enrollees have the ability to live safely and independently in the community.

(3) **Ongoing ICM Services** are provided once the individual completes the Transition Coordination period. The Enrollee continues to receive ongoing ICM as established in Section 3.3.9.

- **Quality of Life** surveys must be conducted for all Enrollees transitioning from nursing homes, and other institutions as defined by the State, to community-based residences to ensure that they are receiving the services and supports they need to maintain the quality of life they desire.

For Enrollees transitioning from nursing homes to community-based residences, Quality of Life surveys are required to be conducted three (3) times per individual: at least three (3) days prior to transition, eleven (11) months post discharge from the nursing home, and twenty-four (24) months post discharge from the nursing home. For RTH cases, the results of the Quality of Life survey must be reported to the State in the manner established by the State. New enrollees who have had previous QOL surveys completed by another entity, the bidder is then responsible for tracking and conducting the remainder of required surveys.

*Critical Incidences*

For Nursing Home Transition and RTH Enrollees, EOHHS reviews and monitors critical incidents that impact the individual during their Transition Coordination Care Management phase. The Bidder must submit documentation, in the manner established by EOHHS, on all critical incidents such as: hospitalizations, emergency room visits, medication errors, neglect, self-neglect, exploitation, police involved incidences, activation of the individuals emergency backup plan when individual is at risk and disasters that result in recipients being displaced from their homes. EOHHS establishes the requirements for critical incident documentation, review, and ongoing monitoring process. The Bidder reviews all critical incidents as they are reported to ensure the Enrollee remains safe in their home environment including the circumstances surrounding the critical incident and the continued needs of the Enrollee.

*Home and Community Care Emergency Back-up Plan*

For Enrollees transitioning from an institutional setting to a home and community based setting, the Transition Coordinator must establish an Emergency Back-Up Plan with the enrollee that will provide support to the individual twenty-four (24) hours per day and seven (7) days per week. The Back-Up Plan identifies key people or agencies that the Enrollee should contact when there is a disruption in the on-going support that is provided to them so that they remain safe and able to function in the community. The Transition Coordinator may utilize the individual's informal or formal supports to comprise initial emergency back-up procedures for the individual. Additionally, the Bidder must assist in obtaining emergency services and supports in urgent cases where the disruption in the on-going support that is provided to the individual has placed him or her at risk.

*Reports to EOHHS*

The Bidder is required to report on all Nursing Home Transition and *RTH* Enrollees as required by EOHHS including but not limited to information related to: referrals, assessments, Plans of Care, transitions, residence information, service provision and care coordination, risk and mitigation plans, critical incidences, 24/7 emergency back up plans, service outcomes, Care Management progress and review updates, service and supports encounter data and other information required by EOHHS and in the prescribed frequency and formats.

*EOHHS Support*

EOHHS will designate a staff person to work with the Bidder in implementing and operating the Nursing Home Transitions Program (NHTP) and *RTH* demonstration grant. The State is prepared to share its policies, procedures, protocols and tools, and report systems currently employed in the NHTP and *RTH* demonstration grant as well as train MMP staff.

The Bidder will designate a staff person to work with EOHHS to implement and ensure ongoing compliance with all transition and documentation requirements outlined in Section 3.3.10

### 3.2.11 Enrollee and Provider Services

The Bidder must meet the requirements in this section regarding Enrollee and Provider Services, respectively. As part of its Enrollee Services function, the Bidder must have an ongoing program

of Enrollee education that takes into account the multi-lingual, multi- cultural nature of the population and also recognizes that some Enrollees have disabilities.

Bidders must meet all current Federal regulatory requirements and CMS guidance requirements for Medicare Advantage plans and Part D plan. In addition, the Bidder shall operate a toll-free Enrollee services telephone line call center. The line will be available nationwide for a minimum of 8am to 8pm Eastern Time, seven days per week. Operators must be available in sufficient numbers to support Enrollees and meet CMS and State-specified standards. Oral interpretation services must be available free of charge to all Enrollees in all non-English languages spoken by Enrollees.

Bidders must ensure that customer service department representatives shall, upon request, make available to Enrollees and potential Enrollees information including, but not limited to, the following:

- The identity, locations, qualifications, and availability of providers
- Enrollees' rights and responsibilities
- The procedures available to an Enrollee and/or provider(s) to challenge or appeal the failure of the MMP to provide a requested service and to appeal any adverse Actions (denials)
- How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
- How to access the Enrollee Ombudsman, the State Enrollee Call Center, and 1-800-Medicare
- Information on all MMP covered services and other available services or resources (e.g., State agency services) either directly or through referral or authorization
- The procedures for an Enrollee to change MMPs or to opt out of the ICI Demonstration

Once a year, the Bidder must notify Enrollees in writing of their rights to request and obtain information about: their benefits, out-of-plan services, freedom of choice provider restrictions, State and MMPs grievance and appeals processes, after hours and emergency coverage, services authorization requirements, referrals for specialty care, and other information as identified in the three-way Contract.

The Bidder staffs a Provider Services function, to be operated at least during regular business hours and to be responsible for the functions identified in the three-way Contract. As part of its Provider Services function, the Bidder has an ongoing program of provider education concerning ICI demonstration benefits and the needs of the Enrollee population. The provider education program includes a quarterly provider newsletter.

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

### 3.2.12 Medical Management and Quality Assurance

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

As a model conducted under the authority of Section 1115A of the Social Security Act, the ICI Demonstration and independent evaluation will include and assess quality measures designed to ensure Enrollees are receiving quality care. In addition, CMS and the State shall conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as the Medicare Advantage, Part D, the State's Comprehensive Section 1115(a) Demonstration Waiver , and the State's Medicaid managed care programs' requirements. The reporting frequency and monitoring process will be specified in the Three-way Contract.

CMS and the State shall coordinate the MMP external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).

CMS and the State shall determine applicable quality standards and monitor the MMPs' compliance with those standards.

MMPs will be required to produce data to evaluate performance to quality metrics including CMS Core Measures and State-specified measures for Years 1, 2 and 3 of the Demonstration. Bidders agree to cooperate with EOHHS and CMS in working to improve quality of care priorities designated by CMS and the State and, to working with EOHHS to produce these measures according to State and CMS guidelines.

The requirements for medical management and quality assurance are outlined below and will be described in more detail in the three-way contract.

*Medical Director*

The Bidder designates a Medical Director responsible for the development, implementation, and review of the internal Quality Assurance Program (QAP). The Medical Director is licensed to practice medicine in the State of RI and should be board-certified, board-eligible, or board-trained in his or her field of specialty. The Medical Director is responsible for:

- The Bidders Utilization Review and Quality Assurance Committees
- Development of medical practice standards and protocols for Bidder
- Overseeing the investigation of all potential quality of care problems
- Oversight of Bidder's Care Management programs

- Development of Bidder's medical policies
- Referral process for specialty and out-of-plan services

The Medical Director is involved in: (1) recruiting and credentialing activities, (2) the process for prior authorizing and denying services, (3) the development and oversight of the Bidder's disease management programs, and (4) the process for ensuring the confidentiality of medical records/client information. The Medical Director serves as the MMP's liaison with its provider community.

*Utilization Review*

The Bidder maintains written policies and procedures to monitor utilization of services by its Enrollees 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, (3) provide for regular UR/QA reporting to the MMP's management and providers, including profiling of provider utilization patterns.

The policies and procedures include protocols for: denial of services, prior approval, hospital discharge planning, physician profiling, and retrospective review of claims. The Bidder is expected to, at minimum, meet the limits for minor assistive devices and home modifications as described in the procurement library. As part of its utilization review function, the Bidder has processes to identify utilization problems and undertake corrective action. The Bidder has a structured process for the approval or denial of covered services. This includes, in the instance of denials, formal written notification to the Enrollee and the requesting or treating provider that includes the basis for the denial, and any applicable appeal rights and procedures including EOHHS level appeal within fourteen (14) days of the request for authorization. The Bidder demonstrates to CMS and 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 Enrollee. The Bidder may engage in direct discussions and/or patient or patient family interviews, as necessary, in order to facilitate discharge planning, consider treatment options or alternatives, and the like for cost-effective, patient- centered medically necessary care. These direct discussions may be used to assess the medical and/or mental health status of a patient.

The Bidder accepts and honors the authorizations that were made prior to the contract commencement date until the authorization period has ended.

*Quality Assurance*

The Bidder has a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas including all subcontractors. Emphasis is placed on, but need not be limited to, clinical areas relating to management of chronic diseases, mental health and substance abuse care, Enrollees with special needs, and access to services for Enrollees.

The Bidder is required to undertake several Quality Improvement Projects (QIPs) during each contract year. EOHHS may specify the focus area for the QIP. The Bidder reports the status and results of each project to CMS and EOHHS, or its designees, as requested, at least within thirty (30) days following presentation to the Bidder's Quality Improvement Committee. The Bidder cooperates fully with CMS/EOHHS or its designees in any efforts to validate QIPs. Each QIP is completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

The Bidder supports joint quality improvement projects involving MMPs and CMS/EOHHS and provides Medicaid HEDIS® and CAHPS® results to CMS/EOHHS, or its designees, within thirty (30) days of receipt of final audited results from NCQA. The Bidder has defined protocols that require routine reporting on the quality of care (e.g., timeliness for conducting the Initial Health Screen) and access to services (e.g., access barrier analysis).

Bidders will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, Enrollee/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements plus any additional Medicaid measures identified by the State. All existing Medicare Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures.

A preliminary draft combined set of core metrics is described in Appendix D Core Metrics. More detail on the measures will be provided in the Three-way Contract. CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the model. A subset of these measures will also be used for calculating the quality withhold payment. The specifics regarding the quality withhold payment and the measures association with that, will be outlined in detail in the final MOU and three-way contract.

Bidders must submit data consistent with requirements established by CMS and/or the State as further described below and in the Three-way Contract. Bidders will also be subject to monitoring efforts consistent with the requirements of Medicare Advantage and Medicare Part D, included in the three-way contract.

*Confidentiality*

The Bidder has written policies and procedures for maintaining the confidentiality of data, including medical records/client information and sexually transmitted infections (STI) appointment records that conform to HIPAA requirements.

The Bidder agrees to make available to the State and/or its designees on a periodic basis, medical and other records for review of quality of care and access issues, and agrees to sign and adhere to a HIPAA Business Associate's Agreement with the State.

*Practice Guidelines*

The Bidder develops (or adopts) and disseminates 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 Enrollees, are developed in consultation with contracting providers, that are reviewed and updated periodically as appropriate. The Bidder disseminates the guidelines to all affected providers and, upon request, to Enrollees and potential Enrollees. Decisions for utilization management, Enrollee education, coverage of services, and other areas to which the practice guidelines apply must be consistent with the practice guidelines.

*Service Provision*

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

*Provider Credentialing*

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

The Bidder must have a uniform credentialing and re-credentialing process and ensure that the process complies consistently with State regulations and current NCQA "Standards and Guidelines for Accreditation of MMPs". For organizational providers including nursing facilities, hospitals, and Medicare certified home health agencies, the Bidder must adopt a uniform credentialing and re-credentialing process and that consistently complies with State regulations.

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

The Bidder has written policies and procedures which pertain to disclosures by providers. In accordance with 42 CFR Section 455.104, disclosures must be obtained from any provider or disclosing entity at any of the following times: when submitting a provider application, when executing a provider application, upon request during re-validation or re-credentialing process, within thirty-five (35) day of any change in ownership.

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

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

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

### 3.2.13 Operational Data Reporting

The Bidder provides EOHHS with uniform utilization, quality assurance, and Enrollee satisfaction/complaint data on a regular basis, described below, and additional data in a manner acceptable to the State. Record content must be consistent with the utilization control requirement of 42 CFR 456.111. The utilization review plan must provide that each Enrollee's record includes information needed for the Utilization Review Committee to perform required utilization review activities. The Bidder also agrees to cooperate with the EOHHS in carrying out data validation activities.

The Bidder agrees to provide, for each Enrollee, a person-level record describing the care received by that individual during the previous quarterly period. In addition, Bidder provides aggregate utilization data for all Enrollees at such intervals as required by EOHHS. The person-level record includes, at a minimum, those data elements listed in the *Encounter Data Business Design* including updates issued by EOHHS' designated Medicaid Management Information System ("MMIS") contractor. The Bidder submits data in an electronic or tape format that conforms to the State's specifications.

The Bidder submits person level records quarterly or more frequently as determined by EOHHS and no more than ninety (90) days past the end of the reporting quarter. The MMP submits aggregate data quarterly and no more than one hundred eighty (180) days past the end of the reporting quarter and assists EOHHS in its validation of utilization data by making available medical records and a sample of its claims data.

The Bidder also: (1) submits a quarterly grievance and appeals report due no later than thirty (30) days after the end of the reporting quarter, (2) submits internal quality assurance reports periodically, (3) collects Enrollee satisfaction data through an annual survey of its Enrollees, (4) submits a quarterly fraud and abuse report due no later than thirty days after the end of the reporting period, and (5) quarterly pharmacy claims information with respect to Drug Rebate

Equalization in a format that is compliant with CMS published guidelines and approved by EOHHS.

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

### 3.2.14 Grievance and Appeals

*Medicaid-Only Population*

The Bidder must meet CMS and State requirements governing the grievance and appeals. The Grievance and Appeals process is detailed below and will be fully detailed in the contract between CMS, EOHHS and the Bidder.

The State has established a Grievance and Appeals function through which Enrollees can seek redress against the Health Plan. The grievance system includes a grievance process, an appeals process, and access to the State's Fair Hearing system. EOHHS requires that Bidders resolve Enrollee and provider complaints through internal mechanisms whenever possible.

The Bidder's policies and procedures for processing grievances permits a provider, acting on behalf of a Enrollee and with the Enrollee's written consent, to file an appeal of an action within 30 days from the date on the Health Plan's Notice of Action. An Action means: (1) whether or not a service is a covered Service; (2) the denial or limited authorization of a requested service, including the type or level of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, or (6) the failure of the Health Plan to act within prescribed time frame as indicated in the contract. The information that is required to be in a Notice of Action is also included in the contract. The time frames for mailing a Notice of Action must comply with 42 CFR 438.404. The Bidder 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.

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

For appeals, the process must: (a) provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the Enrollee or the provider requests expedited resolution; (b) provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing; (c) provide the Enrollee and his or her representative opportunity, before and during the appeals process, to examine the case file, including medical records and other documents and records considered during the appeals process; under certain circumstances certain categories of

medical records and other documents may not be available to the Enrollee based on the type of record including but not limited to mental health records; and (d) include, as parties to the appeal, the ember and his or her representative, or the legal representative of a deceased Enrollee's estate. The Bidder provides written notice of the disposition of all appeals within thirty (30) days from the time the Bidder receives the appeal. For notice of an expedited appeal, the Bidder must also make reasonable efforts to provide oral notice. The information that is required to be in the written notice is indicated in the RHO Contract. The Bidder must continue to provide services during the appeals process if the Enrollee filed for an appeal within ten days of the Notice of Action.

*ICI Demonstration Population (MMEs only)*

Enrollees shall be entitled to file internal grievances directly with the Bidder. Each Bidder must track, report, and resolve its grievances or re-route improperly-filed grievance requests to the coverage decision or appeals processes, as appropriate. Bidders must have internal controls in place for properly identifying incoming requests as a grievance, an initial request for coverage, or an appeal to ensure that requests are processed timely through the appropriate procedures.

The Bidder must establish and maintain an expedited review process for appeals, when the MMP determines (or a request from a Enrollee) or the provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking time for a standard resolution could seriously jeopardize the Enrollee's life, health or ability to attain, maintain, or regain maximum function.

If the Bidder takes an action to deny, limit or delay services an Enrollee may request a State Fair Hearing after the Enrollee has exhausted the Bidder's Appeal Process. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the Enrollee by the Bidder.

Each Bidder must have mechanisms in place to track and report all Appeals. Other than Medicare Part D appeals, which shall continue to be adjudicated under processes, set forth at 42 CFR Part 423, Subpart M unchanged, the following is the baseline for a unified Medicare-Medicaid appeals process:

Appeal time frames

Enrollees, their authorized representatives, including providers who are authorized by the Enrollee, will have:

- Ninety (90) calendar days from the date of denial notice to file a MMP Appeal.
- Thirty (30) calendar days from the Bidder's notice of disposition (i.e. resolution) to request an State Fair Hearing for Medicaid-only services; and
- Thirty (30) calendar days from the notice of the right to a State Fair Hearing following the Independent Review Entity's (IRE) adverse disposition (i.e.,

resolution) to request a State Fair Hearing for Medicare-Medicaid overlapping services. The Enrollee will receive notice of his/her right to request a State Fair Hearing from his/her MMP.

Appeal levels

Initial appeals must be filed with the Bidder. The filing of an internal appeal and exhaustion of the Bidder's internal Appeals process is a prerequisite to filing an external appeal to Medicare or Medicaid.

Subsequent Appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE) if the plan upholds its initial denial.

For Medicaid-only benefits, if the resolution following the Bidder's Appeal process is not wholly in favor of the Enrollee, such Enrollee or his/her authorized representative may request a State Fair Hearing.

Services for which Medicare and Medicaid overlap (including Home Heath, Durable Medical Equipment and skilled therapies, but excluding Medicare Part D) will be defined in a unified way in the Three-Way Contract as required MMP benefits. If the resolution following the Bidder's Appeal process is not wholly in favor of the Enrollee, the Appeal related to these services will be forwarded to the IRE by the Bidder. If the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or his/her authorized representative may then request a State Fair Hearing and/or file a request for hearing with an Administrative Law Judge. Any determination in favor of the Enrollee will require payment by the Bidder for the service or item in question.

Appeal resolution time frames

All initial, MMP-level Appeals must be resolved and Enrollees notified by the MMP as expeditiously as the Enrollee's condition requires, but always within the following timeframes. This excludes Part D appeals, which will be resolved in accordance with existing rules.

1. Appeals related to a medical emergency: The Bidder must decide the Appeal within two (2) business days when a treating provider such as a physician who serves the Enrollee determines the care underlying the Appeal to be an emergency and all necessary information has been received by the MMP. This is considered an expedited Appeal.

2. Other medical care: There are two consecutive levels of non-emergency medical care Appeals. For the first level of Appeal, the Bidder must decide the appeal within fifteen (15) days of all necessary information being received by the Bidder. If the initial decision is against the Enrollee, then the Bidder must Bidder must decide on the Appeal within fifteen (15) days of all necessary information being received by the Bidder.

3. Non-medical care: If the Appeal involves a problem other than medical care, the Bidder must decide the Appeal within thirty (30) days and all necessary information has been received by the Bidder.

External Appeals filed or auto-forwarded to the Medicare external Appeal process shall be resolved under currently existing Medicare Appeal timelines.

For Medicaid-only services appealed to a State Fair Hearing, Standard Appeals will be resolved within ninety (90) calendar days of the filing of an Appeal with the State, not including the number of days the Enrollee took to file for a State Fair Hearing.

For Medicare-Medicaid overlap services, if the Enrollee requests a State Fair Hearing for his/her Medicaid benefits, standard Appeals will be resolved within ninety (90) calendar days of the date the Enrollee filed the hearing request, not including the number of days the Enrollee took to file for a State Fair Hearing.

Continuation of Benefits Pending an Appeal:

All Medicare Parts A and B, and non-Part D benefits will be required to be provided pending the resolution of the Bidder's Appeal process. This means that such benefits will continue to be provided by providers to Enrollees, and the Bidder must continue to pay providers for providing such services pending the resolution of the Bidder Appeal process. This right to aid pending an appeal currently exists in Medicaid, but is generally not currently available in Medicare. Existing Medicaid rules concerning benefits pending an appeal will not change.

For Medicaid-only service and Medicare-Medicaid overlap service appeals: If the request for an Appeal is filed with the Bidder within 10 calendar days of the Notice of Action or prior to the date of the action, services will be required to be provided pending the resolution of the Bidder Appeal process.

Following the Bidder Appeal process, if resolution at the MMP level is not wholly in favor of the Enrollee, the following occurs:

1. For Medicaid-only services, if the Enrollee files an appeal with the State Fair Hearing Agency within 10 calendar days of the Notice of Disposition from the Bidder or prior to the date of the action, services will be required to be provided and paid for pending the resolution of the State Fair Hearing Appeal process.

2. For appeals of Medicare-Medicaid overlap services, the Appeals will be forwarded to the IRE and services will be required to be provided and paid for pending the resolution. If the resolution of the IRE is not wholly in favor of the Enrollee, services will be required to be provided and paid for pending resolution of the State Fair Hearing Appeal process, if the Enrollee files an Appeal with the State Fair Hearing Agency within 10 calendar days of the IRE's decision notice.

Integrated Notice

Enrollees will be notified of all applicable Demonstration, Medicare Appeal, Medicaid Appeal, and State Fair Hearing rights, including whether an individual may receive benefits pending the appeal, through a single notice jointly developed by the State and CMS.

In the case of a decision where both the State Fair Hearing and the IRE issue a ruling, the Bidder hall be bound by the ruling that is most favorable to the Enrollee.

### 3.2.15 Payment To and From MMPs

The ICI Demonstration will evaluate the effect of an integrated care and payment model on both community-based and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management, which will be jointly accomplished by the State and CMS, will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this LOI and/or applicable Medicaid waiver or Section 1115(a) demonstration standards and conditions or State Plan Amendments, Bidders will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as ICI Demonstration-specific and evaluation requirements, as will be further specified in a Three-way Contract to be executed among each MMP, the State, and CMS.

As part of this Demonstration, CMS and the State will implement a new Medicare and Medicaid payment methodology designed to support MMPs in serving Medicare-Medicaid Beneficiaries enrolled in the Demonstration. This financing approach will minimize cost-shifting, align incentives between Medicare and Medicaid, and support the best possible health and functional outcomes for Enrollees.

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Beneficiaries, utilizing a simplified and unified set of rules. Flexibilities will be coupled with specific Enrollee safeguards and are included in this LOI, and the Three-way Contract. MMPs will have full accountability for managing the capitated payment to best meet the needs of Enrollees. CMS and the State expect MMPs to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight, MMPs will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost services if indicated by the Enrollees' wishes, needs, and Interdisciplinary Care Plan.

The Bidder must accept the Medicaid capitation rates as referenced in Appendix A Data Book of this LOI. The State and CMS will makes capitation payments to the Bidder on a monthly basis via electronic funds transfer. Capitation rates will be provided by CMS as soon as they become available or sometime after June 1, 2014.

CMS and the State shall require each MMP to provide a detailed description of its risk arrangements with providers under subcontract with the MMP. This description shall be made available to Enrollees upon request. It will not be permissible for any incentive arrangements to

include any payment or other inducement that serves to withhold, limit or reduce necessary medical and non-medical services to Enrollees.

The State believes that one of the advantages of a managed care system is that it permits Health Plans to conduct selective competitive procurement processes with providers. EOHHS is committed to achieving maximum value for the investment of state dollars. The use of community-based referred providers, selected through a competitive procurement system should improve the quality of care while reducing costs. The MCOs are expected to implement such competitive selective procurement practices.

The Bidder is also expected to enter into creative or performance based payment arrangements intended to foster and reward effective utilization management and quality of care. The Bidder is expected to conduct procurement practices and to establish provider reimbursement systems that enhance the quality and cost-effectiveness of care.

Specifically, the Bidder should demonstrate use of Alternative Payment Methodologies that will advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees. The Bidder must comply with the requirements of M.G.L. Chapter 224, Section 261 of the Acts of the 2012. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w-111, Sec. 1860D-11(i). Alternative Payment Methodologies or methods are defined as, methods of payment that are not solely based on fee-for-service reimbursements; provided that, "alternative payment methodologies" may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements; provided further, that "alternative payment methodologies" may include fee-for-service payments, which are settled or reconciled with a bundled or global payment. Care management, care planning and functional assessment functions that we are requiring can and should eventually be part of these alternative payment arrangements, such that these functions can be part of a global payment to an entity willing to take responsibility for the total care of these members.

Bidders are required to meet the requirement of the three-way 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) implementing reforms required by RI State Legislation (i.e. R.I. General Law Chapter 40-8, Section 40-8-13.4) for paying hospitals for in-patient services (to the extent possible for MMEs), (4) applying Federal and State limitations on physician incentive plans, (5) restricting payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (to the extent possible for MMEs), (6) third party liability, (7) reinsurance, (8) maintaining reserves and accounting for incurred but not reported (IBNR) claims, (9) reimbursement to nursing homes, (10) payment adjustments with respect to non-payment of provider preventable conditions, (11) incentive payments for the attainment of performance goals, and (12) the State conducting audits of the MMP.

Third Party Liability (TPL) is one of three components of EOHHS Program Integrity efforts (compliance and fraud/abuse are the other two that are subsequently discussed). Bidders are expected to 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 Enrollee initially is enrolled with a Health Plan and periodically thereafter, (2) identifying other potential TPL when adjudicating Enrollee 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.

With regard to nursing home payments, the State has implemented a new reimbursement methodology that takes into account the severity of need as well as the facilities costs. The Bidder may implement the current system or may propose their own system that reflects the State's quality indicators. The Procurement Library contains information of the State's current approach for reimbursing nursing homes.

### 3.2.16 Financial Standards, Record Retention, and Compliance

*MMP Financial Standards*

The RI Department of Business Regulation regulates the financial stability of all licensed MCOs in RI. The Bidder agrees to comply with all RI Department of Business Regulation standards.

The success of the RI Medicaid managed care program is contingent on the financial stability of participating Health 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 Health Plans. The areas in which financial benchmarks are established that 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 Reported But Unpaid Claim (RBUC) levels, including days claims outstanding

The Bidder agrees to provide the information necessary for calculating benchmark levels and to continually meet the State's financial reporting requirement to monitor the financial conditions of the Bidder once operational. The Bidder agrees to comply with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

*Record Retention*

The Bidder retains 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 also preserves and maintains all medical 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 (7) years after the disposition of litigation.

*Compliance*

The compliance requirements will be discussed in detail in the three-way contract. In accordance with 42 CFR 438.608, the Bidder 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 the subsequent three-way Contract are submitted to CMS/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 components of the State's Program Integrity efforts (identification and recovery of TPL and detection and control of fraud and abuse are the other two components). Specific requirements related to identify and to control fraud and abuse are discussed in Section 3.4 of this document.

The Bidder: (1) is prohibited to have affiliations with individuals debarred by Federal agencies, (2) must disclose of the ownership and controlling interest within thirty-five (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 thirty-five (35) days upon request, (5) providers must disclose any individual who has more than five (5) percent interest in the provider who was convicted of a crime, (6) discloses to the State any individual who that more than five (5) percent ownership who has been convicted of a crime. These requirements are more fully discussed in the RHO Contract.

### 3.3 RHO and Three-Way Contract Terms and Conditions

The Bidder must meet the Terms and Conditions in a three-way contract to be negotiated between CMS, EOHHS and the successful bidder. Sample model contracts and MOUs from other states which indicate the types of requirements which Bidders may anticipate in RI can be accessed in the procurement library at http://www.eohhs.ri.gov/IntegratedCare.aspx.

For Medicaid only LTSS members, the Bidder must meet the terms and conditions of the Rhody Health Options contract. This contract is available by reference in the procurement library.

EOHHS in no way represents that the contract requirements listed in any other model contract referenced herein will or will not be included in the ICI Demonstration Three-way Contract. References to other model contracts for FAD initiatives are referenced solely for the purpose of assisting Bidders in understanding the structure and types of requirements that other states have set forth for similar, but not identical, initiatives.

When issued, the Three-way Contract will cover: (1) the general provisions of the contract, (2) interpretations and disputes including compliance with Federal and State requirements, (3) contract amendments, (4) payments, (5) guarantees, warranties and certifications including "hold harmless" and insurance requirements as well as requirements related to patents and copy write infringement, non-assignment of the contract, clinical laboratory improvement amendments, (6) personnel and staffing requirements, (7) performance standards and damages including

requirements related to fraud and abuse, (8) inspection of the work performed and access to information, (9) confidentiality of information, (10) termination of the contract, and (11) other required terms and conditions.

The Bidder will further be required to meet terms 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.

EOHHS wishes to inform Bidders that MMPs will be required to adopt a strategic and robust approach to the prevention, detection, investigation and reporting of potential Medicaid or Medicare fraud, waste and abuse to assure that Medicaid and Medicare funds are appropriately expended. Specifically, the MMP will be required to:

- 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 Enrollees 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 MMP's toll-free fraud, waste, and abuse reporting hotline, as well as calls or written correspondence directed to the MMP'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 Contractor's subcontractors (such as pharmacy

benefits manager, vision care, durable medical equipment, and behavioral health subcontractor).

- Demonstrate interfaces between the Bidder's medical 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 Enrollees.

- Uses 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.

### 3.4 Federal Requirements

CMS shall determine whether all such requirements have been met. Medicare past performance is a criterion to accept passive enrollment. Among the mechanisms CMS will use to assess an organization's Medicare performance are the sanctions, the Past Performance Review methodology, and the Medicare Plan Finder "consistently low performing" icon (LPI). Not only will CMS not allow plans to accept passive enrollments based on Medicare past performance/LPI but RI will also use plans' past performance/LPI status as criteria in the selection process.

In addition, every selected MMP must also pass a comprehensive joint CMS/State readiness review. Please see links that contain CMS guidance included in the Procurement Library referenced in Section 2.

Applicants interested in participating in the RI ICI Demonstration must have submitted a Notice of Intent to Participate as a Demonstration Plan to CMS by November 14, 2013. CMS created a Capitated Financial Alignment Demonstration Notice of Intent to Apply (NOIA) Web tool. Completion of this tool is required in order for interested Applicants to obtain the necessary system access to meet the key deadlines articulated in the Medicare timetable. Any organization that is interested in the ICI Demonstration must participate in this non-binding process and begin to prepare for the submission, either by itself or in partnership with a Pharmacy Benefit Manager (PBM) of critical Part D requirements, including a formulary, Medication Therapy Management Program (MTMP), a pharmacy network, and a Part D package. If an interested Applicant did not submit a NOIA to CMS by November 14, 2013, it will not be eligible to offer demonstration plans in 2015. CMS' NOIA process is separate from the process used for non-demonstration MA and Prescription Drug Plan (PDP) contracts. Applicants that are currently offering non- demonstration MA or PDP products still need to submit a Capitated Financial Alignment Demonstration NOIA. The NOIA process can be reviewed in CMS' October 31, 2013 memorandum to Current and Future Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Medicare-Medicaid Plan Sponsors from Cynthia Tudor and in CMS' January 13, 2014 memorandum to Organizations interested in Participating as Medicare-Medicaid Plans in States Seeking to

Implement Capitated Financial Alignment Demonstrations in 2015 (see Procurement Library). CMS will accept only NOIAs submitted electronically through its online Web tool.

In order to participate as a MMP, Bidders must have also completed the following application components with CMS:

- Applications to CMS via the Health Plan Management System (HPMS) by February 25, 2014, the same application timeline as Medicare Advantage and Part D.

- Model of Care specific to the demonstration, as well as preliminary network information, and information on solvency/licensure, fiscal soundness, and administrative and management arrangements.

- Medication Therapy Management Program information by June 2, 2014 submission deadline; Part D formularies by June 2, 2014; plan benefit packages by June 2, 2014; and Additional Demonstration Drug (ADD) files and Part D supplemental formulary files by June 6, 2014.

Additional CMS Application requirements include, but are not limited to:

- solvency/licensure;

- fiscal soundness;

- administrative and management arrangements;

- network adequacy for Medicare medical services and prescription drugs;

- evidence-based Model of Care (MOC);

- submission of an integrated plan benefit package; and,

- provision and coordination/integration of benefits.

Bidders must review CMS guidance for all Medicare requirements to participate as a capitated MMP in the FAD.

## SECTION 4: TECHNICAL PROPOSAL

This chapter describes the instructions for Bidders to follow in preparing and submitting bids. Failure to comply with these instructions in full may result in a Bidder's disqualification. The State also reserves the right to reject any and all proposals received or to cancel this LOI according to the best interests of the State. The response to this LOI requires only a technical proposal. The required format for preparing the Technical Proposal is described below.

### 4.1 Response Limits

The State does not want Bidders to develop excessively elaborate responses to this LOI. The Technical Proposal shall be limited to **125 single-spaced pages (using a font not smaller than**

**12 points)**; excluding the following components: the transmittal letter, the additional technical responses from new Bidders and pertinent attachments the Bidder would like to share with the State or any specific attachments asked for by the State.

### 4.2 Technical Proposal Specifications

The following sections provide information on the specifications for the Technical Proposal, including suggested page allocations.

#### 4.2.1 Transmittal Letter

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 one hundred and twenty (120) days from the date of submission

c) Identification of any proposed sub-contractor arrangements in the proposal

d) Identification of the person who will serve as primary contact for the Bidder, including the individual's address, telephone number, fax number and email address

e) Any other information that the Bidder may want to convey to the State

#### 4.2.2 Assurances/Attestations

All Bidders at minimum shall include the following statements and assurances in their proposals.

- **A statement** that the Bidder is a corporation or other legal entity and is properly licensed to operate as a health maintenance organization or as a MCO within RI; and is NCQA accredited in RI or NCQA accredited in another State and will be accredited within twelve (12) months of the effective start date of a contract pursuant to this LOI.

- **A statement** that the Bidder has submitted a Notice of Intent to Apply (NOIA) for participation in the capitated financial alignment model for MMEs; has submitted an application via the MCO Management System (HPMS) to participate in the financial alignment demonstration; will submit the additional required materials via HPMS (MTMP, Part D formulary, plan benefit package, Additional Demonstration Drug and Part D supplemental formulary files) by their respective deadlines; and understands and will meet all Medicare requirements for the financial alignment model, including Part 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.

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

- **A statement** that the Bidder accepts the State's Medicaid Capitation Rates that will be paid to the successful Bidders.

- **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.

Bidders shall submit copies of their: State Licenses; NCQA Accreditation Certificates; and, CMS approval for being a MAP or SNP or proof that the Bidder has applied to CMS for such approval with their proposal.

### 4.2.3 Experience and Understanding

The Bidder should include the following information in this section:

- 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. This description should include the structure of the organization, including an organizational chart, and financial relationships with any parent organization that is associated with the Bidder.

- Recent NCQA ranking (e.g. Excellent, Commendable, Accredited, Provisional, or Denied) in RI or in other States if not operating in RI as well as NCQA HEDIS® 2009 Score results in RI or in other States if not operating in RI.

- Experience in providing Medicaid services as a MCO in RI under a risk-based contract and the populations served.

- Experience in serving as a commercial MCO in RI under a risk-based contract.

- Experience in serving Medicare Beneficiaries.

- Experience in serving Medicaid Beneficiaries.

- Experience in serving the MME population.

- An understanding of the RI environment; the conditions surrounding this procurement and; knowledge of and experience with the Medicaid population in other states.

- The capability and capacity of the Bidder to provide the Medicaid services to the eligible populations under a risk sharing arrangement.

- The financial viability of the Bidder (as well as adverse factors that may affect the Bidder's financial viability including but not limited to bankruptcy proceedings, major lawsuits, fines).

- Evidence of a reinsurance policy to cover the Medicaid population that describes the type, coverage, limits and insurer for the re-insurance.

- The ability to be ready to serve Enrollees by the stated contract commencement date.

- The composition of the Consumer Advisory Committee.

- The status of the Bidder's financial alignment demonstration application and the status of any other materials required to be submitted via HPMS for participation in the capitated financial alignment model, including materials submitted and forthcoming.

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

### 4.2.4 Technical Response

The following describes the Technical Responses required from the Bidder. The Bidder should consider the content of this LOI, the current RHO contract (included in the Procurement Library) and other information, as appropriate, in providing a complete Technical Response to this LOI.

**A) Plan for Enrollment**

The Bidder should discuss its plan for enrolling the MME populations. As part of its response, the Bidder should highlight its capability and its policies, procedures and practices to:

(1) accept the State supplied monthly list of Enrollees,

(2) enroll Enrollees within seven (7) days after receiving notification from the State,

(3) mail notification of enrollment to Enrollees including effective date and how to access care within ten days after receiving notification from the State,

(4) provide orientation materials to new Enrollees about their benefits, the role of the PCP, what to do in an emergency or urgent medical situation, 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) make at least four (4) attempts, on different days, to make a welcome call to all new community-based Enrollees within thirty (30) days of enrollment to provide the same information,

(6) provide Enrollees with a permanent identification card within ten (10) days after receiving notification from the State,

(7) make at least four attempts, not counting two on the same day**,** to contact the Enrollee within ten days of notification of enrollment to provide information on options for selecting a PCP,

(8) mail a Enrollee Handbook to all Enrollees within ten days of being notified of their enrollment,

(9) publish a revised Enrollee Handbook within six months of the effective contract date, and to update the Enrollee Handbook thereafter when there are new topics, (10) develop marketing materials with EOHHS approval,

(11) discuss the contents of materials and documents noted above,

(12) supply information to Enrollees that are presented in a culturally and disability competent manner, and

(13) meet required enrollment timeframes for enrollments, disenrollments and opt-outs to and from the MMP,

(14) describe other topics deemed appropriate by the Bidder.

**B) Plan for Providing Covered Services and Meeting Accessibility Standards**

The Bidder should discuss its plan for providing the covered services and meeting accessibility standards contained in the LOI. Specifically, the Bidder should describe:

(1) the full range of primary care, acute care, specialty care, behavioral health care, and LTSS (institutional care and HCBS, including a detailed description of the tools or methodology used to determine LTSS service authorization levels,

(2) the service accessibility standards that governs the provision of services including 24 hour 7 day per week coverage, in particular 24/7 coverage for LTSS needs,

(3) additional standards that the Bidder employs above RHO Contract requirements,

(4) how the Bidder coordinates services for individuals with Developmental Disabilities and individuals with SPMI that will continue to be funded and managed by the BHDDH providers,

(5) special programs and services that is provided by the Bidder to MMEs to meet their special needs (e.g. Disease Management Program, Self-Help Medical Management, Pain Management programs, or other services provided by the MMP),

(6) a plan for honoring all existing service authorizations for the designated transition period,

(7) intervention strategies to identify and rectify unnecessary use of the ER, preventable hospital admissions or avoidable institutionalizations,

(8) previously demonstrated capability to provide services to individuals with SPMI and individuals with developmental disabilities at a later point in time, and

(9) other topics deemed appropriate by the Bidder.

**C) Plan for Maintaining a Robust Provider Network**

The Bidder should discuss its plan to develop and maintain a robust and comprehensive network of providers to meet the diverse and complex needs of the MMEs. Specifically, the Plan should describe:

(1) how the Bidder will provide Enrollees with the full range of integrated covered services primary care, acute care, specialty care, behavioral health care and long-term care services and supports for the anticipated Enrollees in the service area,

(2) maintain providers in sufficient number, mix and geographic area,

(3) make available all services in a timely manner,

(4) the specific LTSS network (i.e. institutional and HCBS providers) including a geographic access analysis of the LTSS network to determine the accessibility of services,

(5) the specific role of PCPs,

(6) the employment of NCQA recognized PCMH sites in its network to serve as PCPs,
(7) how the Bidder will monitor providers to ensure that they meet Federal and State requirements,

(8) what steps the Bidder takes to assure the requisites of a person-centered system of care are met by providers,

(9) effective measures that is put in place by the Bidder to improve provider capability to improve the cost- effectiveness of care,

(10) the development of a home-based primary care provider network,

(11) efforts to meet State affordability standards,

(12) the Bidders' approach to maintain the existing network of providers for transitioning to managed care, as well as maintaining the EOHHS contracts with essential community providers for one (1) year,

(13) for home care agencies, the Bidder should distinguish which agencies are Medicare certified, and which agencies are overseen by Medicare-certified agencies, and

(14) other topics that the Bidder deems appropriate.

The Bidder should demonstrate familiarity with the PCMH model and the application of the PCMH model to the MME population. Responses should specify:

(1) what payment methodologies Bidder proposes to support and encourage medical home development and sustainability,

(2) how the Bidder will encourage non-PCMH practices to become recognized medical homes,

(3) the Bidder's expectations and proposed milestones for PCMH implementation for the MME population served, e.g. how many new medical homes will be supported per year, (4) what, if any, special expectations the Bidder will have for medical homes serving the MME population,

(5) how the Bidder will contract with hospitals and specialists to ensure collaboration with medical homes,

(6) how the Bidder will implement and support care management services that are integrated with medical homes,

(7) what methods the Bidder will use to attribute the dual MME population to a medical home, and

(8) how the Bidder will measure medical home implementation for MMEs. If the Bidder proposes using a provider contracting standard different from that developed for CSI RI, they should explain how and why the Bidder's contracts with PCMH's will differ. CSI contracting standards are available in the Procurement Library at http://www.ohhs.ri.gov.

The Bidder should include as an attachment to its proposal a complete listing of its' provider network including names, addresses, telephone numbers, provider specialties and foreign language(s) spoken (if any). The Plan will include a GeoAccess analysis that demonstrates that the network is sufficiently robust and assures timely access to services for Medicaid Enrollees and MMEs, and is currently accepting new Enrollees. Its network must include a plan for meeting the multi-lingual/multi- cultural/geographic and other special needs of the RHO populations.

**D) Plan for Operating a Person-Centered System**

The Bidder should discuss its plan to develop and maintain a person-centered system of care for MMEs. As part of its discussion, the Bidder should describe: (1) the MMPs person-centered systematic approach to care delivery and the processes used to ensure that care is person-centered as they relate to the formation of the ICT, ICP development and ICT meetings and cultural, linguistic and ethnic preferences as they affect health care delivery,

(2) how it may vary among Rhody Health Options, and the MME sub-populations (e.g. the disabled vs. elders; those receiving LTSS and those not receiving LTSS; and by care setting i.e. those in institutional vs. those in home or community care) if at all,

(3) how a self-directed services model will be incorporated into the delivery process,

(4) a plan for including EOHHS' essential community providers as well as *RTH* supports and contracting with specialty providers,

(5) the role of the Advisory Committee, and

(6) other topics deemed appropriate by the Bidder.

**E) Plan for Conducting Risk Profiling**

The Bidder should discuss its plan to conduct risk profiling to identify those in need of care management and to serve as an early warning system to identify those "at risk" of requiring care management, and to identify those who may benefit from care management. Specifically the Bidder should describe:

(1) its overall approach to conducting risk profiling,

(2) its algorithms and analytic approach to initially identify Enrollees in need of Care Management through an analysis of claims data,

(3) the use of predictive models to identify the population requiring, or at risk of requiring, ICM services,

(4) the use of predictive modeling data to support Enrollees who do not require ICM services,

(5) how the Bidder will determine who is "at risk" or will benefit from ICM and Care Management services,

(5) the algorithms, models, classifications and definitions that will be used to stratify populations in terms of their need for ICM services,

(6) the identification of risk behaviors or risk conditions of Enrollees throughout the intervention process signifies the need for care management,

(7) the anticipated benefits of predictive modeling and risk profiling,

(8) the time schedule for operating a comprehensive risk-profiling and early identification system,

(9) additional strategies, beyond risk profiling, to identify Enrollees in need of Care Management services and

(10) the process for synthesizing predictive modeling data with all other information regarding the Enrollee's strength-based needs and preferences;

(11) how predictive modeling data and outputs will be shared with MMP staff and with providers, as appropriate, and,

(12)other topics deemed appropriate by the Bidder.

**F) Plan for Providing Care Management**

The Bidder should discuss its plan for providing Intensive Care Management for individuals who are eligible for LTSS and for individuals who are not eligible for LTSS and are deemed at high-risk and therefore qualify for ICM services. The Bidder should further describe its plan for providing Care Coordination to individuals who are not eligible for LTSS and are not deemed at high-risk.

As part of its discussion the Bidder will describe its policies, processes, decision-making criteria, instruments and protocols, and expected outcomes for each component of the ICM process described within this LOI, including but not limited to:

(1) IHS,

(2) CFNA,

(3) LCM and Care Coordinator roles,

(4) ICP development, including Enrollee goals and timelines to meet such goals, interventions and assignment of tasks within the ICP and monitoring of completion of such tasks and other requirements described in this LOI as well as a detailed description of how service levels are authorized and the specific tool used to determine service authorization levels,

(5) ICT functions and processes including, but not limited to, criteria for when the MMP will call an in-person meeting of the ICT,

(6) How the clinical care team is incorporated into the ICT, including which care management functions will be performed by the provider.

(6) the levels of care management or specific care management services that will be given to Enrollees will different care management needs including but not limited to the conditions

and frequency of face-to-face and telephonic contact with Enrollees based on their acuity level and needs,

(7) proposed ratios of LCMs and Care Coordinators to Enrollees for different Enrollee strata and levels of Care Management (e.g. ICM and Care Coordination),

(8) a strategy to implement, coordinate and monitor the ICP,

(9) the process for transition planning and transition management when Enrollee transitions between levels of care including but not limited to the emergency room, hospital, and community-based care and home,

(10) analysis of ICM and Care Coordination approaches with regard to the effectiveness, appropriateness, and outcomes of services including reporting care management information to EOHHS,

(11) plan for reporting ICM and Care Coordination activities and results to CMS and EOHHS based on prescribed guidelines,

(12)specialized care management and the employment of transition coordinators, peer navigators/peer mentors or ombudsman,

(13) strategies to coordinate ICM and Care Coordination activities with other areas within the MMP (e.g. Enrollee Services, Appeals and Grievances among others)

(13) other topics deemed appropriate by the Bidder.

**G) Plan for Serving Nursing Home Transition MMEs including RTH**

The Bidder should discuss its plan for serving Enrollees who are able to and wish to transition from a nursing home to a community-based setting while maintaining compliance with Nursing Home Transition and RTH requirements. The Bidder should describe its plan for meeting EOHHS requirements related to:

(1) the overall plan to proactively assess Enrollees who may return to the community when feasible and desired and

(2) the process for outlining which Enrollees meet RTH qualifications

(3) the processing of MDS Section Q referrals received from EOHHS,

(4) the process for providing comprehensive LTC Options Counseling,

(5) the process for supporting eligibility determination for MFP,

(6) the process for linking Enrollees to affordable housing,

(7) the overall model and process that will be used to transition Enrollees between the nursing home and the community including, but not limited to, conducting a CFNA and creating an ICP that will optimally support the Enrollee in the community; Transition Coordination and Ongoing Care Management,

(8) the identification and reporting of critical incidences to EOHHS and providing support to Enrollees regarding Enrollees who transition back to the community and, those who have a critical incident, complaint or grievance regarding services provided by the MMP,

(9) the process for developing Emergency Back-Up Plans and for providing support to Enrollees, when needed,

(10) reporting required information to EOHHS,

(11) the protocols, assessment tools and documentation tools that are used throughout the *RTH* process, and

(12) other factors or processes the Bidder believes is vital in meeting *RTH* requirements.

**H) Plan for Providing Enrollee and Provider Services**

The Bidder should discuss its plan for providing Enrollee and provider services as described in Sections 2.10 and 2.11 of the RHO Contract, respectively. The Bidder describes its efforts:

(1) to provide multi-lingual, culturally competent and disability-centric Enrollee services beyond providing services in multiple languages and truly recognizing the person-centered needs of Enrollees that result from racial and ethnic differences, and

(2) plans for using data to continuously improve care including, but not limited to, efforts to identify and address racial and ethnic disparities in care delivery, and,

(3) to enhance provider services that promote the integration and coordination of care.

**I) Plan for Conducting Medical Management and Quality Assurance Efforts**

The Bidder should discuss its plan for conducting medical management activities and to ensuring quality of care as described in Section 2.12 of the RHO Contract. The Bidder describes its plans with regard to:

(1) the Medical Director's background and experience as well as his/her role and responsibilities,

(2) utilization review protocols and criteria used that affect the approval or denial of care, (3) strategies, programs and practices to assure quality of care including, but not limited to, the use of data to inform opportunities for improvement at the Plan, departmental and provider levels

(3) ability to meet Federal and State grievance and appeals requirements described in this LOI for MMEs and the Medicaid-only population.

(4) an approach to understanding and addressing racial and ethnic disparities in care delivery

(5) a process to continuously improve ICM and Care Coordination services under plan leadership and committees

(6) the employment of practice guidelines, and

(7) provider credentialing activities.

**J) Plan for Reimbursing Providers**

The Bidder should discuss its plan for reimbursing providers. Specifically, the Bidder will describe:

(1) the employment of competitive selective procurement practices to improve the quality and reduce the cost of care and specify which services or care it will be used for,

(2) the use of creative or performance based reimbursement arrangements intended to foster and reward effective utilization management and quality assurance,

(3) payments to providers including but not limited to pharmacies, behavioral health specialists, HCBS providers, care management and support service agencies,

(4) how the Bidder intends to reimburse hospitals and meet the requirements of the RHO Contract,

(5) how the Bidder will reimburse nursing homes and whether it will use the State methodology or the MMP's own approach,

(6) the Bidders approach to reimbursing HCBS agencies and how that approach differs from the State's current methodology

(7) the Bidder's approach to using alternative payment arrangements that advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees.

**K) Plan for Compliance, Reporting and Program Integrity**

The bidder should discuss several operational areas in the response. Specifically, the bidder will describe:

(1) The Bidder's plan to meet the operational reporting requirements as described in Section 2.13 of the RHO Model Contract (located in the procurement library) including submission of the encounter data, and operational reports as described in the RHO Model Contract.

(2) The Bidder's plan to implement all relevant Medicaid the program integrity requirements. The Plan will include the policies and practices that cover the Bidder's proposed plan to meet the requirements related to: (1) Medicaid fraud, waste and abuse, (2) corporate compliance, and (3) TPL identification and recovery.

(3) The Bidder's plan for meeting the RHO Contract requirements related to: (1) financial standards as described in Section 2.16, (2) record retention as described in Section 2.17, and (3) compliance as described in Section 2.18 of the model contract found in the procurement library.

## SECTION 5: COST PROPOSAL

Bidders are not required to submit a cost proposal. Bidders must agree to accept the capitation rates as contained in Appendix A Data Book of this LOI. The development of these capitation rates conform with federal regulations, and have been certified by an actuary.

## SECTION 6: EVALUATION AND SELECTION

Proposals will be reviewed by a Technical Review Committee comprised of staff from state agencies. The Technical Proposal must receive a minimum of 70 points out of a maximum of 100 technical points. The proposal will be dropped from further consideration.

EOHHS reserves the exclusive right to select the individual(s) or firm (vendor) that it deems to be in its best interest to accomplish the project as specified herein; and conversely, reserves the right not to fund any proposal(s).

Proposals will be reviewed and scored based upon the following criteria:

| **Criteria** | **Possible Points** |
|---|---|
| Experience and Understanding | 20 points |
| Plan for Enrollment | 5 points |
| Plan for Providing Covered Services and Meeting Accessibility Standards | 8 points |
| Plan for Maintaining a Robust Provider network including the Development of Patient Centered Medical Homes | 8 points |
| Plan for Operating a Person-Centered System | 10 points |
| Plan for Conducting Risk Profiling | 8 points |

| | |
|---|---|
| Plan for Providing Care Management | 10 points |
| Plan for Serving Nursing Home Transition Members, including *RTH* | 10 points |
| Plan for Providing Member and Provider Services | 4 points |
| Plan for Conducting Medical Management and Quality Assurance Efforts | 5 points |
| Plan for Reimbursing Providers | 10 points |
| Plan for Compliance, Reporting, and Program Integrity | 2 points |
| **Total Possible Points** | **100 Points** |

Points will be assigned based on the offeror's clear demonstration of his/her abilities to complete the work, apply appropriate methods to complete the work, create innovative solutions and quality of past performance in similar projects.

Applicants may be required to submit additional written information or be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

**Contract Award and Readiness Review**

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

The State reserves the right to disqualify or not consider any proposal that is determined not to achieve the State's goals or to be in the best interest of the State. Proposals found to be technically or substantively non-responsive at any point in the evaluation process will be rejected and not receive further consideration.

The State also reserves the right to send clarifying questions and to receive clarifying responses from parties submitting LOIs, request interviews and presentations, request additional financial information, contact references, and/or use other appropriate means to evaluate a proposal and the submitting Bidder's qualifications. The State also reserves the right to specify special terms and conditions for individual Bidders as part of making awards. The award will not be considered official until the Bidder complies with these terms and conditions in full.

Bidders who score favorably on the technical evaluation of the written proposal will receive notice that the Bidder was selected as a finalist ("Finalist Notification"). The Finalist Notification will list specific conditions that must be met prior to actual contract award – this period is called the "readiness review." Upon receipt of the Finalist Notification, the readiness review will commence. The readiness review period will take approximately six (6) months in

length and will be conducted jointly by EOHHS and the Centers for Medicare and Medicaid Services (CMS). Contract award is contingent on completing all readiness review requirements successfully. Bidders are advised that participation in or completion of the readiness review period in no way assures them a contract award.

All activities conducted by Bidders during the readiness review period are conducted "at your own risk." Bidders, whether they eventually enter into a contract or not, will not be reimbursed by EOHHS or CMS for work conducted during the readiness review period. All documents produced during the readiness review period that are subject to an exemption provided in R.I. Gen. Laws § 38-2-2 will be considered "confidential working papers" and will not be released publicly outside of EOHHS or CMS.

The readiness review tool to be used and relevant requirements will be released with Finalist Notification. The readiness review will address the following functional areas of MMP operations related to the delivery of Medicare and Medicaid services including, but not limited to:

- Assessment processes
- Care coordination
- Confidentiality
- Enrollee protections
- Enrollee and provider communications
- Monitoring of first-tier, downstream, and related entities
- Organizational structure and staffing
- Performance and quality improvement
- Provider credentialing
- Systems (claims payment, etc.)
- Utilization management

The readiness review will include a desk review, site visit, and separate network validation review. It may include other components as well.

Upon completion of the readiness review, a detailed final evaluation memo will be issued by EOHHS to the Division of Purchasing, indicating which of the successful bidders have met all the conditions for contracting. The Division of Purchases will issue a tentative selection letter outlining the required certification submissions (EEOC, MBE Plan, Insurance, etc.).

Additionally, a three-way contract between the vendor, EOHHS and CMS will be fully executed and will become effective upon issuance of a Purchase Order by the Division of Purchases.

## SECTION 7: PROPOSAL SUBMISSION

Questions concerning this solicitation may be e-mailed to the Division of Purchases at David.Francis@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. Please reference **LOI 7548793** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

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

Responses **(an original plus seven (7) copies)** should be mailed or hand-delivered in a sealed envelope marked "**LOI 7548793 Financial Alignment Demonstration Medicaid Integrated Care Initiative**" to:

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

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

### RESPONSE CONTENTS

Responses shall include the following:

1. One completed and signed four-page R.I.V.I.P generated bidder certification cover sheet (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.

2. One completed and signed W-9 (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.

3. **A separate Technical Proposal** describing the qualifications and background of the applicant and experience with and for similar projects, and all information described

earlier in this solicitation. The Technical Proposal is limited to one hundred and twenty-five (125) pages (this excludes any appendices). As appropriate, resumes of key staff that will provide services covered by this request.

4. In addition to the seven hard copies of proposals required, Respondents are requested to provide their proposal in **electronic format** (**CD-Rom, disc, or flash drive**). Microsoft Word / Excel OR PDF format is preferable. Two (2) electronic copies are requested and should be placed in the proposal marked "original" and "copy".

**CONCLUDING STATEMENTS**

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

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

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

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